FEED MY STARVING CHILDREN

Full-time Employee Benefits Guide

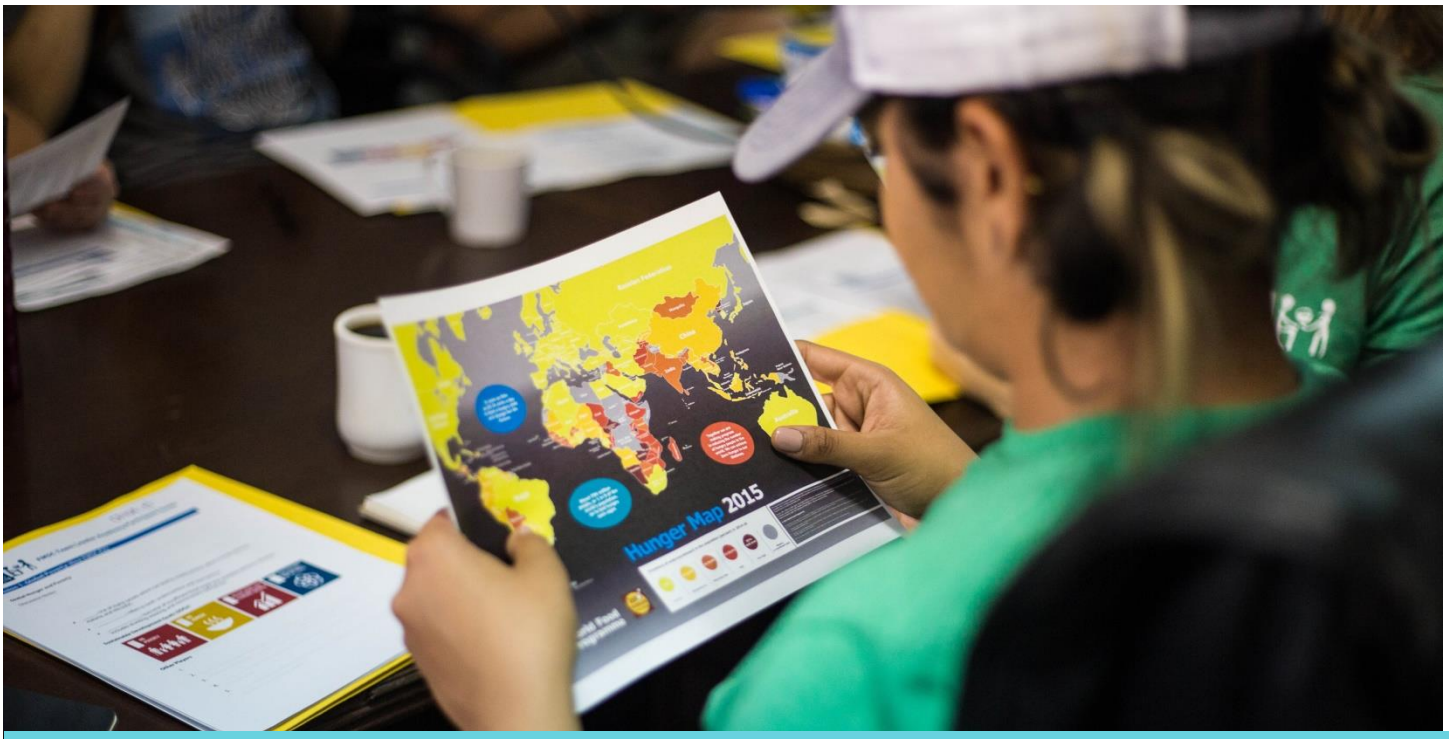
Effective January 1 – December 31, 2020

FULL-TIME EMPLOYEE BENEFITS GUIDE

Contents

"…and if you spend yourselves in behalf of the hungry and satisfy the needs of the oppressed, then your light will rise in the darkness, and your night will become like the noonday."

- Isaiah 58:10



Mission, Vision & Commitment

Mission

Feeding God's starving children, hungry in body and spirit.

Vision

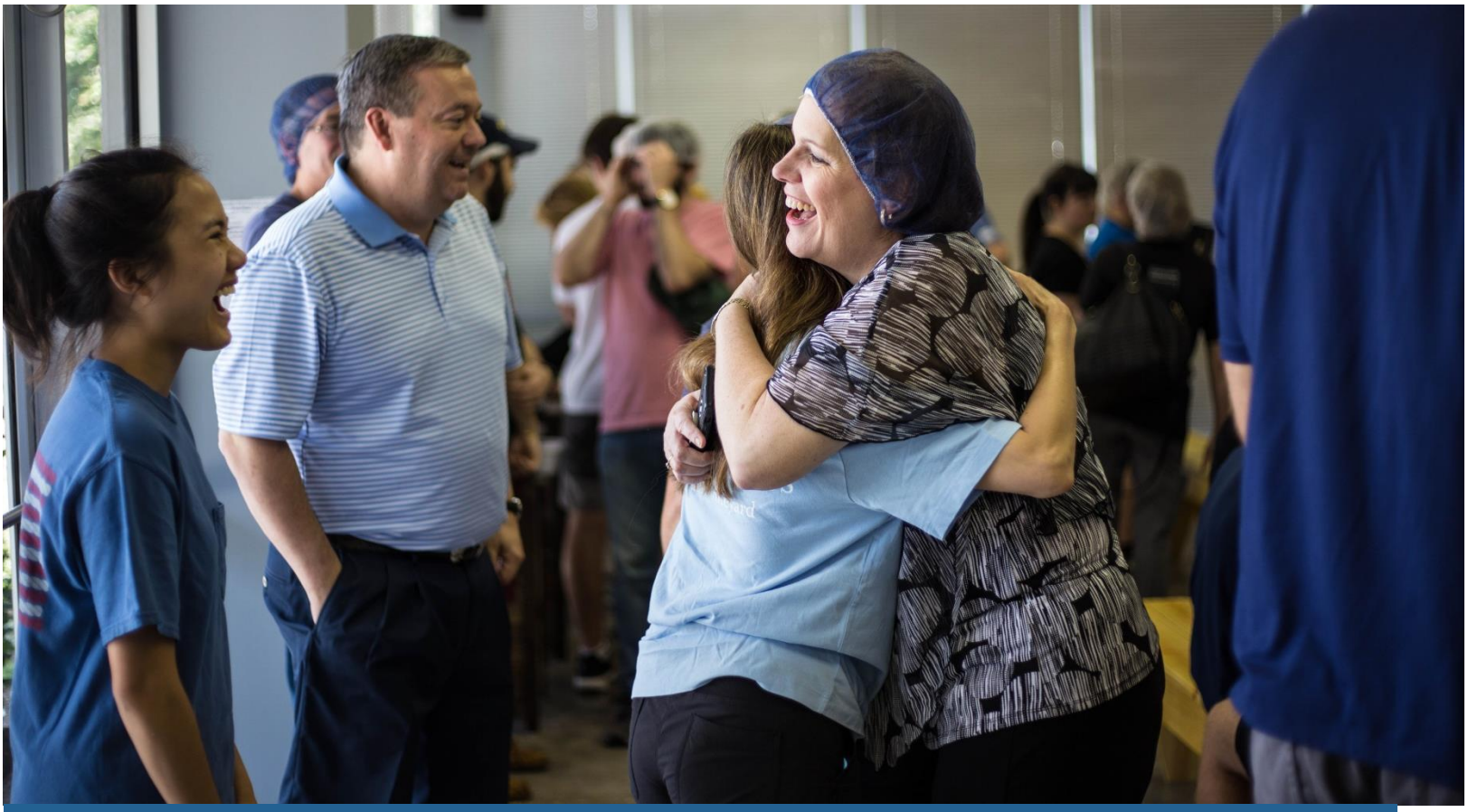
Through God, Feed My Starving Children (FMSC) will strive to eliminate malnutrition and starvation in children throughout the world by helping to instill compassion in a generation that hears and responds to the cries of those in need, until all are fed.

Our commitment to excellence

We will provide for our employees a satisfying work environment that is based on trust, mutual respect and doing the right thing.

Human Resources mission statement

Strategically partnering in building FMSC's global operations by recruiting, developing, rewarding and retaining our national workforce and aligning it with our Christian mission and values.



OUR EMPLOYEES ARE OUR MOST VALUABLE ASSET.

THAT'S WHY FMSC IS COMMITTED TO PROVIDING EMPLOYEES WITH A COMPREHENSIVE BENEFIT PROGRAM THAT SUPPORTS HEALTH AND WELLNESS.

Stay healthy

- Medical Insurance
- Dental Reimbursement Plan
- Health Savings Account
- Flexible Spending Account
- Vision Plan

Feel Secure

- 401(k) Retirement Plan
- Short-term and Long-term Disability
- Basic Life and AD&D Insurance
- Voluntary Life and AD&D Insurance
- Voluntary Critical Illness Insurance
- Voluntary Accident Insurance
- Adoption and Infertility Treatment Assistance

Maintain work / life balance

- Health and wellness discounts and resources through HealthPartners and Mutual of Omaha
- Paid Time Off and Holidays
- FMSC gear

Contact Information

Refer to this list when you need to contact one of your benefit vendors. For general information, contact Human Resources at 763-267-6325.

Retirement Plan – 401(k)
Pentegra
866-633-4015
pentegra.com

Medical Insurance
HealthPartners
952-883-500 or 800-883-2177
healthpartners.com

Health Savings Account
HR Simplified
888-318-7472
hrsimplified.com

Flexible Spending Account
HR Simplified
888-318-7472
hrsimplified.com

Dental Reimbursement
FMSC Human Resources
763-267-6325

Vision Plan
EyeMed
866-939-3633
eyemedvisioncare.com

Short-Term and Long-Term Disability
Mutual of Omaha
FMSC Human Resources
763-267-6325

Life and Accidental Death & Dismemberment Insurance
Mutual of Omaha
FMSC Human Resources
763-267-6325

Other Mutual of Omaha Value-Added Benefits
Mutual of Omaha
FMSC Human Resources
763-267-6325

Paid Time Off and Holidays
FMSC Human Resources
763-404-7871

Adoption and Infertility Treatment Assistance
FMSC Human Resources
763-267-6325

FMSC Gear
FMSC MarketPlace
763-267-6314

Who is eligible and when:

Full-time employees regularly scheduled at least 30 hours per week or expected to average at least 30 hours per week over a 12-month period are eligible to enroll in the following plans on the effective date shown.

Benefit Description	Effective Date
401(k)	1st of the month following a 1-month waiting period
Health Insurance	1st of the month following full-time start date
Health Savings Account	1st of the month following full-time start date
Flexible Spending Account	1st of the month following full-time start date
Dental Reimbursement	1st of the month following full-time start date
Vision & Hearing Care Benefit	1st of the month following full-time start date
Short- & Long-Term Disability	1st of the month following full-time start date
Basic Life & AD&D Insurance	1st of the month following full-time start date
Voluntary Life & AD&D Insurance	1st of the month following full-time start date
Voluntary Accident Insurance	1st of the month following full-time start date
Voluntary Critical Illness Insurance	1st of the month following full-time start date
Adoption & Infertility Treatment Assistance Program	On 1-year anniversary of continuous regular full-time employment
FMSC Gear	All employees are immediately eligible upon date of hire.

Notice of Special Enrollment

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

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

To request special enrollment or obtain more information, contact Human Resources at 763-267-6325 or hr@fmsc.org.

Retirement Plan – 401(k)

Who is eligible and when:

All regular employees age 18 or older are eligible to enroll in the plan at any time after they have met the eligibility requirements as shown below. You can change or cancel the deferral election at any time.

New Hire

(You have not previously been employed by FMSC)

- You will be automatically enrolled in the plan at 1% of pay on the first of the month following a 1-month waiting period. You can change or cancel the deferral election at any time.

Rehire

(You have previously been employed by FMSC)

- If you were previously employed by FMSC for at least 30 days, you will be eligible to enroll on your first day of employment as soon as administratively possible.

Newly-Eligible

(Your employment status changed from PT On-Demand/Casual to PT/FT Regular)

- Once you have been an FMSC employee for at least 30 days, you are immediately eligible to enroll as soon as administratively possible.

Plan features:

FMSC provides this benefit to help you save a portion of your income for retirement. To encourage saving for retirement, FMSC will contribute up to 4% matching contributions as shown below:

Employee Deferral	Employer Match	Total
1%	1%	2%
2%	2%	4%
3%	3%	6%
4%	3.5%	7.5%
5%	4%	9%
>5%	4%	>9%

You May:

- Roll over account balances from a prior employer's plan and/or IRA
- Defer up to 90% of your eligible compensation
- Elect to contribute pre-tax or post-tax (Roth) deferrals

Contributions:

- Your contributions are 100% vested
- Employer match contributions are 100% vested

Medical Insurance

There are three medical plan options to choose from for the 2020 plan year. All three utilize the Perform network with access to HealthPartners' Cigna National network. A high-level overview is below. Please refer to the Certificate of Coverage for specific coverage levels, out-of-network coverage and/or benefit exclusions.

Coverage is also available to spouses and eligible dependents under age 26 - regardless of student or marital status.

Medical Plan Options

		PLAN OPTION #1 $1,500 - $45	PLAN OPTION #2 $2,000 – 75% Three For Free	PLAN OPTION #3 $4,500 – 100% HSA
Deductible	Individual	$1,500	$2,000	$4,500
	Family	$4,500	$6,000	$9,000
Co-Insurance		25%	25%	0%
Out-of-Pocket	Individual	$5,000	$4,750	$4,500
	Family	$10,000	$9,500	$9,000
Preventive Care		No charge	No charge	No charge
Diagnostic Test (X-ray, blood work)		No charge	Deductible, then 25%	Deductible, then 0%
Imaging (CT/PET scans, MRIs)		Deductible, then 25%	Deductible, then 25%	Deductible, then 0%
Office Visits (For Illness or Injury)		$45 Copay	No charge for first 3 visits; then deductible and 25%	Deductible, then 0%
Urgent Care		$45 Copay		Deductible, then 0%
Convenience Care/Retail Health Clinic		$20 Copay		Deductible, then 0%
Virtuwell		No Charge	No Charge	Deductible, then 0%
Emergency Room		Deductible, then 25%	Deductible, then 25%	Deductible, then 0%
Ambulance Services		Deductible, then 25%	Deductible, then 25%	Deductible, then 0%
Outpatient Hospitalization		Deductible, then 25%	Deductible, then 25%	Deductible, then 0%
Inpatient Hospitalization		Deductible, then 25%	Deductible, then 25%	Deductible, then 0%
Prescription Drugs Generic/Formulary/Non-formulary Specialty		$5-$150/$60/$150 25%; up to $500 per Rx	$5-$150/$60/$150 25%; up to $500 per RX	Deductible, then 0% Non-Formulary - Not Covered

*All benefit information in graph above highlights in-network coverage.

HealthPartners Perform Network

Your health is one of our top priorities. That includes making sure you have access to doctors and clinics throughout the United States. We're able to offer this because your HealthPartners health insurance plan works with Cigna to give you a huge network of doctors and clinics. This means it's easy for you to find a doctor wherever you are.

Here are three tips to help you find a doctor or search for care in your network:

- Visit **healthpartners.com/perform** to search by name, specialty, condition or procedure, and more.
- Call your Member Services team at the number on the back of your member ID card. They are here for you, and happy to help.
- When you're at the doctor's office, **show your member ID card**. It has important information your doctor's office needs to file a claim. Point out the Cigna logo in the lower left-hand corner or tell them you have HealthPartners insurance with the Cigna network.

Need anything else?

Your Member Services team is always here for you and happy to answer your questions. Just give them a call at 952-883-5000 or 800-883-2177 – Monday through Friday, 7 a.m. – 7 p.m. CST.

Employee Medical Contributions:

Monthly employee contributions for each medical plan option are illustrated below. Medical plan premiums are deducted from your paycheck on a pre-tax basis. These rates are based on 26 per-pay-period deductions each year.

Plan Option #1: $1,500 - $45 Copay

	Employer Monthly Premium	Employee Monthly Premium	Employee Per Pay Period Premium
Employee Only	$411.44	$160.01	$73.85
Employee + Spouse	$717.46	$611.17	$282.08
Employee + Child(ren)	$569.34	$484.99	$223.84
Family	$864.03	$736.02	$339.70

Plan Option #2: $2,000 - Three for Free

	Employer Monthly Premium	Employee Monthly Premium	Employee Per Pay Period Premium
Employee Only	$438.36	$96.23	$44.41
Employee + Spouse	$807.91	$435.03	$200.78
Employee + Child(ren)	$641.11	$345.22	$159.33
Family	$972.96	$523.90	$241.80

Plan Option #3: $4,500 - 100% HSA

	Employer Monthly Premium	Employee Monthly Premium	Employee Per Pay Period Premium
Employee Only	$433.79	$37.72	$17.41
Employee + Spouse	$855.10	$241.18	$111.31
Employee + Child(ren)	$678.56	$191.39	$88.33
Family	$1,029.78	$290.45	$134.05

HealthPartners Value Added Benefits

- To determine prescription drug coverage: healthpartners.com/genericsadvantagerx

Additional services offered by HealthPartners:

Member Services:

Contact HealthPartners Member Services when you have questions about your coverage, claims, account balances, finding a doctor or specialist and additional health plan services. They can also connect you with the Nurse, Pharmacy or Behavioral Health Navigator programs to help you further understand your benefits and find the care you need. Member Services can be reached Monday-Friday, 7 a.m. to 7 p.m. CST, by calling the number on the back of your ID card: 952-883-5000 or 800-883-2177.

CareLine Services:

Members are able to make a free call to a registered nurse who will help answer your questions about whether you should see a doctor, home remedies and medicines you are taking. They are available 24 hours a day and can be reached at 612-339-3663 or 800-551-0859.

BabyLine:

The BabyLine is a great resource for questions about your pregnancy or new baby. This line is available 24 hours a day at 612-333-2229 or 800-845-9297.

Frequent Fitness Program:

HealthPartners provides covered members up to a $20 credit toward their health club membership dues when they work out 12 times or more per month at a participating health club. The household savings maximum is $40. Participating health clubs include Anytime Fitness, Curves, LA Fitness, Life Time Fitness, Snap Fitness, YMCA, YWCA, local community centers and many more!

Healthy Discounts:

Show your HealthPartners Member ID card to participating retailers to receive Healthy Discounts on pet insurance, exercise equipment, fitness classes, diapers and kids items, healthy eating services, eyewear, spa treatments and more! Find additional discounts at healthpartners.com/discounts.

Assist America:

Whether you're traveling abroad or just out of town for the weekend, you can feel confident you're in good hands when the unexpected happens. Get 24/7 help with filing lost prescriptions, pre-trip info – like immunizations and visa requirements, tracking down lost luggage, and more! Learn more at healthpartners.com/getcareeverywhere.

Health Savings Account (HSA)

Who is eligible and when:

Employees who enroll in the $4,500 High Deductible Health Plan (HDHP) can set up a Health Savings Account (HSA) if they meet the following requirements:

- Are covered under a high deductible health plan (HDHP) on the first day of the month.
- Are *not* enrolled in Medicare.
- *Cannot* be claimed as a dependent on someone else's tax return.
- Are *not* covered under another medical plan that is not a HDHP, including a Flexible Spending Account (unless it is a Limited-Purpose account, which can only be used for dental and vision expenses). *If you anticipate large expenses such as orthodontia or lasik, please reach out to Benefits & Compensation Analyst for options to enroll in a Limited-Purpose FSA account.*

An HSA can be effective as early as the HDHP's effective date if the employee enrolls within that month. If the employee doesn't enroll in the HSA within the month that the HDHP is first effective, then the HSA would be effective as soon as the employee's HSA enrollment form has been processed and the account opened.

Benefits you receive:

The HSA is a tax-favored account that can be set up to pay for current and future medical expenses. The benefits of an HSA include:

- Tax-Deductible – Money contributed to the account is tax-deductible
- Tax-Free – Money and interest in the account is tax-free for qualified expenses
- Tax-Deferred – Leftover accumulated money can grow tax-deferred to help fund retirement
- Yours to Keep – Contributions to your account are yours to keep forever, until you choose to use them

Employees can change contributions to their Health Savings Account at any time.

Current Annual Maximum Contributions

Single	Family	Age 55+
$3,550	$7,100	$1,000 catch-up contribution*

*Employees age 55 and older are eligible to contribute an extra $1,000 per year towards their HSA.

The money in the account can be used to pay for any "qualified medical expense" permitted under federal tax law for you, your spouse and/or dependent(s). Qualified expenses include most medical care and services, dental care and vision care. For a complete list of eligible expenses, please visit irs.gov.

According to the IRS, you must keep records sufficient to show that:

- The distributions were exclusively to pay or reimburse qualified medical expenses,
- The qualified medical expenses had not been previously paid or reimbursed from another source, and
- The medical expenses had not been taken as an itemized deduction in any year.

Do not send these records with your tax return. Keep them with your tax records.

Flexible Spending Account (FSA)

Benefits you receive:

A Flexible Spending Account provides you with an important tax advantage that can help you pay for eligible health care and dependent care expenses on a pre-tax basis. By paying for certain expenses on a pre-tax basis, you lower your taxable income and increase your take-home pay.

Medical FSA

This allows you to pay with pre-tax dollars for certain IRS-approved medical care expenses not covered by your insurance. The current annual maximum amount you can elect to contribute to the plan is $2,700 (minimum contribution is $100). Expenses can be incurred by you, your spouse or eligible dependents.

Examples include:

- Your medical plan's co-pays, deductible and coinsurance
- Medical supplies such as hearing aids, crutches and orthopedic shoes
- Vision services, including contact lenses, contact lens solution, eye examinations, eyeglasses and laser eye surgery
- Dental services and orthodontia (contact Human Resources if you use the plan for orthodontia)
- Chiropractic services
- Acupuncture
- Please note: over-the-counter drugs are not eligible unless prescribed by a doctor.

Dependent Care FSA

The Dependent Care FSA allows you to use pre-tax dollars to pay for qualified dependent care expenses such as caring for children under age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is $5,000 (or $2,500 if married and filing separately) per plan year (minimum contribution is $100).

Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools

Current Annual Maximum Contributions

Medical FSA	Dependent Care FSA
$2,700	$5,000

Dental Reimbursement

Benefits you receive:

FMSC will reimburse each benefit-eligible employee up to $1,200 per year for dental expenses, orthodontia expenses or premiums paid to obtain individual dental insurance for the employee, spouse and/or dependents. To receive this reimbursement, the employee must complete a reimbursement form, attach the receipt along with other needed documentation, and then submit the form to Human Resources for processing.

If you are covered by individual insurance, an Explanation of Benefits (EOB) from the insurance company is required. If covered by a dental savings plan or discount program, a Fee Schedule of Coverage is required. Premiums to another employer-sponsored dental plan (e.g. spouse's group plan through employer) are not reimbursable.

Dental Reimbursement
$1,200*

*Employees hired after January 1 are eligible for a pro-rated amount.

Please note:

If you submit your qualified dental expenses to any other coverage or plan, you *may not* submit these expenses to the FMSC Dental Reimbursement Plan. You will be asked for a signature on your reimbursement request form verifying that the claimed expense amount has not been paid or reimbursed under any other coverage or tax-favored savings plan (Flexible Spending Account, Health Savings Account, etc.)

If you have questions regarding these guidelines, please reach out to HR at hr@fmsc.org or 763-267-6325.

Vision Plan

Benefits you receive:

Reduce your out of pocket expenses for eyeglasses and contact lenses by enrolling in this plan. This is a materials-only plan, meaning that exams are not covered. A snapshot of your in-network vision benefits is shown below.

Remember, one annual exam is completely covered under FMSC's medical insurance – so make sure to bring your medical insurance card to your vision exam appointment.

	In-Network Benefits
Exam	Not covered
Frames	$0 copay; $130 allowance, 20% discount over $130
Lenses Single Vision, Bi-Focal, Tri-Focal, Lenticular	$25 copay
Lenses Progressive (standard) Progressive (premium) Tier 1 Tier 2 Tier 3 Tier 4	$90 copay $110 – 135 copay $110 copay $120 copay $135 copay $90 copay; 20% off charge less $120 allowance
Contact Lenses Conventional Disposable	$0 copay; $130 allowance, 15% discount over $130 $0 copay; $130 allowance, plus balance over $130
Benefit Frequency Lenses or Contact Lenses Frames	12 months 24 months

Employee Vision Contributions:

Vision plan premiums are deducted from your paycheck on a pre-tax basis. These rates are based on 26 per-pay-period deductions each year.

Tier of Coverage	Employee Per Pay Period Premium	Employee Annual Premium
Employee only	$2.09	$54.36
Employee + Spouse	$3.97	$103.32
Employee + Child(ren)	$4.18	$108.72
Family	$6.15	$159.84

Disability Insurance

If you get sick or injured and are unable to work, you don't want to worry about paying for groceries or covering next month's mortgage. Disability income insurance can help replace a significant portion of your income. Some think of it as "paycheck protection."

FMSC pays the *entire* cost of both Short-Term *and* Long-Term Disability Insurance for all regular Full-Time Employees.

Benefits you receive:

Employees who become disabled will be provided with both Short-Term and Long-Term Disability insurance. FMSC pays the *entire* cost of coverage. Any disability benefit received will be taxable to the employee.

	Short-Term Disability	Long-Term Disability
Income replacement	60% of your pre-disability earnings	60% of your pre-disability earnings
Maximum benefit	$1,200 per week	$5,000 per month
Benefits begin	Accident -First day of disability Illness or Childbirth - Eighth day of disability	91st day of disability
Maximum benefit duration	Accident - 13 weeks Illness - 12 weeks	To Social Security Normal Retirement Age

90% of disability claims are for conditions caused by illness, such as arthritis, back pain, and cancer.

Council for Disability Awareness, Disability Statistics, 2016

One in four of today's 20 year-olds will become disabled for at least a year before they retire.

Social Security Administration, Disability and Death Probability Tables for Insured Workers Born in 1997

Basic Life and AD&D Insurance

Benefits you receive:

FMSC provides $50,000 of Basic Life insurance and $50,000 of Basic Accidental Death and Dismemberment insurance for benefit-eligible employees. FMSC pays 100% of the cost of this coverage.

Life Insurance can help with costly expenses involving funeral expenses, assisting your family in paying off debts or a mortgage, or even a memorial donation to a favorite charity.

The Basic Life and AD&D benefits reduce according to the following schedule:

Employee Age	Benefit Reduction
Age 65	Reduces to 65% of original face amount
Age 70	Reduces to 45% of original face amount
Age 75	Reduces to 30% of original face amount
Age 80	Reduces to 20% of original face amount

Additionally, all regular full-time employees receive the following Mutual of Omaha services at no cost as part of their Basic Life and AD&D insurance:

- Employee Assistance Program
- ID Theft Assistance
- Travel Assistance
- Hearing Aid Discount Program

See “Other Mutual of Omaha Value-Added Benefits” section on page 19 for more information.

Voluntary Life and AD&D Insurance

Benefits you receive:

Employees who want to supplement their Basic Life and AD&D insurance have the opportunity to purchase additional coverage for themselves and/or their eligible dependents. Voluntary Life and AD&D insurance must be elected together, and in matching amounts.

Voluntary Life and AD&D Options	Benefit Amount	Guarantee Issue Level*
Employee	Increments of $10,000; maximum is the lesser of 5x your basic annual earnings or $500,000	$100,000 for newly-eligible employees
Spouse**	Increments of $5,000 up to $100,000; not to exceed 100% of employee amount	$25,000 for newly-eligible spouses
Child(ren) **< 19 years old**	Increments of $1,000 up to $10,000	$10,000
Children **< 26 years old (if a full-time student)**	Increments of $1,000 up to $10,000	$10,000

Please note that spouse coverage terminates at age 70.

** New hires qualify for the guaranteed issue level. To take advantage of this opportunity, the application for coverage must be received by Human Resources within 30 days of being eligible for the benefit (your new hire eligibility period).*

***In order to elect Voluntary Life Insurance coverage for your spouse and/or your children, you must elect coverage for yourself.*

The Voluntary Life and AD&D benefits reduce according to the following schedule:

Employee Age	Benefit Reduction
Age 70	Reduces to 65% of original face amount
Age 75	Reduces to 50% of original face amount

Voluntary Life and AD&D Insurance

Voluntary Life and AD&D insurance is paid for by the employee via payroll deduction. For Voluntary Life insurance, employee and spouse premiums are calculated based on the age of the employee. The monthly costs are as follows:

Employee's Age	Employee/Spouse Monthly Cost per $1,000 of benefit
Age <35	$0.086
35-39	$0.106
40-44	$0.152
45-49	$0.229
50-54	$0.363
55-59	$0.584
60-64	$0.896
65-69	$1.642
70+	$3.349

Voluntary Life	Monthly Cost per $1,000 of benefit
Child(ren)	$0.24 *(one premium will insure all covered children)*

Voluntary AD&D	Monthly Cost per $1,000 of benefit
Employee	$0.017
Spouse	$0.017
Child(ren)	$0.051

Calculate your monthly premium:

To calculate your monthly premium, complete the following by entering your coverage amount and rate.

	Coverage Amount				Increment		Life/AD&D Rate		Monthly Cost
Sample	$100,000	÷	$1,000	=	100	X	$.152	=	$15.20
Employee:	$	÷	$1,000	=		X	$	=	$
Spouse:	$	÷	$1,000	=		X	$	=	$
Children:	$	÷	$1,000	=		X	$	=	$

Your Total Monthly Cost

$

Voluntary Accident Insurance

Benefits you receive:

Although accidents are unexpected and usually come without warning, you don't have to let an injury catch you off guard. You can be prepared to handle the accompanying medical expenses with the help of the Accident Insurance offered through Mutual of Omaha.

The Accident Insurance pays a lump-sum cash benefit for covered injuries that employees or an insured family member sustains as a result of an accident (as defined by the policy). Because accident insurance is supplemental, it works in addition to other any other insurance you may have.

The cash benefit from accident insurance can be used to:

- Pay for out-of-pocket medical expenses
- Supplement daily living expenses
- Cover lost income from unpaid time off

	Employee Monthly Premium	Employee Per Pay Period Premium
Employee Only	$11.64	$5.37
Employee + Spouse	$18.49	$8.53
Employee + Child(ren)	$25.22	$11.64
Family	$33.68	$15.55

Example:

You broke your leg!

In exchange for your life of adventure, you receive bills for a visit to the Emergency Room, x-rays, crutches, and two follow-up appointments.

- Emergency Room: $200
- Broken leg: $3,000
- Crutches: $100
- X-ray: $75
- Follow-up visits: $150 total

You receive a total reimbursement of **$3,525.**

Examples of reimbursable expenses:

Urgent care, broken bones, burns, hospital stay, crutches, and much more!

This outline of coverage is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of you, the policyholder and the insurance company. It is, therefore, important that you read your certificate carefully! **This policy is not considered health insurance, and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.**

Voluntary Critical Illness Insurance

Benefits you receive:

An unexpected critical illness often comes without warning and may have lasting effects on you and your families — both physically and financially.

Our Critical Illness Insurance policy offered through Mutual of Omaha can help provide you with the extra financial security you may need to lessen the financial impact associated with the treatment and recovery of a critical illness such as a heart attack, stroke, or cancer.

Examples of a critical illness:

Heart attack, stroke, organ transplant & cancer.

This benefit provides a lump-sum cash benefit upon the diagnosis of a critical illness, as defined by the policy. You have the flexibility to use the cash benefit as they see fit, including payment for:

- Out-of-pocket medical expenses
- Home or car alternations/modifications
- Mortgage/ rent or child/adult care
- Daily living expenses

Anticipated out-of-pocket expenses	
Out-of-pocket medical expenses	$
Travel to treatment centers	$
Child or adult care	$
Income	
Lost income	$
Total Critical Illness Insurance Needed	
	$

Employee Age	Employee or Spouse Monthly Premium for $10,000 of Benefit	Employee Per Pay Period Premium
<30	$3.32	$1.53
30-39	$5.98	$2.76
40-49	$13.30	$6.14
50-59	$28.34	$13.08
60-69	$59.32	$27.38
70-79	$111.28	$51.36
80-99	$156.40	$72.18

Child dependent coverage is offered at no cost for illnesses such as cerebral palsy, structural congenital defects, genetic disorders, congenital metabolic disorders, and type one diabetes.

A pre-existing condition limitation applies. A pre-existing condition is one for which you have received medical treatment, consultation, care or services including diagnostic measures, or if you were prescribed or took prescription medications in the predetermined time frame prior to your effective date of coverage. The pre-existing condition under this plan is 12/12 which means any condition that you receive medical attention for in the 12 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered. Please refer to certificate booklet for full explanation of the plan's benefits, exclusions, limitations, and reductions. **This policy is not considered health insurance, and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.**

Other Mutual of Omaha Value-Added Benefits

Employee Assistance Program

Mutual of Omaha's EAP assists employees and their eligible dependents with personal or job-related concerns, including:

- Emotional Well-Being
- Family and Relationships
- Legal and Financial
- Healthy Lifestyles
- Work and Life Transitions

Visit **mutualofomaha.com/eap** or call 800-316-2796 for confidential consultation and resource services.

Benefits

- Access to EAP Professionals 24 hours a day, seven days a week
- Provides information and referral resources
- Service for employees and eligible dependents
- Online resources for:
  - Substance use and other addictions
  - Dependent and Elder Care resources
- Access to a library of educational articles, handouts and resources via www.mutualofomaha.com/eap
  - Legal library and online forms
  - Financial and online tools

What to Expect

You can trust your EAP professional to assess your needs and handle your concerns in a confidential, respectful manner. Our goal is to collaborate with you and find solutions that are responsive to your needs.

Don't delay if you need help. Visit mutualofomaha.com/eap or call 800-316-2796 for confidential consultation and resource services.

Travel Assistance

Travel Assistance can help you avoid unexpected bumps in the road anywhere in the world. It's available for you, your spouse and dependent children on any single trip, up to 120 days in length, more than 100 miles from home for business and personal travel.

Pre-trip Assistance

** Minimize travel hassles by calling us pre-departure for:

- Information regarding passport, visa or other required documentation for foreign travel
- Travel, health advisories and inoculation requirements for foreign countries
- Domestic and international weather forecasts
- Daily foreign currency exchange rates
- Consulate and embassy locations

For inquiries within the U.S. call toll free:
1-800-856-9947

Outside the U.S. call collect:
312-935-3658

Emergency Travel Support Services

- Phone translation and interpreter services – 24/7 access to telephone translation services
- Locating legal services – referrals for local attorney or consular offices and help maintain business and family communications until legal counsel is retained (includes coordination of financial assistance for bonds/bail)
- Baggage – assistance with lost, stolen or delayed baggage while traveling on a common carrier
- Emergency payment and cash – assistance with advance of funds for medical expenses or other travel emergencies by coordinating with your credit card company, bank, employer, or other sources of credit; includes arrangements for emergency cash from a friend, family member, business or credit card
- Emergency messages – assistance with recording and retrieving messages between you, your family and/or business associates at any time
- Document replacement – coordination of credit card, airline ticket or other documentation replacement
- Vehicle return – if evacuation or repatriation is necessary, return your unattended vehicle to the car rental company

Medical Assistance

- Locating medical providers and referrals
- Communication on your medical status with family, physicians, employer, travel company and consulate
- Emergency evacuation if adequate medical facilities are not available, including payment of covered expenses
- Transportation home for further treatment – in the event of death, assist in the return of mortal remains
- Transportation arrangements for the visit of a family member or friend if your hospitalization is more than seven calendar days
- Return home for dependent children if your hospitalization is more than seven calendar days
- Assistance with lodging arrangements if convalescence is needed prior to, or after, medical treatment
- Coordination with your health insurance carrier during a medical emergency
- Assistance obtaining prescription drugs or other necessary personal medical items

**Available at any time, not subject to 100 mile travel radius.

Travel assistance services are independently offered and administered by AXA Assistance USA, Inc. (AXA). Insurance benefits provided as part of Travel Assistance underwritten by a third party. AXA is not affiliated in any way with Mutual of Omaha companies. There may be times when circumstances beyond AXA Assistance USA's control hinder its endeavors to provide services. AXA Assistance USA will make all reasonable efforts to help you resolve the emergency situation. Both companies are responsible for their own contractual and financial obligations.

ID Theft Assistance

Identity Theft Assistance, provided by AXA Assistance, helps you and your dependents understand the risks of identity theft, learn how to prevent it, and most importantly, assist you if your information is compromised. ID Theft Assistance is available as part of your overall Travel Assistance package offered by your employer.

Awareness and Education

We help you understand the growing threat of identity theft by:

- Promoting awareness of identity theft
- Answering your questions about identity theft and how to recognize if you've become a victim
- Educating you on how to avoid having your identity stolen

Access ID Theft Assistance services by calling AXA Assistance toll-free at: 800-856-9947

Recovery Assistance

If your identity is compromised, the most important thing to do is respond quickly. We assist you by:

- Connecting you to the fraud departments at your bank(s) and credit card companies
- Facilitating access to credit bureaus and obtaining a complimentary credit report
- Guiding you in contacting federal government and local law enforcement agencies and filing reports and complaints

Hearing Discount Program

Program Benefits Include

Call an Amplifon Patient Care Advocate today: 888-534-1747

- Custom hearing solutions – they find the solution that best fits your lifestyle and your budget from one of our 10 manufacturers
- Risk-free 60-day trial – 100 percent money-back guarantee on hearing aid purchase
- Hearing aid low price guarantee – if you find the same product at a lower price, bring us the local quote and we'll not only match it, we'll beat it by 5 percent
- Continuous Care – one year free follow-up, two years of free batteries and a three-year warranty

Accessing Your Benefits is as Easy as...

1. Call Amplifon at 888-534-1747 and a Patient Care Advocate will assist you in finding a hearing care provider near you.
2. Our advocate will explain the Amplifon process, request your mailing information and assist you in making an appointment with a hearing care provider.
3. Amplifon will send information to you and the hearing care provider. This will ensure your Amplifon discounts are activated.

Special money-saving offer!

- Call for a *free* hearing screening appointment.
  (This is not a medical exam and is only intended to assist with amplification selection.)

Floating and Paid Holidays

Floating holidays:

On an employee's full-time hire date and then on each subsequent anniversary, they receive 3 floating holidays to be used on days of their choosing within the next 12 months.

Paid holidays:

FMSC recognizes the following paid holidays:

- New Year's Day
- Good Friday
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving
- Day after Thanksgiving
- Christmas Eve
- Christmas Day

Paid Time Off (PTO)

Benefits you receive:

FMSC provides a flexible PTO program that combines vacation, sick and personal time into one bank of time.

A new full-time employee expected to work on average 40 hours per week over a 12-month period accrues 16 days of PTO during the first 12 months of employment. The employee's PTO accrual increases by one day each year for the first 10 years of employment to a maximum of 26 days per year.

A new full-time employee expected to work on average less than 40 hours per week over a 12-month period accrues 12 days of PTO during the first 12 months of employment. The employee's PTO accrual increases by ¾ of a day each year for the first 10 years of employment to a maximum of 19.5 days per year.

PTO does not expire, but there is a cap on the amount of accrued unused PTO an employee may have in his/her bank.

*See policy in the **Employee Handbook** for more information.*

Adoption & Infertility Treatment Assistance

Benefits you receive:

Employees with at least one year of continuous service in a regular, full-time position at FMSC are eligible for reimbursement up to $2,500 per calendar year with a lifetime maximum of $5,000 for expenses incurred towards adoption and/or infertility treatment.

FMSC Gear

Benefits you receive:

Employees receive 50% off FMSC T-shirts and $15 off FMSC sweatshirts sold in our MarketPlace.*

*The Donation T-shirt, online purchases, and artisan-created MarketPlace goods are not included.

This document is a summary and is not intended as policy or a complete description of benefits. This document is not a guarantee of benefits and is subject to change at any time. Details of each plan are contained in the plan documents which legally govern the operation of the programs. If there is any conflict between this document and any of the plan documents, the plan documents will always govern.

Tax Implications

Some benefits in this Guide are income tax-advantaged and subject to U.S. Internal Revenue Service (IRS) Code. However, no language in this Employee Benefit Guide is intended, nor should be construed as tax advice. Please consult your personal tax preparer, accountant, or financial planner with any questions regarding benefit taxability.

IMPORTANT LEGAL NOTICES

Contents

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 35-38 for more information.

Women's Health and Cancer Rights

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 deductible and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description of the plan you selected.

If you would like more information on WHCRA benefits, call Human Resources at 763-267-6325.

Newborns Act Disclosure – Federal

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

HIPAA Special Enrollment Rights

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program).

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

Loss of Coverage for Medicaid or a State Children's Health Insurance Program.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.

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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Ins. Program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

Statement of ERISA Rights

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

Receive Information about Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $149 per day (up to a $1,496 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

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

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date of Notice: November 11, 2019

Privacy Contact: Jeanie Picardi

401 93rd Avenue NW

Coon Rapids, MN 55433

Phone: 763-913-7026

Email: jpicardi@fmsc.org

Your Rights to Your Health Information. You have the right to:

- Get a copy of your health and claims records. You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct health and claims records. You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- Get a list of those with whom we've shared information. You can ask for a list (accounting) of the times we've shared your health Information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us using the information in this Employee Benefits Guide.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling **1-877-696-6775**, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.

We will not retaliate against you for filing a complaint.

Your choices. For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

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

- Share information in a disaster relief situation
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission: marketing purposes or sale of your information.

Our Uses and Disclosures. How do we typically use or share your health information?

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

- Help manage the health care treatment you receive. We can use your health information and share it with professionals who are treating you. Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional service.
- Run our organization. We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. Example: We use health information about you to develop better services for you.
- Pay for your health services. We can use and disclose your health information as we pay for your health services. Example: We share information about you with your dental plan to coordinate payment for your dental work.
- Administer your plan. We may disclose your health information to your health plan sponsor for plan administration. Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

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

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

- Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director. We can share health information about you with organ procurement organizations. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you:
- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services.
- Respond to lawsuits and legal actions.

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities.

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

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Changes to the Terms of This Notice

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

IMPORTANT NOTICE FROM HEALTHPARTNERS ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Enrollees of Plan # 1 – $1,500 - $45 Plan, or Plan #2 - $2,000 – Three for Free Plan

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

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

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

2. Feed My Starving Children has determined that the prescription drug coverage offered by the HealthPartners medical benefit plan is on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

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

If you decide to join a Medicare drug plan, your current HealthPartners coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current HealthPartners coverage, be aware that you and your dependents may 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 HealthPartners and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact Feed My Starving Children's Human Resources department for further information by email at hr@fmsc.org or call 763-267-6325.

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 HealthPartners changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

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

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

IMPORTANT NOTICE FROM FEED MY STARVING CHILDREN ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Enrollees of Plan #3 - $4,500 High Deductible Health Plan

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

There are three 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. Feed My Starving Children has determined that the prescription drug coverage offered by the HealthPartners health and welfare plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the HealthPartners health and welfare plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from HealthPartners health and welfare plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

Since the coverage under HealthPartners health and welfare plan, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug

plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 HealthPartners coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current HealthPartners coverage, be aware that you and your dependents will not be able to get this coverage back.

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

Contact Feed My Starving Children's Human Resources for further information by email at hr@fmsc.org or call 763-267-6325.

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 HealthPartners 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).

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 January 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507

ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid	**KANSAS – Medicaid**
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

MASSACHUSETTS – Medicaid and CHIP	NORTH CAROLINA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid and CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact HR at hr@fmsc.org or

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 --percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
Feed My Starving Children	41-1601449
5. Employer address	6. Employer phone number
401 93rd Avenue NW	763-267-6325

7. City	8. State	9. ZIP code
Coon Rapids	MN	55433

10. Who can we contact about employee health coverage at this job?
Jessica Jadwin

11. Phone number (if different from above)	12. Email address
	jjadwin@fmsc.org

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

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

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Full-time, regular employees working 30+ hours per week.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

-Enrollee's current legal spouse

-Dependent Children (natural or legally adopted, child for whom enrollee or spouse is legal guardian, child covered under a qualified medical child support order) up to age 26 or disabled.

☐ We do not offer coverage.

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

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

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