Employee Benefit Program Summary

2022

Part-time/ACA Employees

Welcome!

Meridian Services offers eligible employees these benefits:

- Health Insurance
- Dental Insurance
- Supplemental Plans
  - Short-term Disability
  - Accident
  - Medical Bridge
  - Critical Illness
  - Whole Life
- Pet Insurance
- 401(k) Retirement Savings Plan

What You Should Know

- Benefit eligible part-time/ACA employees work over 30-35 hours per week. If you work 20 or more hours per week, you are eligible for the Supplemental Plans.
- Benefits begin on the first of the month following 30 days of employment when your enrollment information is submitted in a timely manner.
- Enrollment, changes, and cancellations for most plans are limited to your initial benefit eligibility period or our annual open enrollment period unless you have a qualifying life event such as marriage, divorce, birth, loss of other coverage, a job status change, or other life events.

Questions about your benefits?
Please contact your Human Resource Generalist.

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Meridian Services, Inc.

EMPLOYEE BENEFIT PROGRAM
2022

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Meridian Services, Inc. reserves the right to change, amend, terminate, or otherwise alter any benefit plan at any time. The benefits described in this document are only summaries. In case of error and for all claim adjudication, the master contracts will prevail. Please read your benefit certificates for more detail and information.

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HEALTH PLAN

Meridian Services, Inc. offers a health plan from Medica for you and your family members, including children to age 26. This plan may be paired with a Health Savings Account (HSA).

Health Plan Highlights

Plan Feature/Service *Network Providers*	**$6,350-0% HSA Plan**
Network Names ***Choose only one***	• Medica Choice Passport with UnitedHealthcare Choice Plus OR • Medica Elect
Deductible* Per calendar year	$6,350/person $12,700/family
Out of Pocket Maximum Per calendar year	$6,350/person $12,700/family
Health Savings Account (HSA)	Meridian offers optional payroll deduction to help you fund an HSA with tax-deductible dollars.
Preventive Care	No charge
Office Visits **Retail Clinic Visits** **Virtual Visits**	100% covered after deductible
Diagnostic Tests	100% covered after deductible
Hospital Stay Facility/professional services	100% covered after deductible
Urgent/Emergency Care Urgent Care Center Hospital ER	100% covered after deductible
Prescription Drugs Retail 31-day supply **Insulin: $25 Copay max per Rx unit** Mail Service offers 93-day supplies for lower costs. *express-scripts.com*	*Use Medica's Preferred Drug List for lowest costs. Visit mymedica.com.* **Generic & Preferred:** 100% covered after deductible *Preventive Rx:* No charge **Non-preferred:** 100% covered after deductible
Out of Network Care	Most services covered at 50% after deductible of $19,050/person

See your Certificate for more detail. The Master Contract will be used in case of error and for all claim processing.

* The deductible is embedded. If you choose family coverage, this means a covered individual will not pay a deductible that is more than the per person amount. All per person deductibles apply toward the family deductible.

(952) 945-8000 (800) 952-3455

mymedica.com

Para obtener asistencia lingüística en español, llame a Servicios al Miembro al 1-888-982-3862.

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Health Plan Premiums

Meridian Services pays the same dollar amount of your premium for health coverage, no matter which plan you choose. You pay the balance of the plan premium with pre-tax payroll deductions. These are the 2022 contributions:

Coverage Status In 2022	Meridian Pays	$6,350-0% HSA Plan	
		You Pay *Per Paycheck*	
		Passport	Elect
Employee Only	$300/month	$70.37	$54.95
Employee + One	$450/month	$237.95	$205.54
Employee + Two or More	$600/month	$405.51	$356.13

Your contribution is deducted twice each month, even if there are three pay periods in one month.

Health Plan Network Providers

Our health plans offer two networks—you choose one to provide your family's care throughout the plan year.

Medica Passport ***https://www.medica.com/find-a-doctor/group/medica-choice-uhg-plus***

Medica Choice® with UnitedHealthcare (UHC) Choice Plus

The Medica Choice® Network is a large, open access network in Minnesota, Wisconsin, North Dakota and South Dakota. More than 96% of Minnesota providers participate in this network. Receive in-network benefits by using the UHC Choice Plus network when out of the Medica Choice® area and have access to over 645,000 providers nationwide. No referrals are needed to see providers within the Medica Choice/UHC Choice Plus networks.

Medica Elect® ***https://www.medica.com/find-a-doctor/group/medica-elect***

With the Medica Elect® Network, you select a primary care clinic to provide for your health care needs. Choose from 225 primary care clinics. Each family member may have their own clinic and clinics may be changed once per month. The primary care clinic you select determines your designated care system. Care systems include:

- Allina Medical Clinics
- RiverWay/North Suburban Clinics
- Minnesota Healthcare Network
- Hennepin County Medical Center
- Integrity Health Network
- Park Nicollet
- St. Luke's
- Children's Health Network
- Lakeview Medical Group

You may self-refer within your care system without a referral. For chiropractic, mental health, ob/gyn, and emergency or urgent care, you may also self-refer within your care system.

PCC (Primary Care Clinic) Numbers: A PCC number is needed when you enroll in a Medica health plan with the Elect network. Call Medica at (800) 952-3455 or visit **https://www.medica.com/find-a-doctor/group/medica-elect**. In the *Before You Receive Care* box, click *Find or change your PCC*.

Using a network provider ensures maximum benefits from your health plan and lowers your out-of-pocket costs. To find a provider:

- Visit ***www.mymedica.com.*** Go to *Links and Tools.* Choose *Find Physician or Facility.* Click *Member through Employer* and find your network name. (Register as a member for best results when you get your ID card.)
- Call Medica Customer Service at (952) 945-8000 or (800) 952-3455.

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Get Virtual Care

Your health plan covers e-visits 24/7 from these virtual care providers for most common physical and mental health conditions. Receive diagnoses, treatment plans and medications if needed.

(844) 733-3627
amwell.com

(877) 440-1001
www.virtuwell.com

About the Health Savings Account (HSA)

For HSA Health Plan Members only

When you are enrolled in the $3,000 HSA Plan or $6,350 HSA Plan, you may open a Health Savings Account (HSA) and contribute tax-deductible dollars to it. HSA funds can pay for qualified medical, dental/vision expenses with no tax consequences. Your HSA dollars may also earn tax-free interest and are always yours to keep, no matter where you work. Unused HSA balances roll-over each year with no limits.

For 2022, you may contribute up to $3,650/person or $7,300/family to an HSA through payroll deduction. We send your funds to Alerus. You may also open an HSA at a bank or other financial institution, but payroll deduction is only available for HSAs established through Alerus. Manage your HSA at:

(800) 433-1685
www.alerusrb.com

Medica Value-added Services

Health plan members have access to these valuable services:

Employee Assistance Program (EAP)

(800) 626-7944   TTY: Use 711

You may call the Optum EAP anytime 24/7 to speak to a counselor for assistance with family issues, legal concerns, financial issues, personal or work concerns, dependency issues, and community resources. This is a confidential service. Visit ***LiveAndWorkWell.com*** for more resources. Enter access code MEDICA.

Value-adds *continued*

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Meridian SERVICES

Fit Choices℠

Receive a $20 credit toward your monthly membership dues when you meet your attendance requirement at any network fitness club. Participating clubs include Lifetime Fitness, Snap Fitness, Anytime Fitness, Curves, Fitness 19, Gold's Gym, and others. Show your Medica ID card at your club when you sign up.

Discounts at the Grocery Store

Each week, your Healthy Savings card is automatically loaded with new savings on the healthiest one-third of foods in a typical grocery store. Just choose the promoted foods, scan your card, and instantly save every time you shop. Visit *www.healthysavings.com/medica* to sign up.

Rx Mail Order

If you take medication for a long-term condition, Medica offers pharmacy mail order through Express Scripts. *express-scripts.com*

Healthy Pregnancy & Parenting Program

Medica members and their babies can achieve optimal health through pregnancy and the first 6 weeks after delivery. Members up to 32-week gestation may enroll by calling 888-992-3875 or registering online at *www.mymedica.com* (Health & Wellness tab). Also available are the Ovia Health apps for on-demand support. Download them from the App Store or Google Play.

mymedica.com

This resource can help you understand and use your Medica health plan and improve your health. Check claims status, use *Find A Doctor*, see prescription drug tools, view your plan benefits, and more. Register as a Medica member for best results.

CallLink® Nurse Line (800) 962-9497

Call any day 24/7 to speak with an experienced registered nurse about health questions, self-care tips, choosing appropriate care, finding a physician or urgent care facility in Medica's provider networks.
(TTY: Use 711)

My Health Rewards by Medica®

This incentive program rewards you for each wellness activity with points and gift card rewards of up to $100 are available.
Log on to *mymedica.com* for more.

Shop for Care

Understand cost variations among providers using price and quality measures.
Visit *www.mainstreetmedica.com.*

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DENTAL PLAN

Meridian Services offers a dental plan from Principal Financial Group. You may use any licensed dentist, but benefits are highest when you use a Premier/Principal Plan Dental provider.

Dental Plan Highlights

Dental Plan Service/Feature	PPO Network Benefit	Out of Network Benefit
Network Name	Premier/Principal Plan Dental	Any licensed dentist *You may be balance-billed for costs over allowed amounts.*
Maximum Annual Benefit *Per calendar year*	$1,500/person	$1,500/person
Deductible *Per calendar year*	$50/person; $150/family	$50/person; $150/family
Preventive & Diagnostic Care Cleanings, Exams, X-rays	100% covered *No deductible*	100% covered *No deductible*
Basic Procedures Fillings, Simple oral surgery, Endodontics, Periodontics	80% covered	80% covered
Major Procedures Root Canal Therapy, Complex oral surgery, Crowns, Onlays, Inlays, Bridges, Dentures	50% covered	50% covered
Orthodontia	Not covered	Not covered

Refer to your Certificate for more detail. The Master Contract will be used in case of error and for all claim adjudication.

Dental Plan Contributions

Meridian Services pays a significant portion of your premium for dental coverage when you elect this plan, including dependent coverage. These are the contributions:

2022 Coverage Status	Meridian Pays *Per Month*	You Pay *Per Paycheck*
Employee	$28.31	$3.54
Employee + Spouse	$54.39	$6.80
Employee + Child(ren)	$56.51	$7.06
Employee + Spouse + Child(ren)	$89.78	$11.22

Your contribution is deducted twice each month, even if there are three pay periods in one month.

Dental Plan Network Providers

Although you may see any dentist you wish, benefits are highest when you see a Premier/Principal Plan Dental provider. To find a provider:

- Visit *www.principal.com.* Click *Insure*, then *Find a Dentist.*
- Call Customer Service at (800) 986-3343.

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SUPPLEMENTAL PLANS

Meridian Services offers full and part-time employees supplemental insurance plans through Colonial Life. If you enroll in a supplemental plan, you pay 100% of the premiums through payroll deduction. Choose from five plans: Short-term Disability, Accident, Medical Bridge, Critical Care, and Whole Life.

Short-term Disability Plan – A Buy-up Option to your Unum STD Plan

Short Term Disability replaces a portion of your income to help make ends meet if you are totally disabled due to a covered accident or covered sickness that happens outside of work. Have you thought about what you would do if you were unable to work? How would you cover the cost of your daily living expenses? Colonial Life's Short Term Disability Insurance provides a monthly benefit to replace lost income in the event of a covered accident or illness. This coverage helps you to maintain your lifestyle.

- Monthly Benefit Period options
- Choice of Elimination / Waiting Period
- Coverage includes maternity (9-month birth exclusion applies) and partial disability benefits.
- *Full – time employees (30+ Hours) protect up to 40% of your monthly income: $400 - $6,500 in $100 increments*
- *Part – time employees (20-29 Hours) protect up to 60% of your monthly income: $400 - $6,500 in $100 increments*
- Guarantee issue (no underwriting questions) for new hires only
- Benefits are paid directly to you, regardless of any other insurance you may have with other companies.
- PORTABLE: If you change jobs you can take your coverage with you at the same affordable rates.
- WAIVER OF PREMIUM is included if you are still disabled after 90 days.
- OWN OCCUPATION definition of disability and worldwide coverage
- LEVEL PREMIUMS: Rates do not increase as you get older.

Per Pay Period Rates

3 Months **0 Days Accident / 7 Days Sickness Elimination Period**

Monthly Benefit	$400	$700	$1000	$1200	$1500	$1800	$2000	$2200	$2500	$3000
Age 17-49	3.28	5.74	8.20	9.84	12.30	14.76	16.40	18.04	20.50	24.60
Age 50-69	3.98	6.97	9.95	11.94	14.93	17.91	19.90	21.89	24.88	29.85

6 Months **0 Days Accident / 14 Days Sickness Elimination Period**

Monthly Benefit	$400	$700	$1000	$1200	$1500	$1800	$2000	$2200	$2500	$3000
Age 17-49	3.14	5.50	7.85	9.42	11.78	14.13	15.70	17.27	19.63	23.55
Age 50-69	4.12	7.21	10.30	12.36	15.45	18.54	20.60	22.66	25.75	30.90

AAA Risk

Rate Example: 30-year old with a 3-month benefit period, 0/7 elimination period and a $1,500 monthly benefit would cost $12.30 per pay period.

Example - Pregnancy Benefit Payout (vaginal delivery using the above criteria)**:** $1,500 monthly benefit = $50 per day payment multiplied by 5 weeks = $1,750 total maternity payment.

Supplemental Plans *continued*

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Accident Plan

Common injuries like major cuts, fractures or dislocations can result in hundreds of dollars in out-of-pocket medical expenses and time missed from work. Colonial's Accident Care Insurance helps cover unexpected expenses such as co-pays, deductibles, co-insurance and includes benefits for initial care (ambulance, ER, doctor's office visit, etc.), hospitalization, follow-up care plus accidental death & dismemberment benefits. The plan includes:

- On & Off Job Accident Coverage with ability to cover your spouse and dependent children
- Health Screening - annual $100 benefit
- Guarantee issue
- Worldwide coverage
- You have the ability to cover your spouse and dependent children

Per Pay Period Rates – Plan 2

Name Insured:	$ 7.84
Employee & Spouse:	$ 12.48
One-parent Family:	$ 12.86
Two-parent Family:	$ 17.51

Example #1:

4 year old fell on the ice and cut his chin, took an ambulance to the hospital where he received stitches. Subsequent to the ER visit, have a doctor's follow-up visit.

Benefit Payments Received:

- Ambulance $ 200
- Emergency Room $ 125
- Follow-Up Treatment $150 ($50 per visit x 3 visits)
- Stitches $ 25

Total Benefit Payment $ 500

Example #2:

Bob broke his ankle sliding into second base playing softball. He took an ambulance to the emergency room for treatment and was admitted to the hospital as his injury required surgery. After the surgery, Bob needed to use crutches for three weeks, go to physical therapy for six days and had two doctor's office follow-up visits to check on his progress.

Benefit Payments Received:

- Ambulance: $ 200
- Emergency Room $ 125
- Hospital Admission $ 1,000
- Surgical ankle fracture $ 900
- Appliances (Crutches) $ 100
- Physical Therapy $ 150 ($25 x 6)
- Follow-Up Doctor's Visit $ 100 ($50 x 2)

Total Benefit Payment $ 2,575

Supplemental Plans *continued*

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Meridian SERVICES

Medical Bridge 3000/Hospital Confinement Plan

Medical Bridge 3000 provides benefits to help pay for deductible and coinsurance costs, as well as everyday living expenses. Benefits are paid directly to the insured and are compatible with High Deductible Health Plans and Health Savings Accounts (HSAs).

- Guaranteed issue for new hires only
- Provides peace of mind should the unexpected occur
- Provides a lump-sum $1,500 or $2,500 benefit for hospital confinement.
- Annual $50 wellness benefit
- Plan is portable, you can take it with you at the same rates should you change jobs or retire
- Rehabilitation Unit Benefit of $100 per day for up to 15 days
- You have the ability to cover your spouse and dependent children.

Common Reasons for Hospital Confinement:

- Pregnancies (9-month birth exclusion applies)
- Accidents
- Pneumonia
- Heart related Issues
- Respiratory Issues
- Stroke

Per Pay Period Rates

PLAN 1 **$1,500 Hospital Confinement Benefit with $50 Annual Wellness Benefit and Rehabilitation Unit Benefit**	**Employee Only**	**Employee & Spouse**	**Employee & Dependent Children**	**Employee, Spouse & Dependent Children**
Employee Age 17-49	8.23	15.13	11.83	18.81
Employee Age 50-59	11.37	21.37	15.18	25.12
Employee Age 60-64	14.84	28.46	18.45	31.41
Employee Age 65-74	18.31	35.92	22.66	38.86
PLAN 2 **$2,500 Hospital Confinement Benefit with $50 Annual Wellness Benefit and Rehabilitation Unit Benefit**	**Employee Only**	**Employee & Spouse**	**Employee & Dependent Children**	**Employee, Spouse & Dependent Children**
Employee Age 17-49	13.12	24.09	18.70	29.81
Employee Age 50-59	18.14	34.05	24.09	39.89
Employee Age 60-64	23.65	45.32	29.25	50.2
Employee Age 65-74	29.36	57.56	35.90	62.44

Example #1:

Laura enrolled in the Medical Bridge $2,500 benefit plan and was admitted to the hospital for delivery.

- Laura received a lump sum benefit payment of $2,500.

Example #2:

Steve enrolled in the Medical Bridge $1,500 benefit plan and was experiencing chest pains and spent 24 hours in hospital observation.

- Steve received a lump sum benefit payment of $1,500.

Supplemental Plans *continued*

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Critical Care Plan

Critical Care insurance provides a lump sum benefit, in the amount you purchase, to help pay the out-of-pocket medical and non-medical expenses of a critical illness, including cancer. Benefits are paid directly to you in addition to other insurance you may have.

Benefits include:

- Full critical illness coverage for these illnesses:
  - Heart Attack
  - Stroke
  - Major Organ Failure
  - End-stage Renal Failure
  - Coronary Artery Bypass
  - Permanent Paralysis
  - Coma
  - Blindness
- Subsequent diagnosis of the same critical illness
- Diagnosis of cancer
- Cancer treatment and care
- Cancer vaccine benefit
- Health Screening Benefit - up to $100 payable each year

Monthly Rates

	Issue Age	Named Insured	Employee + Spouse	One-Parent Family	Two-Parent Family
NON-TOBACCO Rates					
$5,000	16-29	$6.67	$10.27	$6.87	$10.47
	30-39	$8.12	$12.42	$8.32	$12.62
	40-49	$11.37	$17.32	$11.57	$17.52
	50-59	$16.67	$25.57	$16.92	$25.82
	60-74	$23.92	$36.62	$24.17	$36.87
$10,000	16-29	$8.12	$12.42	$8.52	$12.82
	30-39	$11.02	$16.72	$11.42	$17.12
	40-49	$17.52	$26.52	$17.92	$26.92
	50-59	$28.12	$43.02	$28.62	$43.52
	60-74	$42.62	$65.12	$43.12	$65.62
$15,000	16-29	$9.57	$14.57	$10.17	$15.17
	30-39	$13.92	$21.02	$14.52	$21.62
	40-49	$23.67	$35.72	$24.27	$36.32
	50-59	$39.57	$60.47	$40.32	$61.22
	60-74	$61.32	$93.62	$62.07	$94.37
$30,000	16-29	$13.92	$21.02	$15.12	$22.22
	30-39	$22.62	$33.92	$23.82	$35.12
	40-49	$42.12	$63.32	$43.32	$64.52
	50-59	$73.92	$112.82	$75.42	$114.32
	60-74	$117.42	$179.12	$118.92	$180.62
TOBACCO Rates					
$5,000	16-29	$7.52	$11.57	$7.72	$11.77
	30-39	$9.72	$14.82	$9.92	$15.02
	40-49	$15.07	$22.87	$15.27	$23.12
	50-59	$23.72	$36.47	$23.97	$36.72
	60-74	$36.07	$55.37	$36.32	$55.62
$10,000	16-29	$9.82	$15.02	$10.22	$15.42
	30-39	$14.22	$21.52	$14.62	$21.92
	40-49	$24.92	$37.62	$25.32	$38.12
	50-59	$42.22	$64.82	$42.72	$65.32
	60-74	$66.92	$102.62	$67.42	$103.12

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Critical Care Rates *continued*

$15,000	16-29	$12.12	$18.47	$12.72	$19.07
	30-39	$18.72	$28.22	$19.32	$28.82
	40-49	$34.77	$52.37	$35.37	$53.12
	50-59	$60.72	$93.17	$61.47	$93.92
	60-74	$97.77	$149.87	$98.52	$150.62
$30,000	16-29	$19.02	$28.82	$20.22	$30.02
	30-39	$32.22	$48.32	$33.42	$49.52
	40-49	$64.32	$96.62	$65.52	$98.12
	50-59	$116.22	$178.22	$117.72	$179.72
	60-74	$190.32	$291.62	$191.82	$293.12

Whole Life Plan

The Whole Life insurance plan is individually owned, with guaranteed level premiums, guaranteed cash values and a guaranteed death benefit. Coverage is permanent and is guaranteed for the life of the policy (to age 100), provided premiums are paid when due. Coverage for spouses and children may also be added as riders or as individual plans.

Coverage for the Paid-Up at Age 100 Plan can include:

- Death benefit from $10,000 to $500,000
- Terminal illness benefit
- Various riders including accidental death, waiver of premium and others Riders may have age limits

Annual Rates Per $1,000 of Coverage – Paid-Up at Age 100 Plan

Issue Age 18-50								
	$10,000 - $49,999 of Face Amount		$50,000 - $150,000 of Face Amount		$150,001 - $500,000 of Face Amount		Age 65 Cash Value	
Issue Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
18	7.85	11.75	7.03	11.63	6.24	10.69	367	454
19	7.96	12.21	7.13	11.71	6.33	10.71	365	452
20	8.08	12.69	7.24	11.79	6.43	10.73	363	449
21	8.21	13.19	7.36	11.81	6.55	10.75	361	447
22	8.35	13.70	7.48	11.83	6.68	10.78	359	444
23	8.50	14.23	7.61	11.86	6.82	10.81	357	441
24	8.66	14.78	7.75	11.90	6.98	10.85	354	438
25	8.84	15.30	7.92	11.96	7.16	10.91	352	435
26	9.07	15.65	8.14	12.08	7.36	11.03	349	432
27	9.38	16.00	8.41	12.28	7.59	11.23	346	428
28	9.75	16.35	8.72	12.54	7.85	11.49	343	424
29	10.15	16.72	9.06	12.87	8.13	11.80	340	420
30	10.56	17.15	9.41	13.25	8.43	12.15	336	416
31	10.97	17.68	9.78	13.68	8.74	12.52	332	412
32	11.38	18.28	10.17	14.16	9.07	12.91	329	407
33	11.80	18.91	10.59	14.69	9.42	13.33	325	402

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34	12.23	19.54	11.04	15.27	9.78	13.78	320	397
35	12.69	20.16	11.51	15.90	10.17	14.27	316	391
36	13.19	20.76	12.02	16.57	10.59	14.80	311	385
37	13.74	21.36	12.58	17.27	11.04	15.37	306	379
38	14.35	21.96	13.19	17.99	11.52	15.99	301	373
39	15.02	22.56	13.83	18.74	12.04	16.66	296	366
40	15.72	23.21	14.49	19.53	12.60	17.38	291	359
41	16.44	23.97	15.17	20.39	13.21	18.16	285	352
42	17.18	24.90	15.88	21.35	13.87	19.00	279	344
43	17.95	26.04	16.62	22.42	14.57	19.91	272	336
44	18.76	27.39	17.40	23.59	15.31	20.88	265	327
45	19.61	28.94	18.21	24.83	16.07	21.91	258	318
46	20.53	30.64	19.06	26.14	16.85	22.99	250	308
47	21.54	32.44	19.95	27.52	17.64	24.11	242	298
48	22.66	34.32	20.88	28.96	18.45	25.26	233	286
49	23.89	36.29	21.85	30.45	19.29	26.45	224	275
50	25.21	38.41	22.86	31.97	20.18	27.67	214	262

Issue Age 51-60

	$10,000 - $29,999 of Face Amount		$30,000 - $150,000 of Face Amount		$150,001 - $500,000 of Face Amount		Age 65 Cash Value*	
Issue Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
51	26.61	40.75	23.92	33.52	21.13	28.92	203	249
52	28.09	43.37	25.03	35.11	22.14	30.21	192	234
53	29.65	46.27	26.19	36.75	23.22	31.54	180	219
54	31.30	49.45	27.41	38.44	24.38	32.92	167	203
55	33.06	52.83	28.70	40.20	25.62	34.36	154	185
56	34.96	56.33	30.08	42.05	26.95	35.88	161	191
57	37.02	59.89	31.56	44.00	28.37	37.51	169	196
58	39.25	63.51	33.15	46.08	29.87	39.25	177	202
59	41.66	67.22	34.87	48.31	31.45	41.10	186	207
60	44.27	71.14	36.76	50.72	33.11	43.03	195	212

* 10th year cash value, if later than age 65

Issue Age 61-79

	$10,000 - 14,999 of Face Amount		$15,000 - $150,000 of Face Amount		$150,001 - $500,000 of Face Amount		10th Year Cash Value	
Issue Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
61	47.12	75.44	38.84	53.36	34.85	45.02	204	217
62	50.24	80.28	41.12	56.27	36.68	47.06	213	222
63	53.66	85.61	43.60	59.47	38.61	49.16	223	227
64	57.37	91.35	46.27	62.93	40.67	51.33	233	234
65	61.34	97.28	49.10	66.58	42.88	53.60	243	241

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Whole Life Rates ages 61-79 *continued*

66	65.54	103.21	52.07	70.33	45.27	56.01	254	249
67	69.97	109.09	55.19	74.14	47.88	58.59	264	256
68	74.64	114.97	58.47	78.01	50.74	61.38	275	264
69	79.58	120.90	61.92	81.99	53.87	64.41	286	273
70	84.85	127.04	65.58	86.14	57.29	67.71	299	283
71	90.80	134.15	69.60	90.90	61.01	71.32	313	293
72	97.75	142.50	74.29	96.65	65.03	75.28	326	304
73	105.85	152.00	79.80	103.35	69.35	79.63	340	315
74	115.21	162.50	86.14	110.95	73.98	84.41	354	327
75	125.91	173.89	93.33	119.39	78.95	89.64	368	339
76	137.96	186.08	101.37	128.61	84.29	95.34	381	350
77	151.37	198.99	110.26	138.55	90.03	101.53	393	360
78	166.15	212.55	120.00	149.15	96.20	108.23	405	368
79	182.31	226.72	130.59	160.35	102.83	115.46	415	376

(800) 325-4368 *www.coloniallife.com*

This is only a brief summary of the supplemental insurance plans.
All benefits and claim adjudications are determined by the Master Contracts/Summary Plan Descriptions.

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PET INSURANCE PLAN

Meridian offers pet insurance through Nationwide. Choose plans for dogs, cats, birds, and other common pets plus exotics. Premiums may be paid via payroll deduction.

Dogs and Cats

Use any vet. Choose from these plans offering 90% back on vet bills after a $250 annual deductible:

My Pet Protection℠ Plan covers expenses for:

- Accidents & Illness
- Hereditary & Congenital
- Cancer
- Dental diseases
- Behavioral treatments
- Rx therapeutic diets/supplements
- Specialty & ER coverage

My Pet Protection℠ with Wellness Plan covers all of the above, plus these expenses:

- Wellness Exams
- Spay or Neuter
- Flea and Tick
- Teeth Cleaning
- Shots
- More

Both My Pet Protection℠ plans also include boarding or kennel fees if you are hospitalized; advertising, reward and replacement cost if your pet is lost or stolen; and vet expenses associated with the death of a pet. *Conditions apply.*

Other Animals

Plans for avian and exotic pets are also available.

(877) 738-7874 *www.PetsNationwide.com*
www.petinsurance.com/meridiansvs

All plans include **vet***helpline*℠ offering free 24/7 access to veterinarians by phone, email or online chat. (865) 331-2833
For rates and more information, or to enroll in a plan, contact Nationwide.

- Applications approved between the 1st and the 15th of a month become effective on the 1st of the following month.
- Applications approved from the 16th – end of a month are effective 30 – 45 days later on the 1st of the month.

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Meridian SERVICES

401(k) SAVINGS PLAN

Meridian Services offers a 401(k) retirement savings plan through Principal Financial. Eligible employees may begin participating in this plan on the first of the month following 30 days of service with us.

Your Contributions

For 2022, you may defer a portion of your compensation to your 401(k) up to IRS limits. Your contributions are 100% vested at all times.

Our Contributions for You

After one year of service with us and when you contribute to your 401(k), we make matching contributions of $0.50 for every dollar you contribute up to 6% of your total annual compensation. Company contributions are fully vested after five years, according to this schedule:

Year One	20% vested
Year Two	40% vested
Year Three	60% vested
Year Four	80% vested
Year Five	100% vested

(800) 986-3343

www.principal.com

This is only a summary. The 401(k) Summary Plan Description (SPD) will prevail in the event of error or discrepancy.

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Meridian SERVICES

ADMINISTRATIVE INFORMATION

ERISA Review: For complete plan ERISA information, please contact the plan carrier or Meridian Services.

1. **Name of plan:**
The Meridian Services, Inc. Group Benefit Plan

2. **Plan sponsor and plan administrator:**
Meridian Services, Inc.
9400 Golden Valley Road
Golden Valley, MN 55427

3. **Employer federal I.D. number:**
41-1738150 Meridian Services, Inc.

4. **Type of plan:**
There are two types of plans addressed in this summary document:
   1. Health, Dental, and Supplemental Insurance Plans
   2. 401(k) Retirement Savings Plan

5. **Type of funding:**
This plan is funded in part by employee contributions and in part by the plan sponsor employer contributions.

6. **Type of administration:**
The plan sponsor maintains documentation of plan policies and procedures.

7. **Plan group numbers:** *ERISA filing numbers will be different.*
Health Plans - #37850
Dental Plan - #H71972
Supplemental Plans - #E4354486
401(k) Plan - #436106

8. **Request for information:**
If you have questions regarding your benefits, please contact the plan administrator. All requests, appeals, elections and other communications should be in writing and hand delivered, sent by certified mail or via secure email with read receipt.

9. **Plan year:**
All Plans: January 1 – December 31

10. **Eligibility requirements:**
Please review your plan certificates of coverage for more detailed descriptions of benefits and eligibility requirements.

Health Care Reform Compliance
Our health plans conform to all applicable Patient Protection and Affordable Care Act (PPACA) provisions including, but not limited to: A) No pre-existing condition limitations for anyone; B) Coverage for children to age 26; C) An unlimited lifetime maximum benefit level for network services; and D) 100% coverage for eligible preventive services.

Please review the following important notices ►

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The Children's Health Insurance Program (CHIP) Premium Assistance Subsidy Notice

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, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid	MAINE – Medicaid	OREGON – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Phone: 1-800-442-6003 / 711 Website: https://www.maine.gov/dhhs/ofi/applications-forms	Phone: 1-800-699-9075 Websites: http://www.healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html
ALASKA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**	**PENNSYLVANIA – Medicaid**
Website: http://myakhipp.com Phone: 1-866-251-4861 Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Phone: 1-800-862-4840 Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa	Phone: 1-800-692-7462 Website: http://www.dhs.pa.gov//providers/Providers/Pages/Medical/HIPP-Program.aspx
ARKANSAS - Medicaid	**MINNESOTA – Medicaid**	**RHODE ISLAND – Medicaid and CHIP**
Website: http://myarhipp.com Phone: 1-855-MYARHIPP (855-692-7447)	Website: https://www.mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347 or 401-462-0311
CALIFORNIA - Medicaid	**MISSOURI – Medicaid**	**SOUTH CAROLINA – Medicaid**
Phone: 916-445-8322 Website: https://www.dhcs.ca.gov/hipp	Phone: 573-751-2005 Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
COLORADO – Health First & Child Health Plan Plus	**MONTANA – Medicaid**	**SOUTH DAKOTA - Medicaid**
Health First: https://www.healthfirstcolorado.com Health First Service Center: 1-800-221-3943 / 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 / 711	Phone: 1-800-694-3084 Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	Website: http://dss.sd.gov Phone: 1-888-828-0059
FLORIDA – Medicaid	**NEBRASKA – Medicaid**	**TEXAS – Medicaid**
Website: https://flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
GEORGIA – Medicaid	**NEVADA – Medicaid**	**UTAH – Medicaid and CHIP**
Website: https://Medicaid.Georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Medicaid Website: http://dhcfp.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669
INDIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**	**VERMONT– Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip Phone: 1-877-438-4479 All other Medicaid Phone: 1-800-457-4584 https://www.in.gov.medicaid	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 HIPP: 1-800-852-3345 ext 5218	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
IOWA – Medicaid and CHIP (Hawki)	**NEW JERSEY – Medicaid and CHIP**	**VIRGINIA – Medicaid and CHIP**
Website: http://dhs.iowa.gov/ime/members Phone: 1-800-338-8366 Hawki: 1-800-257-8563 http://dhs.iowa.gov/Hawki HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	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	Medicaid Website: https://www.coverva.org/en/hipp/ or https://www.coverva.org/en/famis-select Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
KANSAS – Medicaid	**NEW YORK – Medicaid**	**WASHINGTON – Medicaid**
Website: http://www.kancare.ks.gov Phone: 1-800-792-4884	Website: https://www.health.ny.gov/health_care/medicaid Phone: 1-800-541-2831	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
KENTUCKY – Medicaid	**NORTH CAROLINA – Medicaid**	**WEST VIRGINIA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: http://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 KCHIP: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Medicaid Website: https://chfs.ky.gov	Website: https://medicaid.ncdhhs.gov Phone: 919-855-4100	Website: http://mywvhipp.com Phone: 1-855-699-8447
	NORTH DAKOTA – Medicaid	**WISCONSIN – Medicaid and CHIP**
	Phone: 1-844-854-4825 Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/	Phone: 1-800-362-3002 Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
LOUISIANA – Medicaid	**OKLAHOMA – Medicaid and CHIP**	**WYOMING – Medicaid**
Phone: 1-888-342-6207or 1-855-618-5488 Website: www.medicaid.la.gov or www.ldh.la.gov.la/hipp	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021 or for more information on special enrollment rights, contact:

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

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

OMB Control Number 1210-0137
(expires 1/31/2023)

Notice of 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 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 your 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 within 30 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Human Resources.

WHCRA Enrollment Notice

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 the Company health plans. Therefore, deductibles and coinsurance apply based on the plan you have chosen. (See your health plan certificate for specific information.) If you would like more information on WHCRA benefits, contact your health plan carrier.

MHPAEA Disclosure Requirement

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that criteria for medical necessity determinations made under a plan or insurance coverage with respect to Mental Health/Substance Use Disorder (MH/SUD) benefits must be made available to any current or potential participant, beneficiary, or contracting provider upon request. ERISA requires that plan documents, including documents with information on the medical necessity criteria for both Medical/Surgery (M/S) and MH/SD benefits, be furnished to you within 30 days of request. Contact your health plan carrier to request the MHPAEA information applicable to your health coverage.

Michelle's Law Notice

Notice of Extended Coverage to Participants Covered Under a Group Health Plan

Federal legislation known as "Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year.

Our Health Plan currently permits an employee to continue a child's coverage **to** the child's 26th birthday (or longer if disabled under certain conditions) if that child is enrolled at an accredited institution of learning on a full-time basis, with full-time defined by the accredited institution's registration and/or attendance policies. Michelle's Law requires the Plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for Plan coverage due to loss full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- *Dependent child* means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his or her student status and who was enrolled at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.
- *Medically necessary leave of absence* means a leave of absence or any other change in enrollment:
  - of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury;
  - which is medically necessary; and
  - which causes the dependent child to lose student status under the terms of the Plan.

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- One year after the first day of the leave of absence
- The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student)

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to such child to the same extent as it applies to other dependent children covered under the Plan.

Newborns' Act Disclosure

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).

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your health insurance carrier 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. Your health insurance carrier has determined that the prescription drug coverage offered by your employer 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 15 to December 7. 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 health insurance coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current health insurance coverage, be aware that you and your dependents may or 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 health insurance coverage 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 your health insurance carrier or your employer 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 Your employer 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.

- Visit *www.medicare.com*.
- 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).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. **CMS Form 10182-CC Updated April 1, 2011**

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.

Your Rights - You have the right to:
- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we’ve shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices - You have some choices in the way that we use and share information as we:
- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures - We may use and share your information as we:
- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers’ compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights - When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of 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 on page 1.
- 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 that 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

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
- 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 services.

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.
- 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.

Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS - You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- you ensure that your employer receives advance written or verbal notice of your service;
- you have five years or less of cumulative service in the uniformed services while with that particular employer;
- you return to work or apply for reemployment in a timely manner after conclusion of service; and
- you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION - If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you initial employment; reemployment; retention in employment; promotion; or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.
- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

General Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- *If your Plan provides retiree health coverage only:* Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided?

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

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

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

- ***Disability extension of 18-month period of COBRA continuation coverage***
  If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.
- ***Second qualifying event extension of 18-month period of continuation coverage***
  If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

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

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to your employer, health plan carrier, or visit www.dol.gov/ebsa.

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

Genetic Information Nondiscrimination Act (GINA) Notice

Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members.

What to do if you believe discrimination has occurred: There are strict time limits for filing charges of employment discrimination. To preserve the ability of EEOC to act on your behalf and to protect your right to file a private lawsuit, should you ultimately need to, you should contact EEOC promptly when discrimination is suspected: The U.S. Equal Employment Opportunity Commission (EEOC), 1-800-669-4000 (toll-free) or 1-800-669-6820 (toll-free TTY number for individuals with hearing impairments). EEOC field office information is available at www.eeoc.gov or in most telephone directories in the U.S. Government or Federal Government section. Additional information about EEOC, including information about charge filing, is available at www.eeoc.gov.

Wellness Program Disclosure

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

Notice of Patient Protections

When designating a primary care provider
For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- If your health plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the health plan carrier may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your employer or health plan carrier.

For plans and issuers that require or allow for the designation of a primary care provider for a child:

- For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

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

Family and Medical Leave Act (FMLA)

Leave Entitlements Eligible employees who work for a covered employer (generally those with 50 or more employees) can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave Generally, employees must give a 30-day advance notice of the need for FMLA leave. If it is not possible to give a 30-day notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis but must provide enough information to the employer

so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division at 1-866-4-USWAGE (1-866-487-9243, TTY: 1-877-889-5627 or www.dol.gov/whd), or may bring a private lawsuit against an employer. The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

Your Rights and Protections Against Surprise Medical Bills

For Plan Years beginning on or after January 1, 2022.

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

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

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

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.

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact your employer, health plan carrier, or the insurance commissioner of your state.

Form Approved OMB
No. 1210-0149

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, there was 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 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 tax credit that lowers your monthly premium right away.

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 9.83% 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] (The affordability percentage changes annually.)

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 Meridian Services, Inc.

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 Meridian Services, Inc.		4. Employer Identification Number (EIN) 41-1738150
5. Employer address 9400 Golden Valley Road		6. Employer phone number (763) 450-5000
7. City Golden Valley	8. State MN	9. ZIP Code 55427
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	12. Email address	

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

- As your employer, we offer a health plan to:
  - ☑ All employees. Eligible employees are:
    Regular, full-time employees working over 35 hours per week
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:
    Spouses and eligible dependents of our benefit-eligible employees
  - ☐ 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 to find out if you can get a tax credit to lower your monthly premiums.