2025

Team Member Guide to Benefit Enrollment

Franciscan Missionaries of Our Lady HEALTH SYSTEM

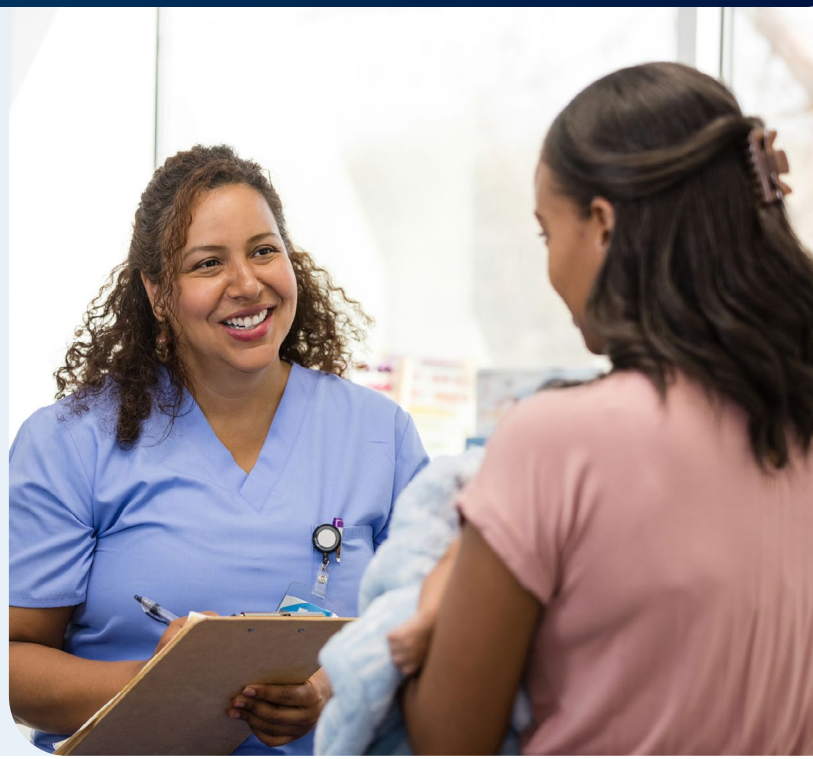
TotalRewards

My Benefits

FMOLHS 2025 Benefits Guide

Inside this guide, you'll find:

- Your 2025 benefit choices and premiums
- Medical plan comparisons
- Highlights of the FMOLHS Total Rewards Program
- Steps to enroll
- Tools and resources



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. See page 50 for more information concerning Medicare Part D coverage.

Let's get started

What's in this Guide and How to Use It

Contents

How to Use this Guide

- Click the Home icon on the bottom left of each page to return to this page.
- Use the Menu on the left of each page to move between sections.
- When you see a link in the text, click to go directly to another page or website to find out more.
- Use the Next and Previous arrows on each page to move within sections.

Total Rewards Program

Similar to how our team members embody roles that surpass their job descriptions and titles, our rewards program extends beyond just compensation and benefits. Our Total Rewards Program is inspired by our team members and what's important to you. We know priorities can change, and we are committed to offering flexible and competitive offerings to care for you and your family, during every stage of life.

Our program is unique to our organization and combines six distinct areas that you can use to meet your individual and family needs:

- My Purpose
- My Personal Growth & Development
- My Compensation
- My Recognition
- My Benefits
- My Health & Well-Being

This guide will help you understand more about the benefit coverage options and rewards available to you as an FMOLHS team member.

Enrollment

Eligibility & Dependent Eligibility

All active full-time (0.8 - 1.0 FTE) and part-time (0.5 - 0.79 FTE) team members are eligible for benefits with FMOLHS.

As a benefits-eligible team member, you and your eligible dependents may participate in the FMOLHS benefits program. Your eligible dependents 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 they are 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, is actively enrolled in coverage under the health plan upon turning age 26, and is approved by your health plan to continue coverage

When you add dependents to your core benefits coverage, you'll need to provide documentation that each dependent meets the eligibility requirements (i.e., marriage certificate, birth certificate, court order, etc.). To maintain coverage, upload the required documents in **Oracle Employee Self Service** under **Benefits** then **My To Do List** before your enrollment deadline. The documents shown here are required in our verification process.

Upload dependent verification documents in Oracle Employee Self Service under Benefits then My To Do List.

Spouse	Natural Child*	Stepchild* (Requires spouse & child verification documents)	Adopted Child/Child Placed for Adoption*	Foster Child*	Grandchild*
Marriage certificate **AND** • Current or previous year tax return face sheet **OR** • Proof of current joint ownership (mortgage, bank account, rental agreement, auto insurance, etc.)	Birth certificate; for newborns, birth letter from hospital	Birth certificate **AND** verification of current marriage between team member and natural parent (see spouse verification requirements)	Adoption certificate/ placement letter from court or adoption agency for pending adoptions	Proof of legal custody, such as a court order	Proof of legal custody, such as a court order **AND** Copy of current tax return that identifies grandchild as a taxable dependent

**Less than age 26 regardless of marital or student status*

FMOLHS reserves the right to audit dependent verification documents at any time.

Enrollment

When Coverage Begins

Coverage begins on the first of the month following 30 days of eligibility from your new hire/new eligibility date.

Making Benefit Changes During the Year

The benefit elections you make during the enrollment period will be effective the first of the month following 30 days from your new hire/new eligibility date. After your enrollment period ends, you may not change or cancel your benefit elections during 2025 unless you experience a qualifying life event. Qualifying life events include, but are not limited to these changes:

- Your FTE status from part-time to full-time or full-time to part-time results in a significant increase or decrease in your premiums (medical and dental)
- Your legal marital status changes (marriage and divorce)
- There's an increase or decrease to the number of your dependents (birth, adoption or child is no longer an eligible dependent)
- Your spouse's employment status results in a loss or gain of coverage
- Your employment status results in a loss or gain 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.*

Changes must be made in Oracle Employee Self Service within 30 days of your qualifying life event (For example, if you get married on March 1st, you must enroll no later than March 30th).

For a list of all qualifying life events and required documents, please visit Oracle Employee Self Service under Benefits then My Benefit Resources.

Enrollment

How to Enroll

You must enroll in **Oracle Employee Self Service** within 30 days of new hire/ new eligibility date.

Be sure you review your Oracle account prior to enrolling and ensure your time zone is set to Central time zone versus the default of UTC time zone. Not updating your time zone may impact your ability to enroll on the last day of the enrollment period.

We have tools and resources to help you choose your benefits! See page 8.

1. **Consider Your Choices**
   Review this guide to understand your options and consider the coverage that fits for you and your family in 2025.
2. **Review Your Personal Information**
   Make updates, if needed, and remember to make sure your Oracle account is set to Central time zone.
3. **Enroll Online from Work or Home**
   eqtm.login.us2.oraclecloud.com
4. **Log in with Your Username and Password**
   - Click the **Me** tab
   - Click the **Benefits** tile

   Note: Before starting your enrollment, review My Benefit Resources for your benefit options and important notices
   - Click the **Enroll in Benefits** button
5. **Add Your Dependents and Beneficiaries**
   - Complete all required fields for each new dependent or beneficiary
   - Upload dependent verification documents to **Oracle Employee Self Service** under **Benefits** then **My To Do List**
6. **Review Your Dependent Child's Eligibility for Coverage**
   - Core benefits (health, dental and vision) – eligible to age 26 regardless of marital or student status
   - Voluntary life benefits – eligible to age 26 regardless of marital status or student status
   - Voluntary accident and critical illness benefits – eligible 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'll receive a "Your benefit elections were saved" message on the screen. **If you do not receive that confirmation message, your elections were not properly completed. You must complete the election process again before your enrollment deadline.**

Go to Oracle Employee Self Service under Benefits then My Benefits to view and print a copy of your elections. You must have a copy of your 2025 benefit elections to report an enrollment problem. You will also receive an email at your FMOLHS email address containing your benefit enrollment summary and other important information needed to complete your enrollment.

Enrollment

Tools to Help You Choose

Tour the Virtual Benefits Fair

You have 24/7 online access to benefits vendors and resources. To support you in your benefits decision-making, visit vendor booths for current information on benefits offered in 2025.

The site is available anytime from any device. Visit **virtualfairhub.com/FMOLHSbenefits**.

Enrolling in an FMOLHS Medical Plan? Register for My Health Toolkit

You'll have instant access to your benefits information, insurance cards, claims and covered local providers when you download the My Health Toolkit mobile app (**MyHealthToolkitLA.com/links/FMOLHS**). This free app is available 24/7 from your mobile device.

Sign up to get started:

1. Go to **MyHealthToolkitLA.com/links/FMOLHS** and select **Register Now**.
2. Enter the number on your Blue Cross Blue Shield 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. You can choose to go paperless.

Enrollment

Your BCBS Membership Card

Your Blue Cross Blue Shield (BCBS) membership card contains important information that helps providers apply your benefits correctly. Keep it with you at all times by downloading your digital membership card to keep on your smartphone. It's so convenient!

Your digital card features the same information as your plastic card, including your deductible and out-of-pocket maximum. With the digital card, you can:

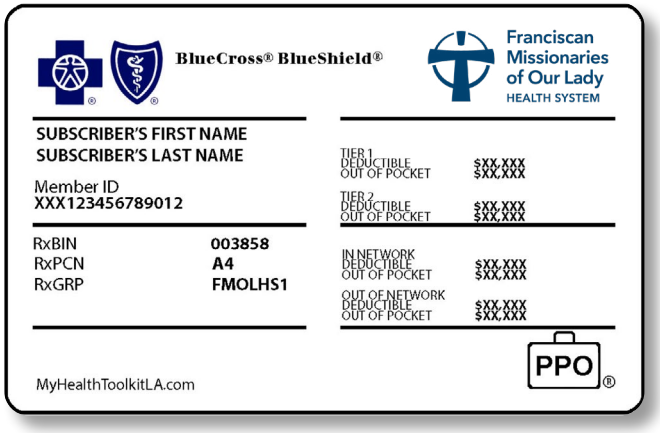
- View your card on your smartphone, tablet or computer
- Email the card to your spouse, child, doctor's office or pharmacy
- Print the card and use it like the plastic version

You can access your digital card through the My Health Toolkit app.

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

Important Note:

When you enroll in any FMOLHS Medical Plan, your card will feature "PPO" in the suitcase icon that appears on the front side of the ID card. All the providers included in the FMOLHS Health Plan Networks are contracted with BCBS PPO Product and as such the BCBS Association requires the "PPO" suitcase be present on the card.



Medical

Medical Plan Options

As you prepare to enroll in benefits, take a moment to review our three medical plan options to make sure the plan you choose is the right fit for you and your family.

All plans are administered through BCBS. The FMOLHS benefits program includes the EPO Plan, PPO Plan and HDHSA Plan. The plan you select should be chosen based on your family's healthcare needs and your budget, and it's important to remember that your costs – including the premium, annual deductible, coinsurance and out-of-pocket maximum – vary based on the plan you choose. As you consider your options, take a moment to compare them. Here's a quick overview:

If you are enrolling as a newly eligible team member, compare the plans before making your 2025 elections.

	EPO Plan	PPO Plan	HDHSA Plan
Network	• Offers access to a narrow network of providers who are in our health system or considered our preferred providers • There is no out-of-network coverage unless otherwise required by law*	In addition to the network of FMOLHS providers (Tier 1) and preferred partners (Tier 2), you also have access to BCBS network of providers (Tier 3) and out of network providers (Tier 4); however, you'll receive a higher level of benefit with a lower out-of-pocket cost when using Tier 1 or Tier 2 providers**	In addition to the network of FMOLHS providers (Tier 1) and preferred partners (Tier 2), you also have access to BCBS network of providers (Tier 3) and out of network providers (Tier 4); however, you'll receive a higher level of benefit with a lower out-of-pocket cost when using Tier 1 or Tier 2 providers
Prescription drug coverage	Express Scripts	Express Scripts	Express Scripts
In-network preventive care covered at 100%	Yes	Yes	Yes
Health Savings Account (HSA)	N/A	N/A	Yes
Costs	Lower per paycheck, lower out-of-pocket costs	Higher per paycheck, lower out-of-pocket costs	Lower per paycheck, higher out-of-pocket costs
Annual deductible (in-network)	$300/Employee Only $600/Employee + Dependents	Varies based on coverage tier	Varies based on coverage tier
Annual out-of-pocket maximum (in-network)	$2,500/Employee Only $5,000/Employee + Dependents	Varies based on coverage tier	Varies based on coverage tier

**If services are not available within the EPO network, a network exception authorization may be requested for consideration of network coverage.*
***If you select the PPO Plan and 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.*

Medical

Medical Plan Comparison

The charts on pages 11-18 are summaries of the 2025 Health Plans for FMOLHS. A more comprehensive Schedule of Benefits for the Medical Plans can be viewed for the **EPO Plan**, **PPO Plan** and **HDHSA Plan**. All covered services are subject to medical necessity as determined by the Plan. All out of network services are subject to reasonable and customary limitations.

EPO Plan

The EPO 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%: cost containment penalties, and above usual and customary charges or allowable charges. There is **no** out-of-network coverage unless stated otherwise required by law.

	FMOLHS EPO Network	Out-of-Network
Annual Deductible		
Employee Only	$300	No Coverage
Employee & Dependents	$600	No Coverage
Maximum Out-Of-Pocket (includes deductible)		
Employee Only	$2,500	No Coverage
Employee & Dependents	$5,000	No Coverage
Coinsurance		
Employee Cost Share	10%	No Coverage

The coinsurance for certain specialty medications considered non-essential health benefits under the Plan will not apply to the deductible or out-of-pocket maximum amounts. To learn more, see **page 23**.

The $3,000 Bariatric Surgery copay does not apply to the deductible or the out-of-pocket maximum amount. You will be required to pay the $3,000 Bariatric Surgery copay even if you have reached your deductible and maximum out-of-pocket amount.

Preventive Care & Condition Management		
Routine Adult Care Visits & Immunizations	100% coverage limited to one routine physical examination annually and approved wellness screenings annually	No Coverage
Routine Child Care Visits & Immunizations	100% coverage	No Coverage
Smoking Cessation Aids	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 healthcare provider without prior authorization	No Coverage
Office Visits		
Primary Care Physician (PCP)	$0 Copay	No Coverage
Specialist	$35 Copay	No Coverage

Medical

EPO Plan continued

	FMOLHS EPO Network	Out-of-Network
Emergent/Urgent Care		
Urgent Care	$60 copay	$60 copay*
Emergency Room	$250 copay	$250 copay**
Ambulance Service	90% coverage after deductible	90% coverage after deductible**
Facility Services		
Outpatient Surgery	$250 copay	No Coverage
Inpatient Care	$200 copay per day (4 day/$800 max)	No Coverage
Bariatric Surgery	$3,000 copay; surgery must be performed at a MBSAQIP Accredited FMOLHS facility	No Coverage
Organ Transplant	90% coverage after deductible when performed at Blue Distinction Center facility	No Coverage
Maternity Care		
Prenatal Care	One-time $50 copay applies for coverage of routine OB visits, initial routine labs and one ultrasound per term pregnancy	No Coverage
Labor & Delivery	$200 copay per day (4 day/$800 max)	No Coverage
Breast Pump/Lactation Counseling	100% coverage	No Coverage
Mental Health And Substance Abuse		
Office Visit	$0 Copay	No Coverage
Outpatient	90% coverage after deductible or included in office visit copay, depending on place of service	No Coverage
Inpatient	$200 copay per day (4 day/$800 max)	No Coverage
Other Services		
Allergy Testing/Serums & Injections	90% coverage after deductible or included in office visit copay, depending on place of service	No Coverage
Laboratory & Diagnostic Services	90% coverage after deductible or included in office visit copay, depending on place of service	No Coverage
Occupational, Physical & 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
Durable Medical Equipment (DME)	90% coverage after deductible	No Coverage

**Out-of-network urgent care benefits at BCBS contracted urgent care centers are now available outside of our service markets at the same coverage level as network urgent care to allow for greater access to care if you are traveling or covering dependents outside of Louisiana and Mississippi.*

***Per **No Surprises Act** in Legal Notices*

Medical

PPO Plan

The PPO 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%: cost containment penalties and above usual and customary charges or allowable charges.

	FMOLHS Network (Tier 1)	Preferred Provider Network (Tier 2)	Non-Preferred Provider Network (Tier 3)	Out-of-Network
Annual Deductible				
Employee Only	$800	$1,200	$3,000	$5,000
Employee & Dependents	$1,600	$2,400	$6,000	$10,000
Maximum Out-Of-Pocket (includes deductible)				
Employee Only	$3,000	$4,500	$6,000	$10,000
Employee & Dependents	$6,000	$9,000	$12,000	$20,000
Coinsurance				
Employee Cost Share	20%	30%	40%	60%

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.

The coinsurance for certain specialty medications considered non-essential health benefits under the Plan will not apply to the deductible or out-of pocket maximum amounts. To learn more, see **page 23**.

The $3,000 Bariatric Surgery copay does not apply to the deductible or the out-of-pocket maximum amount. You will be required to pay the $3,000 Bariatric Surgery copay even if you have reached your deductible and maximum out-of-pocket amount.

Preventive Care & Condition Management				
Routine Adult Care Visits & Immunizations	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
Routine Child Care Visits & Immunizations	100% coverage	100% coverage	100% coverage	40% coverage after deductible
Smoking Cessation Aids	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 healthcare provider without prior authorization			No Coverage

Medical

PPO Plan continued

	FMOLHS Network (Tier 1)	Preferred Provider Network (Tier 2)	Non-Preferred Provider Network (Tier 3)	Out-of-Network
Office Visits				
Primary Care Physician (PCP)	$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		
Emergent/Urgent Care				
Urgent Care	$75 copay	$75 copay	60% coverage after deductible	40% coverage after deductible
Emergency Room	80% coverage after deductible*			
Ambulance Service	80% coverage after deductible*			
Facility Services				
Outpatient Surgery	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Inpatient Care	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Bariatric Surgery	$3,000 copay; surgery must be performed at a MBSAQIP Accredited FMOLHS facility	No Coverage	No Coverage	No Coverage
Organ Transplant	80% coverage after deductible when performed at Blue Distinction Center facility			No Coverage
Maternity Care				
Prenatal Care	One time $50 copay applies to routine OB visits, initial routine labs and one ultrasound per term pregnancy			40% coverage after deductible
Labor & Delivery	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Breast Pump/Lactation Counseling	100% coverage	100% coverage	100% coverage	No Coverage

Per **No Surprises Act in Legal Notices*

Medical

PPO Plan continued

	FMOLHS Network (Tier 1)	Preferred Provider Network (Tier 2)	Non-Preferred Provider Network (Tier 3)	Out-of-Network
Mental Health And Substance Abuse				
Office Visit	$5 copay	$30 copay	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
Inpatient	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Other Services				
Allergy Testing/Serums & Injections	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Laboratory & Diagnostic Services	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Occupational, Physical & 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
Durable Medical Equipment (DME)	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	No Coverage

Medical

HDHSA Plan

The HDHSA Plan is a high deductible health plan with a tax-free **health savings account (HSA)**. The HDHSA Plan includes an annual company contribution to an HSA if you enroll in the Health Savings Account. See pages 33-34 for more information on the HSA.

The HDHSA annual deductible is aggregated, which means the Health Plan doesn't begin paying for the health care expenses of anyone in the family until the entire family deductible has been met. The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: cost containment penalties and above usual and customary charges or allowable charges.

	FMOLHS Network (Tier 1)	Preferred Provider Network (Tier 2)	Non-Preferred Provider Network (Tier 3)	Out-of-Network
HSA Annual Company Contribution*				
Employee Only	$750			
Employee & Dependents	$1,500			
Annual Deductible (Aggregated)				
Employee Only	$1,750	$2,500	$3,500	$5,000
Employee & Dependents	$3,500	$5,000	$7,000	$10,000
Maximum Out-Of-Pocket (Includes Deductible) (Embedded OOP)				
Employee Only	$3,500	$5,000	$7,000	$10,000
Employee & Dependents	$7,000	$10,000	$14,000	$20,000
Coinsurance				
Employee Cost Share	20%	30%	40%	60%

The Out-of-Area coverage is not available under the High Deductible HSA Plan.

The coinsurance for certain specialty medications considered non-essential health benefits under the Plan will not apply to the deductible or out-of pocket maximum amounts. To learn more, see **page 23**.

The $3,000 Bariatric Surgery copay does not apply to the deductible or the out-of-pocket maximum amount. You will be required to pay the $3,000 Bariatric Surgery copay even if you have reached your deductible and maximum out-of-pocket amount.

**Team member must enroll in the HSA and HDHSA Plan to be eligible to receive the HSA Company Contribution.*

Medical

HDHSA Plan continued

	FMOLHS Network (Tier 1)	Preferred Provider Network (Tier 2)	Non-Preferred Provider Network (Tier 3)	Out-of-Network
Preventive Care & Condition Management				
Routine Adult Care Visits & Immunizations	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
Routine Child Care Visits & Immunizations	100% coverage	100% coverage	100% coverage	40% coverage after deductible
Smoking Cessation Aids	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 healthcare provider without prior authorization			No Coverage
Office Visits				
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
Emergent/Urgent Care				
Urgent Care	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Emergency Room	80% coverage after deductible*			
Ambulance Service	80% coverage after deductible*			
Facility Services				
Outpatient Surgery	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Inpatient Care	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Bariatric Surgery	$3,000 copay; surgery must be performed at a MBSAQIP Accredited FMOLHS facility	No Coverage	No Coverage	No Coverage
Organ Transplant	80% coverage after deductible when performed at Blue Distinction Center facility			No Coverage

*Per ***No Surprises Act*** in Legal Notices*

Medical

HDHSA Plan continued

	FMOLHS Network (Tier 1)	Preferred Provider Network (Tier 2)	Non-Preferred Provider Network (Tier 3)	Out-of-Network
Maternity Care				
Prenatal Care	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Labor & Delivery	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Breast Pump/Lactation Counseling	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Mental Health And Substance Abuse				
Office Visit	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
Inpatient	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Other Services				
Allergy Testing/Serums & Injections	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Laboratory & Diagnostic Services	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible
Occupational, Physical & 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
Durable Medical Equipment (DME)	80% coverage after deductible	70% coverage after deductible	60% coverage after deductible	40% coverage after deductible

Note:

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

Medical

Easy Steps to Navigate Our Network

In-Network

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. Our **Network Guides** can help you:

- Find an in-network provider
- 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.

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**. 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.

Did you know?

The FMOLHS Customized Network includes providers in the EPO network and PPO Tier 1 and Tier 2 network. The providers in Tier 1 and Tier 2 of the PPO network are the same providers included in the EPO network.

Medical

Navigating Care & Costs

No Cost and Lower Cost Care

MyChart

No Cost to You

Message your provider for advice or nonemergent questions about your health or medications through your MyChart portal.

- New onset health questions
- Treatment options
- Prescription drug questions or refill requests
- Advice for a health problem
- Schedule in-person or video visit appointments

No appointment needed. If further help is recommended your provider will suggest an appointment.

Video Visits

Fast, easy way to see your provider on your smartphone, tablet or computer.

- Allergies
- Sinus Infections
- Cold and Flu
- Fevers
- Insect Bites
- Pink Eye
- Rashes
- UTI
- Headaches
- Medication management

Convenient appointments offered through 8 p.m. Meet with an FMOLHS primary care provider in our network for free with the EPO Plan or $5 with the PPO plan. (Visits can be scheduled through MyChart.)

Primary Care Provider (PCP)

See your provider in-person for an illness or new medical issue and for care coordination with specialty providers. Same day visits are available.

- Screenings, checkups, vaccines
- Recent hospital stay follow ups
- Medication questions or refills
- Talk about medical concerns
- Chronic diseases (diabetes; COPD; high blood pressure; asthma)
- Depression or anxiety
- Pain
- Muscle pain
- Sprains
- Low back pain
- Migraines, headaches with stiffness in neck
- Minor cuts, minor burns, eye injuries
- Infections
- Flu, colds, strep
- Fever over 24 hours
- Rash
- Urinary tract infections
- Cough, congestion, sinus problems
- Ear infections
- Insect bites
- Pink eye

Appointments offered during normal business hours and extended hours depending on location. (Visits can be scheduled through MyChart.)

Medical

Navigating Care & Costs

Higher Cost Care

Walk-In or Urgent Care

When you are unable to see your primary care provider the same day. For non-life-threatening medical issues that need urgent attention.

*It's important to communicate with your primary care provider after your urgent care visit to provide an update on any new medical issues or medication changes.

No appointment needed. If further help is recommended, your provider will suggest an appointment.

Emergency Room

Emergency same-day care for serious or life-threatening illnesses and injuries. Call 911 immediately for critical needs.

- Serious head, neck or body injuries
- Stroke symptoms, facial drooping, trouble speaking, vision loss, numbness arms/legs (Call 911)
- Chest pain, pressure, numbness arms/legs (Call 911)
- Severe cuts, bleeding, pain, burns
- Severe broken bones, especially bones through skin
- Severe allergic reactions
- Seizures
- Falls, weakness
- Poisoning
- Other life-threatening conditions

No appointment needed due to critical medical need.

Care Outside Our Network

Although this is not common, there may be times when an in-network provider is not available within the FMOLHS customized EPO network and PPO Tier 1 and Tier 2 network. In such a situation, a network exception may be available. To receive an exception, you must complete the **Network Exception form** 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 will notify you of their decision on your request.

Submit all completed requests in writing via:

- Fax: **(803) 264-0259**
- By email: **fmolhsexception@bcbscc.com**
- By mail:

  Blue Cross Blue Shield of South Carolina
  Attn: Network Waiver, AX-630
  P.O. 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.

Preauthorization Requirement List

Before our medical plans provide benefits for certain services and supplies, preauthorization may be required. To preauthorize services, your provider can contact BCBS 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 BCBS at **(833) 468-3594**.

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

- All Inpatient Admissions (Includes Acute, Skilled, Rehabilitation, LTAC, Residential 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, Procedures, Surgeries
- All Plastic & Reconstructive Surgeries & Procedures (Cosmetic procedures are excluded from coverage)
- All CT Scans. MRIs, and PET scans including CTAs and MRAs
- 17 Alpha-Hydroxyprogesterone Caproate (17P)
- Alcohol/Substance Abuse
- Bariatric Surgery, including revisional surgery
- Durable Medical Equipment (purchases over $500 and all rentals)
- Enteral Feedings
- Genetic Studies/ Testing/Therapy
- Home Health
- Hyperbaric Oxygen Therapy
- Specialty Medications including Injectables and IV Infusions
- Mental Health Services (Inpatient, Outpatient, and Residential Services only)
- Orthotics and Prosthetics over $500
- Pain Management procedures including Epidural Steroid Injections
- Podiatry treatment/ Foot Care
- 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 and ABA
- Non-Emergent Air Ambulance and Non-Emergent Ambulance Transportation
- Weight Loss Medications (Authorized by Healthy Lives)

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

Note: Preauthorization of services is not a guarantee of payment of services.

Medical

Pharmacy Benefits

Each of our medical plan options includes prescription drug coverage through Express Scripts.

All prescription drugs covered by the plan are categorized into four tiers: Generic, Preferred, Non-Preferred and Specialty Drugs. Your cost is based on the tier assigned to the prescription drug and whether the medication is for a 30-day or 90-day supply. You may contact Express Scripts for information on your benefit coverage and search for network pharmacies by logging on to **express-scripts.com/fmolhs** or calling Express Scripts Customer Care at **(877) 816-8717**.

Copay Assistance Benefit through SaveOnSP

FMOLHS has partnered with SaveOnSP, a partner of Express Scripts, to provide a copay assistance benefit for certain specialty prescription drugs at little to no cost to you and your family.

Here are some key points about this program:

- Your specialty drug must be filled at an RxONE pharmacy.
- Contact SaveOnSP at **(800) 683-1074** to learn more and enroll in the program.
- Complete the manufacturer copay assistance enrollment process and allow SaveOnSP to monitor your pharmacy account on your plan's behalf.

By following these steps, you can access these expensive specialty drugs potentially at no cost. Any payments made by you or the drug manufacturer for these specialty drugs will not count towards your deductible or out-of-pocket maximum, as they are classified as non-essential health benefits (NEHB) under the Health Plan. However, this classification does not imply that these drugs are not important to you.

The SaveOnSP drug list can be found at **saveonsp.com/fmolhs** and on the ESI website **express-scripts.com/fmolhs**. The list is subject to change.

Reduce Your Out-of-pocket Costs for Medications through RxONE

RxONE is our FMOLHS-owned, in-house pharmacy, where you can receive reduced copays for prescriptions, including mail order/90-day prescriptions and specialty medications. In addition to discounts, RxONE offers personal service through their in-store or curbside delivery options, faster fill times, immunizations and ease of access to our pharmacists. Find an RxONE pharmacy location near you to begin taking advantage of the cost savings and personalized service.

Tips to Make the Most of Your Prescription Drug Coverage

The cost of prescription drugs is rising faster than many other healthcare services and supplies. Here are a few ways to help you save:

- Use mail order service for maintenance medications. If you regularly take medication to treat a chronic condition, such as an allergy, heart disease, high blood pressure or diabetes, use the RxONE mail order option for a 90-day supply for a lower copay.
- Ask your doctor about generic medications. Generic medications are generally just as effective as brand-name medications, yet the cost of generics is substantially lower for you and FMOLHS.
- Review your plan to understand the benefits provided for prescription drugs. Visit **express-scripts.com/fmolhs** to check your plan's coverage and find prices of medications covered.

Medical

The tables on the following pages show the prescription drug benefits (retail and mail order pharmacies) provided through the FMOLHS medical plans.

EPO Prescription Plan

	Cost	
	In-House	Network
Retail pharmacy (30-day supply)		
Generic drug	$10 copay	$15 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	
Prescription Program		
	SaveOnSP Copay Assistance benefit. A copay assistance benefit with more details found on **page 23**. The coinsurance amount on any specialty drug on the formulary classified as non-essential health benefits will not be applied to your deductible or maximum out-of-pocket amount.	

**Mail order copays do not apply to mail order specialty prescriptions*

Medical

PPO Prescription Plan

	Cost	
	In-House	Network
Retail pharmacy (30-day supply)		
Generic drug	$10 copay	$15 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	
Prescription Program		
	SaveOnSP Copay Assistance benefit. A copay assistance benefit with more details found on **page 23**. The coinsurance amount on any specialty drug on the formulary classified as non-essential health benefits will not be applied to your deductible or maximum out-of-pocket amount.	

**Mail order copays do not apply to mail order specialty prescriptions*

Medical

HDHSA Prescription Plan

	Cost	
	In-House	Network
Retail pharmacy (30-day supply)		
Generic drug	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	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	
Prescription Program		
	SaveOnSP Copay Assistance benefit. A copay assistance benefit with more details found on **page 23**. The coinsurance amount on any specialty drug on the formulary classified as non-essential health benefits will not be applied to your deductible or maximum out-of-pocket amount.	

Just Premium

Through the "Just Premium" program, team members who apply and qualify for financial assistance based on total household income can receive a reduced premium for the EPO and PPO Plan options.

The program aligns with our Mission and provides eligible full-time equivalent team members with higher FMOLHS subsidies to improve affordability and access to healthcare coverage.

Based upon your total household income (adjusted gross income), the number of dependents you claim on your 2023 Federal Individual Income Tax Return and your hourly base rate, you and your family may be eligible for the Just Premium reduction.

Dependents Listed on Tax Return	Maximum Household Income
0	$26,355
1	$35,770
2	$45,185
3	$54,600
4+	$64,015
Current maximum hourly rate: $32.00	

To apply for Just Premium:

1. Select My Benefits on our Total Rewards site and then click on the **Just Premium Application** link.
2. Print and complete the application and attach a copy of the first two pages of your 2023 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'll need to submit copies of the first two pages of your tax return and your spouse's return.
3. Return the application and tax return(s) to **JustPremium@fmolhs.org** or fax **(225) 765-9307** within 30 calendar days of your new hire/new eligibility date.

Note:

If you did not file a 2023 Income Tax Return, you will not be eligible for the 2025 Just Premium program.

Medical

2025 Medical Plan Premiums

Bi-weekly team member contributions (26 contributions annually)

	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
EPO Plan				
Just Premium	$23.87	$103.98	$47.16	$129.55
Standard premium	$55.07	$177.85	$109.19	$233.97
Part-time premium	$55.11	$299.46	$200.96	$388.26
PPO Plan				
Just Premium	$65.10	$244.77	$123.96	$309.78
Standard premium	$135.68	$349.64	$246.42	$457.15
Part-time premium	$197.73	$496.00	$370.43	$663.97
HDHSA Plan				
Just Premium	N/A	N/A	N/A	N/A
Standard premium	$98.86	$268.54	$230.28	$371.34
Part-time premium	$144.08	$380.95	$346.16	$488.88

For more information about Just Premium, see **page 27**.

Dental

Dental Plan Options

Proper dental care plays an important role in your overall health. FMOLHS offers two dental plans through Delta Dental: **the Basic Plan and the Buy Up Plan**.

Both options provide preventive care at 100% and benefits for a variety of other dental care services. The plans allow you to visit any licensed dentist, but you'll maximize the value of the plan when you receive dental services from **Delta Dental's network** of providers.

	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	$2,000
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: (Limited to children under 16 years old) (1 per calendar year) 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 bony 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 under 19 years old		$2,000

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

Dental

Dental Plan Premiums

Dental premium contributions are deducted semi-monthly from your paycheck on a before-tax basis (24 deductions annually).

	Basic Plan	Buy Up Plan
Full Time		
Employee Only	$4.40	$9.28
Employee & Family	$25.97	$40.16
Part Time		
Employee Only	$8.30	$15.77
Employee & Family	$29.87	$46.66

Questions about your dental benefits?

Contact Delta Dental at **(800) 521-2651**.

Vision

You are responsible for paying costs that exceed the allowance provided for lenses, frames and contact lenses.

Vision Plan Options

Our benefits program includes two options for vision care through EyeMed Vision Care: **the Basic Plan and the Buy Up Plan**.

Vision care includes regular eye exams, which can help detect diseases like glaucoma, diabetes and loss of sight. Hearing aid discounts are available through both plan options. **Providers in the EyeMed Vision Care network offer the lowest out-of-pocket costs, and your copayments will be paid directly to the provider.** To find a network provider, log on to **EyeMed's website**. If you choose an out-of-network provider, your copayment will be deducted from the out-of-network reimbursement.

	Basic Plan			Buy Up Plan		
	PLUS Network Providers	Insight Network Providers	Non-Network Providers	PLUS Network Providers	Insight Network Providers	Non-Network Providers
Copay						
Examination	No charge	$10 copay	Up to $40 allowance	No charge	$10 copay	Up to $40 allowance
Materials	$15 copay	$15 copay	See below	$10 copay	$10 copay	See below
Benefit Frequency						
Examination Diabetic eye exams are covered under the medical plan	One every plan year			One every plan year		
Lenses	One every plan year			One every plan year		
Frames	One every plan year			One every plan year		
Contacts*	One every plan year			One every plan year		
Covered Materials						
Standard Plastic Lenses						
Single vision lenses	$15 copay		Up to $30 allowance	$10 copay		Up to $30 allowance
Bifocal lenses	$15 copay		Up to $50 allowance	$10 copay		Up to $50 allowance
Trifocal lenses	$15 copay		Up to $70 allowance	$10 copay		Up to $70 allowance
Lenticular	$15 copay		Up to $70 allowance	$10 copay		Up to $70 allowance
Progressive - standard	$70 copay		Up to $50 allowance	$65 copay		Up to $50 allowance
Progressive - premium	$100-190 copay		Up to $50 allowance	$95-$185 copay		Up to $50 allowance
Frames						
Retail frame equivalent	$150 allowance	$100 allowance	Up to $50 allowance	$200 allowance	$150 allowance	Up to $75 allowance
Contact Lenses*						
Elective	$100 allowance		Up to $50 allowance	$150 allowance		Up to $75 allowance
Medically necessary	No charge		Up to $300 allowance	No charge		Up to $300 allowance

**Contact lenses are in lieu of eyeglass lenses and frames benefit.*

Vision

Vision Plan Premiums

Vision premium contributions are deducted semi-monthly from your paycheck on a before-tax basis (24 deductions annually).

	Basic Plan	Buy Up Plan
2025 Premiums		
Employee	$1.89	$2.92
Employee + Spouse	$3.59	$5.84
Employee + Child(ren)	$3.78	$7.31
Family	$5.56	$8.05

Questions about your vision benefits?

Contact EyeMed at **(866) 804-0982.**

Health Savings & Medical Spending Accounts

Health Savings Account (HSA)

Take charge of your healthcare spending with a Health Savings Account (HSA). Your HSA can be used for qualified expenses, including doctor's office visits, eye exams, prescription expenses, laser eye surgery and more. You'll find a complete list of eligible expenses at **IRS.gov**.

The HSA has triple tax advantages:

1. No federal income taxes are required on the money you or FMOLHS contribute to the account. In most states, you avoid state taxes on the account, too.
2. The earnings on your HSA grow tax-free. The account is a great way to save money for healthcare expenses throughout your career and during retirement.
3. The money you withdraw to pay for eligible medical expenses – today or in the future – is not subject to taxes.

Note that HSA elections do not automatically continue from year to year. You must actively enroll each year.

Here's How the HSA Works.

1. **Select the HDHSA Medical Plan for 2025.**
2. **Select HSA and enter your contribution.**

	FMOLHS will contribute up to	You can contribute up to
Employee only	$750	$3,550
Family	$1,500	$7,050

If you are 55 or older, you may contribute an additional $1,000 each year in catch-up contributions. FMOLHS requires a minimum contribution of $1.

3. **Once you complete the required verification steps to open your HSA account**, FMOLHS will send your contributions to Voya where an account will be opened in your name. FMOLHS will make a one-time contribution, while your contributions will be spread over 26 pay periods or the remaining pay periods based on your new hire eligibility date and effective date of coverage.
4. **Use your debit card** issued by Voya or submit eligible expenses for payment or reimbursement. If you contribute to both the HSA and LUFSA, one debit card issued by Voya will be used to access both accounts.
5. **Grow your account! Unused balances roll over from year to year.** The account can add up to a substantial nest egg during your career.
6. **All of the money in the account is yours** to use for eligible healthcare expenses now or in the future – even if you retire or leave FMOLHS.

Health Savings & Medical Spending Accounts

Health Savings Account (HSA)

Important Note:

You are eligible to open and contribute to an HSA if:

- You are enrolled in the HDHSA plan.
- You are not covered by your spouse's medical or FSA plan.
- Your spouse does not have a Medical FSA or Health Reimbursement Account.
- 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.)

For more HSA information, visit Voya's website.

If you do not complete the vetting process and open your HSA with Voya, contributions will be returned and may be taxable to you.

Health Savings & Medical Spending Accounts

Flexible Spending Account (FSA)

A Flexible Spending Account (FSA) is designed to save you money on your taxes.

When you participate in an FSA, your contributions are deducted from your pay on a pre-tax basis and deposited into your FSA. All of the money you elect for the plan year is available on day one and you can use the account to pay for **eligible expenses**. When you enroll in an FSA, you'll receive a debit card that can be used for eligible expenses. You may also pay for eligible services out of pocket and then request reimbursement from your account.

Questions about the FSAs?

We've got answers!

Here's a quick overview of your FSA options:

Account Type	Who's Eligible	Eligible Expenses	Contribution Limits	"Use it or Lose it" at the end of the year?	Benefit
Medical Flexible Spending Account	Benefits-eligible team members enrolled in the EPO, PPO or another health plan that does not include an HSA	Most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, deductibles, eyeglasses and prescribed over-the-counter medications)	$3,200	Yes	Save on eligible expenses not covered by insurance; reduces your taxable income
Limited Use Flexible Spending Account (LUFSA)	Benefits-eligible team members enrolled in the HDHSA Medical Plan or another high deductible health plan with an accompanying HSA	Most dental and vision care expenses that are not covered by the medical plan*	$3,200	Yes	Save on eligible expenses not covered by insurance; reduces your taxable income

**When you use your Voya debit card to pay for eligible dental and vision expenses, the available dollars will always pull from LUFSA first until that account is exhausted and then the dollars will pull from your HSA.*

General FSA Rules and Restrictions

In exchange for the tax advantages an FSA offers, the IRS has imposed the following rules and restrictions for a healthcare FSA:

- Your expenses must be incurred during the 2025 plan year.
- 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 your 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 that FSA elections do not automatically continue from year to year. You must actively enroll each year.

Life and AD&D

Income Protection

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

Basic Life and Accidental Death & Dismemberment (AD&D) insurance coverage is an important component of your financial security. Benefits-eligible team members are automatically enrolled in this coverage through Lincoln Financial Group. Your Basic Life and AD&D coverage is equal to 1.5 times your basic annual earnings (up to a maximum of $50,000). **FMOLHS pays the full cost of this benefit.**

Update Beneficiary Information

It's important to name a primary and contingent beneficiary – and to keep their information up to date – for your life and AD&D insurance coverage. Log into **Oracle Employee Self Service** to designate a beneficiary for your Basic Life and AD&D coverage and voluntary life insurance coverages. You can make updates to beneficiary designations under the **Life Insurance** section. If you need to make a change to your beneficiary after your initial enrollment, you can do so any time during the year.

Life and AD&D

Group Life Insurance

	Basic 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

Benefit Reductions

Benefits through the Basic Life and AD&D Insurance will be reduced when you reach certain ages, as shown here.

If you initially enroll for Employee Life and AD&D Insurance at age 65 or older, the age reductions shown in the chart will apply to any guaranteed issue amount and to the maximum eligible amount.

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

Life and AD&D

Voluntary Term Life Insurance

In addition to the Basic Life and AD&D insurance provided by FMOLHS, you may elect voluntary term life insurance coverage offered by Lincoln Financial Group during your first 30 days of eligibility. If you choose not to elect Voluntary Term Life Insurance during your first 30 days of eligibility, you will not have an opportunity to enroll in the future. You may choose coverage for yourself, your spouse and/or your dependent child(ren). If you enroll in Spouse and/or Dependent Life, a dependent designation is required at the time of enrollment.

	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**. New 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 team member'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 FMOLHS. 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:

If you are not actively at work, the effective date of your coverage will be delayed. In addition, your spouse and dependents cannot be in a period of limited activity on the day coverage takes effect. Dependent child(ren) are eligible from age 14 days to age 26, regardless of marital or student status.

Disability Program

FMOLHS provides Short Term Disability (STD) and Long Term Disability (LTD) administered by Lincoln Financial.

Short Term Disability (STD)

FMOLHS provides Short Term Disability (STD) insurance at no cost to part-time and full-time benefits-eligible team members (0.50-1.0 FTE) after 90 days of continuous employment. This coverage provides protection for up to 60% of your basic annual earnings if you become partially or totally disabled for a short period of time. The STD benefit is payable following a continuous seven-calendar day period during which a team member has a disability. The benefit is payable for up to 12 weeks.

Long Term Disability (LTD)

Our benefits program includes an offer of Long Term Disability (LTD) insurance to full-time benefits-eligible (0.8-1.0 FTE) team members. If elected, coverage begins after six months of continuous employment. If elected during your first 30 days of eligibility, no evidence of insurability (EOI) will be required. If you waive coverage during your first 30 days of eligibility, you will have an opportunity to apply for LTD coverage during annual open enrollment by completing the required EOI at **LincolnFinancial.com/FMOLHS**. FMOLHS Group Core LTD offers coverage that protects up to 50% of your basic monthly salary if you become partially or totally disabled for a long period of time. You and FMOLHS share the cost of this coverage.

You may elect optional coverage through the Group Buy Up LTD plan which provides a benefit of up to 60% of your basic monthly salary. You pay the full cost of the Group Buy Up LTD coverage.

	Group Core LTD	Group Buy-Up LTD
Coverage Amount	50% of basic monthly salary	60% of basic monthly salary
Who Pays	You & FMOLHS share cost	You pay 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

Payments continue as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner. Any other benefits you receive (such as Social Security, Workers' Compensation, pension benefits, or benefits from any similar act or plan) will reduce your LTD benefit amount. Certain exclusions, as well as pre-existing condition limitations, may apply.

To file a claim, go online at **LincolnFinancial.com/FMOLHS** (use company code FMOLHS). Once your claim is filed, check the status of your claim online at **LincolnFinancial.com/FMOLHS** or by phone at **(800) 548-0805**.

See **page 44** for information about the FMOLHS Leave of Absence Program.

Other Voluntary Benefits

FMOLHS offers voluntary benefits through Lincoln Financial Group to all eligible team members. These benefits are designed to provide financial security at an affordable price. You pay for this coverage through payroll deduction (24 deductions).

Critical Illness Insurance

Critical Illness Insurance through Lincoln Financial Group can provide financial support to help you through a serious illness, such as a heart attack, cancer or stroke. This coverage provides a lump-sum benefit to cover out-of-pocket expenses for your treatment, to pay coinsurance, or to take care of everyday living expenses, which may include housekeeping services, special transportation services and childcare.

Take a moment during your enrollment period to review the **highlights of the Critical Illness Insurance** policy.

Rates for Critical Illness are based on your attained age. This means your rate will change as you age. You can view the current rates in Oracle Employee Self Service when enrolling in coverage.

Hospital Indemnity Insurance

Hospital Indemnity Insurance is provided by Lincoln Financial Group and provides supplemental payments associated with a hospital stay that you can use for any purpose, including mortgage/rent payments, utilities, childcare, copayments, coinsurance and deductibles. Hospital Indemnity Insurance can help pay for out-of-pocket costs associated with a hospital stay. It pays both admission and daily benefits for these stays. If you elect this insurance, you'll pay for coverage through payroll deductions.

Review the **highlights of the Hospital Indemnity Insurance** policy to learn more.

Voluntary Accident Insurance

Voluntary Accident Insurance through Lincoln Financial Group helps protect you from unexpected financial stress if you or a covered family member has an accident. The coverage supplements your primary medical plan by providing cash benefits in cases of covered accidental injuries. You can use this money to help pay for medical expenses not paid by your medical plan (such as your deductible or coinsurance) or for anything else, including everyday living expenses.

Accident insurance pays cash for accidental injuries, covers multiple injuries from the same accident, is available for spouses and children, includes travel assistance and includes on the job accidents.

As you consider your benefit elections, take some time to review the **highlights of the Voluntary Accident Insurance** policy.

Hospital Indemnity

	Semi-Monthly (24 deductions)
Employee	$6.33
Employee + Spouse	$13.73
Employee + Child(ren)	$9.78
Employee + Family	$17.91

Voluntary Accident

	Semi-Monthly (24 deductions)
Employee	$3.96
Employee + Spouse	$5.77
Employee + Child(ren)	$6.97
Employee + Family	$9.24

Time Off

Our Total Rewards package includes several time off programs for benefits-eligible team members.

Paid Time Off (PTO)

Eligible team members begin earning PTO immediately upon hire. Time used will be based on the accrual earned. The annual accrual schedule* is:

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)

You may carry over PTO, up to a maximum of 328 hours.

**Part-time PTO accrual rates are prorated (Years of service credit is determined by adjusted hire date.)*

PTO Sell Back

To help team members manage PTO balances, FMOLHS offers a PTO Sell Back program. During annual open enrollment, you may elect to sell back future PTO accruals. The combination of PTO accruals and PTO sell back accruals must not exceed 328 hours at the time of payout. Hours in excess of 328 will not be paid out to you.

Holidays

FMOLHS recognizes these holidays: New Year's Day, Good Friday, Independence Day, Labor Day, Thanksgiving Day and Christmas Day. Part-time holiday accrual rates are prorated.

Bereavement Leave

The program provides up to three (3) scheduled workdays (not to exceed 24 hours) paid leave for a death in your immediate family (parent, step-parent, brother, sister, spouse, dependents including stepchildren, parent-in-law, grandchildren, grandparent and great-grandparent).

Jury Duty

The policy applies to all team members and provides for 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.

Retirement

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

403(b) Retirement Plan

The FMOLHS 403(b) retirement plan features:

- Core contributions from FMOLHS
- Matching contributions from FMOLHS when you contribute to the plan

403(b) Core Contribution

You are eligible for a core contribution of 2% of your pay into your 403(b) account:

- If you work at least 1,000 hours during the payroll year* AND
- If you are employed on the first day of the last pay period of the payroll year*

Your Contributions

The 403(b) Retirement Plan is a convenient way to save for your future through payroll deductions. When you enroll in the plan, you may contribute up to 100% of your pay on a pre-tax or Roth (after-tax) basis, up to the IRS annual limit*. If you are 50 or older (or will reach age 50 by the end of 2025), you may contribute an additional amount annually in catch-up contributions. *Note: 2025 IRS retirement limits are pending publication and will be updated upon availability.*

Newly hired team members are automatically enrolled in the plan at a 4% contribution rate. You may change your deferral rate or opt out at any time.

FMOLHS Matching Contributions

When you contribute to the 403(b) Retirement Plan, you are eligible to receive matching contributions from FMOLHS.

- If you work at least 1,000 hours during the payroll year* AND
- If you are employed on the first day of the last pay period of the payroll year*

FMOLHS will provide a 50% matching contribution for each dollar you contribute to the plan, up to the first 6%. For example, if you contribute 6% of your pay to the 403(b) Retirement Plan, FMOLHS will add an additional 3% to your account. The matching contributions are made annually.

Vesting

FMOLHS core contributions and matching contributions are 100% vested after three years of service*. If you leave FMOLHS before being fully vested, you will forfeit the core and matching contributions. You are always 100% vested in your contributions and their earnings.

Enroll in and manage all of your FMOLHS retirement accounts at LincolnFinancial.com/FMOLHS.

**Hours, pay and employment under the 403(b) Retirement Plan are generally based on the period that corresponds to the W2 issued for the plan year. This period is also referred to as the payroll year.*

Health and Well-Being

FMOLHS offers an engaging well-being program designed to help all team members grow and thrive by participating in health and well-being activities.

By participating in the Health and Wellness Program, you'll make progress on your personal well-being goals, earn points toward rewards, and have fun completing the program's various activities and challenges. You can earn up to 550 points or $550 in rewards.* Rewards include Amazon items, hotels, virtual pre-paid cards, e-gift cards, movie tickets or cash the points in for additional money in your paycheck. Points are available for redemption on the 15th of each month.

**The maximum annual awards are prorated based on your employment status: full-time 100%, part-time 50% and PRN 25%. To receive the reward, you must be actively employed by FMOLHS on the date of the reward payment. Reward payments are subject to state and federal taxes.*

To participate in the Health and Wellness Program and begin earning points, follow these steps:

1. **Complete your HRA Questionnaire** on the Healthy Lives app or **online**
2. **Schedule and complete your wellness visit** with your PCP between December 16, 2024 and December 15, 2025. During your visit, you'll have a wellness exam and biometric screening.
3. **Participate in approved activities** that help you achieve your goals and earn rewards. View the catalog of **approved activities** and choose activities and challenges that fit your work-life schedule. Follow the steps to confirm your participation in the activities.
4. **Redeem your rewards points!** Visit the **Awardco site** to register and access your rewards.

Our wellness partner, Healthy Lives, offers personal health coaches to help you understand wellness screening results and create a customized well-being plan. You can earn points for working with the personal health coach, too!

Visit healthylives.org or call (855) 426-4325 for more information.

Please review the Legal Notice regarding the Wellness Program on page 49.

Health and Well-Being

Employee Assistance Program (EAP)

Caring for your mental health is an essential element of overall wellness.

FMOLHS has partnered with Supportlinc to provide professional and confidential support for personal and family issues. Employee Assistance Program (EAP) services are available to you and your family 24/7 every day of the year to help through day-to-day challenges, major life changes, and anything in between.

The EAP provides a benefit of **ten (10) NO COST** in-person or video counseling sessions for a wide variety of concerns, such as:

- Anxiety
- Depression
- Marriage and relationship problems
- Grief and loss
- Substance abuse
- Anger management
- Stress
- Financial assistance
- Legal assistance
- Family assistance

supportlinc

Contact Supportlinc any time at (888) 881-5462. For online resources, visit supportlinc.com.

Leave of Absence Program

Eligible team members have the following benefits as a part of our leave of absence program:

Managed by FMOLHS

- **Bereavement Leave:** The program provides up to three (3) scheduled workdays (not to exceed 24 hours) paid leave for a death in your immediate family (parent, step-parent, brother, sister, spouse, dependents including stepchildren, parent-in-law, grandchildren, grandparent and great-grandparent).
- **Jury Duty:** The policy applies to all team members and provides for 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.

Administered by Lincoln Financial

- **Family & Medical Leave (FMLA):** The policy provides up to 12 weeks leave for certain family and medical events. To apply for leave, visit **Lincoln Financial's secure online portal** (enter company code: FMOLHS) or call **(800) 548-0805**. Team members must have at least one year of employment with FMOLHS and have performed at least 1,250 hours of service.
- **Personal Leave:** Team members with at least six months service may be eligible for up to 4 weeks of personal leave, dependent upon manager approval.
- **Medical Accommodation Leave:** The policy provides for leave as an accommodation subject to federal and state accommodation laws such as the ADA/ADAAA and PWFA and is available to team members upon their date of hire.
- **Military Leave:** 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 are covered through this policy.

To learn more about the Leave of Absence Program, visit our **Total Rewards site** under My Health and Well-being.

Additional Benefits

To help team members achieve a good balance between their work and personal responsibilities, FMOLHS offers a variety of other benefits and programs.

Benefits and Programs to Support You

Education Assistance: FMOLHS offers Education Assistance to help you grow and progress in your professional journey and encourage you to pursue opportunities to further your education.

Eligible part-time and full-time team members can apply to be reimbursed for eligible educational expenses up to the maximum annual allowance of $3,000 for a full-time team member and $1,500 for a part-time team member. View **Education Assistance FAQs** to learn more.

Credit Union: Enroll and elect payroll deductions to save. Signature loans, new and used car loans are available.

Employee's Blood Donor Program: Team member and family blood bank program. Participate by giving one unit of blood annually.

Health Center Membership: Discounts on various memberships

Payactiv: Financial wellness app that provides access to 40% of your earned but unpaid wages before your actual payday.

Worker's Compensation: Medical expenses and wage replacement for on-the-job injuries/exposures as governed by state law.

My Recognition Program: Provides recognition for milestones and special occasions including birthday, service anniversary and Christmas. In addition, the program recognizes team members who demonstrate the FMOLHS Mission, Values and Core Four Behaviors through the PRAISE program. Points may be awarded with the recognition and can be redeemed through **Awardco**.

Franciscan Service Award: Peer-based recognition of team members who exemplify core values of our organization.

Additional Benefits

Team Member Discounts

Franciscan Missionaries of Our Lady University (FranU) Discounts

FRANCISCAN MISSIONARIES OF OUR LADY UNIVERSITY

FranU offers discounts to help our team members have access to the highest quality education to continue to grow and learn. Discounts are offered to non-university FMOLHS team members. We offer a 50% team member discount and a 40% discount to dependents (up to age 26) of our team members for the following programs:

Undergraduate Certificates	Associate Degree of Science	Bachelor of Science	Bachelor of Arts	Online Bachelor of Business Administration	Online Master's Degree
Catholic Theology and Catechesis **Clinical Microbiology** **Forensic Science**	**Physical Therapist Assistant** **Radiological Technology**	**Medical Laboratory Science** **Nursing** • Pre-Licensure Nursing (BSN) • Accelerated Nursing (BSN) **Respiratory Therapy** **Biology** • Biochemical Analysis track • Pre-Professional Human Medicine track • Accelerated 3+2 Pathway to Physician Assistant Studies • Accelerated 3+3 Pathway to Doctor of Physical Therapy **Health Sciences (online)**	**Theology** **Psychology** **Great Books**	**Business Administration** • General Business track • Health Administration track • Management track	**Master of Healthcare Administration** (50% discount available to team members only)

For more information about FranU, call **(225) 526-1631** or email **admissions@franu.edu**.

FranU 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.

Additional Benefits

Access Perks

Access Perks is a discount program available to all FMOLHS team members. The program offers local and national group discounts when you register on the **Access Perks site**. You'll receive emails about discounts through the website or app. FMOLHS sponsors this benefit and there are no premiums or elections required to participate.

Register Today!

Accessing the mobile app and registering for Access Perks is easy.

1. Download the Access Perks app from the Apple Store or Google Play.
2. Open the app and click on **Set Up Account** to register. **(For the registration, your employee ID will be the first two letters of your first name and your Oracle ID (example: AB12345)).**
3. Complete your registration by setting your password.
4. Start saving at thousands of participating providers, including:

The Access Perks mobile app has GPS/Geolocation functionality that allows you to find deals nearby at home or while traveling. Learn more about the program at FMOLHS.AccessPerks.com or call (877) 408-2603.

Contacts

FMOLHS Benefit Programs

	Website/Email	Phone
General Benefits Information askHR	askHR@fmolhs.org	(833) 482-7547
Medical Plan Blue Cross Blue Shield	MyHealthToolkitLA.com/links/FMOLHS	(833) 468-3594
Dental Plan Delta Dental	deltadentalins.com	(800) 521-2651
Prescription Drug Coverage Express Scripts	express-scripts.com	(877) 816-8717
Health and Well-Being Program Healthy Lives	healthylives.org	(855) 426-4325
Vision Plan EyeMed Vision	eyemed.com	(866) 804-0982
FSA/HSA Voya	myhealthaccountsolutions.voya.com	(833) 232-4673
Basic Life/AD&D Supplemental Life/AD&D Long Term Disability Lincoln National Life Insurance Company	LincolnFinancial.com/FMOLHS	(855) 818-2883
Leave Administration Short Term Disability Lincoln Financial Group	LincolnFinancial.com/FMOLHS (Enter company code: FMOLHS)	(800) 548-0805
Voluntary Critical Illness, Voluntary Accident Insurance, Voluntary Hospital Indemnity Lincoln Financial Group	LincolnFinancial.com/FMOLHS When contacting LFG, your ID is your full SSN.	(855) 818-2883
Retirement Plans (403(b), 457(b), Pension Plans) Lincoln Financial Group	LincolnFinancial.com/FMOLHS	(877) 562-4738
EAP Supportlinc	supportlinc.com	(888) 881-5462
Financial Wellness App PayActiv	payactiv.com support@payactiv.com	(877) 937-6966
Education Assistance Program askHR	askHR@fmolhs.org	(833) 482-7547

Legal Notices

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 your total cholesterol, HDL, LDL, triglycerides, and glucose (including 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.

Employees may be eligible for incentives if they complete the HRA Questionnaire, have a wellness visit with their primary care provider, participate in approved activities, and follow the necessary steps to confirm their participation.

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 supervisor 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 the purpose 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, 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 personal 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 Healthy Lives at (855) 426-4325 or askHR at (833) 482-7547.

Legal Notices

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.

Legal Notices

Required Notices continued

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, 2025
Name of Entity/Sender:	Franciscan Missionaries of Our Lady Health System
Contact–Position/Office:	Human Resources
Address:	P.O. 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.

Legal Notices

Required Notices continued

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.

Legal Notices

Additional Notices

NO SURPRISES ACT NOTICE

YOUR RIGHTS AND PROTECTIONS AGAINTS 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 (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.

Legal Notices

Additional Notices continued

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 (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.)

Legal Notices

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

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

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

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

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

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

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

Chart continues on next page

Legal Notices

GEORGIA – Medicaid	LOUISIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
INDIANA – Medicaid	**MAINE – Medicaid**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
IOWA – Medicaid and CHIP (Hawki)	**MASSACHUSETTS – Medicaid and CHIP**
Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
KANSAS – Medicaid	**MINNESOTA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
KENTUCKY – Medicaid	**MISSOURI – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

Chart continues on next page

Legal Notices

MONTANA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
NEBRASKA – Medicaid	**OREGON – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
NEVADA – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
NEW HAMPSHIRE – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)
NEW JERSEY – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW YORK – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://dss.sd.gov Phone: 1-888-828-0059
NORTH CAROLINA – Medicaid	**TEXAS – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
NORTH DAKOTA – Medicaid	
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	

Chart continues on next page

Legal Notices

UTAH – Medicaid and CHIP	WASHINGTON – Medicaid
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
	WEST VIRGINIA – Medicaid and CHIP
	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
VERMONT– Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VIRGINIA – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Legal Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit, that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

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

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

Legal Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage continued

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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.

Legal Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage continued

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: Franciscan Missionaries of Our Lady Health System, Inc.	**4. Employer Identification Number (EIN):** 72-1028323	
5. Employer address: 4200 Essen Lane	**6. Employer phone number:** (833) 482-7547	
7. City: Baton Rouge	**8. State:** LA	**9. Zip code:** 70809
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above) (833) 482-7547	**12. Email address** askHR@fmolhs.org	

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.