2025
Benefits Guide

SUPPORTIVE LIFESTYLES, INC.

An overview of the benefits provided by Supportive Lifestyles

These benefits are effective on January 1, 2025.

Prepared by Christensen Group, Inc for Supportive Lifestyles

2025 Benefits Guide

Important Contacts

Questions?

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

Beth Pederson

320-220-2445

beth@supportivemn.com

Jane Fischer

320-905-0353

jane@supportivemn.com

Jill Kruger

320-905-7796

jill@supportivemn.com

Coverage	Carrier	Group #	Phone	Website
Medical Insurance	Gravie	Individual Plans	(800) 501-2920	www.gravie.com
Health Savings Account (HSA)	Health Equity	N/A	(866) 346-5800	www.healthequity.com
401(k)	Empower	509330	(800) 338-4015	www.empowermyretirement.com

GRAVIE ICHRA™

Introducing Gravie ICHRA

We've partnered with your employer to provide an exciting new benefit — the **Individual Coverage Health Reimbursement Arrangement** (ICHRA). With Gravie ICHRA, you can easily access pre-tax funds toward the cost of an individual health plan.

How it works

Your employer will announce an annual enrollment window for the ICHRA benefit. **To use Gravie ICHRA, you must enroll in your Health Reimbursement Arrangement during those dates.** Additionally, you must complete all enrollment steps for your health plan.

If you become eligible for ICHRA mid-year, you'll receive a notice. Generally, you have 30 days prior to and 30 days after becoming eligible to enroll in your HRA, and we recommend taking action as soon as possible.

Getting started

1. Visit member.gravie.com to create an account or log in.
2. Enroll in your Health Reimbursement Arrangement (HRA).
3. View and compare plans to find the coverage that's best for you. You'll have access to all qualified health plans in your area.
4. Complete the checkout process and all enrollment steps with the insurance carrier.

GRAVIE care

Gravie Care advisors help you evaluate plan options, verify network coverage, locate providers, decipher EOBs and bills, and so much more.

You are just a phone call or secure message away from someone who's willing to go the extra mile to help make the most of your health plan year-round.

Questions?

Call:
800.501.2920

Secure message:
member.gravie.com/contact

Gravie ICHRA

Frequently asked questions

What is ICHRA?

The Individual Coverage Health Reimbursement Arrangement is a group benefit plan provided by your employer to contribute funds that can be applied toward eligible medical expenses on a pre-tax basis. Eligible ICHRA expenses with Gravie are:

- Premiums for qualified health plans purchased through the individual market
- Premiums for Medicare Part A, B, or C

How do I access ICHRA funds?

Enroll in your HRA from your Gravie Account during the window communicated by your employer — it's the first step before you can apply for health plans. If you're using ICHRA funds toward Medicare premiums, you'll need to submit a paper enrollment form that Gravie Care can provide you with.

How much money is available to me?

When you enroll in your HRA online, you'll see your monthly pre-tax contribution. When viewing plan options, premiums will be offset by that amount. If you enroll in a health plan directly with the insurance company, any premium remainder owed by you can be paid with pre-tax salary deductions.

How does my premium get paid?

Regardless of which individual health plan an employee chooses, Gravie coordinates the medical premium payment from the employer to the carrier using individual assigned accounts created for each member. These accounts are owned and operated by Gravie, don't require an application by the member, have built-in security measures to prevent misuse of funds, and are FDIC insured. This payment system allows Gravie to closely monitor payments to carriers in order to help eliminate payment issues with the individual plans. Medicare members and their families will be sent their ICHRA funds to their personal bank account.

I'm covered by a spouse or parent's group plan. Can I use ICHRA funds toward those premiums?

No, you cannot use ICHRA funds toward the cost of a spouse or parent's group plan. ICHRA can only be paired with individual health plans — i.e., the health plans available for consumers to purchase directly in their area of residence.

Do ICHRA funds continue automatically?

When you enroll in your HRA, you'll fill out a request for recurring reimbursements so that ICHRA funds can continue on an ongoing basis. If Gravie is facilitating your payments to the carrier, we'll complete audits to make sure that your coverage remains active and funds are being applied correctly. However, we are not notified directly in the event of a payment issue. Take care to review your monthly invoices and call Gravie Care if you ever notice a past-due amount.

If you are paying the insurance carrier directly and being reimbursed your ICHRA contribution, Gravie will still attempt to verify the status of your coverage each month. Keep in mind that **ICHRA funds must be used toward premiums**, so your coverage needs to remain active to keep using the benefit. In limited scenarios, if Gravie is unable to verify coverage on your behalf, we may ask that you complete a simple form each month.

My employer used Gravie last year, and I'm using ICHRA now. Do I need to re-enroll?

Yes! **You must actively re-enroll in your HRA each year**. If you're taking action during the federal open enrollment period, and want to keep everything the same as far as your health plan goes, you'll see the option from your Gravie Account to accept the new version of your plan.

I'm currently receiving a government tax credit toward the cost of my health plan; will this be impacted by ICHRA?

Enrolling in ICHRA means that you and your household are not eligible for tax credits. If you're currently enrolled in a marketplace plan, notify the exchange within 30 days of receiving your employer's notice of the ICHRA offering. Gravie Care can help you get started.

GRAVIE ICHRA™

Enrolling in your ICHRA health plan

Your employer and Gravie are working together to administer your health benefits through ICHRA. You get to choose which health plan you want, and we'll be helping to keep everything running in the background.

We're here to help you on your way.

There are three essential steps that you need to take in order to set up your health plan.

STEP 1	STEP 2	STEP 3
Enroll in your HRA	**Enroll in your health plan**	**Set up your autopay**

All three steps are necessary in order to start and keep your coverage. This guide is designed to help walk you through the process with confidence and ease. Remember that if you ever need assistance, you can call Gravie Care® message away! Call 800.501.2920 or send a secure message at member.gravie.com/contact.

STEP 1

Enroll in your HRA

What you'll need to have with you:

- Date of birth, SSN for yourself and all dependents
- Names of doctors, preferred clinics, and other providers you want covered by your plan
- Names and dosage of prescription drugs you need covered

Gravie account creation

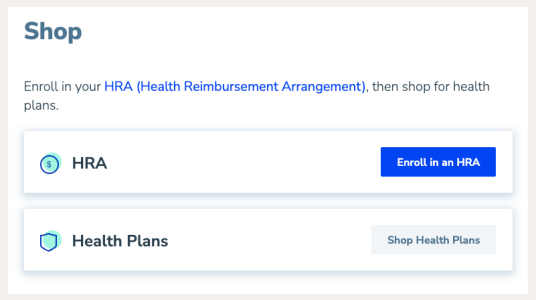
Create your account at member.gravie.com/login or sign in with your existing account credentials.

Create your profile and add dependents

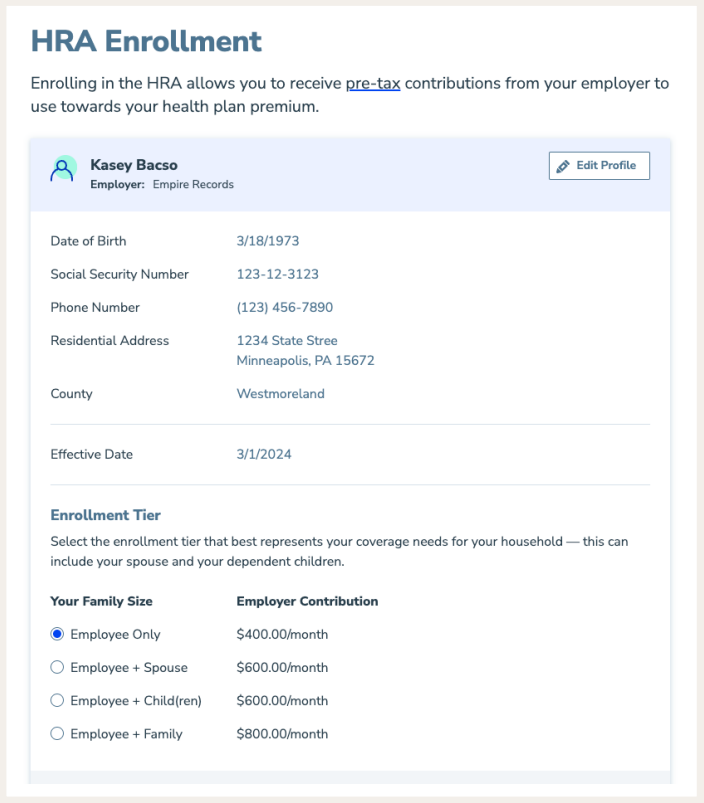
Create your Gravie profile using your information, and your family's information if applicable. This will be used to complete your enrollment forms and applications.

Enroll in your HRA

From your account's home page, select the blue **Enroll in an HRA** button.



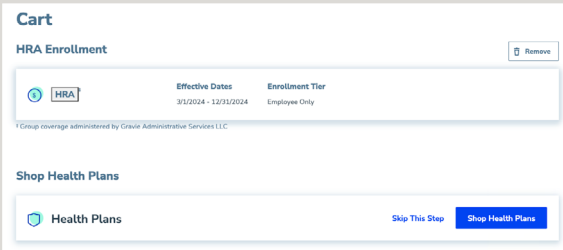
This will take you to the "HRA Enrollment" page. Review your details and select your preferred coverage tier. If enrolling just yourself, select Employee Only. To enroll with a dependent(s), select the appropriate dependent tier. When you're done, type your name in the box and hit **Submit**.



Review and select a health plan

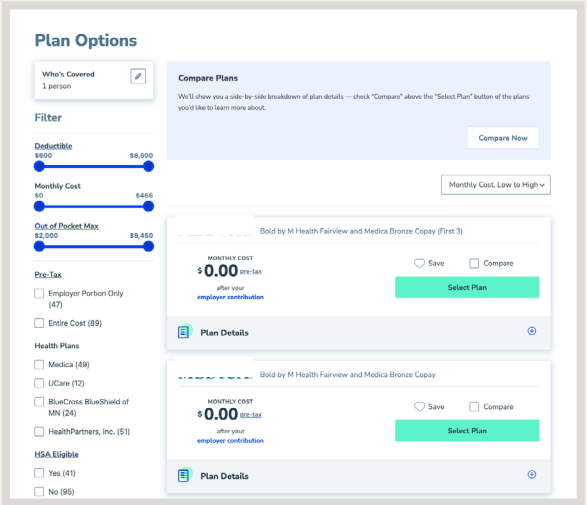
From the "Cart" page, select the blue **Shop Health Plans** button.

On the Health Plan Details page, choose your date and add any dependents who will be on your plan.



*Note: If you're enrolling outside of the annual open enrollment window, you'll be taken to a "Qualifying Event" page. Make your selection, enter your date, and then **Continue**.*

Now it's time to shop! On the Plan Options page, you'll see a detailed list of all the plans available in your area. The filter options on the left side of the page will help narrow the plan options so you can find a plan that works best for you and your eligible family members. You can also use the "Compare" tool to help you choose between plans. Once you've chosen your plan, hit **Select Plan**.



Check out on the Gravie site . . . and then check your email.

Once you've answered the questions on the **Information for your Application** pages, hit **Continue** and you'll be taken to a confirmation page with next steps. Review your information, enter your e-signature in the box, and then select **Continue**.

After you've selected the **Checkout** button at the bottom of the page, you're done with the first step. Now it's time to enroll in your health plan.

STEP 2

Complete enrollment with your carrier

You'll receive an email from Gravie with detailed instructions for completing your application.

Follow the instructions to submit your application to your carrier

Each carrier has their own enrollment process, and each requires that you complete their process all the way to the end in order to be enrolled. But don't worry – we're here to help! Follow all the instructions provided in the email from Gravie to complete your application and submit it to your chosen carrier. If you get stuck, call Gravie Care.

Watch for email confirmation from your carrier that the application was received

Once your application has been processed, you'll want to keep an eye out for any communication from the carrier. If you need assistance, let us know.

STEP 3

Set up autopay for your monthly premium payments

When you enrolled in your ICHRA, Gravie created a unique account that is to be used to make your payments to your carrier. This virtual bank account is called Gravie CompletePay. Each month, your individual CompletePay account is funded by your employer and is then used to send premium payments to your carrier.

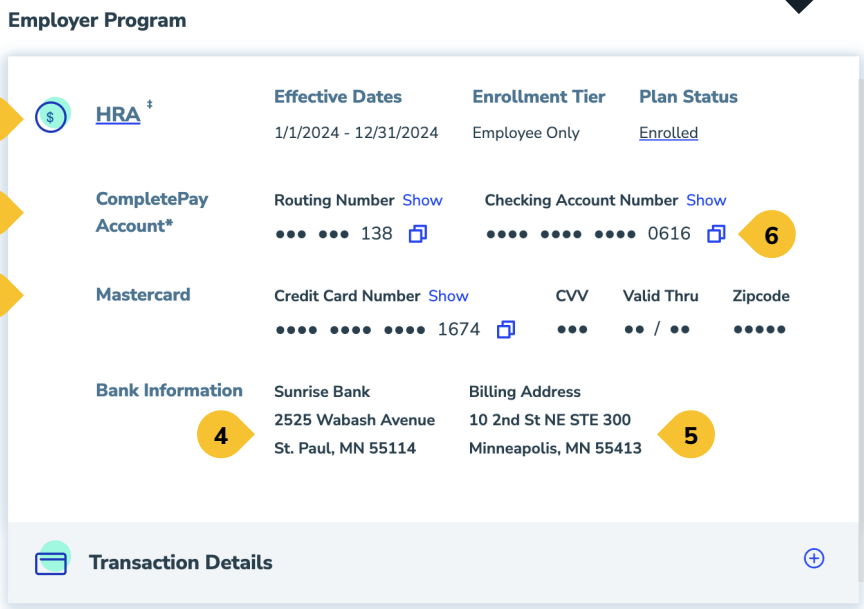
Depending on the carrier you've chosen, the email you'll receive from Gravie will prompt you to follow one of these two processes to set up autopay using your CompletePay account:

- **Scenario 1**: Set up autopay as part of the application process. You enter your Gravie CompletePay account details while completing your own application on your insurance carrier's enrollment site.
- **Scenario 2**: Set up autopay with your carrier after you've submitted your application, but before the deadline. You submit your own application on the carrier's enrollment site, and then provide your Gravie CompletePay account details directly to the carrier while your application is being processed. **In this case, you'll need to pay attention to your carrier's specific payment deadline so that you set up your autopay in time to activate coverage.**

Understanding your account details

You can find the detailed Gravie ICHRA CompletePay™ account information you need, including your account numbers and bank details, on the My Plans section of your Gravie account. Below is a guide to the info. on your card:

Remember to use **your Gravie account info** to set up your payments. Entering your personal bank info will cause extra work for you.



1. HRA enrollment details
2. CompletePay checking account details
3. CompletePay credit card details
4. Bank address for your CompletePay account
5. Billing address for your CompletePay account
6. Copy/Paste button to copy account numbers into carrier's site

* CompletePay account information must only be used for payment of ICHRA premium to your carrier

‡ Group coverage administered by Gravie Administrative Services LLC

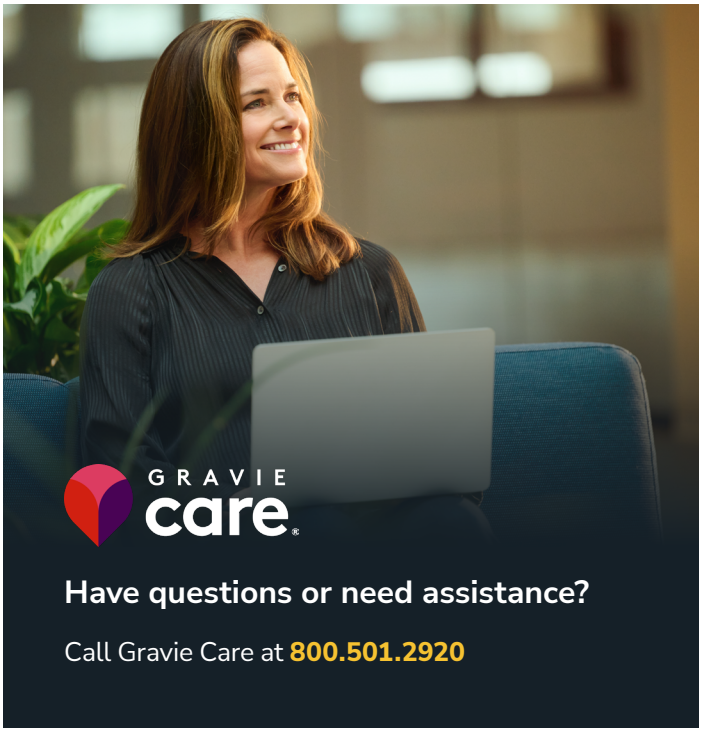
Be sure to complete steps 1-3 right away.

When you complete your checkout in your Gravie account, Gravie begins loading your CompletePay account with funds from your employer. This process may take up to 7 business days. To ensure that your account is funded prior to your payment due date, we encourage you to complete your checkout process on Gravie's platform as soon as possible.

> **Important note:**
>
> Depending on your carrier's policy, you may need to submit your first month's premium payment using your CompletePay account, and then set up autopay using the same account.

Once you've completed all the steps, you're all set!

You should be receiving your ID cards from your carrier. Payments will be made automatically each month. We recommend that you review any communications from your carrier, just to make sure that everything is on track from month to month.



Health Savings Account

Overview & Details

HealthEquity

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

Tax-Free Deposits	The money you contribute to your HSA isn't taxed (up to the IRS annual limit)
Tax-Free Earnings	Your interest and any investment earnings grow tax-free
Tax-Free Withdrawals	Money used toward eligible health care expenses isn't taxed – now or in the future

Setting aside pre-tax dollars into your HSA you pay fewer taxes and increase your take-home pay by your tax savings. You save money on eligible expenses that you are paying for out of your pocket. The amount you save depends on your tax bracket.

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

2025 HSA Contribution Limits

Single Coverage: $4,300

Family Coverage: $8,550

If you are 55 and older you may contribute an additional $1,000 to your HSA.

401(k) Plan
Details

Eligibility Requirements

Employees must be 21 years old and have one year of service with Supportive Lifestyles. You may change your deferral amount at any time after the initial eligibility requirements are completed.

Contribution Limits

The 2025 calendar year maximum 401(k) contribution is $23,500 per individual. If you are over 50 years old before 12/31, you may contribute additional "catch-up" contribution of up to $7,500 ($30,500 total). Note: The IRS may update this contribution limit at their discretion.

Employer Match

Supportive Lifestyles will make a safe harbor matching contribution equal to $1.00 for each $1.00 deferred on their first 3% of compensation and $0.50 for each $1.00 deferred on the next 2%.

Vesting

You will always be 100% vested in all your plan accounts. Should your employment with Supportive Lifestyles end, you will be entitled to 100% of the contributions made to you by Supportive Lifestyles.

Rollovers

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

Withdrawals

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

Contact Information

Spencer Rose, CIMA, QKA - Investment Advisor

(952) 653-1047

srose@cgfinancial.com

Ross Dahlof - Investment Advisor

(952) 653-1071

rdahlof@cgfinancial.com

Scott Lichter - Investment Advisor

(952) 653-1077

slichter@cgfinancial.com

This is not a Summary Plan Description. If there are differences between this information and the Plan Document or Summary Plan Description, the Plan Document will control. This Plan intends to comply with Section 404(c) of ERISA.

Other Benefits

Summary

Bereavement Leave Days:

1. Death in employee's immediate family (spouse, parent, children, son-in-law or daughter-in-law); time allowed is 5 days
2. Death of an employee's sibling; time allowed is 4 days.
3. Death of an employee's grandparent or the employee's spouse's grandparent, spouse of a sibling; time allowed is 2 days.

Birthday Vacation Day:

A birthday "vacation day" will be granted to scheduled full-time employees. This is a paid day off, equivalent to one shift. The "birthday" vacation day" must be used by the employee within 2 weeks of their actual birthday and is paid at their most frequent shift wage, not at "holiday pay."

Unemployment Compensation:

Unemployment compensation is provided and paid for by Supportive Lifestyles, Inc. It provides economic security for an employee who becomes unemployed through no fault of his or her own. An example would include a layoff due to lack of work.

Workers Compensation:

The cost of this insurance is paid for by Supportive Lifestyles, Inc. It is designed to protect your income and pay for medical expenses in the event of a work-related illness or injury.

2025 Holiday Calendar

The company observes and allows double pay for the following holidays:

New Year's Eve (4pm – 12am)

New Year's Day (all day)

Easter (all day)

Memorial Day (all day)

Independence Day (all day)

Labor Day (all day)

Thanksgiving Day (all day)

Christmas Eve (4pm – 12am)

Christmas Day (all day)

Vacation/Earned Sick and Safe Time (ESST)

Earned Sick and Safe Time is required by the State of Minnesota and is intended to be used for an employee to care for themselves or a family member in situations involving illness, injuries, physical or mental health conditions; in situations of domestic violence, sexual assault or stalking, closure of a family member's school or care facility due to weather or public emergency; or when, determined by a health authority, that the employee or family member is at risk of infecting others with a communicable disease. For more information, please refer to the Earned Sick and Safe Time Notice issued by the MN Department of Labor.

An employee may choose to use their Vacation/ESST time for reasons other than as described above. Employees will begin accruing their Vacation/ESST on the first day of their employment at an earning rate of 1 hour for every 30 hours worked. Employees will be paid at the hourly rate that they would have normally earned during that shift (excluding overtime pay and holiday pay).

Employees can accrue a maximum of 48 hours of Vacation/ESST per calendar year. Unused hours can be carried over into the next year, however, employees cannot carry a balance of more than 160 hours at any given time.

The Vacation/ESST balance, accrual and time used will be listed on the employees' bi-weekly pay stub. Any discrepancy must be reported to the payroll department within 30 days of issuance.

When employment ends, the maximum hours of Vacation/ESST that can be paid out is 40 hours per week.

Personal Leave

Personal leave days are granted to all full-time scheduled employees after 3 months of continuous full-time and worked employment. Full-time employment is 72 or more scheduled hours per pay period. Personal Leave may be used for any vacations, sick day, appointments, hospital stays, etc.

A full-time employee may carry a Personal Leave balance up to, but not to exceed 400 hours at any given time. Quarterly earnings statements will be issued that reflect an employee's personal leave balance, time earned, and time used. Any discrepancies must be reported within 30 days of receipt of the earning statement.

If an employee ceases to be full time, the employee will discontinue earning personal leave. If the employee reverts to full time, they must begin earning anew (except in cases where a leave of absence has been approved).

Personal Leave Earning Schedule

1st year: After 3 months of continuous full time scheduled and worked hours:

1. If the employee becomes eligible between January to June, the employee will earn 30 hours and an additional 30 hours to be earned in July.
2. If the employee becomes eligible in July or later, they will earn 30 hours for the 1st year of continuous full time scheduled and worked employment.

If the employee maintains continuous full-time scheduled and worked employment, Personal Leave hours per year will be earned as follows:

2nd	30 hours	35 hours
3rd	35 hours	35 hours
4th	35 hours	40 hours
5th	40 hours	40 hours
6th	40 hours	45 hours
7th	45 hours	45 hours
8th	45 hours	50 hours
9th	50 hours	50 hours
10th	50 hours	55 hours
11th	55 hours	55 hours
12th	55 hours	60 hours
13th	60 hours	60 hours
14th	60 hours	65 hours
15th	65 hours	65 hours
16th	65 hours	70 hours
17th	70 hours	70 hours
18th	70 hours	75 hours
19th	75 hours	75 hours
20th	75 hours	80 hours
21st	80 hours	80 hours
22nd	80 hours	85 hours
23rd	85 hours	85 hours
24th	85 hours	90 hours
25th	90 hours	90 hours
26th	90 hours	95 hours
27th	95 hours	95 hours
28th	95 hours	100 hours
29th	100 hours	100 hours
30th +	100 hours	100 hours

The maximum earning rate for Personal Leave is 200 hours per calendar year.

Paid Parental Leave (PPL)

Eligible employees are provided up to 4 weeks of Paid Parental Leave following:

- Birth of a child
- Placement of a child in the employee's home for adoption
- Or the placement of a child in the employee's home to adjudicate parentage in cases of surrogacy when the employee is the intended parent.

PPL is available to both parents if they are both eligible employees.

- "Child" refers to a person who is under the age of 18 at the time that PPL is to commence
- "Eligible employee" refers to an employee who qualifies as an "eligible employee" under the federal Family and Medical Leave Act (FMLA)
    - An employee who has been employed by Supportive Lifestyles, Inc. for at least 12 months, and has worked for at least 1250 hours during the 12-month period immediately preceding the start of leave
    - PPL will run concurrently with leave allowed in FMLA and MN Statute 181.941
- "New Parent" refers to an eligible employee who experiences a qualifying event.
- "Qualifying Event" refers to
    - Employee or the employee's spouse/partner giving birth to the employee's child
    - The placement of a child in the employee's home for adoption
    - The placement of a child in the employee's home to adjudicate parentage in cases of surrogacy when the employee is intended to be the legal parent of the child.
    - In the case of multiples (twins, etc.), the concurrent placement with the employee of more than one child in a home for adoption, or the concurrent placement with the employee of more than one child to adjudicate parentage in cases of surrogacy when the employee is the intended parent constitutes a single qualifying event.
- Employees must provide reasonable notice to the Personnel Director before taking PPL.
    - To confirm a parent-child relationship, Personnel Director will require reasonable documentation, which may include but are not limited to, a child's birth certificate, a court document establishing parentage, etc.
- Full-time eligible employees are provided up to 4 consecutive weeks of PPL, up to 36 hours per week (144 hours is the maximum hours allowed), per qualifying event.
- Eligible employees who are not full-time employees are provided up to 4 weeks of PPL, up to a weekly prorated amount based upon their schedule and demonstrated typical workweek, per qualifying event and ultimately determined by the Director or Director of Operations. (Example: an employee working 20 hours per week may receive 20 hours per week of PPL for 4 weeks (80 hours total)).
- Employees who have worked for Supportive Lifestyles for 6 months to 12 months are eligible for a maximum 40 hours of PPL maximum, prorated as outlined above.
- PPL cannot be used retroactively, & PPL not used within 12 months of the qualifying event cannot be carried over or cashed out. Eligible employees may be allowed intermittent or reduced schedule use of PPL, at the discretion of the Personnel Director.
    - Cannot be used prior to the child's birth, prior to the child's placement in the employee's home for adoption by the employee or prior to the date of the child's placement in the employee's home to adjudicate the employee as the child's parent in the case of surrogacy
- **Eligible employees are limited to one PPL per qualifying event per calendar year and lifetime maximum of 4 qualifying events.**

Additional Information

School Conference and Activities Leave

Part time employees are not eligible to earn paid personal leave time, however, they are allowed up to a maximum of 24 hours of unpaid personal leave per calendar year, which includes the time off to attend a child's school conferences and activities. Unpaid time off must be approved by the site coordinator or personnel director and cannot be carried over from year to year.

Nursing Mothers, Lactating Employees, and Pregnancy Accommodations

Pregnant employees have the right to request and receive reasonable accommodations, which may include, but are not limited to, more frequent or longer breaks, seating, limits to heavy lifting, temporary transfer to another position, temporary leave of absence or modification in work schedules or tasks. Supportive Lifestyles will not require an employee to take a leave or accept accommodation.

Lactating employees have the right to reasonable paid break times to express milk at work unless they are expressing milk during a break that is not usually paid, such as but not limited to: time between shifts where the employee is not clocked in. Supportive Lifestyles Inc. will provide a clean, private, and secure room, that is not a bathroom, located near the work area that includes access to an electrical outlet for employees to express milk.

Supportive Lifestyles, Inc. recognizes that it is against the law to retaliate, or take negative action, against a pregnant or lactating employee for exercising their rights under this law. Employees who believe their rights have been violated under this law can contact the MN Department of Labor and Industry's Labor Standards Division at 651-284-5075.

Important Terms

Annual Deductible

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

Conversion

The ability to convert your group life insurance policy to an individual life insurance policy.

Copays & Coinsurance

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

Embedded vs Non-Embedded

Embedded plans effectively have two deductible amounts within one plan: single and family. The single deductible is embedded in the family deductible, so no one family member can contribute more than the single amount toward the family deductible.
Non-embedded means the entire family deductible must be met before the plan pays.

Network

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

Out-of-Pocket Maximum

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

Portability

The ability to keep your current group life insurance policy when you are no longer an eligible employee or dependent.

Pre-Existing Condition Limitation

A condition that is excluded from coverage for a specific period, based on diagnosis or treatment.

Premium

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

Preventive Care

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

Legal Notices

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

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

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

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

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

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

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/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	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)	KANSAS – Medicaid
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	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	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/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	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-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)

General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your employer.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Family Medical Leave Act (FMLA)

Who is eligible for FMLA leave?

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

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

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

What are the qualifying reasons for FMLA leave?

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

- ✓ Birth and care of an employee's son or daughter;
- ✓ Placement of a son or daughter with the employee for adoption or foster care;
- ✓ Care for an employee's spouse, son, daughter or parent who has a serious health condition;
- ✓ An employee's own serious health condition that makes the employee unable to perform any one of the essential functions of the employee's position; or
- ✓ Any qualifying exigency arising out of the fact that a family member (spouse, son, daughter or parent of the employee) is a covered military member on covered active duty or has been notified of an impending call or order to covered active duty in the Armed Forces.

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

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

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

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

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

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

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

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

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

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

Plan Benefits While on FMLA Leave

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

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

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

Women's Health and Cancer Rights Act of 1998 Notice

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. As specified in the Act, if you or a covered family member had or are going to have a mastectomy, you maybe entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

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

USERRA Rights

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

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

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

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

Mental Health Parity and Addiction Equity Act of 2008

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

Michelle's Law

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

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

The date that is one year after the first day of the medically necessary leave of absence.

The date on which the dependent's coverage would otherwise end under the Plan's terms.

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

The dependent is suffering from a serious illness or injury.

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

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

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

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

Newborns' and Mothers' Health Protection Act

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

HIPAA Notice of Privacy Practices

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

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

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

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

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

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

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

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

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

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

OTHER PERMITTED USES AND DISCLOSURES

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

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

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

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

Right to Inspect and Copy: You have the right to inspect and obtain a copy of your medical information that may be used to make decisions about your benefits under the Plans. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. If the Plans do not maintain the health information, but know where it is maintained, you will be informed of where to direct your request.

- Your Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You also must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend any of the following information:
    - Information that is not part of the medical information kept by or for the plan.
    - Information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
    - Information that is not part of the information which you would be permitted to inspect and copy.
    - Information that is accurate and complete.

- Your Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" (that is, a list of certain disclosures the plan has made of your health information). Generally, you may receive an accounting of disclosures if the disclosure is required by law, made in connection with public health activities, or in situations similar to those listed above as "Other Permitted Uses and Disclosures". You do not have a right to an accounting of disclosures where such disclosure was made:
    - For treatment, payment, or health care operations.
    - To you about your own health information.
    - Incidental to other permitted disclosures.
    - Where authorization was provided.
    - To family or friends involved in your care (where disclosure is permitted without authorization).
    - For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
    - As part of a limited data set where the information disclosed excludes identifying information.

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

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

- Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

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

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

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

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

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

4. Changes to This Notice. We can change the terms of this notice at any time. If we do, the new terms and policies will be effective for all of the medical information we already have about you as well as any information we receive in the future. We will send you a copy of the revised notice.
5. Complaints. If you believe your privacy rights have been violated, you may file a complaint with the plan or with the Secretary of the Department of Health and Human Services.

All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

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

HIPAA Initial Notice of Special Enrollment Rights

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

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

Qualified Medical Child Support Orders (QMCSOs)

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

Wellness Plans

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

Genetic Information Nondiscrimination Act of 2008 (GINA)

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

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

Additionally, the plan will generally not:

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

Notice Regarding Designation of Primary Care Providers

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

Notice Regarding Coverage for Obstetric or Gynecological Care

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

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You are protected from balance billing for:

Emergency services

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

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

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

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

Minnesota law prohibits balance billing

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

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

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

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

Your health plan generally must:

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

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

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

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income..12

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

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

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

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

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		4. Employer Identification Number (EIN)
Supportive Lifestyles, Inc		**41-1777803**
5. Employer Address		6. Employer phone number
19 2nd Ave SW, PO Box 738		**320-220-2445**
7. City	8. State	9. Zip code
New London	**MN**	**56273**
10. Who can we contact about employee health coverage at this job?		
Beth Pederson		
11. Phone number (if different from above)	12. Email address	
320-220-2445	**beth@supportivemn.com**	

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:
  All regular, full-time employees scheduled to work 30 or more hours per week.

- With respect to dependents:

  ■ We do offer coverage. Eligible dependents are:
  Legally Married Spouse
  Legal Children
  Stepchildren

  ☐ 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.

NOTICE REGARDING WELLNESS PROGRAM

[Name of wellness program] is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for [be specific about the conditions for which blood will be tested.] You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of [indicate the incentive] for [specify criteria]. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive [the incentive].

Additional incentives of up to [indicate the additional incentives] may be available for employees who participate in certain health-related activities [specify activities, if any] or achieve certain health outcomes [specify particular health outcomes to be achieved, if any]. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting [name] at [contact information].

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as [indicate services that may be offered]. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and [name of employer] may use aggregate information it collects to design a program based on identified health risks in the workplace, [name of wellness program] will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) [indicate who will receive information such as "a registered nurse," "a doctor," or "a health coach"] in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. [Specify any other or additional confidentiality protections if applicable.] Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact [insert name of appropriate contact] at [contact information].

Other notices that require plan-specific customization:

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

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

Disclaimers

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

Value Added Services Disclaimer

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

401(k) Disclaimer

This is not a Summary Plan Description. If there are differences between this information and the Plan Document or Summary Plan Description, the Plan Document will control. This Plan intends to comply with Section 404(c) of ERISA.