TotalRewards

My Benefits

2023

Team Member Guide to Benefit Enrollment

Franciscan Missionaries of Our Lady HEALTH SYSTEM

Information Resources

Your 2023 Total Rewards

Just as our team members are more than job descriptions and titles, our rewards program is more than just compensation and benefits. Total Rewards is our commitment to provide value to you and your family throughout your career at Franciscan Missionaries of Our Lady Health System. It combines six distinct areas that you can use to meet your individual and family needs: My Purpose, My Compensation, My Benefits, My Personal Growth & Development, My Recognition, and My Health & Well-Being. When all of these components are tied together, they create a Total Rewards package that is unique to our organization. This guide will help you understand more about the rewards available to you as a team member of FMOLHS.

Benefit Education

Our goal is to make benefits easy to understand so you can make the most of them. We have an interactive online learning experience available on our Total Rewards page. In this interactive learning experience, you can pick and choose the topics you want to dive deeper into. Check out all of the education resources available by visiting the page today.

- Click here for the Total Rewards page
- Click here for 2023 Interactive Benefit Education Video or scan the QR code at right to directly access the benefit education video
- Click here to review the FMOLHS EPO and PPO Network
- Click here to learn about FMOLHS Network Navigation Resources to help you help find a provider in our network.

Have Questions? Need assistance with your Benefit Enrollment?

The FMOLHS askHR Team is available by phone or email.

- **Phone:** 833-482-7547
- **Email:** askHR@fmolhs.org

Note

In addition to these resources, we are committed to keeping you informed. Stay up to date on the latest communication and updates through: Oracle Employee Self Service, your FMOLHS email, fmolhs.org/TotalRewards and TeamTalk.

Your 2023 Enrollment Options

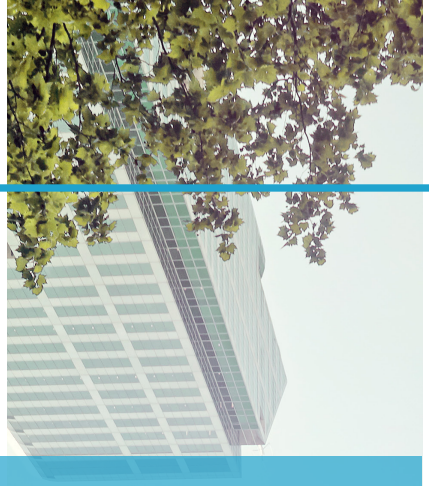
Your enrollment options will be displayed in Oracle Employee Self-Service in the following order:

BENEFIT PLAN	NEW ENROLLEE	FUTURE ENROLLEE
FMOLHS HEALTH PLAN HEALTH SAVINGS ACCOUNT (HSA) MEDICAL FLEXIBLE SPENDING ACCOUNT (FSA) LIMITED MEDICAL FLEXIBLE SPENDING ACCOUNT (LUFSA) FMOLHS DENTAL PLAN VISION PLAN	Team members who are within their 1st 30 calendar days of eligibility may enroll through Oracle Employee Self-Service.	Enroll through Oracle Employee Self-Service annually during the Open Enrollment period.
LINCOLN VOLUNTARY EMPLOYEE LIFE LINCOLN VOLUNTARY SPOUSE LIFE LINCOLN VOLUNTARY DEPENDENT LIFE	Team members who are within their 1st 30 calendar days of eligibility may enroll through Oracle Employee Self-Service.	For those outside of their 1st 30 calendar days of eligibility, enrollment in coverage is not available.
LONG TERM DISABILITY	Team members who are within their 1st 30 calendar days of eligibility may enroll through Oracle Employee Self-Service.	Team members who previously waived coverage must complete evidence of insurability online during the Open Enrollment period at MyLincolnPortal.com for eligibility review.
LINCOLN VOLUNTARY ACCIDENT LINCOLN VOLUNTARY CRITICAL ILLNESS	Team members who are within their 1st 30 calendar days of eligibility may enroll through Oracle Employee Self-Service.	Enroll through Oracle Employee Self-Service annually during the Open Enrollment period.
COMPANY-PROVIDED GROUP LIFE INSURANCE		
GROUP BASIC LIFE (COMPANY-PAID)	Company-provided Basic Life Insurance coverage. Team members do not need to enroll. Team members do need to designate a beneficiary in Oracle Employee Self Service.	Eligible Team members are automatically enrolled in the Basic Life Insurance. Team members do need to designate a beneficiary in Oracle Employee Self Service.
403(b) AND 457(b) RETIREMENT ENROLLMENT PROCESS		
403(b) AND 457(b) RETIREMENT PLANS	Eligible Team members enroll at LincolnFinancial.com/FMOLHS	Eligible Team members enroll at LincolnFinancial.com/FMOLHS

You can verify your enrollment and print a copy of your elections in Oracle Employee Self Service by clicking on Me/Benefits/My Benefits.

Note

Most benefits are effective on the first day of the month following 30 days of employment. Long Term Disability benefits are effective first of the month following 6 months of employment. (New Hire date: March 5; benefits are effective on October 1.)



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In this guide we use the term "Company" to refer to FMOLHS. This guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits program offered by the Company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. This guide is not intended to answer all of your questions, but to provide you with a tool to answer most of your questions. Full details of the plans are contained in the Plan Documents, which are available on your facility intranet and govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Important Information

Enrollment for the 2023 Plan Year

Complete your benefit enrollment and submit complete dependent verification documentation within 30 calendar days of your new hire/new eligibility date (e.g. for a new hire date of May 1, enrollment and documentation deadline is May 30). If you meet the income guidelines, apply for the health plan premium reduction, Just Premium, within 30 calendar days of your eligibility date (see page 10 for details).

Member Cards

Team Members who enroll in the following benefits will receive member identification cards:

- Medical Cards – FMOLHS Health Plan through Blue Cross Blue Shield (BCBS)
- Dental Cards – Delta Dental
- Vision Cards – UNUM
- Medical Flexible Spending Account (FSA)/Health Savings Account (HSA) – Payflex

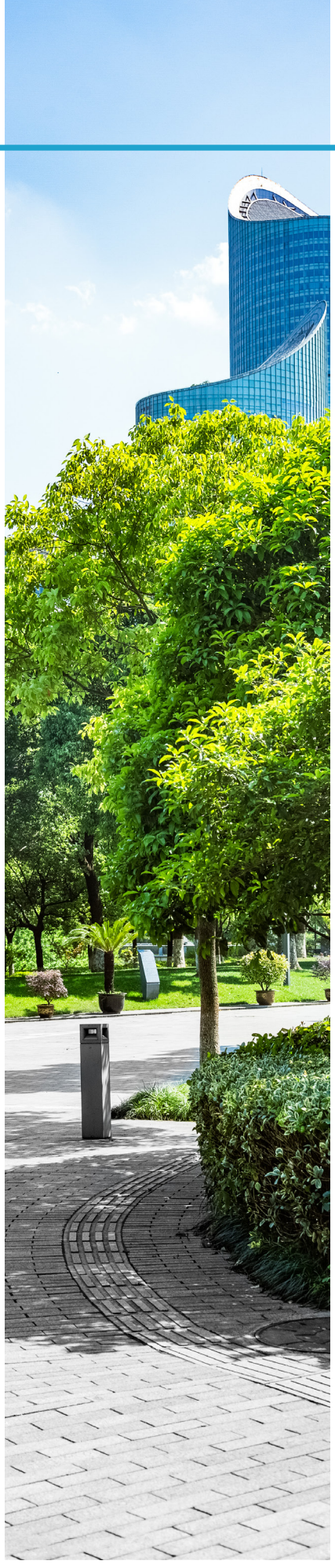
Human Resources Contact

Reach out using the method that works best for you:

- Submit an Oracle Service Request by clicking on Help Desk/HR Service Requests.*
- Email askHR@fmolhs.org
- Call 833-4UaskHR (833-482-7547)

askHR

*This is the fastest method for getting an answer to your question.



Note

If you (and/or your Dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 58 for more information concerning Medicare Part D coverage.

Important Information

Be Healthy. Be Happy.

Register for My Health Toolkit to help you get started. You will have anywhere, anytime access to your benefits information, insurance cards, claims and covered local providers.

Download the My Health Toolkit mobile app. It's free at: www.MyHealthToolkitLA.com/links/FMOLHS.

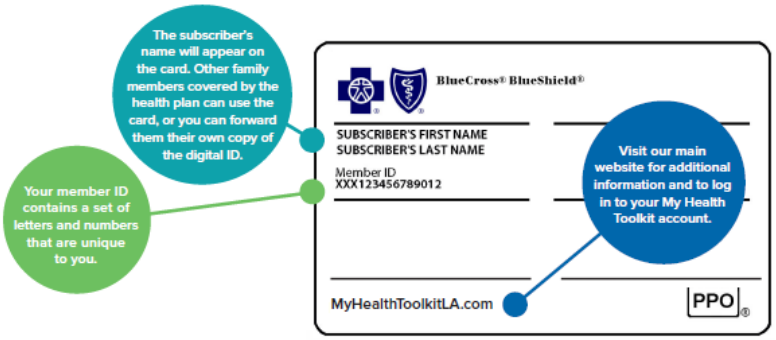
Get Started Today

Why wait? It's easy to sign up. In just a few clicks, you will have everything you need at your fingertips.

1. Go to www.MyHealthToolkitLA.com/links/FMOLHS and select Register Now.
2. Enter the number on your membership card and your date of birth. If you don't have your membership card, you can enter your social security number.
3. Choose a username and password.
4. Enter your email address and choose to go paperless, if you would like.

Your Membership Card

Your Blue Cross Blue Shield membership card contains important information that helps providers apply your benefits correctly. Keep it with you at all times by downloading your digital ID card to keep on your smart phone. It is all about convenience. Your digital ID card has the same information that your plastic card will have. In 2023, your membership card will now include your deductible and out of pocket maximums. You will be able to:



- View your card on your smartphone, tablet or computer
- Email the card to a spouse, child, doctor's office or pharmacy
- Print the card from a smartphone, tablet or computer and use the print out just like a plastic card

Accessing your Digital ID Card

To access your digital ID card through the My Health Toolkit app you will need to follow these instructions:

- Log in to My Health Toolkit.
- From your mobile device, select Insurance Card.
- From a computer select Insurance Card and then View Your Card.

Note

Sign Up for My Health Toolkit at:
www.MyHealthToolkitLA.com/links/FMOLHS

Enrollment

All eligible team members must enroll online through Oracle Employee Self Service.

Things to Consider

Before you enroll, it is a good opportunity for you to assess your benefit needs.

- Does your spouse have benefits coverage available through another employer?
- Did you get married, divorced or have a baby recently? If so, do you need to add any dependent(s) or add your beneficiary designation?
- Did any of your children reach his or her 26th birthday this year? If so, they are not eligible for benefits.

Your Eligible Dependents for Core Benefits Enrollment

Dependents eligible for coverage in the FMOLHS Benefit Plans include:

- Your legal spouse.
- Your dependent children up to age 26 (includes stepchildren, legally-adopted children or children placed with you for adoption, foster children and grandchildren for whom you have legal custody).
- Your dependent child, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your Health Plan to continue coverage past age 26.
- **Please note that verification of eligibility will be required once dependents are enrolled. See page 8 for dependent verification requirements.**

Note

All eligible Team Members must enroll within 30 calendar days of new hire/new eligibility date.

Qualifying Life Events Include:

Enrollment changes based upon a qualifying life event must occur within 30 calendar days of that event.* (For Example: If you get married on March 1st, you must enroll no later than March 30th.)

- Change in your FTE status from part-time to full-time or full-time to part-time that results in a significant increase or decrease in your premiums (medical or dental)
- Change in your legal marital status (marriage and divorce)
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Change in your spouse's employment status (resulting in a loss or gain of coverage)
- Change in your employment resulting in a gain or loss of coverage
- Entitlement to Medicare or Medicaid*

*If you become eligible for or lose coverage under Medicaid or a state child health plan, you must enroll or terminate coverage within 60 days.

Dependent Verification

DEPENDENT TYPE	ACCEPTED/REQUIRED VERIFICATION DOCUMENTS
NATURAL CHILD*	Birth Certificate; for newborns, birth letter from hospital
STEP CHILD* (Requires current spouse & child verification documents)	Birth Certificate **AND** verification of current marriage between Team Member and natural parent (**see spouse verification requirements below**)
ADOPTED CHILD/CHILD PLACED FOR ADOPTION*	Adoption Certificate/placement letter from court or adoption agency for pending adoptions
FOSTER CHILD*	Proof of Legal Custody, such as a court order
GRANDCHILD* (Requires 2 documents)	Proof of Legal Custody, such as a court order **AND** copy of current tax return that identifies grandchild as a taxable dependent
SPOUSE (Requires 2 documents)	Marriage Certificate; **AND** current or previous year tax return face sheet **OR** proof of current joint ownership (such as a joint mortgage, joint rental agreement, joint bank account, joint auto insurance etc.)

*Less than age 26 regardless of marital or student status

Dependent verification documents for any newly enrolled or previously unverified dependents must be received within 30 calendar days of new hire/new eligibility date in order to maintain dependent coverage. FMOLHS reserves the right to audit dependent verification documents at any time.

Note

Upload Dependent Verification Documents in Oracle Employee Self Service under Benefits/My Documents.

How to Enroll in Oracle Employee Self Service

1. Understand Your Choices!

The Team Member Guide to Benefits Enrollment is available by clicking on My Benefits on our Total Rewards page.

2. Review Your Personal Information

3. Enroll Online from Work or Home

https://eqtm.login.us2.oraclecloud.com

4. Log in with Your Username and Password

a. Click the **Me** tab

b. Click the **Benefits** tile

» Note: Before starting your enrollment, be sure to review **My Benefit Resources Card** for your benefit options and important notices

c. Click **Start Enrollment** button

5. Add Your Dependents and Beneficiary(s)

a. Be sure to complete all required fields for each dependent and beneficiary

b. Upload dependent verification documents to Oracle Employee Self Service under Benefits/My Documents.

6. Review Your Dependent Child's Eligibility for Coverage

a. Core Benefits (Health, Dental, Vision) – To age 26 regardless of marital or student status.

b. Voluntary Life Benefits – Unmarried dependent children to age 21; to age 25 if a full time student.

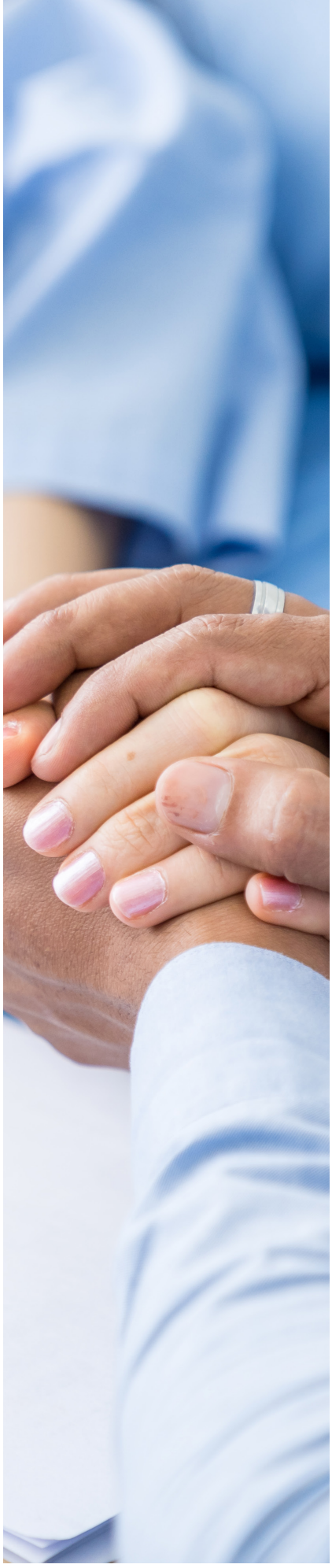
c. Voluntary Accident and Critical Illness Benefits – To age 26 regardless of marital status or student status.

7. Save and Print Your Elections!

If your benefit elections are properly completed and saved, you will get a confirmation message on the screen that states, "Your benefit elections were saved.."

If you do not receive a confirmation message, your elections were not properly completed. You must complete the election process again within 30 days of your new hire/new eligibility date.

Go to My Benefits card to view and print a copy of your elections. You must have a copy of your 2023 benefit elections to report a problem with your enrollment.



2023 Premium Reduction Opportunities – EPO and PPO Medical Plans

Team members are required to complete an annual application to determine eligibility for "Just Premium". "Just Premium" aligns with our Mission and expands the offer of medical plan premium reductions to team members who apply and qualify for financial assistance based on total household income.

Based upon your total household income (adjusted gross income), the number of dependents you claim on your 2021 Federal Income Tax Return, your FTE status (only available to full-time team members), and your hourly rate, you and your family may be eligible for the Just Premium reduction.

DEPENDENTS LISTED ON TAX RETURN	MAXIMUM HOUSEHOLD INCOME
0 to 1	$34,373
2	$35,482
3	$41,026
4 or more	$46,570
Current Maximum Hourly Rate $32.00	

Approved team members will receive higher FMOLHS medical plan subsidies to improve affordability and access to coverage. Team Members may select from the EPO or PPO Plans for themselves and their eligible dependents.

Please submit a completed application and tax return within 30 calendar days of your new hire/new eligibility date.

To apply for Just Premium:

- Select My Benefits on our Total Rewards and then click on the Just Premium Application link.
- Print and complete the application and attach a copy of the first two pages of your 2021 Federal Individual Income Tax Return. If you are married, filing jointly, submit one tax return. If you are married, filing single or head of household, you will be required to submit the first two pages of both your tax return and your spouse's return.
- Return application/tax return(s) to JustPremium@fmolhs.org or fax 225-765-9307 within 30 calendar days of your new hire/new eligibility date.

Note

Individuals who did not file a 2021 Income Tax Return will not be eligible for the 2023 Just Premium.

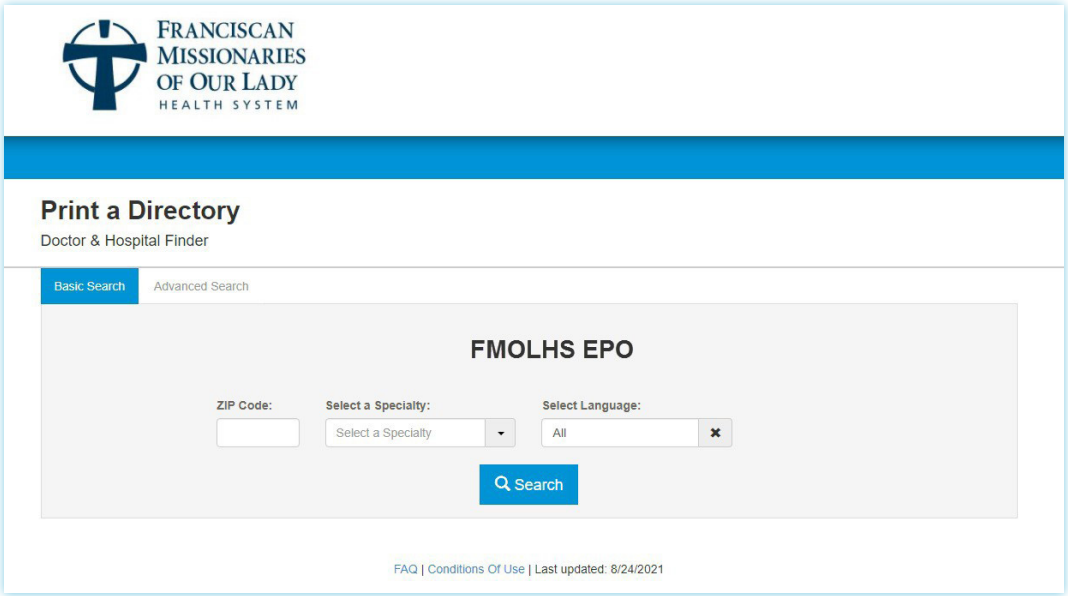
My Health Benefits

Blue Cross Blue Shield
www.MyHealthToolkitLA.com/links/fmolhs • 833-468-3594

Health coverage is one of the most important benefits FMOLHS can provide. Health benefits provide significant value through support for and protection against potentially large financial expenses, as well as covering preventive care. FMOLHS is committed to keeping team members healthy and productive by offering comprehensive health care plans. The option you choose will be in place for all of 2023, unless you have a qualifying life event. Health benefits will be administered by Blue Cross Blue Shield.

How Do I Find a Provider?

FMOLHS has a customized provider directory for its Plan members. To see the current list of the FMOLHS EPO Network or PPO Tier 1 or Tier 2 Network providers online, visit www.MyHealthToolkitLA.com/links/fmolhs. If you do not have access to the website, please call Blue Cross Blue Shield Customer Service at 833-468-3594 for assistance.



Navigate Our Provider Network the Easy Way

STEP 1 FINDING AN IN-NETWORK PROVIDER

We understand the importance of finding a healthcare provider who can best meet the needs of you and your family. We also understand how daunting it might be to scroll through a list of doctors in search of the best fit. That's why we offer team members a resource to help navigate our FMOLHS customized network.

They are called **Network Guides**, and they are available in most locations by phone 24/7 for team members in both Louisiana and Mississippi.

Whether it be our EPO network or our PPO Tier 1 or Tier 2 network, our **Network Guides** can help you:

- **Find a provider in network**
- **Check if a provider you are already seeing is in network prior to enrollment**
- **Assist with scheduling an appointment with network-based primary care physicians**
- **Check availability of a specialty service within our network**

Call **(855) 875-6265** to connect with a Network Guide today. You will be prompted to select a guide for either our Louisiana or Mississippi network.

NOTE: *Always verify a provider's network status by calling Blue Cross Blue Shield at* **(833) 468-3594** *or by logging on to* **MyHealthToolkitLA.com/links/fmolhs**. *You will have access to the EPO and PPO Tier 1 and Tier 2 networks at this site.* ***If the provider address listed on the directory is not the address where care will be delivered, the provider may not be in network. Contact BCBS to confirm.***

STEP 2 ACCESSING CARE IN OUR NETWORK

We offer a variety of ways to connect and access care with an FMOLHS primary care provider. Your PCP is responsible for providing comprehensive care, for having knowledge of your overall medical history, and in assisting you with navigating certain health risks and your healthcare journey.

In-Person Visits

Meet face to face with your provider for wellness checks or appointments that need full evaluations.

Video Visits

Same great care from your own provider from the comfort of your home.

Virtual Extended Hours

Avoid urgent care or ER fees and meet virtually with a FMOLHS primary care provider in our network after hours for free with the EPO plan or for $5 with the PPO Plan.

Available in Louisiana only. We're working to expand this care opportunity to Mississippi.

All appointment types are available to schedule through **MyChart** *for all ages.*

STEP 3 ACCESSING CARE OUTSIDE OUR NETWORK

If you need services that are not available within our EPO or PPO Tier 1 or Tier 2 network, Network Exceptions are available. To receive an exception, you must complete the Network Exception form on the Total Rewards My Benefits page and have it signed by your provider. Signed and completed forms must be submitted to BCBS of South Carolina **before** services are rendered to be considered. BCBS SC will notify you of their decision on your request.

Submit all completed requests in writing via fax to **(803) 264-0259**, by email to **FMOLHSEXCEPTION@BCBSSC.COM** or by mail to:

Blue Cross Blue Shield of South Carolina
Attn: Network Waiver, AX-630
PO Box 100300
Columbia, SC 29202

NOTE: *The network exception MUST be requested and approved before services are rendered. If the request is made after services are rendered, it will not be considered unless otherwise required by law.*

Road Map to Care

Think of your Primary Care Physician (PCP) as your go-to for your health care needs. Your PCP plays an important role in your healthcare journey. Ultimately, building a relationship with your PCP and going to them regularly for illnesses, yearly checkups and screenings can lead to better health outcomes and a higher level of satisfaction with care.

In need of a Primary Care Physician? Our Network Guides can help you find a provider. Call now at 855-875-6265.

First Stop

Primary Care Physician (PCP)
Having one doctor who knows your overall health history and can better guide you as you navigate certain health risks leads to better patient experience.

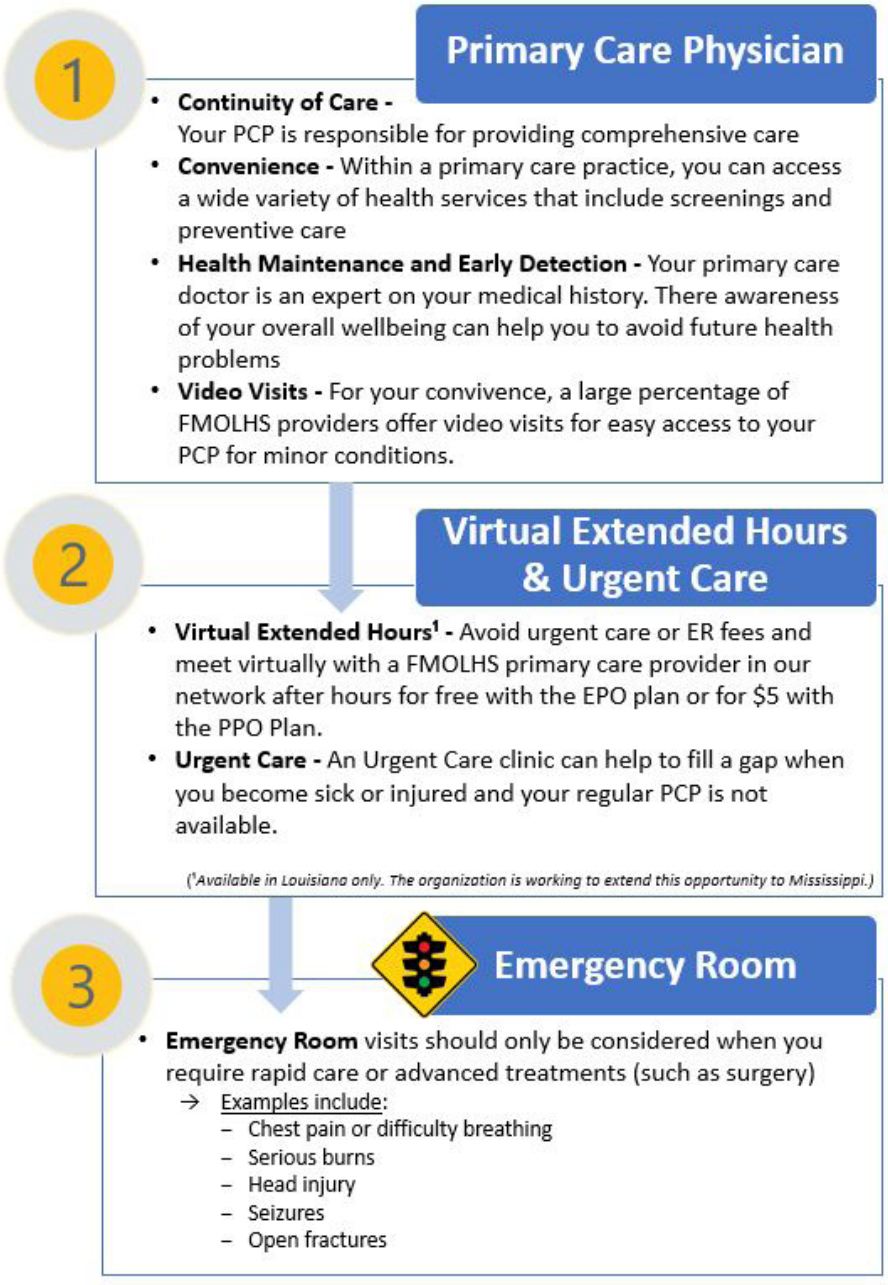
There are several ways you can connect and receive care from your in-network PCP, through in-person visits to convenient virtual visits like video or virtual extended hours. See our network navigator page to learn more about each care opportunity available in your area.

Second Stop

If it's the weekend or it's later in the evening, Virtual Extended Hours and Urgent Care are good options to consider.

Third Stop

There are several medical conditions that are considered emergencies because treatment is only available in a hospital setting.



Which Plan Is Right for Me — the EPO Plan, PPO Plan or HDHSA Plan?

Choosing the most cost-effective health plan is more than just signing up for the one with the lowest paycheck deduction.

EPO Plan

The EPO Plan provides access to a narrow network of healthcare providers that are either a part of our health system or considered our preferred partners. This means that the plan will allow for eligible medical services as long as you visit a healthcare provider — doctor, hospital or other place offering health care services — within our narrow EPO network. With this plan, the cost shared by you will be lower, whether that is through premiums, copays, deductibles or your out-of-pocket-maximum limit for the year. The plan offers a $250 individual and $500 family deductible and a $0 copay for PCP office visits.

Upon enrolling in the EPO Plan, you will gain access to providers who offer high quality care and who are more clinically integrated with our organization's electronic medical record system, allowing for more comprehensive care. In addition, you can designate a primary care provider (PCP) that can act as your personal health advocate and coordinate your healthcare. It's important to know that coverage for medical services outside of the EPO network will only be allowed in the event a medical service is needed that is not available within the network. In an emergency, however, eligible services will be covered.

This plan may be a better option for those who would like lower deductibles and copays at time of service as well as overall reduced out-of-pocket expense.

PPO Plan

The PPO health plan design has higher deductibles, coinsurance and copays than the EPO Plan, and continues to offer out-of-network coverage for most services. The pharmacy design copays remain the same including the specialty copays — $100 if filled at RxONE and $150 if filled by Express Scripts. If you reside outside of Louisiana or Mississippi, you are eligible for out-of-area coverage at the Tier 2 coverage level if you see a BCBS provider in your home state. The out-of-area coverage is based solely upon the employed team member's address outside of Louisiana or Mississippi. The PPO has higher monthly premiums, but offers out-of-network coverage if needed. This plan choice is beneficial for those individuals who need out-of-area coverage or need a broader network coverage including out-of-network coverage.

HDHSA Plan

The HDHSA Plan design has higher deductibles and out-of-pocket maximums along with FMOLHS funding. FMOLHS will provide $750 individual and $1500 family contribution to your HSA account to help with out-of-pocket medical expenses. The deductibles for the HDHSA Plan are $1,750 individual and $3,500 family. If you can take on more financial risk, perhaps you might consider the HDHSA Plan.

With a High Deductible Health Plan and a Health Savings Account (HSA), you can save additional pre-tax dollars to pay for medical expenses. You decide how to spend your dollars. Unused HSA dollars roll over from year-to-year. (There are restrictions and limitations to enrollment in the HSA.)

Choosing the health plan that is right for you is important. You want to make sure you're covered for the year ahead, while ensuring you choose the most effective option based on your personal health needs.

MY HEALTHCARE NEEDS	CONSIDER THE EPO PLAN	CONSIDER THE PPO PLAN	CONSIDER THE HDHSA PLAN
I HAVE A CHRONIC DISEASE, SEE SPECIALIST PHYSICIANS, AND/ OR TAKE SEVERAL BRAND PRESCRIPTION MEDICATIONS.	✓	✓	
I AM VERY HEALTHY, HAVE NO PLANNED MEDICAL PROCEDURES, TAKE ONE GENERIC PRESCRIPTION MEDICATION AND ONLY HAVE ROUTINE PREVENTIVE CARE.	✓		
I HAVE A SURGERY SCHEDULED AND CAN USE TIER 1 PROVIDERS.	✓		
I AM PREGNANT OR PLAN TO BECOME PREGNANT.	✓		
I HAVE SAVED DOLLARS TO PAY TOWARD MY DEDUCTIBLE AND CAN AFFORD TO PAY THE CO-INSURANCE COSTS OF MY MEDICAL CARE.		✓	✓
I HAVE YOUNG CHILDREN WHO ARE OFTEN SICK OR INJURED.	✓		
I AM LOOKING FOR A HIGH DEDUCTIBLE PLAN THAT ALLOWS ME TO PAY FOR HEALTHCARE EXPENSES WITH DOLLARS I SAVE ONCE I RETIRE.			✓
I SEE A PROVIDER THAT IS IN TIER 3 OF THE PPO NETWORK AND WOULD LIKE TO CONTINUE TO SEE THIS PROVIDER EVEN THOUGH MY OUT OF POCKET EXPENSE IS HIGHER.		✓	
I WORK REMOTELY IN A STATE OTHER THAN LA OR MS AND NEED TO ACCESS CARE FOR MYSELF AND MY FAMILY		✓	

How Will I Be Billed for a Physician Office Visit?

If you are enrolled in the EPO Plan and choose a provider in the EPO network, your primary care visit will be a $0 copay. There is no coverage outside of the EPO network. If you are enrolled in the PPO Plan, your office visit copay pays for your share of the cost of the office visit. When you have additional services, those services are subject to deductible and coinsurance. All services under the HDHSA Plan are subject to deductible and coinsurance. The chart below gives examples of how services would process under the EPO and PPO Plan.

IF YOU HAVE:	YOU WILL PAY UNDER EPO PLAN:	YOU WILL PAY UNDER PPO PLAN:
PCP Office Visit	No Cost	Copay
Specialty Office Visit	Copay	Copay
Injections	Included with Applicable Office Visit Copay*	Deductible & Coinsurance
X-rays	Included with Applicable Office Visit Copay*	Deductible & Coinsurance
Lab work	Included with Applicable Office Visit Copay*	Deductible & Coinsurance

*For some services, coinsurance and deductible may apply.

How Will I Be Billed for Medical Services?

The chart below gives examples of medical services that require the attention of a physician who may send a separate bill for payment.

IF YOU HAVE:	YOU WILL ALSO RECEIVE A BILL FROM:
X-rays	The radiologist
Certain lab tests	The pathologist
Surgery	The anesthesiologist & surgeon
Visit by your personal physician	Your personal physician
EKG	Cardiologist

Please note for the PPO Plan: If you have a procedure performed at an FMOLHS facility, your provider may or may not be a FMOLHS Network Tier 1 provider. If the provider is not a FMOLHS Network Tier 1 provider, but is an in-network provider, you will receive a separate bill from the provider for the services performed and the provider will be paid at the Tier 2 benefit level.

For example: if you have elected the PPO Plan (80% FMOLHS Network Tier 1 / 70% Preferred Provider Network Tier 2) you would be responsible for 30% of the in-network anesthesiologist's bill after you have met your deductible.

How Do I View My Medical Claims Online?

To register for Blue Cross Blue Shield Online Services, after you receive your new medical ID card visit www.MyHealthToolkitLA.com/links/FMOLHS. You will need your medical ID card to register.

- Select Register Now
- Select Register
- Follow the steps given to register

www.MyHealthToolKitLA.com/links/FMOLHS allows you to:

- View medical claims
- View or print explanations of benefits
- View, request or print an ID card
- Find a network provider

What If a Medical Service or a Claim Is Denied? What Are My Appeal Rights?

When a claim for benefits or service denial occurs under the FMOLHS Health Plan, the member receives an explanation of benefits (EOB) or service denial letter explaining the reason for the denial. The member has the right to file an appeal to request a review of the denial.

The appeal should include policy holder name, health plan ID number, patient name, details regarding the claim/service being appealed (such as a claim number), and date and provider of service. For full details, please see the Grievances and Appeals Process in the FMOLHS Health Plan Document posted on your facility intranet.

You must file an appeal within 180 days after you have been notified of the denial of benefits.

Send requests for review of a denial of benefits by mail to:

Blue Cross Blue Shield
Columbia Service Center
Attention: Appeals Coordinator AX-830
P.O. Box 100121
Columbia, SC 29202-3121

Health Plan Summaries

The charts below give a summary of the 2023 Health Plans for FMOLHS. All covered services are subject to medical necessity as determined by the Plan. All out-of-network services are subject to reasonable and customary (R&C) limitations.

EPO Plan

The Plan will pay the designated percentage of covered charges if the provider is in the EPO network until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the calendar year unless stated otherwise. The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: deductible(s), cost containment penalties, and above usual and customary charges. There is no out-of-network coverage under the EPO Plan unless otherwise required by law.

	EPO PLAN	
	FMOLHS EPO NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE		
EMPLOYEE ONLY	$250	No Coverage
EMPLOYEE WITH DEPENDENTS	$500	No Coverage
MAXIMUM OUT-OF-POCKET (INCLUDES DEDUCTIBLE)		
EMPLOYEE ONLY	$2,000	No Coverage
EMPLOYEE WITH DEPENDENTS	$4,000	No Coverage
OFFICE VISIT		
PRIMARY CARE PHYSICIAN (PCP)	$0 copay	No Coverage
SPECIALIST	$35 copay	No Coverage
EMERGENCY ROOM/URGENT CARE		
EMERGENCY ROOM	$250 copay	$250 copay
URGENT CARE	$60 copay	No Coverage
OTHER COPAYS		
OUTPATIENT SURGERY	$250 copay	No Coverage
INPATIENT	$200 copay per day (4 day/$800 max)	No Coverage
PHYSICIAN SERVICES		
INPATIENT VISITS	Included in Inpatient copay	No Coverage
OUTPATIENT	Included in Office Visit copay, Outpatient Surgery copay, or 100% coverage after deductible (depending on place of service)	No Coverage
HOSPITAL SERVICES		
ROOM AND BOARD	Included in Inpatient copay	No Coverage
INTENSIVE CARE UNIT	Included in Inpatient copay	No Coverage
OUTPATIENT SURGERY	Included in outpatient surgery copay	No Coverage
SKILLED NURSING FACILITY	$200 copay per day (4 day/$800 max)	No Coverage
BARIATRIC SURGERY Plan Coverage for Bariatric surgery is available only to a Full-Time or Part-Time Active employee who is a Class A Participant who remains in that status on the date of service and satisfies the requirements in Exhibit C and employee's covered spouse and dependent who satisfies the requirements in Exhibit C.	$3,000 copay; Surgery must be performed at a MBSAQIP Accredited FMOLHS facility	No Coverage
ORGAN TRANSPLANT Blue Distinction Centers coverage only.	90% coverage after deductible when performed at Blue Distinction Center facility	No Coverage
OTHER SERVICES		
ALLERGY TESTING	90% coverage after deductible or included in office visit copay, depending on place of service	No Coverage
ALLERGY SERUM AND INJECTIONS	90% coverage after deductible or included in office visit copay, depending on place of service	No Coverage
OTHER INJECTIONS	90% coverage after deductible or included in office visit copay, depending on place of service	

EPO PLAN (CONTINUED)

	FMOLHS EPO NETWORK	OUT-OF-NETWORK
OTHER SERVICES		
DIAGNOSTICS	90% coverage after deductible or included in office visit copay, depending on place of service	No Coverage
LABORATORY	90% coverage after deductible or included in office visit copay, depending on place of service	No Coverage
CHEMOTHERAPY	90% coverage after deductible or included in office visit copay, depending on place of service	No Coverage
HOME HEALTH CARE	90% coverage after deductible; limited to 50 visits per calendar year	No Coverage
HOSPICE CARE	90% coverage after deductible	No Coverage
AMBULANCE SERVICE	90% coverage after deductible	No Coverage
OCCUPATIONAL THERAPY PHYSICAL THERAPY SPEECH THERAPY	90% coverage after deductible; maximum of 120 visits per year (and maximum of 20 visits per week) combined Occupational, Physical, and Speech Therapy	No Coverage
APPLIED BEHAVIOR ANALYSIS (ABA)	90% coverage after deductible maximum of 20 hours per week annually	No Coverage
SPECIFIC GENETIC TESTING (MUST SATISFY MEDICALLY NECESSARY CRITERIA)	90% coverage after deductible drawn/ordered by FMOLHS Geneticist	No Coverage
SMOKING CESSATION AIDS Smoking cessation is available through the prescription benefit program.	100% coverage of screening for tobacco use and two tobacco cessation attempts per year which includes four tobacco cessation counseling sessions of at least 10 minutes each without prior authorization and 90 day supply of Smoking Cessation Aids when prescribed by a health care provider without prior authorization	No Coverage
DURABLE MEDICAL EQUIPMENT (DME)	90% coverage after deductible	No Coverage
INSULIN PUMP	90% coverage after deductible; limited to 1 per 5 years	No Coverage
ORTHOTICS AND PROSTHETICS	90% coverage after deductible	No Coverage
GENERIC DIABETES PRESCRIPTION MEDICATIONS AND SUPPLIES	100% coverage of Generic Diabetes Prescription Medications and Preferred Supplies through the pharmacy benefit.	No coverage
MENTAL HEALTH AND SUBSTANCE ABUSE		
INPATIENT INCLUDING PARTIAL HOSPITALIZATION (PHP), INTENSIVE OUTPATIENT PROGRAM (IOP), AND RESIDENTIAL	$200 copay per day (4 day/$800 max)	No Coverage
OFFICE VISIT	$0 Copay	No Coverage
OTHER OUTPATIENT SERVICES	90% coverage after deductible or included in office visit copay, depending on place of service	No Coverage
PREGNANCY CARE AND DELIVERY		
LABOR & DELIVERY AND ASSOCIATED CHARGES	$200 copay per day (4 day/$800 max)	No Coverage
MATERNAL/FETAL ULTRASOUND	90% coverage after deductible or included in office visit copay, depending on place of service and other than included in prenatal care	No Coverage
IN NETWORK BREAST PUMP AND LACTATION COUNSELING THROUGH HEALTHY LIVES	100% coverage	No Coverage
PRE-NATAL CARE	One-time $50 copay applies for coverage of routine OB visits, initial routine labs and one ultrasound per term pregnancy.	No Coverage
PREVENTIVE CARE		
ROUTINE WELL ADULT CARE Generally limited to approved preventive or wellness services, which could include the following annual screenings depending on your age, gender, and health status: Lipid (Cholesterol), HGB A1C (Diabetes), Bone Marrow Density Test, Mammogram, Pap Test, Fecal Occult Blood Test, Colonoscopy, Depression Screening, Obesity Screening and Counseling. *Please call the Claims Administrator to confirm coverage	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually	No Coverage
ADULT IMMUNIZATIONS Immunizations are subject to current CDC Recommendations which include age limitations	100% coverage	No Coverage
ROUTINE WELL CHILD CARE Unlimited routine office visits through age two (2); annually ages three (3) up. Includes: office visits, routine physical examination and immunizations in accordance with CDC Guidelines and preventive care in accordance with federal guidelines.	100% coverage	No Coverage

*FMOLHS follows federal guidelines for coverage of preventive/wellness screenings.

PPO Plan

The Plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the calendar year unless stated otherwise. The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: deductible(s), cost containment penalties, and above usual and customary charges.

PPO PLAN

	FMOLHS NETWORK (TIER 1)	PREFERRED PROVIDER NETWORK (TIER 2)	NON-PREFERRED PROVIDER (TIER 3)	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE				
EMPLOYEE ONLY	$800	$800	$3,000	$5,000
EMPLOYEE WITH DEPENDENTS	$1,600	$1,600	$6,000	$10,000
MAXIMUM OUT-OF-POCKET (INCLUDES DEDUCTIBLE)				
EMPLOYEE ONLY	$3,000	$4,000	$6,000	$10,000
EMPLOYEE WITH DEPENDENTS	$6,000	$8,000	$12,000	$20,000

Out of Area Coverage. A subscriber (team member) who is enrolled in the PPO Plan and whose home address is in a state other than Louisiana or Mississippi may (i) access care at Tier 2 network coverage with a BCBS PPO network provider in their home state for themselves and their enrolled dependents or (ii) access providers in the FMOLHS Louisiana and Mississippi networks at Tier 1 or Tier 2 coverage. Any other network access would follow the Tier 3 or Out-of-Network coverage. The Out of Area Coverage is based solely on the subscriber's (team member's) home address. A dependent's address does not entitle the dependent to Out of Area Coverage.

OFFICE VISIT				
PCP/MEDICAL HOME	$5 copay office visit only, all other services subject to deductible and coinsurance	$30 copay office visit only, all other services subject to deductible and coinsurance	60% coverage after deductible	40% coverage after deductible
SPECIALIST	$45 copay office visit only, all other services subject to deductible and coinsurance	$70 copay office visit only, all other services subject to deductible and coinsurance		
EMERGENCY ROOM/URGENT CARE				
EMERGENCY ROOM	80% coverage after deductible			
URGENT CARE	$75 copay	$75 copay	60% coverage after deductible	40% coverage
PHYSICIAN SERVICES				
INPATIENT VISITS	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
OUTPATIENT	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
HOSPITAL SERVICES				
ROOM AND BOARD	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
INTENSIVE CARE UNIT	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
SURGERY	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
SKILLED NURSING FACILITY	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
BARIATRIC SURGERY Plan Coverage for Bariatric surgery is available only to a Full-Time or Part-Time Active employee who is a Class A Participant who remains in that status on the date of service and satisfies the requirements in Exhibit C and employee's covered spouse and dependent who satisfies the requirements in Exhibit C	$3,000 copay; Surgery must be performed at a MBSAQIP Accredited FMOLHS facility	No coverage	No coverage	No coverage
ORGAN TRANSPLANT Blue Distinction Centers coverage only.	80% coverage after deductible when performed at Blue Distinction Center facility			No coverage
OTHER SERVICES				
ALLERGY TESTING	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
ALLERGY SERUM AND INJECTIONS	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
OTHER INJECTIONS	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
DIAGNOSTICS	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
LABORATORY	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
CHEMOTHERAPY	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
HOME HEALTH CARE	80% coverage after deductible; maximum of 50 visits per calendar year	70% coverage after deductible; maximum of 50 visits per calendar year	60% coverage after deductible; maximum of 50 visits per calendar year	No coverage
HOSPICE CARE	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
AMBULANCE SERVICE	80% coverage after deductible			

PPO PLAN (CONTINUED)

	FMOLHS NETWORK (TIER 1)	PREFERRED PROVIDER NETWORK (TIER 2)	NON-PREFERRED PROVIDER (TIER 3)	OUT-OF-NETWORK
OTHER SERVICES				
OCCUPATIONAL THERAPY PHYSICAL THERAPY SPEECH THERAPY	80% coverage after deductible;	70% coverage after deductible	60% coverage after deductible	No coverage
	Maximum of 120 visits per year (and maximum of 20 visits per week) combined with Occupational, Physical, and Speech Therapy			
APPLIED BEHAVIOR ANALYSIS (ABA)	80% coverage after deductible; max 20 hours per week annually	70% coverage after deductible; max 20 hours per week annually	60% coverage after deductible; max 20 hours per week annually	No coverage
SPECIFIC GENETIC TESTING (MUST SATISFY MEDICALLY NECESSARY CRITERIA)	80%; drawn/ordered by FMOLHS Geneticist	No coverage	No coverage	No coverage
SMOKING CESSATION AID Smoking cessation is available through the prescription benefit program	100% coverage of screening for tobacco use and two tobacco cessation attempts per year which includes four tobacco cessation counseling sessions of at least 10 minutes each without prior authorization and 90 day supply of Smoking Cessation Aids when prescribed by a health care provider without prior authorization			No coverage
DURABLE MEDICAL EQUIPMENT (DME)	80% coverage after deductible;	70% coverage after deductible	60% coverage after deductible	No coverage
INSULIN PUMP	80% coverage after deductible; limited to 1 per 5 years	70% coverage after deductible; limited to 1 per 5 years	60% coverage after deductible; limited to 1 per 5 years	No coverage
ORTHOTICS AND PROSTHETICS	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
GENERIC DIABETES PRESCRIPTION MEDICATIONS AND PREFERRED SUPPLIES	100% coverage of Generic Diabetes Prescription Medications and Preferred Supplies through the pharmacy benefit		No coverage	No coverage
MENTAL/NERVOUS AND SUBSTANCE ABUSE				
INPATIENT Including Partial Hospitalization (PHP), Intensive Outpatient Program (IOP) and Residential	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
OFFICE VISIT ONLY	$5 copay	$30 copay	60% coverage after deductible	40% coverage after deductible
OTHER OUTPATIENT SERVICES	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
PREGNANCY CARE AND DELIVERY				
LABOR & DELIVERY AND ASSOCIATED CHARGES	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
MATERNAL/FETAL ULTRASOUND	80% coverage after deductible; other than included in pre-natal care	70% coverage after deductible; other than included in pre-natal care	60% coverage after deductible; other than included in pre-natal care	40% coverage after deductible
IN NETWORK BREAST PUMP AND LACTATION COUNSELING THROUGH HEALTHY LIVES	100% coverage	100% coverage	100% coverage	No coverage
PRE-NATAL CARE	One time $50 copay applies to routine OB visits, initial routine labs and one ultrasound per term pregnancy.			40% coverage after deductible
PREVENTATIVE CARE				
ROUTINE WELL ADULT CARE Generally limited to approved preventive or wellness services, which could include the following annual screenings depending on your age, gender, and health status: Lipid (Cholesterol), HGB A1C (Diabetes), Bone Marrow Density Test, Mammogram, Pap Test, Fecal Occult Blood Test, Colonoscopy, Depression Screening, Obesity Screening and Counseling.* **Please call the Claims Administrator to confirm coverage**	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually.	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually.	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually.	40% coverage after deductible; Limited to one routine physical examination annually and approved wellness screenings annually.
ADULT IMMUNIZATIONS Immunizations are subject to current CDC Recommendations which include age limitations	100% coverage	100% coverage	100% coverage	40% coverage after deductible
ROUTINE WELL CHILD CARE Unlimited routine office visits through age two (2); annually ages three (3) up. Includes: office visits, routine physical examination and immunizations in accordance with CDC Guidelines and preventive care in accordance with federal guidelines.	100% coverage	100% coverage	100% coverage	40% coverage after deductible

*FMOLHS follows federal guidelines for coverage of preventive wellness screenings.

HDHSA

HDHSA Plan – A high deductible health plan with a tax-free health savings account (HSA). You determine how much you'll contribute to the account, when to use the money to pay for qualified medical, prescription, dental and vision services, and when to reimburse yourself. HSAs allow you to save and roll over money if you do not spend it in the calendar year. The money in this account is portable, even if you change plans or jobs. Company HSA contributions will be pro-rated based on enrollment date.

You cannot open an HSA if:

- You have other health coverage that helps you pay for health care expenses before your deductible is met.
- You or your spouse has a flexible spending account (FSA) or health reimbursement arrangement (HRA). (You are allowed to participate in a Limited Use FSA, which would only cover Dental and Vision expenses.)
- You also have Medicare or TRICARE.
- Someone else can claim you as a dependent.
- You have used Veterans Affairs hospital or medical services in the three months prior to opening your HSA, unless it was for a disability related to your military service.

HIGH DEDUCTIBLE HSA PLAN

	FMOLHS NETWORK (TIER 1)	PREFERRED PROVIDER NETWORK (TIER 2)	NON-PREFERRED PROVIDER (TIER 3)	OUT-OF-NETWORK
HSA ANNUAL CONTRIBUTIONS				
EMPLOYEE ONLY	$750			
EMPLOYEE WITH DEPENDENTS	$1,500			
ANNUAL DEDUCTIBLE (AGGREGATED)				
EMPLOYEE ONLY	$1,750	$1,750	$3,500	$4,000
EMPLOYEE WITH DEPENDENTS	$3,500	$3,500	$7,000	$8,000
MAXIMUM OUT-OF-POCKET (INCLUDES DEDUCTIBLE) (EMBEDDED OOP)				
EMPLOYEE ONLY	$3,500	$4,000	$7,000	$10,500
EMPLOYEE WITH DEPENDENTS	$7,000	$8,000	$14,000	$21,000
The Out of Area coverage is not available under the High Deductible HSA Plan.				
OFFICE VISIT CHARGE ONLY				
PRIMARY CARE PHYSICIAN (PCP)	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
SPECIALIST	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
EMERGENCY ROOM/URGENT CARE				
EMERGENCY ROOM	80% coverage after deductible	80% coverage after deductible	80% coverage after deductible	80% coverage after deductible
URGENT CARE	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
PHYSICIAN SERVICES				
INPATIENT VISITS	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
OUTPATIENT	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
HOSPITAL SERVICES				
ROOM AND BOARD	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
INTENSIVE CARE UNIT	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
SURGERY	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
SKILLED NURSING FACILITY	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible

HDHSA PLAN (CONTINUED)

	FMOLHS NETWORK (TIER 1)	PREFERRED PROVIDER NETWORK (TIER 2)	NON-PREFERRED PROVIDER (TIER 3)	OUT-OF-NETWORK
HOSPITAL SERVICES				
BARIATRIC SURGERY Plan Coverage for Bariatric surgery is available only to a Full-Time or Part-Time Active employee who is a Class A Participant who remains in that status on the date of service and satisfies the requirements in Exhibit C and employee's covered spouse and dependent who satisfies the requirements in Exhibit C	$3,000 copay; Surgery must be performed at a MBSAQIP Accredited FMOLHS facility	No coverage	No coverage	No coverage
ORGAN TRANSPLANT Blue Distinction Centers coverage only	80% coverage after deductible when performed at Blue Distinction Center facility			No coverage
OTHER SERVICES				
ALLERGY TESTING	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
ALLERGY SERUM AND INJECTIONS	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
OTHER INJECTIONS	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
DIAGNOSTICS	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
LABORATORY	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
CHEMOTHERAPY	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
HOME HEALTH CARE	80% coverage after deductible; maximum of 50 visits per calendar year	70% coverage after deductible; maximum of 50 visits per calendar year	60% coverage after deductible; maximum of 50 visits per calendar year	No coverage
HOSPICE CARE	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
AMBULANCE SERVICE	80% coverage after deductible			
OCCUPATIONAL THERAPY PHYSICAL THERAPY SPEECH THERAPY	80% coverage after deductible;	70% coverage after deductible	60% coverage after deductible	No coverage
	Maximum of 120 visits per year (and maximum of 20 visits per week) combined with Occupational, Physical, and Speech Therapy			
APPLIED BEHAVIOR ANALYSIS (ABA)	80% coverage after deductible; max 20 hours per week annually	70% coverage after deductible; max 20 hours per week annually	60% coverage after deductible; max 20 hours per week annually	No coverage
SPECIFIC GENETIC TESTING (MUST SATISFY MEDICALLY NECESSARY CRITERIA)	80%; drawn/ordered by FMOLHS Geneticist	No coverage	No coverage	No coverage
SMOKING CESSATION AID Smoking cessation is available through the prescription benefit program	100% coverage of screening for tobacco use and two tobacco cessation attempts per year which includes four tobacco cessation counseling sessions of at least 10 minutes each without prior authorization and 90 day supply of Smoking Cessation Aids when prescribed by a health care provider without prior authorization			No coverage
DURABLE MEDICAL EQUIPMENT (DME)	80% coverage after deductible;	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
INSULIN PUMP	80% coverage after deductible; limited to 1 per 5 years	70% coverage after deductible; limited to 1 per 5 years	60% coverage after deductible; limited to 1 per 5 years	No coverage
ORTHOTICS AND PROSTHETICS	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
GENERIC DIABETES PRESCRIPTION MEDICATIONS AND PREFERRED SUPPLIES Employee must satisfy deductible	100% coverage of Generic Diabetes Prescription Medications and Preferred Supplies through the pharmacy benefit		No coverage	No coverage
MENTAL/NERVOUS AND SUBSTANCE ABUSE				
INPATIENT Including Partial Hospitalization (PHP), Intensive Outpatient Program (IOP) and Residential	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
OFFICE VISIT ONLY	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
OTHER OUTPATIENT SERVICES	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
PREGNANCY CARE AND DELIVERY				
LABOR & DELIVERY AND ASSOCIATED CHARGES	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
MATERNAL/FETAL ULTRASOUND	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible

HDHSA PLAN (CONTINUED)

	FMOLHS NETWORK (TIER 1)	PREFERRED PROVIDER NETWORK (TIER 2)	NON-PREFERRED PROVIDER (TIER 3)	OUT-OF-NETWORK
PREGNANCY CARE AND DELIVERY				
IN-NETWORK BREAST PUMP AND LACTATION COUNSELING THROUGH HEALTHY LIVES	100% coverage	100% coverage	100% coverage	No coverage
PRE-NATAL CARE	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
PREVENTATIVE CARE				
ROUTINE WELL ADULT CARE Generally limited to approved preventive or wellness services, which could include the following annual screenings depending on your age, gender, and health status: Lipid (Cholesterol), HGB A1C (Diabetes), Bone Marrow Density Test, Mammogram, Pap Test, Fecal Occult Blood Test, Colonoscopy, Depression Screening, Obesity Screening and Counseling. ***Please call the Claims Administrator to confirm coverage**	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually.	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually.	100% coverage Limited to one routine physical examination annually and approved wellness screenings annually.	40% coverage after deductible; Limited to one routine physical examination annually and approved wellness screenings annually.
ADULT IMMUNIZATIONS Immunizations are subject to current CDC Recommendations which include age limitations	100% coverage	100% coverage	100% coverage	40% coverage after deductible
ROUTINE WELL CHILD CARE Unlimited routine office visits through age two (2); annually ages three (3) up. Includes: office visits, routine physical examination and immunizations in accordance with CDC Guidelines and preventive care in accordance with federal guidelines.	100% coverage	100% coverage	100% coverage	40% coverage after deductible

*FMOLHS follows federal guidelines for coverage of preventive wellness screenings.

Note

When you enroll in the HSA plan, PayFlex will provide you with a debit card that includes the FMOLHS annual contribution to help pay for eligible expenses.

Health Plan Premiums
(Bi-weekly Team Member Contributions – 26 Contributions)

HEALTH PLAN PREMIUMS
(BI-WEEKLY TEAM MEMBER CONTRIBUTIONS – 26 CONTRIBUTIONS)

	TEAM MEMBER ONLY	TEAM MEMBER & SPOUSE	TEAM MEMBER + CHILD(REN)	FAMILY
EPO PLAN				
JUST PREMIUM	$21.89	$95.40	$43.27	$118.85
STANDARD PREMIUM	$50.52	$163.16	$100.17	$214.65
PART-TIME PREMIUM	$50.56	$274.74	$184.36	$356.20
	TEAM MEMBER ONLY	TEAM MEMBER & SPOUSE	TEAM MEMBER + CHILD(REN)	FAMILY
PPO PLAN				
JUST PREMIUM	$48.23	$180.39	$90.93	$228.96
STANDARD PREMIUM	$100.54	$257.67	$180.75	$337.88
PART-TIME PREMIUM	$146.51	$365.53	$271.72	$490.74
	TEAM MEMBER ONLY	TEAM MEMBER & SPOUSE	TEAM MEMBER + CHILD(REN)	FAMILY
HDHSA PLAN				
JUST PREMIUM	N/A	N/A	N/A	N/A
STANDARD PREMIUM	$82.00	$222.74	$191.00	$308.00
PART-TIME PREMIUM	$119.50	$315.97	$287.12	$405.50

My Pharmacy Benefits

Express Scripts (ESI) • www.express-scripts.com • 877-816-8717

Prescription Drug Coverage for Medical Plans

Your prescription drug program will be coordinated through Express Scripts (ESI). Your cost is determined by the tier assigned to the prescription drug product. All prescription drug products on the prescription drug list (Express Scripts' National Preferred Formulary) are assigned as Generic, Preferred, Non-Preferred and Specialty. You may contact ESI for information on your benefit coverage and search for network pharmacies by logging on to www.express-scripts.com or calling ESI Customer Care at 877-816-8717.

Why Do My Prescriptions Cost So Much?

In recent years, drug costs have increased, outpacing inflation by nearly four times annually. Rising drug costs are one of the single largest causes of the ballooning cost of health care. Although rising drug costs are inevitable, there are many ways you, the patient, with the help of your physician, can minimize your prescription drug costs while maintaining the same quality of health.

You share the cost of your medications with your employer. Your share of the cost is called a copay or coinsurance.

Some plans offer lower copays for less costly drugs. For example, they charge one copay for a Generic drug, a higher copay for a Preferred drug, and an even higher copay for a Non-Preferred drug.

Coinsurance is a percent of the drug's cost. When you pay a percentage, your cost may be high for many reasons:

- The cost of the drug may be high. Let's assume your coinsurance is 20%. In this case, a $250 drug will be more costly than a $25 drug.
- Your drug may not be on the Preferred Drug List, so you pay at a higher tier.
- You may be buying a more expensive brand-name drug when there is a generic equivalent available for less money.

How Can I Minimize My Medication Costs?

- Consider Mail Order for your maintenance medications. You receive a 3-month supply for only two copays if you fill your prescription at RxONE.
  Example:

	EPO PLAN	ANNUAL COST
PRESCRIPTION		
GENERIC – IN-HOUSE	$10 per month	$120
GENERIC – MAIL ORDER	$20 per 3 months	$80
YOUR ANNUAL SAVINGS	N/A	$40

- You can explore the benefits available to you before enrolling by visiting https://www.express-scripts.com/fmolhs. Here you can review plan options, find prices on medications under the plan, and explore an overview of the benefits offered.
- Print a copy of the Express Scripts National Preferred formulary and bring it with you when you visit your physician. Log on to www.express-scripts.com, and click on Register. Once you complete the registration you will have access to your account information, benefits and formulary list.
- Let your physician know that you would like to try generics first, if that is an appropriate option for you.
- Ask your provider if there are Over-the-Counter (OTC) products available to obtain the same results as prescription medications. Often these OTC products will be less expensive than your copay and will provide the same relief.
- Get a $5 discount when you fill your prescription at an in-house pharmacy. Get an additional $5 discount when your prescription is written by the Franciscan Clinic and filled at the in-house pharmacy. Refer to page 27 for a listing of the in-house pharmacy locations/services.

EPO PRESCRIPTION PLAN

	COST	
	IN-HOUSE	NETWORK
RETAIL PHARMACY (30-DAY SUPPLY)		
GENERIC DRUG	$10 copay	$15 copay
GENERIC DIABETIC PRESCRIPTION MEDICATIONS AND SUPPLIES	$0 copay	$0 copay
PREFERRED DRUG	$35 copay	$70 copay
NON-PREFERRED DRUG	$70 copay	$110 copay
SPECIALTY DRUG	Filled by RxONE – $100 copay	Filled by Express Scripts – $150 copay
MAIL ORDER PHARMACY (90-DAY SUPPLY — RXONE OR EXPRESS SCRIPTS)		
GENERIC DRUG PREFERRED DRUG NON-PREFERRED DRUG	2x in-house copay*	3x network copay*
BRAND-NAME DRUGS WHEN GENERIC IS AVAILABLE		
	The brand copayment, plus the difference between the retail cost of the brand-name drug and of the generic drug. Note: The difference will not be applied to the out-of-pocket maximum.	
IMMUNIZATIONS		
	According to CDC Immunization Schedules; Subject to age limitations	

*Mail order copays do not apply to mail order Specialty Prescriptions.

PPO PRESCRIPTION PLAN

	COST	
	IN-HOUSE	NETWORK
RETAIL PHARMACY (30-DAY SUPPLY)		
GENERIC DRUG	$10 copay	$15 copay
GENERIC DIABETIC PRESCRIPTION MEDICATIONS AND SUPPLIES	$0 copay	$0 copay
PREFERRED DRUG	$45 copay	$70 copay
NON-PREFERRED DRUG	$70 copay	$110 copay
SPECIALTY DRUG	Filled by RxONE – $100 copay	Filled by Express Scripts – $150 copay
MAIL ORDER PHARMACY (90-DAY SUPPLY – RXONE OR EXPRESS SCRIPTS)		
GENERIC DRUG PREFERRED DRUG NON-PREFERRED DRUG	2x In-house copay*	3x Network copay*
BRAND-NAME DRUGS WHEN GENERIC IS AVAILABLE		
	The brand copayment, plus the difference between the retail cost of the brand-name drug and of the generic drug. Note: The difference will not be applied to the out-of-pocket maximum.	
IMMUNIZATIONS		
	According to CDC Immunization Schedules; Subject to age limitations	

*Mail order copays do not apply to mail order Specialty Prescriptions.

HDHSA PRESCRIPTION PLAN

	COST	
	IN-HOUSE	NETWORK
RETAIL PHARMACY (30-DAY SUPPLY)		
GENERIC DRUG	20% after deductible	20% after deductible
GENERIC DIABETIC PRESCRIPTION MEDICATIONS AND SUPPLIES	20% after deductible	20% after deductible
PREFERRED DRUG	20% after deductible	20% after deductible
NON-PREFERRED DRUG	20% after deductible	20% after deductible
SPECIALTY DRUG (RXONE OR EXPRESS SCRIPTS)	20% after deductible	20% after deductible
MAIL ORDER PHARMACY (90-DAY SUPPLY — RXONE OR EXPRESS SCRIPTS)		
GENERIC DRUG PREFERRED DRUG NON-PREFERRED DRUG	20% after deductible	
BRAND-NAME DRUGS WHEN GENERIC IS AVAILABLE		
	The brand copayment, plus the difference between the retail cost of the brand-name drug and of the generic drug. Note: The difference will not be applied to the out-of-pocket maximum.	
IMMUNIZATIONS		
	According to CDC Immunization Schedules; Subject to age limitations	

*Mail order copays do not apply to mail order Specialty Prescriptions.

IN-HOUSE PHARMACY OVERVIEW

PHARMACY	LOCATION	SERVICE AREA	SERVICES						
			RETAIL	SPECIALTY	DELIVERY	FLAVOR-ING	MAIL ORDER	EMPLOYEE HEALTHPLAN DISCOUNT *	IMMUNI-ZATIONS
RxONE I Ascension	1014 West St. Claire Blvd Ste. 1010 225-271-6098	LA	✓		✓		✓	✓	✓
RxONE I Med Plaza	7777 Hennessy Blvd Ste 114, BR 225-765-8951	LA	✓	✓	✓			✓	✓
RxONEl Lake	5000 Hennessy, Chapel Hallway Rm 101, BR 225-374-0260	LA	✓	✓	✓			✓	✓
RxONE I Tower Drive	2600 Tower Dr., Monroe 318-966-6290	LA	✓			✓		✓	✓
RxONE I St Francis	309 Jackson St, Monroe 318-966-7242	LA & MS	✓				MS only	✓	✓
RxONE I Lourdes	4809 Ambassador Caffery Pkwy, Laf 337-470-4342	LA & MS	✓	✓			MS only	✓	✓
O'Donovan Pharmacy	5131 O'Donovan Dr, BR 225-374-0270	LA	✓	✓	✓		✓	✓	✓
Mid City Pharmacy	1401 N. Foster Dr, BR 225-987-9184	LA	✓		✓			✓	✓
Lake Children's Pharmacy	8300 Constantin Blvd, BR 225-374-1350	LA	✓	✓		✓		✓	✓
Our Lady of the Angel OP	433 Plaza St., Bogalusa, LA 985-730-7219	LA	✓						

Preauthorization Requirement List

Note: The following services, supplies and care must be preauthorized or reimbursement from the Plan may be reduced.

To preauthorize services, your provider can contact Blue Cross Blue Shield at 833-468-3594. If preauthorization requirements are not met, covered expenses will be paid at 50% if the services are Medically Necessary and 0% if the services are not Medically Necessary.

If you have any questions regarding medical preauthorization, call Blue Cross Blue Shield at 833-468-3594.

- All Inpatient Admissions (Includes acute, Skilled, Rehabilitation, LTAC and Treatment Room Services)
- All Clinical Trials, Experimental & Investigational Procedures/Treatment
- All Transplant Services Including Pre-Transplant Evaluations
- All Out-of-Network and Out-of-Area Services, except inpatient admissions, outpatient services, residential treatment, home health and hospice
- All Plastic & Reconstructive Surgeries & Procedures (Cosmetic procedures are excluded from coverage)
- All CT Scans and MRIs including CTAs and MRAs
- 17 Alpha-Hydroxyprogesterone Caproate (17P)
- Alcohol/Substance Abuse
- Applied Behavior Analysis
- Bariatric Surgery
- Diabetic Education
- Durable Medical Equipment (purchases over $500 and all rentals)
- Enteral Feedings
- Epidural Steroid Injections
- Genetic Studies/Testing/Therapy
- Growth Hormones
- Home Health
- Hyperbaric Oxygen Therapy
- Injectables (Boniva, Reclast, Hyalgan, Synagis, Orthovisc, Supartz, Botox, & Growth Hormones)
- Insulin Pump
- IV Infusions
- Mental Health Services
- Orthotics and Prosthetics over $1,000 (with the exception of fracture or sprain diagnosis)
- PET Scans
- Pain Management procedures
- Podiatry treatment
- Diagnostic studies and/or treatment of Sleep Disorders
- Surgery (hysterectomy, varicose vein, nasal/septal surgery, breast reduction, surgical intervention to correct sleep apnea, oral surgery)
- Therapies – Physical, Speech, Occupational
- Non-Emergent Air Ambulance and Non-Emergent Ambulance Transportation
- Weight Loss Program & Medications

(This list is not inclusive of all codes requiring prior authorizations; please contact Member Services for benefits, eligibility, and code specific requirements at 833-468-3594.)

Which Preventive Services Can I Get With No Out-of-Pocket Expenses?

Depending on your age, you may have access at reduced or no cost to such preventive services as:

- One adult routine preventive care visit annually:
- Blood pressure, diabetes, and cholesterol tests;
- Screening tests for many common types of cancers, including mammograms and colonoscopies (the test used to screen for colon cancer) in accordance with U.S. Preventive Services Task Force (USPSTF) recommendations;
- Counseling from your health care provider on such topics as quitting smoking, losing weight, eating healthy, treating depression, and reducing alcohol use;
- Routine vaccinations against disease, such as measles, polio, meningitis, flu and pneumonia shots in accordance with CDC recommendations;
- Counseling, screening, and vaccines to ensure healthy pregnancies; and
- Regular well-baby and well child visits from birth to age 21.

Screening in these areas (blood pressure, cholesterol, glucose, obesity) can be completed by scheduling your annual well visit with your Primacy Care Provider.

Note

For a complete list of affected preventive services, go to www.healthcare.gov/coverage/preventive-care-benefits/

2023 ADULT PREVENTIVE SERVICE RECOMMENDATIONS[1] THIS CHART IS INTENDED AS A REFERENCE TOOL FOR YOUR CONVENIENCE.

PREVENTION/SCREENING	AGE			
	21-39	40-49	50-64	65 or older
ABDOMINAL AORTIC ANEURYSM SCREENING				One time screening by ultrasonography in men ages 65-75 who have ever smoked
BREAST CANCER SCREENING (BRCA[2]; MEDICATION[3])	As recommended by your health care provider*	Screening mammography, every year, for women age 40 years and older, with or without clinical breast examination		
CERVICAL CANCER SCREENING	Cytology (Pap smear) every 3 years women ages 21 – 65 or			As recommended by your health care provider*
	Ages 30 – 65 years who want to lengthen the interval, screening with a combination of cytology & human papillomavirus (HPV) testing every 5 yrs.			
CHOLESTEROL ABNORMALITIES SCREENING: MEN	Men ages 20 – 35 for lipid disorders if they are at increased risk for coronary heart disease			
	Men ages 35 and older for lipid disorders			
CHOLESTEROL ABNORMALITIES SCREENING: WOMEN	Women ages 30 – 45 years for lipid disorders if they are at increased risk for coronary heart disease			
		Women age 45 years and older for lipid disorders		
COLORECTAL CANCER SCREENING	As recommended by your health care provider*		Adults beginning at age 45, fecal occult blood testing annually, sigmoidoscopy every 5 years, or colonoscopy every 10 years	
DIABETES SCREENING	Beginning at age 45 (If you have high blood pressure or high cholesterol, are overweight, or have a close family history of diabetes, you should consider an earlier screening.)			
HEPATITIS C SCREENING	Adults age 18 – 79 without known liver disease, a one-time screening for hepatitis C virus (HCV)			
IMMUNIZATIONS[4]	Refer to the CDC's posted schedule of immunizations			
LUNG CANCER SCREENING Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery			Annual screening with low-dose computed tomography in adults age 50 – 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years.	
OSTEOPOROSIS SCREENING	Bone density in younger women whose fracture risk is equal to or greater than that of a 65 year old white woman who has no additional risk factors.			Bone density for women age 65 years or older
WELLNESS OFFICE VISIT: PHYSICAL EXAM, BLOOD PRESSURE, BODY MASS INDEX (BMI)	Annually			

* High Risk: There is no age limit for screening if you are at high risk:
Colon cancer: If you or a close relative had colorectal polyps or colorectal cancer or if you have inflammatory bowel disease.
Breast cancer: This might include women who carry genes that increase their risk of breast cancer, such as the "BRCA" genes or who have close relatives who were diagnosed with breast cancer at a young age.

[1] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics (current as of June 2022)

[2] BRCA risk assessment and genetic counseling/testing: Screen women whose family history may be associated with an increased risk for potentially harmful BRCA mutations. Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.

[3] Breast cancer preventive medications: Asymptomatic women aged ≥35 years without a prior diagnosis of breast cancer who are at increased risk for the disease. Clinicians engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk.

[4] Adult immunizations: https://www.cdc.gov/vaccines/schedules/index.html

Additional preventive care benefits may be covered under the health plan.

Care Management

In partnership with your primary care provider, you have access to additional resources to meet your health goals. A care team will work closely with physicians to provide the care needed for individuals with chronic diseases such as diabetes, high blood pressure, heart failure and asthma. The entire care team will work together to provide seamless care, will help individuals navigate the health care system and get connected with the resources needed to better manage their disease.

Below are a couple of the focus areas and the benefits available for health plan members who qualify:

Transition Care

Targets patients who are discharged from the hospital and have previously been identified as having a high likelihood of readmission within 30 days.

Complex Care

Targets patients who are living with complex chronic conditions, such as hypertension and diabetes, and are at high risk for either an emergency or inpatient encounter.

Diabetes Management Program

Disease management is a confidential program provided by FMOLHS to help you or a covered dependent living with a chronic condition. Diabetes coaching is available through Healthy Lives. Eligible team members and dependents will have access to a personal health coach and together develop achievable goals and strategies for improving their overall health.

When you work with a nurse coach, you'll get tips and practical tools for managing your chronic condition. They will also help you set up a plan to reach personal goals. Coaching is a great way to re-energize yourself to improve or manage your condition.

Maternity Management

In partnership with your health care provider, a Healthy Lives registered nurse will assist you throughout your pregnancy with your personalized health needs. Maternity management nurses will have personal contact each trimester and provide first year of life education. Individuals engaged in maternity management receive free preconception counseling and prenatal information.

My Health and Well-Being

My Health and Well-being Program

Now more than ever we recognize the importance of offering opportunities to care for your health and well-being. Our well-being program provides you with a more streamlined and personalized program and gives you more opportunities to engage and get rewarded for participating in health and well-being activities.

Your primary care physician (PCP) should be your main point of contact in your wellness journey. You'll have to complete this PCP visit along with completing the HRA questionnaire to be eligible for rewards under the well-being program. Each point you earn equals $1 in rewards. Team members can earn up to 550 points or $550 in rewards.*

You have many options on how to redeem points that you earn. We have partnered with a company called Awardco, which will enable you to redeem your wellness points on things such as Amazon items, hotels, virtual pre-paid cards, e-gift cards, movie tickets, or cash the rewards out for additional money on your paycheck. The choice is yours! **Earned points will be available for redemption on the 15th of each month.**

Note

For questions about the Well-being Program, please contact Healthy Lives at 855-426-4325 or visit www.ourhealthylives.org. You can also get additional information by visiting our Total Rewards site at fmolhs.org/totalrewards on the My Health and Well-being page.

To participate in the 2023 Health and Wellness Program and to begin earning points, follow the steps below:

1. Complete your HRA Questionnaire on the Healthy Lives app or web-based portal.
2. Schedule and complete your wellness visit with your PCP between December 16, 2022 and December 15, 2023. During your wellness visit, your PCP will perform your annual wellness exam and your biometric screening.
   - *NOTE: Contact our Network Guides at 855-875-6265 if you need assistance finding a primary care provider or scheduling an appointment.*
3. Engage in approved activities that help you achieve your goals and earn your rewards.
   - *There is a catalog of approved activities available on the Total Rewards site on the My Health and Well-being page or on the Healthy Lives portal. Review the activities and determine which best fit with your work-life schedule and complete the activities. Then follow the steps to confirm your participation in the activities.*
4. Redeem your points for rewards of your choice on the Awardco site, which can be accessed through the Healthy Lives portal or online at https://fmolhs.awardco.com. You will need to register on the Awardco site to access your rewards.

*Maximum annual rewards are prorated based on employment status: Full time 100%, part-time 50% and PRN 25%. To receive the reward, the team member must be actively employed on the date of the reward payment. Reward payments are subject to state and federal taxes.

In addition to completing your wellness visit with your PCP, you can work with our partner, Healthy Lives, and meet with a personal health coach to review your wellness screening results, create a personal plan to help you reach your health and well-being goals, and earn rewards for doing so.

Your medical information is private and protected. Your participation in the Healthy Lives Wellness program is your personal choice. The results of your screening and personal wellness plan are not shared with your employer.

Healthy Lives Wellness Program

Working well begins with living well. We're pleased to be a partner for your personal health journey. As a benefit to every team member, we offer the Healthy Lives Wellness Program to support and encourage individual health goals. All team members can participate at no cost. Whether at home or work, these tools and personal coaching help each team member and their family identify what's important to their health and well-being with a plan to achieve results. Body, mind and spirit – our wellness approach is comprehensive and complements your personal physician's care and personal health goals.

Personal Coaching and Continual Education

Once the wellness visit and biometric screening are complete with your PCP, schedule a one-on-one health coaching session with Healthy Lives, Your health coach will explain the screening results and create a personal plan to help you reach your health goals. You'll be surrounded and supported by a work environment that wants you to succeed. Timely health topics are delivered via live remote presentations, podcasts, in-person seminars and more. Everything is at your fingertips through the mobile Healthy Lives app to help you keep track of your progress, review health and well-being activities to earn wellness points, and schedule the education that's important to you. Your coach will make suggestions too! Here are some of the options offered:

Wellness Classes	Walking Groups	Tobacco Cessation	Health Coaching
Farm To Work	Stretch Breaks	Meal Planning	Pregnancy Program
Team Challenges	Stress Management	Nutrition Education	Diabetes Prevention

Kinesics

Kinesics is a platform to improve balance and mobility that is personalized to address your individual needs. Schedule through the Healthy Lives app/portal, and you will receive a full range of motion evaluation and a one-on-one results review. Team members receive a customized flexibility and mobility program that is 100% unique to your body and includes video tutorials, so you feel confident about executing your program.

Healthy Lives Wellness App

Take your plan and your progress with you everywhere using the mobile app. This interactive tool helps you keep track of total well-being and manage your healthy lifestyle choices. Through this mobile tracker, you'll also stay connected to all of the Healthy Lives Wellness resources, including chats with a health coach. The app is free to download and compatible with all mobile devices.

To learn more about the Health and Wellness Program and Healthy Lives, visit www.OurHealthyLives.org or call 855-426-4325 for Louisiana ministries or 601-200-6448 for Mississippi ministries.

Notice Regarding Wellness Program

Healthy Lives is a voluntary wellness program available to both health plan and non-health plan members. 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 total cholesterol, HDL, LDL, triglycerides and glucose (include cotinine screening, if appropriate). Your blood pressure, height, weight, and waist circumference will also be measured. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

Incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. 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 Healthy Lives at 855-426-4325.

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 wellness programming and content. 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 FMOLHS may use aggregate information it collects to design a program based on identified health risks in the workplace, Healthy Lives 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. In order to provide you with services under the wellness program, your personally identifiable health information may be shared with one or more of the following: Mercer, Lockton Companies, Blue Cross Blue Shield, Express Scripts (ESI) and Health Leaders Network.

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. 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 Human Resources.

My Dental Benefits

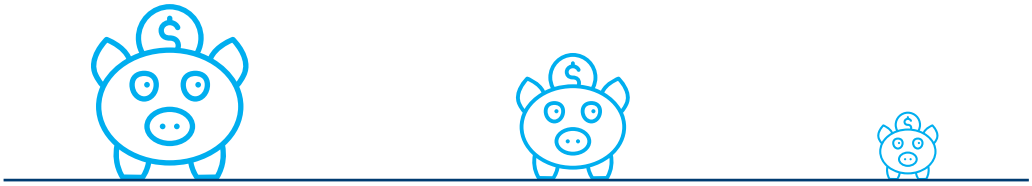
Delta Dental
www.deltadentalins.com • 800-521-2651

Diagnostic and Preventive Care Services will no longer accrue towards your plan year maximums. This includes x-rays, cleanings and exams.

Proper dental care plays an important role in your overall good health. Our Dental Plan is designed to encourage preventive treatment, allowing team members to achieve oral health while striving to minimize dental costs. The Dental Plan will be administered by Delta Dental. Enrolled team members will also have access to hearing aid discounts.

Choose a PPO Dentist to Save!

The dental plan allows a participant to visit any licensed dentist, but by taking advantage of the nationwide PPO network you will maximize the value of the plan. You can search the Delta Dental PPO Network for a dentist near you by visiting http://www.deltadentalins.com/dentist-directory/ppo.html.



Delta Dental PPO | Delta Dental Premier® | Non-Delta Dental

1. Greater Savings

PPO dentists have agreed to reduce fees, which leaves more money in your pocket.

2. Quality Assurance

Delta monitors PPO dentists to ensure that proper licensing, cleanliness and safety procedures are followed and send regular updates on policies and contracting requirements.

3. No Balance Billing

PPO dentists cannot charge you more than their set fees. Out-of-Network dentists may bill the difference between their usual feel and Delta Dental's contracted rate — a process known as "balance billing".

4. Avoid Unbundling

PPO dentists agree to not unbundle services that are part of a treatment. Out-of-Network dentists may charge for these services separately, making the overall cost higher.

5. Less Paperwork

PPO dentists handle all claim forms and other paperwork for you. If you choose an out-of-network dentist, you may be required to submit the claim yourself.

6. No Prepayment Required

When you choose a PPO dentist, you will pay only your portion of the bill. Out-of-Network dentists may require you to pay up front and request a reimbursement from Delta Dental when the claim is submitted.

Note

While you may seek services covered under the Dental Plan from any dentist, you will have access to discounted pricing when utilizing the PPO network dentists.

Dental Premiums

Dental premium contributions will be deducted from your paycheck on a before-tax basis. Your tier of coverage will determine your semi-monthly premiums (24 deductions).

	BASIC PLAN		BUY UP PLAN	
	FULL TIME	PART TIME	FULL TIME	PART TIME
2023 PREMIUMS				
TEAM MEMBER	$3.90	$7.80	$7.92	$15.83
TEAM MEMBER + FAMILY	$24.50	$28.40	$36.15	$44.07

Dental Plan Coverage

	DENTAL PLAN	
	BASIC PLAN	BUY UP PLAN
ANNUAL DEDUCTIBLE		
EMPLOYEE AND EACH COVERED FAMILY MEMBER	$50 per person, up to $150 per family	$50 per person, up to $150 per family
CALENDAR YEAR MAXIMUM (FOR COVERED SERVICES)		
EMPLOYEE AND EACH COVERED FAMILY MEMBER	$1,000 per person	$1,550 per person
CLASS I: PREVENTIVE AND DIAGNOSTIC SERVICES	COVERED AT*	COVERED AT*
ORAL EXAMS AND CLEANINGS (2X PER CALENDAR YEAR) X-RAYS: FULL MOUTH (1 EVERY 36 MONTHS) BITEWING (1 SERIES PER 12 MONTHS) FLUORIDE APPLICATION (1 PER CALENDAR YEAR; LIMITED TO DEPENDENT CHILDREN UNDER 16 YEARS OLD) SPACE MAINTAINERS (LIMITED TO NON-ORTHODONTIC TREATMENT)	100%, no deductible	100%, no deductible
CLASS II: BASIC RESTORATIVE SERVICES		
FILLINGS, ENDODONTICS, PERIODONTAL SCALING, DENTURE ADJUSTMENTS AND REPAIRS, EXTRACTIONS, ANESTHETICS, ORAL SURGERY INCLUDING BONEY IMPACTED WISDOM TEETH	50%**	80%**
CLASS III: MAJOR RESTORATIVE SERVICES		
CROWNS, DENTURES, BRIDGES	50%**	50%**
CLASS IV: ORTHODONTIA	No coverage	50%**
LIFETIME MAXIMUM (FOR ORTHODONTIA SERVICES ONLY) APPLIES TO DEPENDENT CHILDREN LESS THAN 19 YEARS OF AGE		$1,500

* Up to a maximum allowed charge (excludes exams, cleanings and x-rays)
** After plan deductible.

Note

Extraction of wisdom teeth, including bony impacted teeth, is covered under the Dental Plan only and requires pre-certification prior to services.

My Vision Benefits

UNUM Vision • www.alwaysassist.com • 866-679-3054

Vision Buy-Up Plan

Vision health is an indicator of overall health. Regular eye exams can detect diseases like glaucoma, diabetes and loss of sight. Vision benefits allow for access to quality vision care. To ensure that you and your family will get the care you need, FMOLHS now offers 2 comprehensive vision benefit plans provided by UNUM vision. Enrolled team members will also have access to hearing aid discounts.

In-network copayments are paid directly to the provider.

Out-of-network copayments will be deducted from the out-of-network reimbursement.

- Contact lenses are in lieu of eyeglass lenses and frames benefit.
- The insured is responsible for paying any charges in excess of this allowance.

Network Providers offer the lowest out-of-pocket costs. To find a network provider, log on to www.alwaysassist.com and select provider locator.

Eligibility

Full-time and regular part-time (0.5 – 1.0 FTE) team members.

Vision Premiums (semi-monthly; 24 deductions)

	VISION	
	BASIC PLAN	BUY UP PLAN
2023 PREMIUMS		
TEAM MEMBER	$2.47	$3.05
TEAM MEMBER + SPOUSE	$4.93	$6.11
TEAM MEMBER + CHILD(REN)	$6.17	$7.64
TEAM MEMBER + FAMILY	$6.79	$8.41

Vision Plan Summary

	BASIC PLAN		BUY UP PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
COPAY				
EXAMINATION	$10 copay	Up to $35 allowance	$10 copay	Up to $50 allowance
MATERIALS	$15 copay	See covered services	$10 copay	See covered services
BENEFIT FREQUENCY				
EXAMINATION	12 months	12 months	12 months	12 months
LENSES	12 months	12 months	12 months	12 months
FRAMES	12 months	12 months	12 months	12 months
CONTACTS (in lieu of Lenses and Frames)	12 months	12 months	12 months	12 months
COVERED MATERIALS				
STANDARD PLASTIC LENSES*				
SINGLE VISION LENSES	100% after copay	Up to $25 allowance	100% after copay	Up to $50 allowance
BIFOCAL LENSES	100% after copay	Up to $40 allowance	100% after copay	Up to $60 allowance
TRIFOCAL LENSES	100% after copay	Up to $50 allowance	100% after copay	Up to $70 allowance
LENTICULAR	$80 allowance	Up to $50	$80 allowance	Up to $70 allowance
PROGRESSIVE	$70 allowance	Up to $40	$70 allowance	Up to $60 allowance
FRAMES				
RETAIL FRAME EQUIVALENT	100% up to $100 allowance ($94 at Walmart, Sam's Club and Costco)	Up to $50 allowance	100% up to $150 allowance ($94 at Walmart, Sam's Club and Costco)	Up to $60 allowance
CONTACT LENSES				
ELECTIVE	100% up to $100 allowance (in lieu of frames)	Up to $100 allowance	$100 up to $150 allowance (in lieu of frames)	$100 allowance
MEDICALLY NECESSARY	100% after copay	Up to $210	100% after copay	Up to $210

*Scratch resistant coating and Polycarbonate Lenses for children are covered at Walmart only.

Note

Members receive a discount on LASIK or PRK prices with participating surgery providers.

My Health Savings Accounts – HSA

Take charge of your health care spending with a Health Savings Account (HSA). Contributions to an HSA are tax free and withdrawals for qualified medical expenses are tax free.

Your HSA can be used for qualified expenses, including those of your spouse and/or taxable dependent(s), even if they are not covered by your plan. If you are not enrolled in a HDHSA but you have unused HSA funds from a previous account, those funds can still be used for qualified medical expenses.

PayFlex will issue you a debit card, giving you direct access to your account balance. When you have a qualified medical expense, you can use your debit card to pay. You must have a balance to use your debit card. There are no receipts to submit for reimbursement.

Eligible expenses include doctors' office visits, eye exams, prescription expenses, laser eye surgery and more. IRS Publication 502 provides a complete list of eligible expenses and can be found on www.irs.gov.

Eligibility

You are eligible to open and fund an HSA if:

- You are enrolled in the HDHSA plan.
- You are not covered by your spouse's HDHSA plan.
- Your spouse does not have a Medical Flexible Spending Account (FSA) or Health Reimbursement Account (HRA).
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

Individually Owned Account

You own and administer your Health Savings Account. You determine how much you'll contribute to the account, when to use the money to pay for qualified medical expenses, and when to reimburse yourself. HSAs allow you to save and roll over money if you do not spend it in the calendar year. The money in this account is portable, even if you change plans or jobs. There are no vesting requirements or forfeiture provisions.

How to Enroll

You must elect the HDHSA plan with FMOLHS. You will need to complete all HSA enrollment materials and designate the amount to contribute on a pre-tax basis. FMOLHS will establish an HSA account with PayFlex in your name and send in your contribution once bank account information has been provided and verified.

Maximize Your Tax Savings

Contributions to an HSA are tax-free (they can be made through payroll deduction on a pre-tax basis when you open an account with PayFlex). The money in this account (including interest and investment earnings) grows tax-free. As long as the funds are used to pay for qualified medical expenses, they are spent tax-free.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax.

HSA Funding Limits

FMOLHS will provide an HSA employer contribution that will be deposited on an annual basis ONLY if the employee contributes to the HSA.

Each year, the IRS places a limit on the maximum amount that can be contributed to HSA accounts. For 2023, contributions are limited to the following:

	TEAM MEMBER CONTRIBUTION MAXIMUM	EMPLOYER CONTRIBUTION	TOTAL CONTRIBUTION MAXIMUM
TEAM MEMBER	$3,100	$750	$3,850
FAMILY	$6,250	$1,500	$7,750
CATCH-UP (AGES 55+)	$1,000	N/A	N/A

Employee HSA contributions in excess of the IRS annual contribution limits ($3,100 for individual coverage and $6,250 for family coverage for 2023) are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you can do one of two things:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed from your HSA.
- Leave the excess contributions in your HSA and pay 6% excise tax on excess contributions. Next year you may want to consider contributing less than the annual limit to you HSA to make up for the excess contribution during the previous year.

The FMOLHS HSA will be established with PayFlex. You may be able to roll over funds from another HSA. For more enrollment information, contact PayFlex or visit www.payflex.com.

Note

For more information on Health Savings Accounts (HSA) visit www.payflex.com

My Flexible Spending Account – FSA

PayFlex
www.payflex.com • 844-PayFlex (729-3539)

FLEXIBLE SPENDING ACCOUNT (FSA)		
	MEDICAL FSA	LIMITED USE FSA
HOW MUCH CAN I CONTRIBUTE?	$2,750 per year	$2,750 per year
WHO IS ELIGIBLE?	0.5 – 1.0 FTE	0.5 - 1.0 FTE

PayFlex will administer the Medical and Limited Use Flexible Spending Accounts.

Medical Flexible Spending Account

The Health Care FSA allows you to set aside money through payroll deductions on a pre-tax basis to pay for out-of-pocket health care expenses, such as deductibles, copays, coinsurance, prescribed medications, dental expenses, vision expenses, Lasik and more. By paying for these expenses with pre-tax dollars, you reduce the amount of your taxable income and increase your take-home pay.

Limited Use Flexible Spending Account

Designed to complement a Health Savings Account, a Limited Use Flexible Spending Account (LUFSA) allows for reimbursement of eligible Dental and Vision expenses. If you enroll in the HSA account and also enroll in the Medical FSA in 2023, the Medical FSA automatically becomes a Limited Use FSA (LUFSA). You must decide how much to set aside for this account. You may contribute up to $2,750 in the LUFSA. Again the LUFSA can only be used for eligible dental and vision expenses. When you use your PayFlex debit card to pay for eligible dental and vision expenses, the available dollars will always pull from the LUFSA first until that account is exhausted and then the dollars will pull from your HSA account.

FSA Debit Card: Medical Flexible Spending Account

The FSA Debit Card allows you to pay for eligible health care expenses at the point of service and deducts funds directly from your FSA account. Over-the-counter (OTC) purchases require a doctor's prescription in order for the OTC medicine or drug to be eligible for reimbursement from an FSA. For OTC purchase reimbursement, you will have to substantiate the purchase by submitting your receipt and doctor's prescription to PayFlex. You may use your FSA Debit Card at locations such as doctors' and dentists' offices, pharmacies, and vision service providers. The card cannot be used at locations that do not offer services under the Plan, unless the provider has also complied with IRS regulations. Should you attempt to use the card at an ineligible location the swipe transaction will be denied. Should you need to submit a receipt, you will receive an email or mailed Receipt Notification from PayFlex, but you should always retain a receipt for your records.

General FSA Rules and Restrictions

In exchange for the tax advantages FSAs offer, the IRS has imposed the following rules and restrictions for Health Care FSAs:

- Your expenses must be incurred during the Plan year of 2023.
- Your dollars cannot be transferred from one FSA to another.
- You must "use it or lose it"— any unused funds will be forfeited.
- You cannot change FSA election in the middle of the Plan year unless you have a qualified life status change, such as a marriage, divorce, or birth of a child.

Note

If you have any money remaining in your FSA at the end of the year, you forfeit it. In other words, "USE IT OR LOSE IT."

2.5-Month Grace Period

- The 2.5-month grace period allows participants an additional period of time to incur expenses after the Plan year ends (December 31, 2023).
- If an expense is incurred between January 1, 2023 and March 15, 2024 AND submitted for reimbursement on or before March 31, 2024, any remaining balance in the previous Plan year that ended December 31, 2023, will be paid out for the claim, even though the service was provided in the NEW Plan year.

FSA FAQs

What should I do if I receive a substantiation letter or online notification?

Include these notices when you submit your receipts to PayFlex. Keep a copy of these letters and copies of all receipts for your records. You can substantiate a claim by:

MAIL	FAX	UPLOAD
PayFlex Systems USA, Inc. Flex Claims Department P.O. Box 981158 El Paso, TX 79998-1158	855-703-5305 Use letter as your cover sheet	www.payflex.com Select Learn More next to Substantiation Alert and click Upload My Receipts

If I do not comply with these substantiation notices, will I lose the ability to use my debit card?

Yes, if you do not respond within the period of time noted on the second notification, your card will be deactivated until acceptable documentation or payment is provided to PayFlex.

How can I access my FSA dollars when my debit card is deactivated?

You can purchase eligible items or services with another form of payment and submit a claim form along with receipts to PayFlex while your card is inactive.

What are acceptable forms of substantiation?

- An Explanation of Benefits (EOB) is the preferred form of documentation.
- An itemized receipt is also acceptable, but it must show:
  - Date of purchase or service
  - Amount of purchase or service
  - Description of item or service
  - Name of merchant or service provider
  - Name of patient if a medical claim

Please note: Itemized receipts/statements showing prior balances or 'estimated' insurance payments will not be acceptable. If insurance is indicated, the receipt/statement must show insurance payment posted and final patient responsibility. Credit card receipts are not acceptable forms because they do not provide the specific item purchased; therefore, PayFlex cannot determine if the expense was an FSA eligible item.

I thought purchases at certain vendors were automatically substantiated and considered approved purchases?

As of February 2009, no additional substantiation is required for debit card transactions that are approved at the point of sale by merchants (specifically pharmacies) who have adopted the Inventory Information Approval System (IIAS). The IIAS system compares the SKU on the item being purchased to a list of FSA eligible items sold at the store. When a FSA debit card is used, the pharmacy will only allow the card to pay for the FSA eligible items and any non-FSA eligible items will need to be paid for using an alternative method of payment. If merchants still have not adopted this system, FSA debit cards might not work at their places of business.

Contact Information:

You can reach Customer Service at: 844-729-3539

Send Claims To:
PayFlex Systems USA, Inc.
Flex Department
P.O. Box 981158
El Paso, TX 79998-1158

My Life Insurance

Lincoln Financial Group
www.LincolnFinancial.com/FMOLHS • 855-818-2883

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

Basic Life and Accidental Death and Dismemberment (AD&D) is a part of the FMOLHS benefits plan and is an essential part of your future financial security. It is important to understand how your plan works and what benefits you will receive.

Your Basic Life insurance benefit is equal to 1.5 times your basic annual earnings up to a maximum of $50,000. **This benefit is provided at no cost to you.** If you are eligible (0.5 – 1.0 FTE) you are automatically enrolled in Basic Life insurance through Lincoln National Life Insurance Company.

Beneficiary Designation

Your beneficiary designation is the person you name to receive your life insurance benefits in the event of your death. This includes any life insurance benefits payable under the Supplemental or Voluntary Life insurance plans available through FMOLHS. Benefits payable for a dependent's death under the Dependent Life insurance plan are payable to you if living; otherwise, if no beneficiary is listed, the insurance company will specify the beneficiary based on contract guidelines. The primary purpose of life insurance is to provide financial support to a beneficiary when he or she needs it most – at the loss of a loved one. Therefore, it is very important your beneficiary designations be kept up to date.

	GROUP LIFE
COVERAGE AMOUNT	1.5x annual salary
WHO PAYS	Company pays full cost
WHEN BENEFITS ARE PAYABLE	If you die while covered under the plan
MAXIMUM BENEFIT	$50,000
WHEN CAN I CHANGE MY ELECTION	N/A

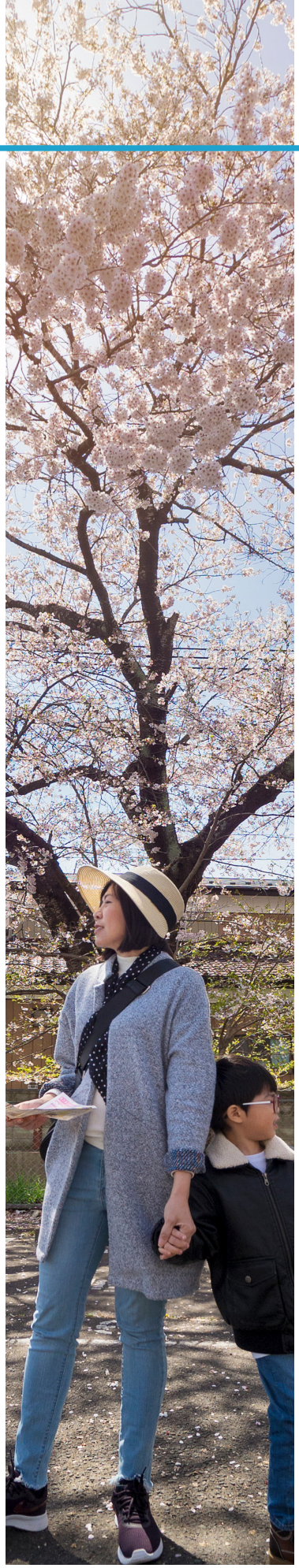
Employee Basic Life and AD&D Insurance will be reduced as follows:

AGE	REDUCTION
At age 65	Benefit will reduce by 35% of the original amount
At age 70	Benefit will reduce an additional 15% of the original amount
At age 75	Benefit will reduce an additional 15% of the original amount
At retirement	Benefit will terminate when the insured person retires

If a team member first enrolls for Employee Life and AD&D Insurance at age 65 or older, the above age reductions will apply to any guarantee issue amount and to the maximum eligible amount.

Note

It is important that you name a primary and contingent beneficiary to receive your Life Insurance benefits. You can designate a beneficiary when making your New Hire/Newly Eligible benefit elections in Oracle Employee Self Service under Me/Benefits. When making your elections, you will be prompted to designate a beneficiary under the Life Insurance section.



My Retirement Benefits

Our retirement benefits are a cornerstone of our benefit program and demonstrate our support for you as you plan for your future.

Our goal is to ensure we have a strong, sustainable benefit for many years to come while continuing to invest as we always have in our team members' future. We're also recognizing the increasing desire for team members to have more control of their retirement benefits and how they plan for their future.

What's included in this section (and why it's important)

- Snapshot of our retirement plans
- How to enroll – Steps to enroll in the FMOLHS 403(b) plan during open enrollment
- What to do and resources to help

You will enroll and make contribution election changes to all of our retirement plans directly on our custom Lincoln Financial website at www.LincolnFinancial.com/FMOLHS.

Snapshot of Our Retirement Plans

The 403(b) retirement program allows you more control over how much you save, investment decisions and to select from a variety of fund options. As your retirement planning partner, FMOLHS is committed to providing you with a robust plan that is designed to help you pursue your retirement goals, and help you build even bigger dreams. With the retirement program, you will enjoy a host of benefits, including:

Employer matching contributions (see below for details)

- Employer core retirement contributions
- A fully portable plan that moves with you when you retire or change jobs
- Greater control over investment decisions
- A robust plan website accessible via computer, mobile or wearable app
- Personalized expert help from on-site Lincoln Financial retirement consultants
- A range of diverse investment options
- Exceptional website and customer service support
- Ability to make hardship withdrawals or plan loans, if certain criteria are met
- Ability to make withdrawals from your account at age 59½, even if you are actively employed

403(b) Savings Plan

- Employer Contribution: If you work at least 1,000 hours and are employed on the last day of the year, you are eligible for a core contribution of 2% of your pay into your 403(b) account
  - FMOLHS will make a core contribution if you meet the requirements for hours worked and employment as of the last day of the calendar year even if you choose not to contribute your own money into the account.
  - Employer core contribution will be made annually
- New Hires: You will be automatically enrolled at 4%. You may change your deferral rate or opt-out at any time.
- You may elect to contribute anywhere from 1% to 100% directly from your paycheck, pre-tax or Roth after-tax; you are always 100% vested in your contributions

Employer Match Contribution Account

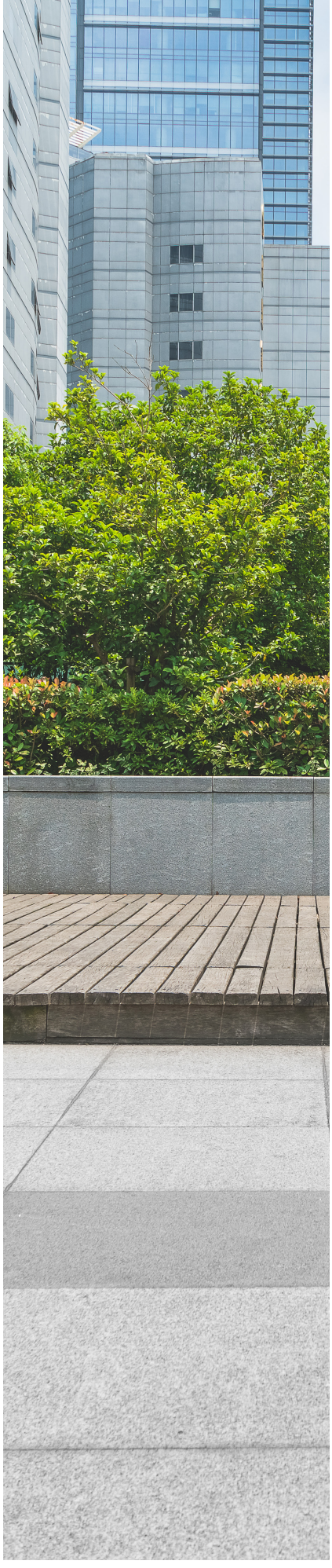
- You are eligible if you are contributing to the 403(b).
- You must work at least 1,000 hours and be employed on the last day of the calendar year to be eligible.
- FMOLHS will provide a 50% matching contribution for each dollar you contribute to the 403(b) plan, up to the first 6% (3% maximum).
- Matching contributions will be made annually

Vesting

- FMOLHS employer and matching contributions are 100% vested after 3 years of service.

Note

You will enroll and manage your retirement accounts — 403(b) and 457(b) — directly on the Lincoln Financial website at LincolnFinancial.com/FMOLHS.



What to Do and Resources to Help

HOW TO ENROLL	
REGISTER	» Register and secure your account at LincolnFinancial.com/Register. » Log into your account at LincolnFinancial.com/Retirement. You must take action to enroll.
ENROLL	» Select the amount you'd like to contribute, » Confirm your investment option — either the default investment or one you prefer — – and click Submit. That's it! You're enrolled. – You may also elect to set up an automatic contribution increase
BENEFICIARY AND E-DELIVERY	» Make sure you designate your beneficiary for each retirement account » Sign up for E-Delivery to receive your quarterly statement

RESOURCES TO HELP YOU		
403(b) SAVINGS PLAN (EMPLOYER CONTRIBUTION AND MATCH), 457(b) PLAN	» Detailed information about all of the retirement plans is available on our Total Rewards page and www.LincolnFinancial.com/FMOLHS. » If you have questions about your retirement plan, call the Lincoln Customer Contact Center at 877-562-4738 and speak to a Customer Service Representative weekdays from 9:00 a.m. to 7:00 p.m. Central. » To receive personal assistance, go to LincolnFinancial.com/FMOLHSschedule to schedule a free one-on-one personal consultation or contact one of your Lincoln Financial retirement consultants.	**Contact:** Ryan Jones Ryan.Jones@LFG.com 225-305-8539 Jayme Schwartzenburg Jayme.Schwartzenburg@LFG.com 225-363-8767

Lincoln WellnessPATH®

Your Path to Financial Wellness

Wellness isn't just about physical health. There are emotional and financial components, too. Whether you want to save more or need to pay off debt, getting your finances in order can have an impact on your overall well-being. It can help you move forward with confidence and be ready for whatever life brings. That's where Lincoln can help.

Lincoln WellnessPATH® provides tools and personalized steps to manage your financial life. From creating a budget to building an emergency fund to paying down debt, our easy-to-use online tool helps you turn information into action so you can focus on both short- and long-term goals, such as saving for retirement.

To get started, log in to your account at LincolnFinancial.com/WellnessPATH.

My Disability Insurance

Short Term Disability Insurance

- Eligible Members (0.5 – 1.0 FTE); Coverage is effective on the 91st day of continuous eligibility.
- Employer-paid – **no cost to team members**.
- Short Term Disability (STD) insurance protects a portion of your income if you become partially or totally disabled for a short period of time.

	GROUP SHORT TERM DISABILITY
COVERAGE AMOUNT	Up to 60% of basic annual Earnings
WHO PAYS	Company pays full cost
WHEN BENEFITS ARE PAYABLE	Following 7 days of illness or injury
MAXIMUM BENEFIT DURATION	12 weeks

Certain exclusions apply. Please refer to My Benefits on our Total Rewards page at fmolhs.org/totalrewards.

Long Term Disability Insurance

Lincoln Financial Group • LincolnFinancial.com/FMOLHS • 855-818-2883

	LONG TERM DISABILITY	
	GROUP CORE LTD	GROUP BUY-UP LTD
COVERAGE AMOUNT	50% of basic monthly salary	60% of basic monthly salary
WHO PAYS	Employee & company share cost	Employee pays full cost
WHEN BENEFITS ARE PAYABLE	Following 90 days of disability	Following 90 days of disability
MAXIMUM MONTHLY BENEFIT	$3,000 per month	$10,000 per month
WHEN EVIDENCE OF INSURABILITY IS REQUIRED	Any election after original enrollment period	Any election after original enrollment period

- Eligible Members (0.8 – 1.0 FTE)
- You must participate in the Core Plan to be eligible for the Buy-up option

Long Term Disability (LTD) insurance protects a portion of your income if you become partially or totally disabled for a long period of time. You must be disabled for at least 90 days before you can receive a Long Term Disability insurance benefit payment. Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner. If you may be entitled to some other income benefit, you are required to actively pursue it. Any other benefits you receive (such as Social Security Disability, Workers' Compensation, pension benefits or benefits from any similar act or plan) will reduce your LTD benefits. Certain exclusions, as well as pre-existing condition limitations, may apply. Please refer to My Benefits on our Total Rewards website at fmolhs.org/totalrewards.

My Voluntary Benefits

FMOLHS offers special voluntary benefits, through Lincoln Life Insurance Company to all eligible team members. These benefits are designed to provide financial security at an affordable price.

VOLUNTARY BENEFIT PLANS		
PLAN	NEW ENROLLEES	FUTURE ENROLLEES
LINCOLN VOLUNTARY EMPLOYEE LIFE	Team members who are within their first 30 days of eligibility may enroll through Oracle Employee Self Service. Team Members may elect coverage in $10,000 increments up to a maximum of $150,000.	Enrollment in coverage is not available at any future date for team members who do not enroll within their first 30 calendar days of eligibility.
LINCOLN VOLUNTARY SPOUSE LIFE LINCOLN VOLUNTARY DEPENDENT LIFE	Team members who are within their first 30 days of eligibility may enroll through Oracle Employee Self Service.	Enrollment in coverage is not available at any future date for team members who do not enroll within their first 30 calendar days of eligibility.
LINCOLN VOLUNTARY ACCIDENT	Team members who are within their first 30 days of eligibility may enroll through Oracle Employee Self Service.	Eligible to enroll in coverage during annual Open Enrollment period.
LINCOLN VOLUNTARY CRITICAL ILLNESS	Team members who are within their first 30 days of eligibility may enroll through Oracle Employee Self Service.	Eligible to enroll in coverage during annual Open Enrollment period.

These policies are portable. If coverage under these policies ends for any reason other than non-payment of premium or your spouse or dependent child ceasing to meet the definition of an eligible dependent, they are eligible for portability. To port your coverage, contact Lincoln Financial Group within 31 days of your coverage terminating and pay the applicable premium. (See your certificate for details.)

Eligible dependents for these plans include your legal spouse and dependent children as defined below by benefit.

- Voluntary Life Benefits – Unmarried dependent children to age 21; to age 25 if a full time student.
- Voluntary Accident and Critical Illness Benefits – To age 26 regardless of marital status or student status.

Note: Please ensure that you are managing your dependent child's eligibility and enrollment in these plans. Eligibility is only reviewed by Lincoln at the time of a claim.

Voluntary Critical Illness

Critical Illness coverage can help and it's affordable. If a serious illness strikes, the last thing you want to worry about is bills. With Critical Illness insurance, you can get a cash benefit even if you're receiving benefits from other insurance. Use the cash for anything you want or need.

Lincoln CareCompass℠ services: your guide to being well even if you're sick. Of course, money isn't everything, especially when someone is critically ill. That's why our Critical Illness coverage comes with Lincoln CareCompass℠ benefits and services to help you before, during and after a critical illness.

- You do not have to be terminally ill to receive benefits.
- Coverage is available for you and your spouse. Eligible children are covered for $5,000 at no additional cost.
- A Health Screening Benefit is included, which provides a $75 benefit per insured team member and/or spouse per calendar year for a covered health screening test.
- Coverage is portable — you can take your plan with you if you change jobs or retire. (See your certificate for details.)

Please note that these are just highlights of the enhanced benefits being offered to you and limitations and exclusions apply. Please contact Lincoln for a complete list of limitations and exclusions.

VOLUNTARY CRITICAL ILLNESS INSURANCE POLICY HIGHLIGHTS

BENEFIT OPTIONS	
EMPLOYEE	$10,000 or $20,000
SPOUSE	$10,000
CHILD EMBEDDED	25%
GUARANTEE ISSUE	
RECURRENCE (SAME CONDITIONS)	100% – after 12 month treatment free
MAXIMUM COVERED CONDITIONS	Unlimited
PRE-EXISTING	12/12
BENEFIT WAITING PERIOD	None
AGE REDUCTIONS	None
BENEFIT DETAIL	
CORE BENEFITS	
HEART ATTACK	100%
ARTERIAL / VASCULAR DISEASE	25%
STROKE	100%
INVASIVE CANCER	100%
NON-INVASIVE CANCER	25%
SKIN CANCER	$250
MAJOR ORGAN FAILURE	100%
RENAL (KIDNEY) FAILURE	100%
OCCUPATIONAL DISEASE	
OCCUPATIONAL HIV	100%
OCCUPATIONAL HEPATITIS	100%
TUBERCULOSIS	25%
MRSA	25%

BENEFIT DETAIL	
SUPPLEMENTAL BENEFITS	
ADVANCED ALZHEIMER'S	100%
ADVANCED PARKINSON'S	100%
ADVANCED ALS	100%
ADVANCED MS	25%
ADVANCED COPD	100%
LOSS OF SPEECH	25%
LOSS OF SIGHT	25%
LOSS OF HEARING	25%
ACCIDENTAL INJURY	
TRAUMATIC BRAIN INJURY	100%
SEVERE BURNS	100%
PERMANENT PARALYSIS	100%
CHILD CONDITIONS	
SPINA BIFIDA	100%
CYSTIC FIBROSIS	100%
MUSCULAR DYSTROPHY	100%
CEREBRAL PALSY	100%
TYPE 1 DIABETES	100%
CLEFT LIFE/PALATE	100%
DOWN'S SYNDROME	100%
HEALTH ASSESSMENT BENEFIT	
	$75

Voluntary Accident

We provide cash for accidental injuries, and you decide the best way to spend it. And because your employer offers this coverage at a group rate, it's protection you can afford.

Accident Insurance

- Pays cash for accidental injuries
- Covers multiple injuries from the same accident
- Is available for spouses and children
- Includes travel assistance
- Includes on the job accidents
- Is available at an affordable rate

VOLUNTARY ACCIDENT INSURANCE POLICY HIGHLIGHTS

BENEFITS	
EMERGENCY CARE	
AMBULANCE	$225
INITIAL CARE	$75
EMERGENCY CARE TREATMENT	$150
FRACTURE BENEFIT (NON-SURGICAL)	
PER FRACTURE	$100 — $3,500
SURGICAL TREATMENT	2x non-surgical benefit
CHIP FRACTURES	25%
DISLOCATION BENEFITS (NON-SURGICAL)	
PER INJURY	$100 – $2,625
SURGICAL TREATMENT	2x non-surgical benefit
PARTIAL DISLOCATION	25%
SPECIFIC INJURY BENEFITS	
BLOOD TRANSFUSION	$375
BURNS, 2ND OR 3RD DEGREE	$100 – 10,000
SEVERE TRAUMATIC BRAIN INJURY	$5,000
CONCUSSION	$150
DENTAL CROWN	$150
DENTAL EXTRACT	$75
EYE (REMOVAL OF FOREIGN BODY)	$150
EYE (SURGICAL REPAIR)	$300
LACERATION	$35-400
SURGICAL BENEFITS	
PER SURGERY	$150 – $1,500
REPAIR OF LIGAMENTS, TENDONS, ROTATOR CUFF, KNEE CARTILAGE, RUPTURED DISC	$750
HOSPITAL & ONGOING CARE BENEFITS	
HOSPITAL ADMISSION	$1,000
HOSPITAL CONFINEMENT	$200
PHYSICIAN FOLLOW-UP	$75
ALTERNATE CARE AND REHABILITATIVE CONFINEMENT	$150
OCCUPATIONAL, PHYSICAL, CHIROPRACTIC THERAPY	$35
PAIN MANAGEMENT	$75
MEDICAL MOBILITY DEVICES (CANE, KNEE WALKER, WALKER, CRUTCHES, WALKING BOOT)	$75
WHEELCHAIR	$150/$300
PROSTHESIS	$750

BENEFITS	
RECOVERY BENEFITS	
FAMILY CARE	$50
COMPANION LODGING	$100
TRANSPORTATION	$200
CHILD SPORTS INJURY BENEFITS	
CHILD INJURY	Additional 25%
ACCIDENTAL DEATH & DISMEMBERMENT	
TEAM MEMBER	$25,000
SPOUSE	$10,000
CHILD	$5,000
TRANSPORTATION OF REMAINS	$5,000
LOSS OF OR LOSS OF USE OF: HAND, FOOT, ARM, LEG, EYE, HEARING	$5,000 – $10,000
MOTOR VEHICLE BENEFITS	
MOTOR VEHICLE INJURY	$100
MOTOR VEHICLE DEATH	$2,500
SEATBELT	Additional 25% of motor vehicle injury or death benefit
AIRBAG	Additional 25% of motor vehicle injury or death benefit
HELMET	Additional 25% of motor vehicle injury or death benefit
SAFE RIDER (BICYCLE, SCOOTER, SKATEBOARD, ETC.)	$100
HELMET	$100
HEALTH ASSESSMENT BENEFIT	
COVERED BENEFITS: Dental Preventive Exams, Annual Physical, Eye Exam, Hearing Exam, Depression Screening, Substance Abuse Screening/Counseling, and Tetanus Immunization, Additional Adult Tests: Osteoporosis Screening (Bone Mineral Density). Accident/Fall prevention counseling. Additional Child Tests: Sports/School Physicals, Concussion Screening, Immunizations (DTP, MMR, Rotavirus, Chickenpox, Meningitis)	$50

	SEMI-MONTHLY (24 DEDUCTIONS)
TEAM MEMBER ONLY	$3.96
TEAM MEMBER + SPOUSE	$5.77
TEAM MEMBER + CHILD(REN)	$6.97
TEAM MEMBER + FAMILY	$9.24

Voluntary Term Life Insurance

Live for now. Plan for then. Every day, you provide for the ones you love. You make sure they're happy and secure, with thoughtful touches to let them know you care. Life insurance lets you plan for the future and continue to show your love even after you're gone.

Life insurance can help:

- Protect your loved ones from financial burdens
- Pay for your children's or grandchildren's education
- Build a secure retirement fund for your spouse or partner
- Assist a disabled adult child
- Leave a legacy for your loved ones or a favorite charity

Policy Highlights

Eligibility (for Team Members and Dependents): All Active full time and part time team members 0.5 – 1.0 FTE. A delayed effective date will apply if the team member is not actively at work. Spouse and dependents cannot be in a period of limited activity on the day coverage takes effect. Unmarried Dependent Child(ren) are eligible from age 14 days to age 21; age 25 if a full time student.

	VOLUNTARY EMPLOYEE LIFE	VOLUNTARY SPOUSE LIFE	VOLUNTARY DEPENDENT LIFE
WHEN YOU CAN ENROLL	Team members who are within their first 30 days of eligibility may enroll through Oracle Employee Self-Service. Team members may enroll in $10,000 increments up to a maximum of $150,000. If you terminate coverage, you will not have an opportunity to re-enroll.	Team members who are within their first 30 days of eligibility may enroll through Oracle Employee Self-Service. You must be enrolled in Voluntary Employee Life in order to elect Spouse coverage. Spouse coverage amount cannot exceed the employee's elected coverage amount. If you terminate coverage, you will not have an opportunity to re-enroll.	Team members who are within their first 30 days of eligibility may enroll through Oracle Employee Self-Service. You must be enrolled in Voluntary Employee Life in order to elect Dependent coverage. If you terminate coverage, you will not have an opportunity to re-enroll.
COVERAGE AMOUNT	$10,000 increments	$10,000 increments	$10,000
MAXIMUM BENEFIT	$150,000 initial enrollment	$30,000	$10,000

Coverage is portable — you can take your coverage with you if you leave the company. To port your coverage, contact Lincoln Financial Group within 31 days of your coverage terminating and pay the applicable premium. (See your certificate for details.)

Note

You can designate a beneficiary when making your New Hire/Newly Eligible benefit elections in Oracle Employee Self Service under Me/Benefits. When making your elections, you will be prompted to designate a beneficiary under the Life Insurance section.

My EAP

New Directions
www.ndbh.com • 800-624-5544

When life's a little much, reach out and get in touch.

Let's be real: life can be tough. When your responsibilities start to feel overwhelming and showing up each day with a smile on your face seems difficult, it's important to reach out for help. You can lean on your free and confidential Employee Assistance Program (EAP) for support.

We've got your back.

A free benefit from your workplace, the EAP can help you or anyone in your household:

- Be more present and productive at work
- Receive support when you don't feel like yourself
- Get help with responsibilities that are distracting or stressful
- Grow personal and career skills
- Be a caring, loving friend or family member
- Receive care after a traumatic event or diagnosis
- Make healthy lifestyle choices
- Improve and inspire daily life

We're here for you, always.

Life happens, regardless of the day or time. That's why we make ourselves available 24/7, even on holidays. So whenever you need to reach out, we're here for you.

SERVICES

- ✓ Counseling
  - In-person
  - Telephone
  - Text messaging
  - In-the-moment
- ✓ Consultation on
  - Finances
  - Legal needs
  - Managing employees
  - Life
- ✓ Crisis support
- ✓ Coaching
- ✓ Adult and Child care resources
- ✓ Personal and Professional training
- ✓ Digital behavioral health tools

Support Line
Call anytime
800-624-5544

Mobile App
Search for New Directions EAP

Web
Visit ndbh.com
For resources

ndbh.com
Company Code: FMOLHS
800-624-5544

BetterHelp Online Therapy

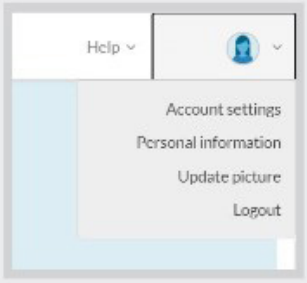
Support is more convenient than ever.

BetterHelp is the largest online therapy platform worldwide that makes mental healthcare more convenient, discreet and accessible to a licensed therapist. Professional therapy is available anytime, anywhere, through a computer, tablet or smartphone.

1. Login at **eap.ndbh.com (Company Code: FMOLHS)** select "**Request Counseling**" then select "**online.**"
2. Complete registration and get matched with a therapist.
3. Download app and start your EAP therapy sessions.
4. Verify the number of sessions covered within your EAP benefit and stay updated on your remaining sessions by following the steps below:

   Check sessions on your BetterHelp account

   - Navigate to the upper right of your homepage and select the downward arrow
   - Select "**Account Settings**"
   - Scroll to "**Payment Settings**" then view your number of remaining sessions
   - Reach out to your employer if you have questions regarding your number of allotted sessions
5. You will receive an email notification from BetterHelp outlining your options after you have exhausted the covered benefit sessions.



If you have questions about continuing services for any additional needs, please call the free New Directions support line at 800-624-5544 to hear your options. You may also continue with BetterHelp at a self-pay rate. If you choose to continue services with self-pay, you will be prompted to enter credit card information on the BetterHelp website.

NEW DIRECTIONS® | betterhelp

My Discounts

Team members may register on the Access Perks site and enter their personal email to receive emails with updates about available discounts or access discounts through the App or website. The company sponsors this benefit for the employees and there are no premiums or elections required to participate.

What is Access Perks?

Access Perks is a team member discount program that includes both Local and National group discounts

- All employed team members are eligible to participate (FMOLHS will provide Access Perks with a demographic file that includes an employee number that will identify your eligibility)
- **Your employee ID will be the first two letters of your first name and your Oracle ID (ex. ABXXXXX)**
- Members will have access to discounts through the Access Perks Web Portal or the My Deals Mobile App
- Mobile App has a GPS/Geolocation functionality that allows users to find deals nearby instantly no matter if they are close to home or traveling

Contact Access Perks at 877-408-2603 or visit the website at FMOLHS.AccessPerks.com.

How do I Access the Mobile App?

Accessing the mobile app is easy, all you need to do is go into the Apple Store or GooglePlay and search for "Access Perks." Once you have downloaded the app, you will be able to open it and register by clicking "Set Up Account." Once your registration is complete and you have set your password you are ready to start saving at thousands of participating providers. Some great examples are listed below:

Advance Auto Parts · AVIS · carter's babies and kids · Foot Locker.com · CINEMARK · Papa John's Better Ingredients. Better Pizza.

redbox · Choice Hotels · KOHL'S · Six Flags · Walt Disney World · Target

Download on the App Store · GET IT ON Google Play

Merchant Locations As of 5/31/2018

Category	Online	Mobile
DINING	55,475	43,751
Casual and Fine Dining	17,579	14,123
Quick Serve	29,553	23,341
Desserts, Catering, etc.	8,343	6,287
HEALTH & BEAUTY	39,220	35,793
SHOPPING	38,167	35,470
SERVICES	35,702	22,621
MOVIES	35,451	33,701
AUTOMOTIVE	30,362	19,244
HOME & GARDEN	28,172	20,669
HOTELS	26,725	25,983
CAR RENTAL	23,650	23,636
REC & ENTERTAINMENT	12,868	8,354
CONDO & RESORTS	4,606	4,587
GOLF	2,264	1,234
SKI & SNOWBOARD	820	190
CRUISES & TOURS	47	41
TOTAL	333,529	275,274

FRANCISCAN
MISSIONARIES OF OUR LADY
UNIVERSITY

Franciscan Missionaries of Our Lady University (FranU) Discounts

Mission Statement: The mission of Franciscan Missionaries of Our Lady University is to educate and form Franciscan servant leaders of all faiths. We honor and preserve the legacy of our founders by preparing highly skilled professionals, integrated thinkers, and faith-filled citizens. Inspired by the Franciscan Missionaries of Our Lady to be a living witness to Jesus Christ and the Gospel message, the University is in communion with the teachings of the Catholic Church.

Non-University FMOLHS Employee Discounts

We offer discounts to help our Health System Heroes get the education that they deserve. FMOLHS invests back into the people who invest their time in our organization. **We offer a 50% employee discount and a 40% dependent of an employee discount on the following programs:**

Undergraduate Programs

Associate Degree

- Physical Therapist Assistant
- Radiological Technology

Bachelor of Science

- Health Sciences
  - Biology track
  - Health Service Administration track
  - Psychology track
- Medical Laboratory Science
  - MLS
  - MLT-MLS
- Nursing
  - Pre-Licensure Nursing (BSN)
  - Online RN-BSN
- Respiratory Therapy
- Biology
  - Biochemical Analysis & Instrumentation (BAI) track
  - Pre-Professional Human Medicine track
  - Accelerated 3 + 2 Pathway to Physician Assistant Studies

Bachelor of Arts

- Theology
- Psychology

Bachelor of Business Administration

- Business Administration
  - General Business track
  - Health Administration track
  - Management track

Note

For more information on the programs, reach out to FranU:

Call: 225-526-1631

Email: admissions@franu.edu

Helping You Balance Your Work and Personal Life

Studies show that team members who are healthy and happy are those who have achieved a good balance between their work and personal responsibilities. To help you achieve this balance, the Health System offers numerous benefits that allow you to spend more time with your friends and family, recover from an illness, enjoy your holidays or pursue other interests. Each of these benefits are summarized in the table below.

BENEFITS	WHEN YOU ARE ELIGIBLE	WHAT YOU RECEIVE
PAID TIME OFF (PTO)	Immediately. Eligible full time (AF) and part time (PT) 0.5 – 1.0 FTE Time may be used upon accrual	Annual Accrual 0 – 4 years 132 hrs (16.5 days) 5 – 9 years 156 hrs (19.5 days) 10 – 14 years 180 hrs (22.5 days) 15 – 19 years 204 hrs (25.5 days) 20 – 24 years 228 hrs (28.5 days) 25 years + 252 hrs (31.5 days) PTO may be carried over to a max of 328 hours; part time PTO accrual rates are prorated (Years of service credit is determined by adjusted hire date)
PTO SELL BACK	Eligible full time (AF) and part time (PT) 0.5 – 1.0 FTE Annually during the sell back period	To assist with managing PTO accrual balances, team members may elect to "sell back" future PTO accruals. The combination of PTO accruals and PTO sell back accruals will not exceed 328 hours. Hours in excess of 328 will not be paid out.
SHORT TERM DISABILITY	Active full time (AF) and part time (PT) 0.5 to 1.0 FTE Eligible Team members are automatically enrolled in the Short Term Disability benefit on the 91st day of continuous eligibility.	Team members may receive a bi-weekly disability income benefit if they become disabled as a result of an injury or illness, including a pregnancy-related condition, while covered under the short term disability. **Important PAY information while on a leave of absence:** If you are on a leave of absence for your own illness and are eligible for short term disability, you must return all required leave documents to Leave Administration by the due date in order to initiate your disability claim.
HOLIDAYS	Immediately Active full time (AF) and part time (PT) 0.5 – 1.0 FTE	New Year's Day, Good Friday, Independence Day, Labor Day, Thanksgiving Day and Christmas Day Part time holiday accrual rates are prorated.
BEREAVEMENT LEAVE	Immediately Active full time (AF) and part time (PT) 0.5 – 1.0 FTE	Up to 3 scheduled work days (not to exceed 24 hours) paid leave for death in team member's immediate family, defined as parent, step-parent, brother, sister, spouse, dependents (including stepchildren), parent-in-law (mother-in-law, father-in-law), grandchildren, grandparent, and great grandparent
JURY DUTY	Immediately All employed team members	Time off from regularly scheduled work to serve on a local, state or federal jury in response to a jury summons, and may be eligible for jury compensation
CONTINUING EDUCATION	Immediately	As approved
EDUCATION ASSISTANCE	See FMOLHS policy on TeamLink	Visit FMOLHS Total Rewards page under My Growth and Development for more information.
EMPLOYEE HEALTH SERVICES	Immediately	Free annual influenza inoculation and Hepatitis B vaccine program
CREDIT UNION	Immediately	Regular share savings account by direct deposit, signature loans, and new and used car loans
FRANCISCAN SERVICE AWARD	Upon nomination	Peer-based recognition of employees who exemplify core values of the organization
FAMILY & MEDICAL LEAVE (FMLA)	After 1 year employed & 1,250 hours of service	Up to 12 weeks leave for certain family and medical events. Apply for all Leave status online or contact Leave Administration: 833-4uaskHR (833-482-7547)

BENEFITS	WHEN YOU ARE ELIGIBLE	WHAT YOU RECEIVE
PERSONAL LEAVE	After 6 months	Up to 4 weeks may be granted upon manager approval
MEDICAL LEAVE	Upon date of hire	Up to 12 weeks
MILITARY LEAVE	Immediately	Leave while serving in the "Uniformed Services" including voluntary and involuntary service and time spent in active duty, inactive duty training, and full time National Guard duty
EMPLOYEE'S BLOOD DONOR PLAN	Immediately	Employee and family blood bank program. Participate by giving one unit of blood each year.
HEALTH CENTER MEMBERSHIP	Immediately	Discounts on various memberships
WORKERS' COMPENSATION	Immediately	Medical expenses and wage replacement for on-the-job injuries/exposures as governed by state law
ACCESS PERKS	Immediately	Allows you to save money and earn rewards just for being a team member of FMOLHS. Team Members are automatically enrolled at no cost and are eligible to receive discounts on purchases from thousands of local and national merchants
PAY ACTIV	Immediately	Financial wellness app that gives you access to 40% of your earned but unpaid wages before your actual payday
FRANU TUITION DISCOUNT	See FranU policy on TeamLink	Team Members receive a 50% tuition discount for undergraduate programs and their dependents receive a 40% tuition discount for undergraduate programs

Required Notices

Important Notice from Franciscan Missionaries of Our Lady Health System About Your Prescription Drug Coverage and Medicare under the FMOLHS Health Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Franciscan Missionaries of Our Lady Health System and about your options under Medicare's prescription drug coverage. You are responsible for providing this notice to any Medicare eligible dependents covered under the Health Plan. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Franciscan Missionaries of Our Lady Health System has determined that the prescription drug coverage offered by the FMOLHS Health plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Franciscan Missionaries of Our Lady Health System coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current Franciscan Missionaries of Our Lady Health System coverage, be aware that you and your dependents will not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Franciscan Missionaries of Our Lady Health System and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the person listed at the end of these notices for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Franciscan Missionaries of Our Lady Health System changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2023
Name of Entity/Sender:	Franciscan Missionaries of Our Lady Health System
Contact—Position/Office:	Human Resources
Address:	PO Box 83780 Baton Rouge, LA 70884-3780
Phone Number:	833-482-7547

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 833-482-7547.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 833-482-7547.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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

To request special enrollment or obtain more information, contact Human Resources at 833-482-7547.

NO SURPRISES ACT NOTICE

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.

1. 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's 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 costs 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 provider.

2. 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 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.

Health care services may be provided to you at a network health care facility by facility-based physicians who are not in your health plan. You may be responsible for payment of all or part of the fees for those Out-of-Network Services, in addition to applicable amounts due for co-payments, coinsurance, deductibles and non-Covered Services.

Specific information about In-Network and Out-of-Network facility-based physicians can be found at www.MyHealthToolkitLA.com/links/FMOLHS and by calling Member Services at (833) 468-3594. You may access these websites from home. If you have any questions about how to do this, please contact askHR@fmolhs.org or call 1-833-482-7547.

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.

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.

Professional services rendered by independent healthcare professionals are not part of the hospital bill. These services will be billed to the patient separately. Please understand that physicians or other healthcare professionals may be called upon to provide care or services to you or on your behalf, but you may not actually see, or be examined by, all physicians or healthcare professionals participating in your care; for example, you may not see physicians providing radiology, pathology, and EKG interpretation. In many instances, there will be a separate charge for professional services rendered by physicians to you or on your behalf, and you will receive a bill for these professional services that is separate from the bill for hospital services. These independent healthcare professionals may not participate in your health plan and you may be responsible for payment of all or part of the fees for the services provided by these physicians who have provided out-of-network services, in addition to applicable amounts due for copayments, coinsurance, deductibles, and non-covered services.

We encourage you to determine if independent healthcare professionals are participating in the Plan by checking the Plan's website at www.MyHealthToolkitLA.com/links/FMOLHS and/or calling Member Services at (833) 468-3594. You may access these websites from home. If you have any questions about how to do this, please contact askHR@fmolhs.org or call 1-833-482-7547.

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 Department of Health and Human Services (HHS) at 1-800-985-3059.

Visit: https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Newborns' and Mothers' Health Protection Act

Statement of Rights under the Newborns' and Mothers' Health Protection Act

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

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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid

WEBSITE	http://myalhipp.com/
PHONE	1-855-692-5447

ALASKA – Medicaid

	The AK Health Insurance Premium Payment Program
WEBSITE	http://myakhipp.com/
PHONE	1-866-251-4861
EMAIL	CustomerService@MyAKHIPP.com
MEDICAID ELIGIBILITY	https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

WEBSITE	http://myarhipp.com/
PHONE	1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

	Health Insurance Premium Payment (HIPP) Program
WEBSITE	http://dhcs.ca.gov/hipp
PHONE	916-445-8322 / (fax) 916-440-5676
EMAIL:	hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

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

FLORIDA – Medicaid

WEBSITE	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
PHONE	1-877-357-3268

GEORGIA – Medicaid

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

INDIANA – Medicaid

	Healthy Indiana Plan for low-income adults 19-64
WEBSITE	http://www.in.gov/fssa/hip/
PHONE	1-877-438-4479
	All other Medicaid
WEBSITE	https://www.in.gov/medicaid/
PHONE	1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

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

KANSAS – Medicaid

WEBSITE	https://www.kancare.ks.gov/
PHONE	1-800-792-4884

KENTUCKY – Medicaid

	Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) Program
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
KCHIP PHONE	1-877-524-4718
KENTUCKY MEDICAID WEBSITE	https://chfs.ky.gov

LOUISIANA – Medicaid

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

MAINE – Medicaid

ENROLLMENT WEBSITE	https://www.maine.gov/dhhs/ofi/applications-forms
PHONE	1-800-442-6003 TTY: Maine relay 711
WEBSITE	Private Health Insurance Premium https://www.maine.gov/dhhs/ofi/applications-forms
PHONE	1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

WEBSITE	https://www.mass.gov/masshealth/pa
PHONE	1-800-862-4840 TTY: 617-886-8102

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

MISSOURI – Medicaid

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

MONTANA – Medicaid

WEBSITE	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
PHONE	1-800-694-3084
EMAIL	HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

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

NEVADA – Medicaid

MEDICAID WEBSITE	http://dhcfp.nv.gov
MEDICAID PHONE	1-800-992-0900

NEW HAMPSHIRE – Medicaid

WEBSITE	https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
PHONE	603-271-5218
TOLL FREE FOR HIPP PROGRAM	1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

WEBSITE	https://www.health.ny.gov/health_care/medicaid/
PHONE	1-800-541-2831

NORTH CAROLINA – Medicaid

WEBSITE	https://medicaid.ncdhhs.gov/
PHONE	919-855-4100

NORTH DAKOTA – Medicaid

WEBSITE	http://www.nd.gov/dhs/services/medicalserv/medicaid/
PHONE	1-844-854-4825

OKLAHOMA – Medicaid and CHIP

WEBSITE	http://www.insureoklahoma.org
PHONE	1-888-365-3742

OREGON – Medicaid

WEBSITE	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html
PHONE	1-800-699-9075

PENNSYLVANIA – Medicaid

WEBSITE	https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
PHONE	1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

WEBSITE	http://www.eohhs.ri.gov/
PHONE	1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA – Medicaid

WEBSITE	https://www.scdhhs.gov
PHONE	1-888-549-0820

SOUTH DAKOTA - Medicaid

WEBSITE	http://dss.sd.gov
PHONE	1-888-828-0059

WEBSITE	http://gethipptexas.com/
PHONE	1-800-440-0493

UTAH – Medicaid and CHIP

MEDICAID WEBSITE	https://medicaid.utah.gov/
CHIP WEBSITE	http://health.utah.gov/chip
PHONE	1-877-543-7669

VERMONT– Medicaid

WEBSITE	http://www.greenmountaincare.org/
PHONE	1-800-250-8427

VIRGINIA – Medicaid and CHIP

WEBSITE	https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp
MEDICAID AND CHIP PHONE	1-800-432-5924

WASHINGTON – Medicaid

WEBSITE	https://www.hca.wa.gov/
PHONE	1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

WEBSITE	http://dhhr.wv.gov/bms http://mywvhipp.com
MEDICAID PHONE	304-558-1700
CHIP TOLL-FREE	1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

WEBSITE	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
PHONE	1-800-362-3002

WYOMING – Medicaid

WEBSITE	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
PHONE	1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, 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 1/31/2023)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____

.

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

[1] An employer-sponsored 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.

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

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☐ Some employees. Eligible employees are:

- With respect to dependents:

☐ We do offer coverage. Eligible dependents are:

☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Important Contacts

Benefits Information
askHR
askHR@fmolhs.org
833-482-7547

Medical Plan
Blue Cross Blue Shield
www.MyHealthToolkitLA.com/links/fmolhs
833-468-3594

Dental Plan
Delta Dental
www.deltadentalins.com
800-521-2651

Prescription Drug Coverage
Express Scripts (ESI)
www.express-scripts.com
877-816-8717

Health and Well-Being Program
Healthy Lives
www.ourhealthylives.org
855-426-4325

Vision Plan
UNUM Vision
www.alwaysassist.com
866-679-3054

FSA/HSA
PayFlex
www.payflex.com
844-PayFlex (729-3539)

Basic Life/AD&D
Supplemental Life/AD&D
Long Term Disability
Lincoln National
Life Insurance Company
www.LincolnFinancial.com/FMOLHS
855-818-2883

Leave Administration
Short Term Disability
FMOLHS Leave
Administration Team
askHR@fmolhs.org
833-482-7547

Voluntary Critical Illness
Voluntary Accident
Lincoln Financial Group
855-818-2883
www.LincolnFinancial.com/FMOLHS
When contacting LFG, your ID is your full SSN.

Retirement Plans
403(b) and 457(b) Plans
Lincoln Financial Group
www.LincolnFinancial.com/FMOLHS
877-562-4738

EAP
New Directions
www.ndbh.com
800-624-5544

Financial Wellness App
Payactiv
www.payactiv.com
support@payactiv.com
877-937-6966

Education Assistance Program
Wiley Beyond
855-206-4965
https://wbp.wiley.com/fmolhs

Before you finish the enrollment process, did you remember to...

- Get your questions answered?
- Review your benefit options?
- Review and update your personal information, dependents and beneficiaries in Oracle Employee Self Service?
- Enroll in core benefits – Health, Dental, Vision, Medical FSA – within 30 days of your new hire/new eligibility date?
- Enroll/Review Voluntary Benefits within 30 days of your new hire/new eligibility date?
- Click SUBMIT when you have completed your enrollment in Oracle Employee Self Service?
- Save a printed copy of your benefit elections?
- Upload dependent verification documents in Oracle Employee Self Service under Me/Benefits/My Documents within 30 days of your new hire/new eligibility date?
- Designate a beneficiary for your life insurance coverages?
- If your benefit elections are properly completed and saved, you will get confirmation message on the screen that states, "Your benefit elections were saved."

  If you do not receive a confirmation message, your elections were not properly completed and you must complete the election process again within 30 days of your new hire/new eligibility date.
- Go to My Benefits card to view and print a copy of your elections. You must have a copy for your 2023 benefit elections to report a problem with your enrollment.

See page 9 for details on how to access Oracle Employee Self Service from work or home.

askHR

Help is a phone call or click away.

Reach out using the method that works best for you:

- Submit an Oracle Service Request by clicking on Help Desk/HR Service Requests.*
- Email askHR@fmolhs.org
- 833-4UaskHR (833-482-7547)

*This is the fastest method for getting an answer to your question.

Franciscan Missionaries of Our Lady Health System