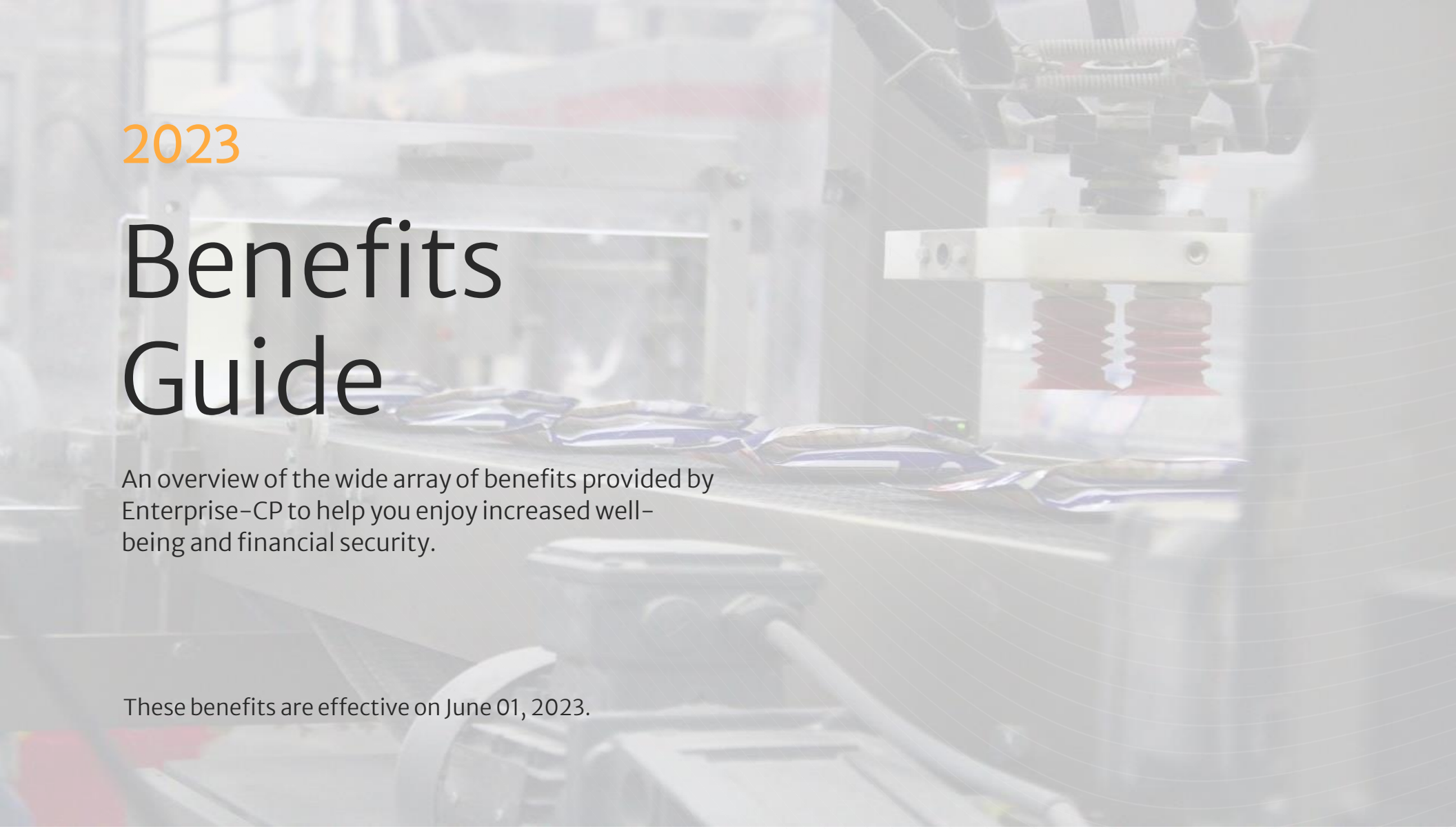

2023

Benefits Guide

An overview of the wide array of benefits provided by Enterprise-CP to help you enjoy increased well-being and financial security.

These benefits are effective on June 01, 2023.

ECP ENTERPRISE

Prepared by Christensen Group, Inc for Enterprise-CP

Contents

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

Benefits Offered

Throughout this booklet we will cover the following employee benefits being offered by Enterprise-CP.

Medical Insurance
Health Reimbursement Account (HRA)
Health Savings Account (HSA)
Flexible Spending Account (FSA)
First Stop Health
Dental Insurance
Vision Insurance
Basic Life Insurance
Voluntary Life Insurance
Short Term Disability Insurance
Long Term Disability Insurance

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

Benefits Eligibility

As an employee of Enterprise-CP you may opt-in to annual benefits for you and your dependents when you meet certain work requirements.

Eligible members

The following members are eligible to receive benefits during the upcoming plan year:

Employee
Legal Married Spouse
Legal Children
Stepchildren

Work requirements

All regular, full-time employees scheduled to work 30 hours, or more, and their eligible dependents

When your benefits begin

All benefits begin on the first of the month following 30 days of employment.

Benefits Summary

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

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

QUESTIONS?

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

Liz Bakker
evbakker@enterprisecp.com
(320) 357-3506

Coverage	Carrier	Group #	Phone	Website
Medical	Blue Cross Blue Shield of MN	10704759 10704731	(651) 662-8000	www.bluecrossmnonline.com
Health Reimbursement Account (HRA)	HealthEquity	-	(877) 924-3967	www.healthequity.com
Health Savings Account (HSA)	Bremer Bank	-	(800) 908-2265	www.bremer.com
Flexible Spending Account (FSA)	HealthEquity	-	(877) 924-3967	www.healthequity.com
Telemedicine and Mental Health	First Stop Health	-	(888) 691-7867	www.fshealth.com
Vision	EyeMed	tbd	(651) 662-8000	www.eyemed.com
Dental	Delta Dental of MN	102076	(800) 448-3815	www.deltadentalmn.org
Basic Life	Mutual of Omaha	tbd	(888) 493-6902	www.mutualofomaha.com
Voluntary Life	Mutual of Omaha	tbd	(888) 493-6902	www.mutualofomaha.com
Short Term Disability	Mutual of Omaha	tbd	(888) 493-6902	www.mutualofomaha.com
Long Term Disability	Mutual of Omaha	tbd	(888) 493-6902	www.mutualofomaha.com

Key Terms

Annual deductible (ded)

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

Out-of-pocket maximum

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

Copays & coinsurance

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

Network

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

Premium

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

Preventative care

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

Embedded vs non-embedded

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

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

Medical Plan

What is a medical plan?

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

Who is the carrier?

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

Aware
High Value

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

Do you need to take action?

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

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

Medical Plan

Preventative Care

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

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

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

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

Covered preventative care services

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

Medical Plan

Summary of Plan Options

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

	$5,000 HSA Plan	
In Network	Aware Network	HighValue Network
Deductibles (Single / Family) – Calendar Year	$5,000 / $10,000	
Out-of-Pocket Max (Single / Family) – Calendar Year	$7,500 / $15,000	
HRA Reimbursement (Single / Family)	$2,000 / $4,000	
Emp. Deductible (Single / Family)	**$3,000 / $6,000**	
Emp. Max Out of Pocket (Single / Family)	**$5,500 / $11,000**	
For the coverages listed below, after you reach your maximum out of pocket – you are covered at 100%		
Preventative Care	100% coverage	
Primary Care Visit	ded; then 75% coverage	
Specialist Visit	ded; then 75% coverage	
Virtual Care E-Visit	First five visits are free; then ded; then 75% coverage	
Inpatient & Outpatient	ded; then 75% coverage	
Emergency Room	ded; then 75% coverage	
Urgent Care	ded; then 75% coverage	
Pharmacy / RX (30 Day Supply)	ded; then 75% coverage	
Employee Monthly Contribution	**Aware Network**	**High Value Network**
Employee	$41.07	$0.00
Employee + Spouse	$391.09	$304.84
Employee + Child(ren)	$320.67	$230.32
Employee + Family	$621.56	$486.02

Note: Employees waiving coverage will receive a taxable payment in lieu, but in order to continue receiving such, will be required at any given point to provide proof of other qualifying health coverage. Amount of the payment in lieu is as follows:
If participating in the Wellness Program payment in lieu is $324 per month.
If **not** participating in the Wellness Program payment in lieu is $162 per month.
(current employees' participating in pay in lieu will be grandfathered at their current amount)

Medical Plan

Summary of Plan Options

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

	$2,000 Copay Plan	
In Network	Aware Network	HighValue Network
Deductibles (Single / Family) – Calendar Year	$2,000 / $6,000	
Out-of-Pocket Max (Single / Family) – Calendar Year	$4,500 / $9,000	
Preventative Care	100% coverage	
For the coverages listed below, after you reach your maximum out of pocket – you are covered at 100%		
Primary Care Visit	$40 copay	
Specialist Visit	$40 copay	
Virtual Care E-Visit	First five visits are free; then $20 copay	
Inpatient & Outpatient	ded; then 70% coverage	
Emergency Room	ded; then 70% coverage	
Urgent Care	ded; then 70% coverage	
Pharmacy / RX (30 Day Supply)	$15 / $50 / $70 / $120; 70% coverage up to $500/prescription	
Employee Monthly Contribution	Aware Network	High Value Network
Employee	$78.88	$26.58
Employee + Spouse	$533.49	$423.66
Employee + Child(ren)	$474.87	$359.79
Employee + Family	$880.35	$707.73

Note: Employees waiving coverage will receive a taxable payment in lieu, but in order to continue receiving such, will be required at any given point to provide proof of other qualifying health coverage. Amount of the payment in lieu is as follows:
If participating in the Wellness Program payment in lieu is $324 per month.
If **not** participating in the Wellness Program payment in lieu is $162 per month.
(current employees' participating in pay in lieu will be grandfathered at their current amount)

Medical Plan

Blue Cross Blue Shield Of MN Networks & Virtual Care

Aware

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

To search the Aware network at: https://www.bluecrossmnonline.com/find-a-doctor/landing?productName=Aware&productId=901&displayProductName=Aware

High Value

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

To search the High Value Network at: https://www.bluecrossmnonline.com/find-a-doctor/landing?productName=High%20Value%20Network&productId=1060&displayProductName=High%20Value%20Network

Virtual Care: Doctor on Demand (Video Chat)

See a doctor in minutes. Live video visits include assessment, diagnosis, and prescription when necessary. Video capabilities are required, and service is available 24/7. Visits to treat conditions like colds, the flu, and allergies.

Visit https://doctorondemand.com/bluecrossmn to get started!

Medical Plan

Blue Cross Blue Shield Of MN Value Adds

Omada

An online program that can help you lose weight, feel great and lower your risk for type 2 diabetes and heart disease through one-on-one guidance from a professional health coach and interactive tools. Omada combines science and support to help you develop healthy habits that last. You get personal support and interactive tools to get and keep you motivated:

- One on one guidance from a professional health coach
- A welcome kit with a wireless smart scale and other tools to track your progress
- An online peer group for motivation from people who get it
- Interactive weekly lessons on nutrition, fitness, sleep and stress
- On-the-go convenience with a mobile app
- And more

This program is available at no cost to you and adult family members if you qualify.

Visit omadahealth.com/bcbsmn1

Blue Care Advisor

Blue Care Advisor provides a robust, comprehensive and integrated platform for our members. Members will have access to a single platform for all of their benefits and wellbeing needs, including activity tracking and incentives (Get Active Program), health assessment and a personalized experience that will steer members to their next best action to help them achieve optimal health outcomes. Earn up to $240 when you redeem points for completing the health assessment and tracking your daily steps.

Register at bluecrossmn.com/bcs or download the Blue Care Advisor app.

Learn To Live

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

Health Reimbursement Account (HRA)

What is an HRA?

An HRA is an employer-sponsored arrangement that reimburses employees on a tax-free basis for their eligible medical expenses. Unlike a health savings account (HSA), employees do not need to participate in a high-deductible health plan (HDHP) to be eligible for an HRA. It is common, however, for HRAs to be paired with an HDHP in order to maximize premium savings and increase employee awareness of medical spending.

HRAs are funded completely by employer contributions. Different from HSAs or health flexible spending accounts (FSAs), employees cannot make contributions to an HRA. Most employers with HRAs create notional, or unfunded, accounts for each participating employee and reimburse eligible medical expenses up to each employee's HRA balance.

Who is the administrator?

Your HRA is administered by Health Equity.

(877) 924-3967
www.healthequity.com

Do you need to take action?

Employers may link HRA contributions with some type of employee behavior, such as participating in a wellness program.

When you are enrolled in our BlueCross BlueShield health plan, Enterprise-CP provides a Health Reimbursement Arrangement (HRA) through Health Equity. When you incur eligible claims, your HRA can help pay for them.

Notes:
--Unused HRA funds do not carry-over from year to year.

HRA

Details & Overview

After you pay claims in the amount shown below, your HRA begins to pay:

1. Your health services provider submits their claims to BCBS and they will submit to HealthEquity on your behalf, you do not need to submit documentation to have your claims processed.
2. HealthEquity issues reimbursement directly to you.
3. You pay your health services providers.

Refer to your HRA documentation for more information.

IF YOU ENROLLED IN THE $5,000-25% HSA

Single Coverage

1

You pay the first $0 - $3,000 of your deductible

2

Enterprise-CP will reimburse you for expenses $3,001 - $5,000

3

After you have reached the out-of-pocket maximum of $7,500 BCBS pays 100% of eligible expenses

Family Coverage

1

You pay the first $0 - $6,000 of your deductible

2

Enterprise-CP will reimburse you for expenses $6,001 - $10,000

3

After you have reached the out-of-pocket maximum of $15,000 BCBS pays 100% of eligible expenses

Health Savings Account (HSA)

What is an HSA?

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

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

Who is the administrator?

Your HSA is administered by Bremer Bank.

Bremer Bank
(800) 908-2265
www.bremer.com

Do you need to take action?

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

You will be able to contribute pre-tax earnings to your HSA.

HSA

Overview & Details

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

Tax-Free Deposits

The money you contribute to your HSA isn't taxed (up to the IRS annual limit)

Tax-Free Earnings

Your interest and any investment earnings grow tax-free

Tax-Free Withdrawals

Money used toward eligible health care expenses isn't taxed – now or in the future

Employer Contribution Info

	Base	Successful Completion of Wellness Program	Non-Smoker
Employee	$50	$15	$15
Employee + Spouse	$75	$15	$15
Employee + Child(ren)	$75	$15	$15
Family	$100	$15	$15

2023 HSA Contribution Limits

Single Coverage: $3,850

Family Coverage: $7,750

55+ Catch-up: $1,000

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

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.

Flexible Spending Account (FSA)

What is an FSA?

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

Who is the administrator?

Your FSA is administered by Health Equity.

(877) 924-3967
www.healthequity.com

Do you need to take action?

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

FSA

Overview & Details

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

Medical & Limited FSA

Election Maximum: $3,050

Note: If you are enrolled in the $5000-25% HSA plan, you can use your FSA dollars on dental & vision expenses only.

Medical FSA Eligible Expenses

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

Limited FSA Eligible Expenses (for those enrolled $5000-25% HSA plan)

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

Using your plan dollars

The Flexible Spending plan runs June 1st, 2023 – May 31st, 2023.
Funds not claimed by July 31st, 2024 will be lost per IRS rules.

First Stop Health

What is a First Stop Health?

First Stop Health is Telemedicine and Virtual Counseling available to you via phone or video 24/7 at no cost.

Even if you are not enrolled in the Enterprise-CP medical plan – this service is available for free for you and your family.

Who is the administrator?

Your Telemedicine and Virtual Counseling benefits are administered by First Stop Health:

First Stop Health
www.fshealth.com

Download the app from the app store or google play.

Do you need to take action?

All employee are automatically enrolled in this coverage, no action needed.

First Stop Health
Summary

General Health

Get treated within minutes for minor illness, injuries, and prescriptions

- Cough & Sore Throat
- Infections (Sinus, Ear, UTI, ect.)
- Skin Rash
- Muscle/Joint Pain
- Medication Refill

Virtual Counseling

- Anxiety
- Depression
- Marital/Relationship
- Substance Misuse
- Workplaces Issues

Download First Stop Health from the app store or google play

Visits are FREE – No Deductible, No copays!

Prescriptions, if needed, are an extra charge through your insurance.

All regular, full-time employees working 40 hours a week and dependents who live in the same house are eligible to use this benefit!

Dental Insurance

What is Dental Insurance?

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

Who is the provider?

Your Dental Insurance is provided by Delta Dental of MN.

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

Do you need to take action?

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

Dental Insurance

Summary of Coverage

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

	Solutions-Dual Option Plus Ortho		
In Network	**Plan Option I**		**Plan Option II**
	PPO	Premier	Premier
Calendar Year Deductible (Single / Family)	$0	$25 / $75	$25 / $75
Calendar Year Maximum (per person)	$2,000	$2,000	$1,000
Preventative Care: *Exams, Cleanings, X-rays, & Space Maintainers*	100%	80%	100%
Basic Services: *Palliative Treatment, Periodontal Maintainers, Fillings, Simple Extractions, Endodontics, & Sealants*	80%-90% coverage	Ded; then 50%-80% coverage	Ded; 80% coverage
Major Services: *Inlays, Onlays, Crowns, Crown Repairs, Bridges, Dentures & Implants*	50% coverage	Ded; then 50% coverage	Ded; then 50% coverage
Child Orthodontic Coverage: *Orthodontic coverage for ages 8 to 19*	50% coverage Lifetime maximum: $1000	50% coverage Lifetime maximum: $1000	50% coverage Lifetime maximum: $1000

Employee Contribution per Month	This is your contribution, paid pre-tax through payroll deductions.
Employee	$0.00
Employee + Spouse	$34.08
Employee + Child(ren)	$34.80
Employee + Family	$77.64

Dental Plan

Delta Dental of MN Networks

PPO

For the highest benefit level, use a Delta Dental PPO network provider.

To search the PPO network: https://www.deltadentalmn.org then click on find a dentist and search the Delta Dental PPO network by city and state.

Premier

For the highest benefit level, use a Delta Dental Premier network provider.

To search the Premier network: https://www.deltadentalmn.org then click on find a dentist and search the Delta Dental Premier network.

Plan Option I – PPO

If your dentist is participating with PPO, you will receive the richest benefit by electing Plan Option I – PPO. You will receive the first column of benefits.

Plan Option I – Premier

You might want to elect Plan Option I when seeing a premier dentist if you are expecting your dental expenses more than $1000. This plan option will have your preventive services paid at 80% so you will pay 20% but you maximum is $2000. This is the second column of benefits.

Plan Option II – Premier

If your dentist is in the Premier network and you don't expect to use more than the $2000 maximum, you will receive the highest percentage of coverage by electing Plan Option II. This plan option works well if your dentist is in the Premier network and you are looking at having your preventive services done and maybe a filling or extraction. This is the third column of benefits.

Vision Insurance

What is Vision Insurance?

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

Who is the provider?

Your Vision Insurance is provided by EyeMed.

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

Insight

For the highest benefit level, use an Insight network provider.

To search for a network provider: https://www.eyemed.com, click on find an eye doctor and select the Insight network.

Do you need to take action?

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

Vision Insurance

Summary of Coverage

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

	EyeMed Exams + Materials
In Network	Insight
Eye Exams (Once every 12 months)	$10 copay
Lenses (Once every 12 months)	
Single	$25 copay
Bifocal	$25 copay
Trifocal	$25 copay
Lenticular	$25 copay
Frames (Once every 12 months)	$130 allowance
Elective Contact Lenses (in lieu of lenses and frames)	
Conventional	$130 allowance
Disposable	$130 allowance
Medically Necessary Contact Lenses (Once per 12 months)	Covered in full
Employee Contribution per Month	
This is your contribution, paid pre-tax through payroll deductions.	
Employee	$7.05
Employee + One	$13.40
Employee + Child(ren)	$14.10
Family	$20.73

Life Insurance and AD&D

What is Life Insurance?

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

Who is the carrier?

Your Basic Life Insurance is administered by Mutual of Omaha.

Mutual of Omaha
(800) 628-8600
www.mutualofomaha.com

Your Voluntary Life Insurance is administered by Mutual of Omaha.

Mutual of Omaha
(800) 628-8600
www.mutualofomaha.com

Do you need to take action?

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

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

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

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

Life and AD&D

Summary of Coverage

Enterprise-CP pays 100% of premiums for your Basic Life and AD&D Insurance.

Employer paid Plan Features	Benefit
Employee Life and AD&D Benefit Amount	1x Annual Salary up to $50,000
Conversion Privilege	Available
Age Reductions	Reduces to 65% at age 65, 50% at age 70

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

Employee paid Plan Features	Benefit
Employee Life and AD&D Benefit Amount	Increments of $10,000 to lesser of 5x annual salary or $500,000 Guaranteed Issue: $100,000
Dependent Spouse Life and AD&D Benefit	$5,000 increments to $250,000, not to exceed 100% of employee's election Guaranteed Issue: $25,000
Dependent Child(ren) Life and AD&D Benefit	Live Birth through 26: $10,000
Age Reductions	Age 65: 65% of original; Age 70: 50% of original
Accelerated Benefits, Conversion Option, Waiver of Premium	All Included

Guarantee Issue Amount

One-time true Open Enrollment

This year only, all employees are eligible to enroll in coverage, up to the guaranteed issue amount, with no health questions

Employees – up to $100,000
Spouses – up to $25,000
Children – up to $10,000

Short & Long-Term Disability (STD & LTD)

What is Short Term Disability Insurance?

Short Term Disability provides a portion of your income if you are disabled due to an illness or injury for a short period of time.

What is Long Term Disability Insurance?

Long Term Disability provides a portion of your income if you are unable to work due to a qualified disability for an extended period of time.

Who is the carrier?

Your Short & Long-Term Disability Insurance is administered by Mutual of Omaha.

Mutual of Omaha
(800) 628-8600
www.mutualofomaha.com

Do you need to take action?

Your Short Term Disability insurance is paid by the employee. You will need to make an enrollment election if you want to participate in the voluntary short- term disability.

Your Long Term Disability Insurance is paid by Enterprise-CP. No action is needed, as you will be automatically enrolled if you meet the definition of eligibility found at the beginning of this booklet.

Voluntary Short-Term Disability

Summary of Coverage

The following is your Short Term Disability benefit for the upcoming year. This plan is 100% paid by you. You can see you per payroll cost when enrolling in Ease.

Plan Features	
Employee Benefit Amount	Up to 60% of pre-disability earnings
Maximum Benefit Amount	$1,250 per week
Elimination Period (Accident)	0 days
Elimination Period (Illness)	7 days
Benefit Duration	13 weeks
Pre-Existing Condition	3/6

Long Term Disability

The following is your Long-Term Disability benefit for the upcoming year.
This benefit is paid 100% by Enterprise-CP.

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

Employee Assistance Program

Life can be unpredictable and it's not always easy - so it's a big deal to know there's help available when you need it. That's what the Employee Assistance Program (EAP) is all about. EAP offers help 24/7 with a variety of issues, including: Depression and Anxiety, Relationships, Substance Abuse, Tips on parenting and grandparenting. **This service is free to all benefit eligible employees.**

To schedule an appointment, call: (800) 316-2796

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, 2023. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322/Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA-Medicaid	**MAINE-Medicaid**
A 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	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003/TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740/TTY: Maine relay 711

Legal Notices

INDIANA–Medicaid	MASSACHUSETTS–Medicaid and CHIP
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
IOWA–Medicaid and CHIP (Hawki)	**MINNESOTA–Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS–Medicaid	**MISSOURI–Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY–Medicaid	**MONTANA–Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
LOUISIANA–Medicaid	**NEBRASKA–Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA–Medicaid	**SOUTH CAROLINA–Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE–Medicaid	**SOUTH DAKOTA–Medicaid**
Website: https://www.dhhs.nh.gov/programs-services/Medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059

Legal Notices

NEW JERSEY–Medicaid and CHIP	TEXAS–Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK–Medicaid	**UTAH–Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA–Medicaid	**VERMONT–Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA–Medicaid	**VIRGINIA–Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA–Medicaid and CHIP	**WASHINGTON–Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON–Medicaid	**WEST VIRGINIA–Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	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)
PENNSYLVANIA–Medicaid	**WISCONSIN–Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p- 10095.htm Phone: 1-800-362-3002
RHODE ISLAND–Medicaid and CHIP	**WYOMING–Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

Legal Notices

To see if any other states have added a premium assistance program since July 31, 2023, 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

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 1/31/2023)

Legal Notices

General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

** 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 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."

Legal Notices

General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

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.

Legal Notices

General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

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.

Legal Notices

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.

Legal Notices

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.

Legal Notices

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.

Legal Notices

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.

Legal Notices

HIPAA Notice of Privacy Practices (1 of 5)

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.

Legal Notices

HIPAA Notice of Privacy Practices (2 of 5)

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.

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- 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.

Legal Notices

HIPAA Notice of Privacy Practices (4 of 5)

- 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.

Legal Notices

HIPAA Notice of Privacy Practices (5 of 5)

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.

Legal Notices

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.

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.

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."

Legal Notices

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.

Legal Notices

Your Rights and Protections Against Surprise Medical Bills (1 of 2)

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.

Legal Notices

Your Rights and Protections Against Surprise Medical Bills (2 of 2)

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.