TotalRewards

My Benefits

2022

Team Member Guide to Benefit Enrollment

Open Enrollment

November 1 – November 15

Enroll through Employee Self-Service

FRANCISCAN MISSIONARIES OF OUR LADY HEALTH SYSTEM

Information Resources

Your 2022 Total Rewards

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

Online Benefit Education

As part of our efforts to keep you informed, a quick overview has been created. This course is stored in HealthStream — our learning management software.

HealthStream Access

Access is easy. Go to TeamLink, then select HealthStream. For assistance, call the HELP desk at 866-532-4772.

To review the Online Benefit Education course, simply follow the steps below:

- Once you are in HealthStream, select the "Catalog" tab, which is the fifth tab under the FMOLHS logo.
- In the search bar, type in Benefits Education — the 2022 Benefits Education Course will appear.

Select the correct course, which will then direct you to the Course Learning Activities page and will allow you to enroll in the course.

- Select the "Enroll" link, "View", and then "Open" to begin the Benefits Education PowerPoint presentation.
- Upon completion of the presentation, you will be automatically directed to the test which will acknowledge your review of the information.

Team members may attend at any location.

Enrollment Assistance

Our Lady of the Angels

Outside the Cafeteria

Wednesday, November 3, 2021 ..... 11 am - 1 pm
Friday, November 12, 2021 ..... 11 am - 1 pm

Our Lady of Lourdes

Computer Lab 2nd Floor ACC

Monday, November 1, 2021 ..... 2 pm – 6 pm
Friday, November 12, 2021 ..... 2 pm – 6 pm

Our Lady of the Lake

Computer Lab (Chapel)

Friday, November 5, 2021 ..... 8 am – 12:30 pm
Friday, November 12, 2021 ..... 12:30 pm – 4:30 pm

Our Lady of the Lake Ascension

Computer Lab

Wednesday, November 3, 2021 ..... 6 am - 10 am

Senior Services

Ollie Steele Burden Manor (Library)

Thursday, November 11, 2021 ..... 1 pm - 3 pm

St. Clare Manor (HR Office)

Tuesday, November 9, 2021 ..... 1 pm - 4 pm

St. Catherine

Education Room

Thursday, November 4, 2021 ..... 7 am - 10 am
Thursday, November 11, 2021 ..... 12 pm - 3 pm

St. Dominic

Computer Lab (Main Hospital)

Wednesday, November 3, 2021 ..... 8 am - 12 pm
Wednesday, November 10, 2021 ..... 11 am - 3 pm

St. Francis

HR Conference Room (EH Building)

Thursday, November 4, 2021 ..... 8 am - 12 pm
Thursday, November 11, 2021 ..... 12:30 pm - 4:30 pm

Virtual Education

WebEx

Tuesday, October 19, 2021 ..... 10 am - 10:45 am
Thursday, October 28, 2021 ..... 2 pm - 2:45 pm

Your 2022 Enrollment Options

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

BENEFIT PLAN	CURRENT ENROLLEE	NEW ENROLLEE
GRANDFATHERED (GF) PLANS GF GROUP LIFE PLANS GF LINCOLN CRITICAL ILLNESS PLAN	You will have an opportunity to review and maintain coverage through Lawson Employee Self-Service. If you terminate coverage in a Grandfathered Plan, you will not have an opportunity to re-enroll.	Not available after 12/31/2014.
FMOLHS HEALTH PLAN FMOLHS DENTAL PLAN VISION PLAN MEDICAL FLEXIBLE SPENDING ACCOUNT MEDICAL LIMITED USE FLEXIBLE SPENDING ACCOUNT HEALTH SAVINGS ACCOUNT LINCOLN VOLUNTARY ACCIDENT	Your 2021 election terminates on December 31, 2021. You must re-enroll in or waive coverage for 2022 through Lawson Employee Self-Service.	Team members who are within their first 30 days of eligibility may enroll through Lawson Employee Self-Service.
LINCOLN VOLUNTARY EMPLOYEE LIFE	Team members currently enrolled may add $10,000 or $20,000 coverage.	Team members who are within their first 30 days of eligibility may enroll through Lawson Employee Self-Service.
LINCOLN VOLUNTARY CRITICAL ILLNESS LINCOLN VOLUNTARY SPOUSE LIFE LINCOLN VOLUNTARY DEPENDENT LIFE	You will have an opportunity to review and maintain coverage through Lawson Employee Self-Service.	Team members who are within their first 30 days of eligibility may enroll through Lawson Employee Self-Service.
THESE BENEFITS CONTINUE IN 2022 AS CURRENTLY ELECTED		
LONG TERM DISABILITY	Your LTD elections will continue unless you terminate the coverage. Team members do not need to re-enroll. Team members who previously waived coverage must complete evidence of insurability online at Lincoln Financial Website by November 15, 2021 for eligibility review.	Team members who are within their first 30 days of eligibility may enroll through Lawson Employee Self-Service.
GROUP BASIC LIFE (COMPANY-PROVIDED)	Company-provided Basic Life Insurance coverage continues. Team members do not need to re-enroll.	Eligible Team members are automatically enrolled in the Basic Life Insurance.
403(B) RETIREMENT ENROLLMENT PROCESS		
403(B) RETIREMENT	Enroll through Lincoln Financial Website	Eligible Team members enroll at LincolnFinancial.com/FMOLHS

To view your current 2021 benefits, log in to Lawson Employee Self-Service and click on "Current Benefits" under the Benefits tab.

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

Important Information

Enrollment for the 2022 Plan Year

All team members are required to enroll or re-enroll in the core benefits (Health, Dental, Vision, Medical FSA) and some voluntary benefits, whether you intend to make plan changes or not. Core benefits will terminate on December 31, 2021, for any team members who do not re-enroll by November 15, 2021.

Member Cards

- Medical Cards – Team members who currently participate in the Health Plan should maintain their current ID cards. If you would like a new card, you can access and print your digital ID card online. New cards will only be issued for new enrollees or changes in enrollment.
- Dental Cards – Team members who currently participate in the Dental Plan should maintain their current ID cards. New cards will only be issued for new enrollees or change in enrollment.
- Vision Cards – Team members who currently participate in the Vision Plan should maintain their current ID cards. New cards will only be issued for new enrollees or change in enrollment.
- Debit Cards – All team members who currently participate in the Medical FSA or HDHSA Medical Plan should maintain their current debit cards. 2022 elections will be funded on the current card by January 6, 2022.

Human Resources Contact

Reach out using the method that works best for you:

- Submit an online request* on TeamLink, by clicking the askHR link
- Email askHR@fmolhs.org
- Call 833-4UaskHR (833-482-7547)

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

Note

NEW Enrollment Dates for the 2022 Plan Year: Monday, November 1, 2021 through Monday, November 15, 2021.

Important Information

Be Healthy. Be Happy.

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

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

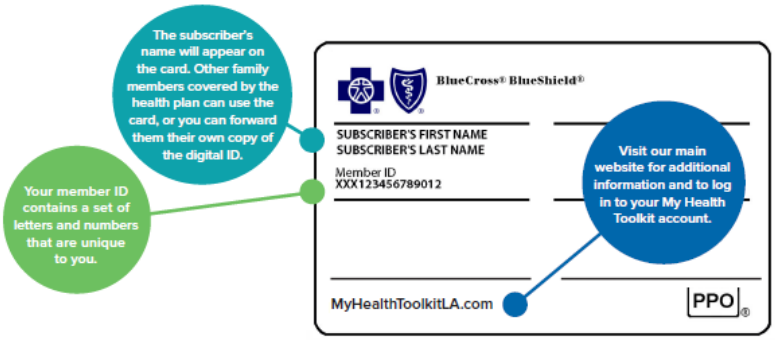
Get Started Today

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

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

Your Membership Card

Your Blue Cross Blue Shield membership card contains important information that helps providers apply your benefits correctly. Keep it with you at all times by downloading your digital ID card to keep on your smart phone. It is all about convenience. Your digital ID card has the same information that your plastic card will have. In 2022, your membership card will now include your deductible and out of pocket maximums. You will be able to:



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

Accessing your Digital ID Card

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

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

Note

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

What's New in 2022

Our 2022 Total Rewards offerings are unique to our ministry and have been developed with you in mind. These new programs and coverage options incorporate feedback you've shared through past surveys on what is important to you for benefit coverage, health, recognition and more.

NEW Health Plan Option – The EPO Plan

We're introducing a new health plan option called the EPO (Exclusive Provider Organization) plan. This plan provides access to a narrow network of healthcare providers that are either part of our health system or considered our preferred partners.

There are several advantages to choosing this plan.

1. These providers provide higher quality care and are more clinically integrated with our electronic medical record system, allowing sharing of data between providers.
2. These providers are either employed by the health system or are partners of the health system. By using our providers and facilities, you are helping to preserve the future of our organization and our mission.
3. The cost to you will be lower, whether that is through premiums, copays, deductibles, or your out-of-pocket maximum limit for the year. In addition, your Primary Care Physician office visits are completely covered by the plan with no cost to you!

It is important to know that coverage outside of this narrow network will only be allowed in the event a medical service is needed that isn't available within the network. In that event, there is a network exception process that you would follow to request approval from BCBS before going out of network to receive the care, unless it is a true emergency. You can visit page 16 of this guide for more details on the EPO plan and page 18 for the network exception process.

NEW PPO Plan

We have consolidated our Buy Up and Value Plans into one PPO plan to offer you a broader network of coverage as well as continued out-of-network coverage. In the new PPO plan, your out-of-pocket expense will include deductible and coinsurance for most services.

Out-of-Area Benefit Coverage for Out of State Team Members

For team members who live outside of Mississippi or Louisiana and enroll in the PPO Plan for 2022, you will have Tier 2 coverage through a BCBS provider in your home state. Those who enroll also have the option to access providers in the FMOLHS Louisiana and Mississippi Tier 1 or 2 networks. Any other access would be considered a Tier 3 or 4 benefit. Out-of-area coverage is only available based on the team member's home address outside of the states of Louisiana and Mississippi.

Note

Team members are encouraged to carefully review all health plan options as well as the networks associated with each plan to determine the coverage decision that is right for you and your family. More information about the different health plans is available beginning on page 16 of this booklet.

NEW Network Navigation Resource

If you need assistance navigating our FMOLHS customized network, we now have Network Guides available to assist you in both Louisiana and Mississippi. The Network Guides can assist with finding a primary care physician or specialist and scheduling appointments. Refer to page 14 for more information on the Network Navigation Resource.

Additional Dental Plan Options

This year we are offering two dental plan options for you and your family to have a more personalized choice in what plan works best to fit your needs. The options are:

- **The Basic Dental Option –** This plan offers reduced semi-monthly premiums, has less coverage for major dental services and a reduced maximum limit. It does not include orthodontia coverage. For those of you with basic dental needs throughout the calendar year, this plan may be better.
- **The Buy Up Dental Option –** While this dental plan has higher semi-monthly premiums, it offers more coverage for major dental services, includes orthodontia coverage and has a higher annual maximum limit. This plan may be better suited for those with moderate to major dental service needs throughout the calendar year.

Helping you and your family achieve your weight loss goals: Bariatric Program changes

In 2022, we are extending the option to participate in the Team Member Bariatric Coverage Program to an eligible team member's spouse or dependent who has been enrolled in a FMOLHS medical plan for a minimum period of 12 months. To be eligible for the Bariatric Surgery benefit, you must obtain written pre-authorization and satisfy all requirements between the date of the pre-authorization and the date of the surgery. For more information on the requirements of the program, refer to the Health Plan Document under My Benefits on our Total Rewards page at fmolhs.org/totalrewards.

Increased Just Premium Eligibility

It is important to us to make healthcare accessible to all. We know that health insurance can be a significant expense, which is why we offer a discounted premium opportunity called Just Premium. This year the eligibility criteria for Just Premium, which is determined by total household income, has increased by more than $1,000 across all tiers. Team members must apply annually in order to be considered. Eligibility is determined using your 2020 Federal Income Tax Return. Applications and more information are available under My Benefits on our Total Rewards page at fmolhs.org/totalrewards or by contacting askHR@fmolhs.org.

Save on your Medication Copays through RxONE

When you use our in-house pharmacy option, RxONE, you can receive reduced copays for medications, including specialty medications from preferred providers with convenient delivery and pick up locations throughout our ministry. For more information on pharmacy benefits and to learn more about the perks of using RxONE, go to page 28.

NEW Ways to Achieve and Get Rewarded for Your Health and Well-Being Goals

Now more than ever, we recognize the importance of offering opportunities to care for your health and well-being. We have enhanced our prior wellness program to provide you with a more streamlined wellness program and give you more opportunities to engage and get rewarded for participating in health and well-being activities.

How It Works:

Your primary care physician (PCP) should be your main point of contact in your wellness journey. Beginning in 2022, there will no longer be Healthy Lives screenings. Instead, your PCP will perform your annual wellness exam and screening at your well visit. You'll have to complete this PCP visit along with completing the HRA questionnaire to be eligible for rewards under this new wellness program. You will need to go to the Healthy Lives App or portal and complete the HRA questionnaire. Healthy Lives will continue to offer coaching services to our team members and activities to help you earn points under our new program. Each point you earn equals $1 in rewards, and you have many options on how to redeem points that you earn. We have partnered with a company called Awardco, which will enable you to redeem your wellness points on things such as Amazon items, hotels, virtual pre-paid cards, e-gift cards, movie tickets, or cash the rewards out for additional money on your paycheck. The choice is yours! And in 2022, earned points will be available for redemption at the end of each quarter rather than having to wait until the end of the calendar year. For more information on the NEW Health and Wellness program, go to page 33.

NEW Access your Total Rewards Anywhere, Anytime – Available Fall 2021

You've shared that you would like more ways to access information about benefits and Total Rewards, which is why we've developed a new website accessible at work, at home or on the go. When you visit fmolhs.org/totalrewards, you can check out all of the Total Rewards opportunities and information available to team members when it's most convenient for you.

Enrollment

All eligible team members must enroll online through Lawson Employee Self Service by November 15, 2021.

Things to Consider

Before you enroll, it is a good opportunity for you to re-assess your benefit decisions and determine if you need to make changes. The elections that you make are effective on January 1, 2022.

- Does your spouse have benefits coverage available through another employer?
- Did you get married, divorced or have a baby recently? If so, do you need to add or remove any dependent(s) or update your beneficiary designation?
- Did any of your covered children reach his or her 26th birthday this year? If so, they are no longer eligible for benefits.

Your Eligible Dependents for Core Benefits Enrollment

Dependents eligible for coverage in the FMOLHS Benefit Plans include:

- Your legal spouse.
- Your dependent children up to age 26 (includes stepchildren, legally-adopted children or children placed with you for adoption, foster children and grandchildren for whom you have legal custody).
- Your dependent child, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your Health Plan to continue coverage past age 26.
- **Please note that verification of eligibility will be required once dependents are enrolled if your dependents have not already been certified. See page 10 for dependent verification requirements.**

Qualifying Life Events Include:

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

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

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

Dependent Verification

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

*Less than age 26 regardless of marital or student status

Dependent verification documents for any newly enrolled or previously unverified dependents must be received by November 15, 2021 in order to maintain dependent coverage. FMOLHS reserves the right to audit dependent verification documents at any time.

Note

Submit Dependent Verification Documents to askHRDocuments@fmolhs.org by November 15, 2021.

How to Enroll in Lawson Employee Self Service

1. Understand Your Choices!

The Benefits Guide is available by clicking the My Benefits link on our Total Rewards page at fmolhs.org/total-rewards.

2. Enroll Online from Work or Home

From work: Teamlink

From home: http://access.fmolhs.org, click the Teamlink App

St. Dominic from home: my.stdom.com > Employee Self Service

3. Log in with Your Username and Password

Louisiana FMOLHS Ministries

a. From Teamlink, click My Benefits

b. Click the Lawson Employee Self Service Link

c. Click on Special Events tab

d. Click on Welcome to Open Enrollment link

e. Password issue, call 866-532-4772

Mississippi FMOLHS Ministries (St. Dominic)

a. On the landing page, click the world icon

- » Click bookmarks to display EES bookmarks
- » Hover the cursor over Employee Self Service

b. Enroll in benefits

- » Hover the cursor over benefits
- » Click open enrollment

c. Password issue, call 601-200-4000

4. Review Your Personal Information

5. Update or Add Your Dependents and Beneficiary(s)

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

b. Submit dependent verification documents to askHRDocuments@fmolhs.org

6. Review Your Dependent Child's Eligibility for Coverage

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

b. Voluntary Benefits (Life, Accident, Critical Illness) – Unmarried dependent children to age 21; to age 25 if a full time student.

7. Save and Print Your Elections!

If your benefit elections are properly completed and saved, you will see a message that states: "Congratulations! Your enrollment has been successful . . ."
And you will receive an enrollment confirmation email at your Team Mail address.

If you do not receive an email confirming your elections, your elections were not properly completed and you must complete the election process again NO LATER THAN November 15.

You must have a copy of your 2022 benefit elections and/or your confirmation email to report a problem with your enrollment.

2022 Premium Reduction Opportunities – EPO and PPO Medical Plans

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

Based upon your total household income (adjusted gross income) and the number of dependents you claim on your 2020 Federal Individual Income Tax Return; you and your family may be eligible for the Just Premium reduction.

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

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

To ensure that you receive a decision on eligibility for the Just Premium prior to your Health Plan enrollment, please submit complete application and tax return by October 31, 2021. Applications that are submitted by November 15th will still be reviewed, but you may not know the status of your eligibility until after you have enrolled in benefits. We are unable to allow changes to benefit elections after November 15, 2021, regardless of your Just Premium eligibility.

To apply for Just Premium:

- Select My Benefits on our Total Rewards page at fmolhs.org/totalrewards and then click on the Just Premium Application link.
- Print and complete the application and attach a copy of the first two pages of your 2020 Federal Individual Income Tax Return. If you file married filing jointly, submit one tax return. If you are married, filing single or head of household, you will be required to submit the first two pages of both your tax return and your spouse's return.
- Complete applications must be returned by email to JustPremium@FMOLHS.org or by fax (225) 765-9307 by November 15, 2021.

Note

Individuals who did not file a 2020 Income Tax Return will not be eligible for the 2022 Just Premium.

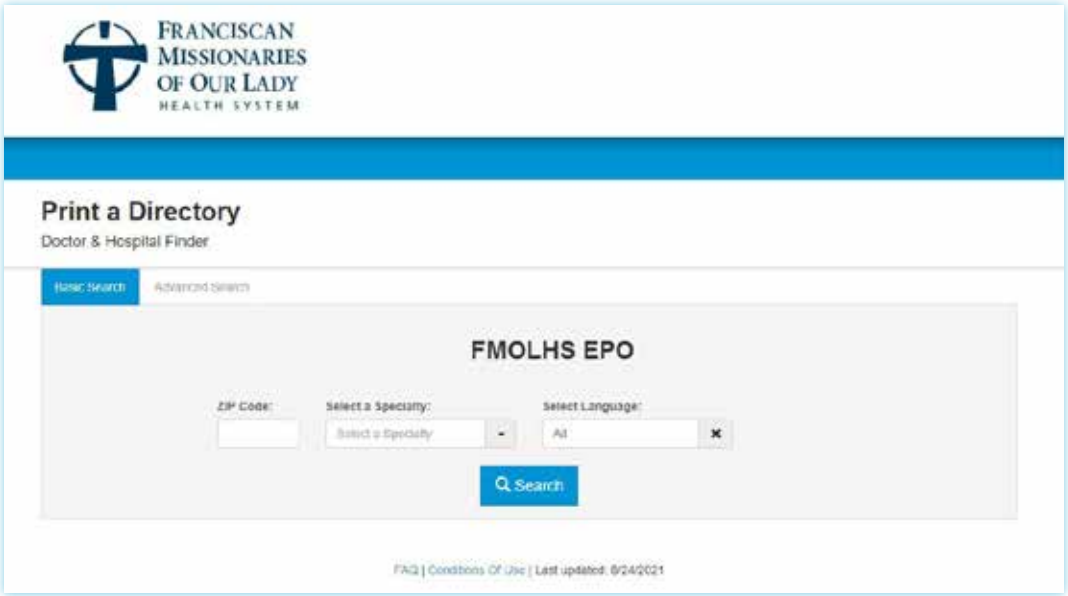
My Health Benefits

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

Health coverage is one of the most important benefits FMOLHS can provide. Health benefits provide significant value through support for and protection against potentially large financial expenses, as well as covering preventive care. FMOLHS is committed to keeping team members healthy and productive by offering comprehensive health care plans. The option you choose will be in place for all of 2022, unless you have a qualifying family status change. Health benefits will be administered by Blue Cross Blue Shield.

How Do I Find a Provider?

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



Network Navigation Resource

We understand the importance of finding the healthcare provider to best meet the needs of you and your family. We are now offering team members a resource - **Network Guides** - to help navigate our FMOLHS customized network. Whether it be our new narrow EPO network or our PPO Tier 1 or Tier 2 network, our Network Guides can help you find a provider, assist with scheduling an appointment with network Primary Care Physicians, and check availability of a specialty service within our network.

To access our Network Guides, simply call 855-875-6265. You will then be prompted to select a Network Guide for either our Louisiana or Mississippi network. Our Network Guides are available in most locations 7 days a week, 24 hours a day.

Note

Always verify a provider's network status by calling Blue Cross Blue Shield or by logging on to www.MyHealthToolkitLA.com/links/fmolhs.

Road Map to Care

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

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

First Stop

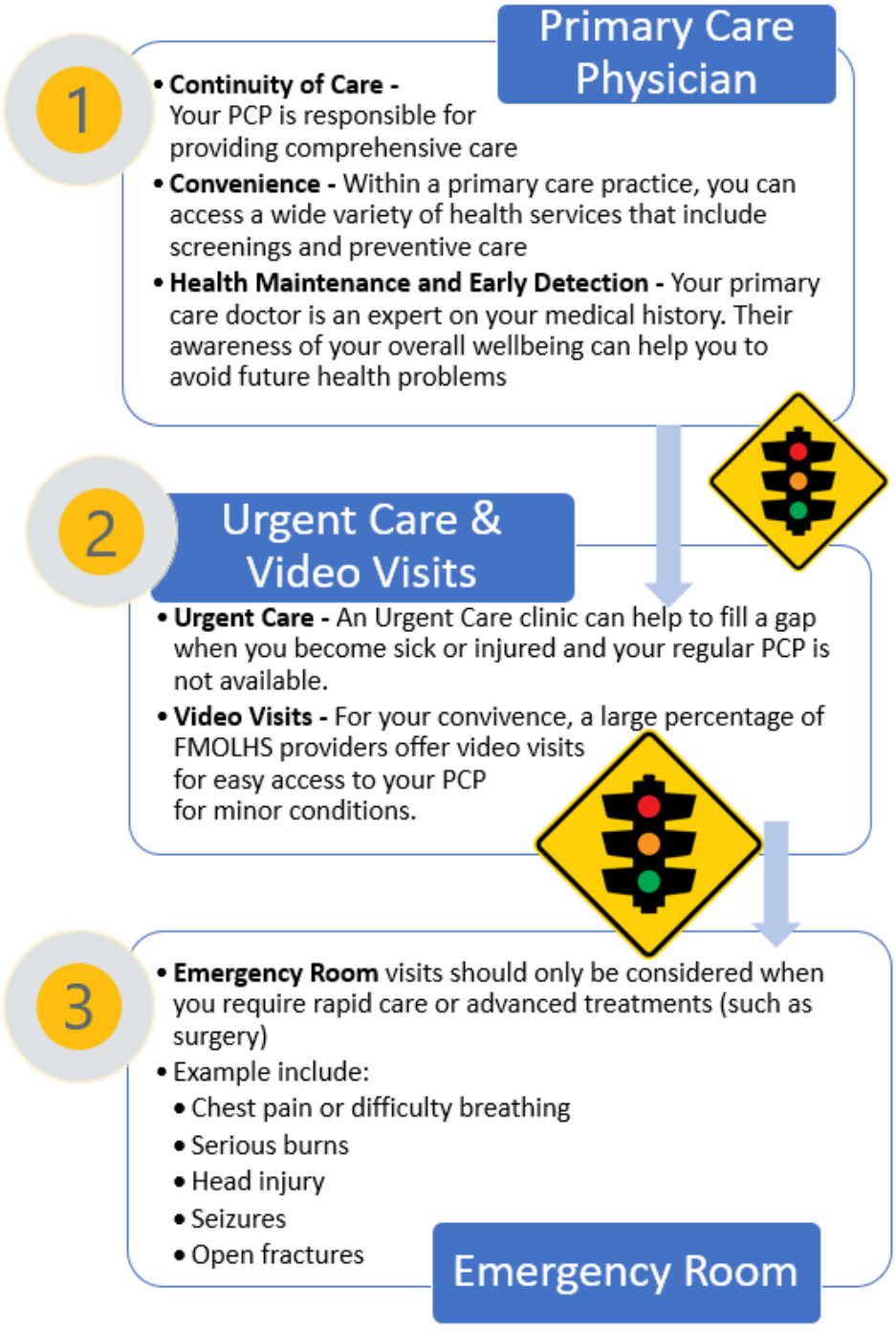
Primary Care Physician (PCP) Having one doctor who knows your overall health history and can better guide you as you navigate certain health risks leads to better patient experience.

Second Stop

If you come down with a minor illness or infection and your PCP is unavailable for an in-person visit because you are traveling, it's the weekend or it's later in the evening, Video Visits and Urgent Care are good options to consider.

Third Stop

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



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

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

EPO Plan

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

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

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

PPO Plan

In 2022, we have consolidated our Buy Up and Value Plans into one single PPO Plan. The PPO health plan design has new deductibles, coinsurance and copays, and continues to offer out-of-network coverage for most services. The pharmacy design is consistent with the 2021 copays including the specialty copays - $100 if filled at RXOne and $150 if filled by Express Scripts. If you reside outside of Louisiana or Mississippi, you are eligible for out-of-area coverage at the Tier 2 coverage level if you see a BCBS provider in your home state. The out-of-area coverage is based solely upon the employed team member's address outside of Louisiana or Mississippi. The PPO has higher monthly premiums, but offers out-of-network coverage if needed. This plan choice is beneficial for those individuals who need out-of-area coverage or need a broader network coverage including out-of-network coverage.

HDHSA Plan

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

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

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

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

How Will I Be Billed for a Physician Office Visit?

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

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

*For some services, coinsurance and deductible may apply.

How Will I Be Billed for Medical Services?

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

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

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

For example: if you have elected the PPO Plan (80% FMOLHS Network Tier 1 / 75% Preferred Provider Network Tier 2) you would be responsible for 25% of the in-network anesthesiologist's bill after you have met your deductible.

How Do I View My Medical Claims Online?

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

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

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

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

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

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

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

You must file an appeal within 90 days after you have been notified of the denial of benefits.

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

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

How do I request a network exception if my healthcare provider has prescribed a service or treatment that is not available in the customized EPO or PPO network?

As a member of FMOLHS Group Health Plan, if you need services that are not available within the EPO or PPO Tier 1 or Tier 2 Network, you may receive network benefits for those services provided you receive approval from Blue Cross Blue Shield of South Carolina before the services are rendered. Once the exact service(s) is known, you and your provider should complete the FMOLHS: Network Exception Request From and provide all necessary information to BCBS SC. The network exception form can be found under My Benefits on our Total Rewards page at fmolhs.org/totalrewards or on www.MyhealthToolkitla.com/links/fmolhs under forms. Your provider's signature is required on the form in order to be considered.

Once the request and documentation are reviewed, BCBS SC will review the request and render a decision or, if necessary, submit the request to the FMOLHS Plan Administrator for a final review and decision. If the request is approved, BCBS SC will notify the member of the determination. If the request is not approved, BCBS SC will notify the member in writing that the services will be considered Out-of-Network. Submit all completed requests in writing via fax to (803) 264-0259, or mail to:

BlueCross BlueShield of South Carolina
Attn: Network Waiver, AX-630
PO Box 100300
Columbia SC 29202

Health Plan Summaries

The charts below give a summary of the 2022 Health Plans for FMOLHS. All covered services are subject to medical necessity as determined by the Plan. All out-of-network services are subject to reasonable and customary (R&C) limitations.

EPO Plan

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

	EPO PLAN
	FMOLHS EPO NETWORK
ANNUAL DEDUCTIBLE	
EMPLOYEE ONLY	$250
EMPLOYEE WITH DEPENDENTS	$500
MAXIMUM OUT-OF-POCKET (INCLUDES DEDUCTIBLE)	
EMPLOYEE ONLY	$2,000
EMPLOYEE WITH DEPENDENTS	$4,000
OFFICE VISIT	
PCP/MEDICAL HOME	$0 copay
SPECIALIST	$35 copay
EMERGENCY ROOM	
EMERGENCY	$200 copay
NON-EMERGENCY	$350 copay
URGENT CARE	$60 copay
OTHER CO-PAYS	
OUTPATIENT	$250 copay
INPATIENT	$200 copay per day (4 day/$800 max)
PHYSICIAN SERVICES	
INPATIENT VISITS	Included in Inpatient copay
SURGERY ALLERGY TESTING ALLERGY SERUM AND INJECTIONS INJECTIONS DIAGNOSTICS LABORATORY CHEMOTHERAPY	Included in Office Visit or Outpatient Copay[1]
HOSPITAL SERVICES	
ROOM AND BOARD	Included in Inpatient Copay
INTENSIVE CARE UNIT	Included in Inpatient Copay
OUTPATIENT SURGERY	Included in Outpatient Copay
SKILLED NURSING FACILITY	$200 copay per day (4 days/$800 max)
BARIATRIC SURGERY	$3000 copay; Surgery must be performed at a MBSAQIP Accredited FMOLHS facility.
ORGAN TRANSPLANTS	90%[2] when performed at a Blue Distinction Center Network facility
PREGNANCY/DELIVERY	
LABOR & DELIVERY AND ASSOCIATED CHARGES	$200 copay per day (4 day/$800 max)
MATERNAL/FETAL ULTRASOUND	90%[2]

[1]For some services, coverage may be 90% after deductible
[2] After deductible

EPO MEDICAL PLAN (CONTINUED)

	FMOLHS EPO NETWORK
OTHER SERVICES & SUPPLIES	
HOME HEALTH CARE	90%[2]; maximum of 50 visits per calendar year
HOSPICE CARE	90%[2]
AMBULANCE SERVICE	90%[2]
OCCUPATIONAL THERAPY SPEECH THERAPY PHYSICAL THERAPY	90%[2]; maximum of 120 visits per calendar year of combined Occupational, Speech and Physical Therapy
APPLIED BEHAVIOR ANALYSIS (ABA)	90%[2]; maximum of 20 hours per week annually
SPECIFIC GENETIC TESTING FOR DIAGNOSED MEMBERS ONLY	90%[2]; drawn/ordered by FMOLHS Geneticist
SMOKING CESSATION AIDS	100% up to amaximum of a 90-day treatment regimen maximum benefit of two per year.[3]
DURABLE MEDICAL EQUIPMENT	90%[2]
INSULIN PUMP	90%[2]; limited to one per five years
ORTHOTICS & PROSTHETICS	90%[2]
MENTAL/NERVOUS AND SUBSTANCE ABUSE	
INPATIENT Includes Partial Hospitalization, Intensive Outpatient Program and Residential	$200 copay per day (4 day/$800 max)
OUTPATIENT OFFICE VISIT ONLY	$0 copay
OTHER OUTPATIENT SERVICES	Included in Office Visit or Outpatient Copay[1]

[1]For some services, coverage may be 90% after deductible
[2]After deductible

100% Preventive Care at a Network Provider!

- Routine Well Adult Care (Limited to approved wellness screenings)
- Adult Immunizations
  - Subject to CDC recommendations which include age limitations
- Routine Well Child Care
  - Includes office visits, routine physical examination and immunizations in accordance with CDC guidelines.
- Prenatal Care
  - One-time $50 copay applies for coverage of routine OB visits, initial routine labs and one ultrasound per term pregnancy.

PPO Plan

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

PPO MEDICAL PLAN

	FMOLHS NETWORK TIER 1	PREFERRED PROVIDER NETWORK TIER 2	NON-PREFERRED PROVIDER TIER 3	OUT-OF-NETWORK TIER 4
ANNUAL DEDUCTIBLE				
EMPLOYEE ONLY	$800	$800	$3,000	$5,000
EMPLOYEE WITH DEPENDENTS	$1,600	$1,600	$6,000	$10,000
OOP (INCLUDES DEDUCTIBLE)				
EMPLOYEE ONLY	$3,000	$4,000	$6,000	$10,000
EMPLOYEE WITH DEPENDENTS	$6,000	$8,000	$12,000	$20,000
OFFICE VISIT CHARGE ONLY				
PCP/MEDICAL HOME	$5 copay[1]	$30 copay[1]	60%[2]	40%[2]
SPECIALIST	$45 copay[1]	$60 copay[1]	60%[2]	40%[2]
EMERGENCY ROOM (BENEFITS ARE PAID 100% AFTER APPLICABLE COPAYMENT APPLIED)				
NON-EMERGENCY	20%	20%	20%	20%
EMERGENCY	20%	20%	20%	20%
URGENT CARE	$75 copay	$75 copay	60%	40%
PHYSICIAN SERVICES				
INPATIENT VISITS SURGERY ALLERGY TESTING ALLERGY SERUM AND INJECTIONS INJECTIONS DIAGNOSTICS LABORATORY HOSPICE CARE AMBULANCE SERVICE CHEMOTHERAPY	80%[2]	75%[2]	60%[2]	40%[2]
HOSPITAL SERVICES				
ROOM AND BOARD INTENSIVE CARE UNIT SKILLED NURSING FACILITY OUTPATIENT SURGERY	80%[2]	75%[2]	60%[2]	40%[2]
BARIATRIC SURGERY	$3,000 copay; Surgery must be performed at a MBSAQIP Accredited FMOLHS facility.	Not Covered	Not Covered	Not Covered
ORGAN TRANSPLANTS	80%[2] when performed at a Blue Distinction Center Network facility	80%[2] when performed at a Blue Distinction Center Network facility		No Coverage

PPO MEDICAL PLAN (CONTINUED)

	FMOLHS NETWORK TIER 1	PREFERRED PROVIDER NETWORK TIER 2	NON-PREFERRED PROVIDER TIER 3	OUT-OF-NETWORK TIER 4
PREGNANCY/DELIVERY				
LABOR & DELIVERY AND ASSOCIATED CHARGES	80%[2]	75%[2]	60%[2]	40%[2]
MATERNAL/FETAL ULTRASOUND	80%[2] other than included in the prenatal benefit	75%[2] other than included in the prenatal benefit	60%[2]	40%[2]
OTHER SERVICES & SUPPLIES				
HOME HEALTH CARE	80%[2]; maximum of 50 visits per calendar year	75%[2]; maximum of 50 visits per calendar year	60%[2]; maximum of 50 visits per calendar year	No Coverage
OCCUPATIONAL THERAPY SPEECH THERAPY PHYSICAL THERAPY	80%[2]; maximum of 120 visits per calendar year of combined Occupational, Speech and Physical Therapy	75%[2]; maximum of 120 visits per calendar year of combined Occupational, Speech and Physical Therapy	60%[2] ; maximum of 120 visits per calendar year of combined Occupational, Speech and Physical Therapy	40%[2]
APPLIED BEHAVIOR ANALYSIS (ABA)	80%[2]; maximum of 20 hours per week annually	75%[2]; maximum of 20 hours per week annually	NA	No Coverage
SPECIFIC GENETIC TESTING FOR DIAGNOSED MEMBERS ONLY	80%[2] Drawn/ordered by FMOLHS Geneticist	No Coverage	No Coverage	No Coverage
SMOKING CESSATION AIDS	100% up to a maximum of a 90-day treatment regimen; maximum benefit of two per year.[3]	100% up to a maximum of a 90-day treatment regimen; maximum benefit of two per year.[3]	100% up to a maximum of a 90-day treatment regimen; maximum benefit of two per year.[3]	No Coverage
DURABLE MEDICAL EQUIPMENT	80%[2]	75%[2]	60%[2]	No Coverage
INSULIN PUMP	80%[2]; limited to one per five years	75%[2]; limited to one per five years	60%[2]; limited to one per five years	No Coverage
ORTHOTICS & PROSTHETICS	80%[2]	75%[2]	60%[2]	40%[2]
MENTAL/NERVOUS AND SUBSTANCE ABUSE				
INPATIENT Includes Partial Hospitalization, Intensive Outpatient Program and Residential	80%[2]	75%[2]	60%	40%[2]
OUTPATIENT OFFICE VISIT ONLY	$5 copay[1]	$30 copay[1]	60%	40%[2]

[1] All other services subject to deductible and coinsurance
[2] After deductible

Out-of-Area Coverage

An enrolled team member whose home address is in a state other than Louisiana or Mississippi may access care at Tier 2 network coverage for BCBS PPO providers in their home state for themselves and their enrolled dependents. Enrollees also have the option to access providers in the FMOLHS Louisiana and Mississippi networks at Tier 1 or 2 coverage. Any other network access would follow the Tier 3 or 4 benefit. The OOA benefit is based solely on the team member's home address.

100% Preventive Care at a Network Provider!

- Routine Well Adult Care (Limited to approved wellness screenings)
- Adult Immunizations
  - Subject to CDC recommendations which include age limitations
- Routine Well Child Care
  - Includes office visits, routine physical examination and immunizations in accordance with CDC guidelines.
- Prenatal Care
  - One-time $50 copay applies for coverage of routine OB visits, initial routine labs and one ultrasound per term pregnancy.

HDHSA

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

You cannot open an HSA if:

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

HDHSA

	FMOLHS NETWORK TIER 1	PREFERRED PROVIDER NETWORK TIER 2	NON-PREFERRED PROVIDER TIER 3	OUT-OF-NETWORK TIER 4
FMOLHS HSA ANNUAL CONTRIBUTIONS				
EMPLOYEE ONLY	$750			
EMPLOYEE WITH DEPENDENTS	$1,500			
ANNUAL DEDUCTIBLE				
EMPLOYEE ONLY	$1,750	$1,750	$3,500	$4,000
EMPLOYEE WITH DEPENDENTS	$3,500	$3,500	$7,000	$8,000
MAXIMUM OUT-OF-POCKET (INCLUDES DEDUCTIBLE)				
EMPLOYEE ONLY	$3,500	$4,000	$7,000	$10,500
EMPLOYEE WITH DEPENDENTS	$7,000	$8,000	$14,000	$21,000
OFFICE VISIT CHARGE ONLY				
PCP/MEDICAL HOME	80%[2]	75%[2]	60%[2]	40%[2]
SPECIALIST	80%[2]	75%[2]	60%[2]	40%[2]
EMERGENCY ROOM				
NON-EMERGENCY	80%[2]	80%[2]	80%[2]	80%[2]
EMERGENCY	80%[2]	80%[2]	80%[2]	80%[2]
URGENT CARE	80%[2]	75%[2]	60%[2]	40%[2]
PHYSICIAN SERVICES				
INPATIENT VISITS SURGERY ALLERGY TESTING ALLERGY SERUM AND INJECTIONS INJECTIONS DIAGNOSTICS LABORATORY HOSPICE CARE AMBULANCE SERVICE CHEMOTHERAPY	80%[2]	75%[2]	60%[2]	40%[2]

HDHSA (CONTINUED)

	FMOLHS NETWORK TIER 1	PREFERRED PROVIDER NETWORK TIER 2	NON-PREFERRED PROVIDER TIER 3	OUT-OF-NETWORK TIER 4
HOSPITAL SERVICES				
ROOM AND BOARD INTENSIVE CARE UNIT SKILLED NURSING FACILITY OUTPATIENT SURGERY	80%[2]	75%[2]	60%[2]	40%[2]
ORGAN TRANSPLANTS	80%[2] when performed at a Blue Distinction Center Network facility	80%[2] when performed at a Blue Distinction Center Network facility		No Coverage
BARIATRIC SURGERY	$3,000 copay; Surgery must be performed at a MBSAQIP Accredited FMOLHS facility.	Not covered	Not covered	Not covered
PREGNANCY/DELIVERY				
LABOR & DELIVERY AND ASSOCIATED CHARGES	80%[2]	75%[2]	60%[2]	40%[2]
MATERNAL/FETAL ULTRASOUND	80%[2]	75%[2]	60%[2]	40%[2]
OTHER SERVICES & SUPPLIES				
HOME HEALTH CARE	80%[2], maximum of 50 visits per calendar year	75%[2], maximum of 50 visits per calendar year	60%[2], maximum of 50 visits per calendar year	No Coverage
OCCUPATIONAL THERAPY SPEECH THERAPY PHYSICAL THERAPY	80%[2], maximum of 120 visits per calendar year of combined Occupational, Speech and Physical Therapy	75%[2] maximum of 120 visits per calendar year of combined Occupational, Speech and Physical Therapy	60%[2], maximum of 120 visits per calendar year of combined Occupational, Speech and Physical Therapy	No Coverage
APPLIED BEHAVIOR ANALYSIS (ABA)	80%[2], maximum of 20 hours per week annually	75%[2], maximum of 20 hours per week annually	NA	No Coverage
SPECIFIC GENETIC TESTING FOR DIAGNOSED MEMBERS ONLY	80%[2], drawn/ordered by FMOLHS Geneticist	No Coverage	No Coverage	No Coverage
SMOKING CESSATION AIDS	100% up to a maximum of a 90-day treatment regimen; maximum benefit of two per year.[3]	100% up to a maximum of a 90-day treatment regimen; maximum benefit of two per year.[3]	100% up to a maximum of a 90-day treatment regimen; maximum benefit of two per year.[3]	No Coverage
DURABLE MEDICAL EQUIPMENT	80%[2]	75%[2]	60%[2]	No Coverage
INSULIN PUMP	80%[2], limited to one per five years	75%[2], limited to one per five years	60%[2], limited to one per five years	No Coverage
ORTHOTICS & PROSTHETICS	80%[2]	75%[2]	60%[2]	40%[2]
MENTAL/NERVOUS AND SUBSTANCE ABUSE				
INPATIENT INCLUDES PARTIAL HOSPITALIZATION, INTENSIVE OUTPATIENT PROGRAM AND RESIDENTIAL	80%[2]	75%[2]	60%[2]	40%[2]
OUTPATIENT OFFICE VISIT ONLY	80%[2]	75%[2]	60%[2]	40%[2]

[2] After deductible

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

100% Preventive Care at a Network Provider!

- Routine Well Adult Care (Limited to approved wellness screenings)
- Adult Immunizations
  - Subject to CDC recommendations which include age limitations
- Routine Well Child Care
  - Includes office visits, routine physical examination and immunizations in accordance with CDC guidelines.

Health Plan Premiums (Biweekly Team Member Contributions - 26 Contributions)

HEALTH PLAN PREMIUMS (BIWEEKLY TEAM MEMBER CONTRIBUTIONS - 26 CONTRIBUTIONS)

	EMPLOYEE ONLY	EMPLOYEE & SPOUSE	EMPLOYEE + CHILD(REN)	FAMILY
EPO PLAN				
JUST PREMIUM	$20.85	$90.85	$41.21	$113.19
STANDARD PREMIUM	$48.12	$155.39	$95.40	$204.43
PART-TIME PREMIUM	$48.15	$261.65	$175.59	$339.24
	EMPLOYEE ONLY	EMPLOYEE & SPOUSE	EMPLOYEE + CHILD(REN)	FAMILY
PPO PLAN				
JUST PREMIUM	$44.87	$167.80	$84.59	$212.98
STANDARD PREMIUM	$93.52	$239.69	$168.14	$314.30
PART-TIME PREMIUM	$136.30	$340.02	$252.76	$456.50
	EMPLOYEE ONLY	EMPLOYEE & SPOUSE	EMPLOYEE + CHILD(REN)	FAMILY
HDHSA PLAN				
JUST PREMIUM	NA	NA	NA	NA
STANDARD PREMIUM	$76.28	$207.20	$177.67	$286.51
PART-TIME PREMIUM	$111.17	$293.93	$267.09	$377.21

My Pharmacy Benefits

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

Prescription Drug Coverage for Medical Plans

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

Why Do My Prescriptions Cost So Much?

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

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

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

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

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

How Can I Minimize My Medication Costs?

- Consider Mail Order for your maintenance medications. You receive a 3-month supply for only two copays. Example:

	COPAY	ANNUAL COST
PRESCRIPTION		
GENERIC – NETWORK	$15 per month	$180
GENERIC – MAIL ORDER	$30 per 3 months	$120
YOUR ANNUAL SAVINGS	N/A	$60

- Print a copy of the Express Scripts National Preferred formulary and bring it with you when you visit your physician. Log on to www.express-scripts.com, and click on Register. Once you complete the registration you will have access to your account information, benefits and formulary list.
- Let your physician know that you would like to try generics first, if that is an appropriate option for you.
- Ask your provider if there are Over-the-Counter (OTC) products available to obtain the same results as prescription medications. Often these OTC products will be less expensive than your copay and will provide the same relief.
- Get a $5 discount when you fill your prescription at an in-house pharmacy. Get an additional $5 discount when your prescription is written by the Franciscan Clinic and filled at the in-house pharmacy. Refer to page 28 for a listing of the in-house pharmacy locations/services.

EPO PRESCRIPTION PLAN

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

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

PPO PRESCRIPTION PLAN

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

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

HDHSA MEDICAL PLAN

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

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

IN-HOUSE PHARMACY OVERVIEW

PHARMACY	LOCATION	SERVICE AREA	SERVICES						
			RETAIL	SPECIALTY	DELIVERY	FLAVOR-ING	MAIL ORDER	EMPLOYEE HEALTHPLAN DISCOUNT *	IMMUNI-ZATIONS
RxONE I Livingston	5000 O'Donovan Blvd, Walker LA 225-271-6098	LA	✓		✓		✓	✓	✓
RxONE I Med Plaza	7777 Hennessy Blvd Ste 114, BR 225-765-8951	LA	✓	✓	✓			✓	✓
RxONEl Mary Bird Perkins	4950 Essen Ln, St. 540, BR 225-374-0260	LA	✓	✓	✓			✓	✓
RxONE I Tower Drive	2600 Tower Dr., Monroe 318-966-6290	LA	✓			✓		✓	✓
RxONE I St Francis	309 Jackson St, Monroe 318-966-7242	LA & MS	✓				MS only	✓	✓
RxONE I Lourdes	4809 Ambassador Caffery Pkwy, Laf 337-470-4342	LA & MS	✓	✓			MS only	✓	✓
O'Donovan Pharmacy	5131 O'Donovan Dr, BR 225-374-0270	LA	✓	✓	✓		✓	✓	✓
Mid City Pharmacy	1401 N. Foster Dr, BR 225-987-9184	LA	✓		✓			✓	✓
Lake Children's Pharmacy	8300 Constantin Blvd, BR 225-374-1350	LA	✓	✓		✓		✓	✓
Our Lady of the Angel OP	433 Plaza St., Bogalusa, LA 985-730-7219	LA	✓						

Preauthorization Requirement List

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

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

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

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

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

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

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

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

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

Note

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

2022 ADULT PREVENTIVE SERVICE RECOMMENDATIONS[1] THIS CHART IS INTENDED AS A REFERENCE TOOL FOR YOUR CONVENIENCE.

PREVENTION/SCREENING	AGE 21-39	AGE 40-49	AGE 50-64	AGE 65 or older
ABDOMINAL AORTIC ANEURYSM SCREENING				One time screening by ultrasonography in men ages 65-75 who have ever smoked
BREAST CANCER SCREENING (BRCA[2]; MEDICATION[3])	As recommended by your health care provider*	Screening mammography, every 1 to 2 years, for women age 40 years and older, with or without clinical breast examination		
CERVICAL CANCER SCREENING	Cytology (Pap smear) every 3 years women ages 21 – 65 or			As recommended by your health care provider*
	Ages 30 to 65 years who want to lengthen the interval, screening with a combination of cytology & human papillomavirus (HPV) testing every 5 yrs.			
CHOLESTEROL ABNORMALITIES SCREENING: MEN	Men ages 20-35 for lipid disorders if they are at increased risk for coronary heart disease			
	Men 35 and older for lipid disorders			
CHOLESTEROL ABNORMALITIES SCREENING: WOMEN	Women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease			
		Women age 45 years and older for lipid disorders		
COLORECTAL CANCER SCREENING	As recommended by your health care provider*		Adults beginning at age 45-65 or older, fecal occult blood testing annually, sigmoidoscopy every 5 years, or colonoscopy every 10 years	
DIABETES SCREENING	Screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg or in adults age 40-70 years of age who are overweight or obese.			
HEPATITIS C SCREENING	Adults age 18-79 without known liver disease, a one-time screening for hepatitis C virus (HCV)			
IMMUNIZATIONS[4]	Refer to the CDC's posted schedule of immunizations			
LUNG CANCER SCREENING Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery			Annual screening with low-dose computed tomography in adults age 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years.	
OSTEOPOROSIS SCREENING	Bone density in younger women whose fracture risk is equal to or greater than that of a 65 year old white woman who has no additional risk factors.			Bone density for women age 65 years or older
WELLNESS OFFICE VISIT: PHYSICAL EXAM, BLOOD PRESSURE, BODY MASS INDEX (BMI)	Annually			

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

[1] http://www.uspreventiveservicestaskforce.org/uspstf/uspsrecsdate.htm (current as of June 2021)

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

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

[4] Adult immunizations: http://www.cdc.gov/vaccines/schedules/easy-to-read/adult.html

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

Care Management

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

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

Transition Care

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

Complex Care

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

Diabetes Management Program

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

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

Maternity Management

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

My Health and Well-Being

Introducing an Enhanced Health and Wellness Program

Now more than ever we recognize the importance of offering opportunities to care for your health and well-being. We have enhanced our wellness program to provide you with a more streamlined program and give you more opportunities to engage and get rewarded for participating in health and well-being activities.

Your primary care physician (PCP) should be your main point of contact in your wellness journey. Beginning in 2022, there will no longer be Healthy Lives screenings. Instead, your PCP will perform your annual wellness exam and screening at your well visit. You'll have to complete this PCP visit along with completing the HRA questionnaire to be eligible for rewards under this new wellness program. Each point you earn equals $1 in rewards. Team members can earn up to 550 points or $550 in rewards.*

You have many options on how to redeem points that you earn. We have partnered with a company called Awardco, which will enable you to redeem your wellness points on things such as Amazon items, hotels, virtual pre-paid cards, e-gift cards, movie tickets, or cash the rewards out for additional money on your paycheck. The choice is yours! And in 2022, earned points will be available for redemption at the end of each quarter rather than having to wait until the end of the calendar year.

Note

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

To participate in the 2022 Health and Wellness Program and to begin earning points, follow the steps below:

1. Complete your HRA Questionnaire on the Healthy Lives app or web-based portal.
2. Schedule and complete your wellness visit with your PCP between January 1, 2022 and December 31, 2022.** During your wellness visit, your PCP will perform your annual wellness exam and your biometric screening.
   - *NOTE: Contact our Network Guides at 855-875-6265 if you need assistance finding a primary care provider or scheduling an appointment.*
3. Engage in approved activities that help you achieve your goals and earn your rewards.
   - *COMING SOON! There will be a catalog of approved activities available on the Total Rewards site at fmolhs.org/totalrewards on the My Health and Well-being page or on the Healthy Lives portal. Once available, review the activities and determine which best fit with your work-life schedule and complete the activities. Then follow the steps to confirm your participation in the activities.*
4. Redeem your points for rewards of your choice on the Awardco site, which can be accessed through the Healthy Lives portal or online at https://fmolhs.awardco.com. You will need to register on the Awardco site to access your rewards.

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

**In order to help our team members jump start their rewards for 2022, we will give credit in 2022 for satisfying this step if a PCP visit was completed from November 1, 2020 through December 31, 2021. However, it is highly recommended you have an annual visit with your PCP, so please complete step two in 2022.

Healthy Lives • www.ourhealthylives.org • 855-426-4325

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

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

Healthy Lives Wellness Program

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

Personal Coaching and Continual Education

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

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

Kinesics

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

Healthy Lives Wellness App

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

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

Notice Regarding Wellness Program

Healthy Lives is a voluntary wellness program available to both health plan and non-health plan members. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for total cholesterol, HDL, LDL, triglycerides and glucose (include cotinine screening, if appropriate). Your blood pressure, height, weight, and waist circumference will also be measured. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

Incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Healthy Lives at 855-426-4325.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as wellness programming and content. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and FMOLHS may use aggregate information it collects to design a program based on identified health risks in the workplace, Healthy Lives will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. In order to provide you with services under the wellness program, your personally identifiable health information may be shared with one or more of the following: Lockton Companies, Blue Cross Blue Shield, Express Scripts (ESI) and Health Leaders Network.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources.

My Dental Benefits

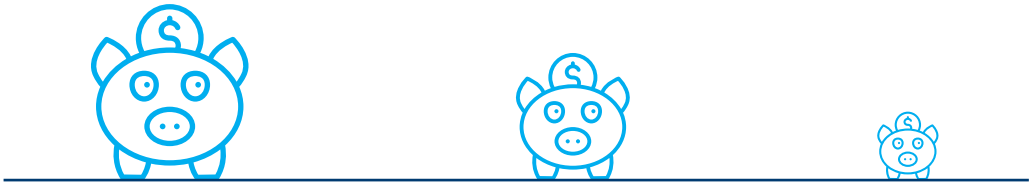
Delta Dental • www.deltadentalins.com • 800-521-2651

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

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

Choose a PPO Dentist to Save!

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



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

1. Greater Savings

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

2. Quality Assurance

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

3. No Balance Billing

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

4. Avoid Unbundling

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

5. Less Paperwork

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

6. No Prepayment Required

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

Note

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

Dental Premiums

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

	BASIC PLAN		BUY UP PLAN	
	FULL TIME	PART TIME	FULL TIME	PART TIME
2022 PREMIUMS				
EMPLOYEE	$3.90	$7.80	$7.92	$15.83
EMPLOYEE + FAMILY	$24.50	$28.40	$36.15	$44.07

Dental Plan Coverage

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

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

Note

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

My Vision Benefits

AlwaysCare Vision • www.alwayscarebenefits.com• 888-729-5433 ext 2013

Vision Buy-Up Plan

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

In-network copayments are paid directly to the provider.

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

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

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

Eligibility

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

Vision Premiums (semi-monthly; 24 deductions)

	VISION	
	BASIC PLAN	BUY UP PLAN
2022 PREMIUMS		
EMPLOYEE	$2.47	$3.05
EMPLOYEE + SPOUSE	$4.93	$6.11
EMPLOYEE + CHILD(REN)	$6.17	$7.64
EMPLOYEE + FAMILY	$6.79	$8.41

Vision Plan Summary

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

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

This is a summary only. You may access the Summary Plan Description via the FMOLHS intranet.

Note

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

My Health Savings Accounts – HSA

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

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

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

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

Eligibility

You are eligible to open and fund an HSA if:

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

Individually Owned Account

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

How to Enroll

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

Maximize Your Tax Savings

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

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

HSA Funding Limits

Each year, the IRS places a limit on the maximum amount that can be contributed to HSA accounts. For 2022, contributions are limited to the following:

HSA FUNDING LIMITS	
EMPLOYEE	$2,900
FAMILY	$5,800
CATCH -UP CONTRIBUTION (AGES 55+)	$1,000

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

EMPLOYER HSA CONTRIBUTION	
EMPLOYEE	$750
FAMILY	$1,500

HSA contributions in excess of the IRS annual contribution limits ($2,900 for individual coverage and $5,800 for family coverage for 2022) are not tax deductible and are generally subject to a 6% excise tax.

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

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

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

Note

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

My Flexible Spending Account – FSA

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

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

PayFlex will administer the medical and limited use flexible spending accounts.

Medical Flexible Spending Account

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

Limited Use Flexible Spending Account

Designed to complement a Health Savings Account, a Limited Use Flexible Spending Account (LUFSA) allows for reimbursement of eligible Dental and Vision expenses. If you enroll in the HSA account and also enroll in the Medical FSA in 2022, the Medical FSA automatically becomes a Limited Use FSA (LUFSA). You must decide how much to set aside for this account. You may contribute up to $2,750 in the LUFSA. Again the LUFSA can only be used for eligible dental and vision expenses. When you use your PayFlex debit card to pay for eligible dental and vision expenses, the available dollars will always pull from the LUFSA first until that account is exhausted and then the dollars will pull from your HSA account.

FSA Debit Card: Medical Flexible Spending Account

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

General FSA Rules and Restrictions

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

- Your expenses must be incurred during the Plan year of 2022.
- Your dollars cannot be transferred from one FSA to another.
- You must "use it or lose it"— any unused funds will be forfeited.
- You cannot change FSA election in the middle of the Plan year unless you have a qualified life status change, such as a marriage, divorce, or birth of a child.

Note

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

2.5-Month Grace Period

- The 2.5-month grace period allows participants an additional period of time to incur expenses after the Plan year end (December 31, 2022).
- If an expense is incurred between January 1, 2022 and March 15, 2023 AND submitted for reimbursement on or before March 31, 2023, any remaining balance in the previous Plan year that ended December 31, 2022, will be paid out for the claim, even though the service was provided in the NEW Plan year.

FSA FAQs

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

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

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

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

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

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

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

What are acceptable forms of substantiation?

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

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

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

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

Contact Information:

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

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

My Life Insurance

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

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

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

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

Beneficiary Designation

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

Note

It is important that you name a primary and contingent beneficiary to receive your Life insurance benefits. To elect your beneficiary designations for your group life insurance products, log into Lawson Employee Self-Service and click on beneficiary.

Group Life, Grandfathered Group Supplemental Life and Group Dependent Life

Team members may have Supplemental Life in place for themselves and their family members. Those currently covered are eligible to continue enrollment in the plans. Premiums are paid through post-tax payroll deductions.

Team members who are currently enrolled in Grandfathered Group Supplemental and Group Dependent Life can continue enrollment in this benefit. New enrollments are not being accepted in these plans. Grandfathered Supplemental Life and Dependent Life coverage is convertible if your employment ends for a reason other than a total disability or retirement. To continue insurance, written application and the first premium payment must be made within 31 days of the date insurance would otherwise end.

	GROUP LIFE	GRANDFATHERED GROUP SUPPLEMENTAL LIFE	GRANDFATHERED GROUP DEPENDENT LIFE
COVERAGE AMOUNT	1.5x Annual Salary	Increments of $10,000 to a max of $100,000	$10,000 for spouse $5,000 for each child*
WHO PAYS	Company pays full cost	You pay full cost	You pay full cost
WHEN BENEFITS ARE PAYABLE	If you die while covered under the plan	If you die while covered under the plan. This benefit is in addition to your basic life benefit	If your dependent dies while covered under the plan
MAXIMUM BENEFIT	$50,000	$100,000	Same as coverage amount
WHEN CAN I CHANGE MY ELECTION	N/A	These plans are frozen as of December 31, 2014. Team Members may maintain the grandfathered coverage level elected in 2014 or dis-enroll. Once you dis-enroll, you are no longer eligible for this coverage.	

*** Unmarried dependent children are eligible from birth to age 21 (age 25 if a full-time student)**.

Employee Basic Life and AD&D Insurance, as well as the Grandfathered Group for Supplemental Life Insurance, will be reduced as follows:

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

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

Note

If you are already enrolled in any of the Group life benefits, you may continue your coverage.

My Retirement Benefits

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

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

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

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

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

Snapshot of Our Retirement Plans

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

Employer matching contributions (see below for details)

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

403(b) Savings Plan

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

Employer Match Contribution Account

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

Vesting

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

Note

You will enroll and manage your retirement accounts (Pension, 401(a), 403(b), 457(b)) directly on the Lincoln Financial website at LincolnFinancial.com/FMOLHS.

What to Do and Resources to Help

WHAT TO DO IF YOU'RE ALREADY ENROLLED (YOUR CURRENT ELECTION WILL CONTINUE)	
REGISTER	» If you aren't registered, register and secure your account at LincolnFinancial.com/Register. » If you've already registered, log into your account at LincolnFinancial.com/Retirement
DESIGNATE BENEFICIARY	» Make sure you designate your beneficiary for each retirement account
E-DELIVERY	» Sign up for E-Delivery to receive your quarterly statement

WHAT TO DO IF YOU HAVEN'T ENROLLED	
REGISTER	» If you aren't registered, register and secure your account at LincolnFinancial.com/Register. » If you've already registered, log into your account and follow the prompts to enroll. You must take action to enroll.
ENROLL	» Select the amount you'd like to contribute, » Confirm your investment option — either the default investment or one you prefer — – and click Submit. That's it! You're enrolled. – You may also elect to set up an automatic contribution increase
BENEFICIARY AND E-DELIVERY	» Make sure you designate your beneficiary for each retirement account » Sign up for E-Delivery to receive your quarterly statement

RESOURCES TO HELP YOU		
FOR THE 403(B) SAVINGS PLAN, 457(B) PLAN, FROZEN 401(A) PLAN, OUR LADY OF THE LAKE PENSION PLAN, OUR LADY OF LOURDES PENSION PLAN, ST. FRANCIS PENSION PLAN AND ST. DOMINIC PENSION PLAN PARTICIPANTS	» Detailed information about all of the retirement plans is available on our Total Rewards page and www.LincolnFinancial.com/FMOLHS. » If you have questions about your retirement plan, call the Lincoln Customer Contact Center at 877-562-4738 and speak to a Customer Service Representative weekdays from 9:00 a.m. to 7:00 p.m. Central. » To receive personal assistance, go to LincolnFinancial.com/FMOLHSschedule to schedule a free one-on-one personal consultation or contact one of your Lincoln Financial retirement consultants.	**Contact:** Ryan Jones Ryan.Jones@LFG.com 225-305-8539 Jayme Schwartzenburg Jayme.Schwartenburg@LFG.com 225-363-8767

Introducing Lincoln WellnessPATH®

Your path to financial wellness

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

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

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

My Disability Insurance

Short Term Disability Insurance

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

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

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

Long Term Disability Insurance

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

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

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

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

Note

NEW - Evidence of Insurability (EOI) is the information Lincoln uses to verify your good health when you're purchasing long term disability insurance. EOI is required if you previously waived LTD coverage and would like to elect coverage during Open Enrollment. You can now submit your EOI online at MyLincolnPortal.com. First time user? Register using Company Code FMOLHS.

My EAP

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

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

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

We've got your back.

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

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

SERVICES

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

We're here for you, always.

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

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

BetterHelp Online Therapy

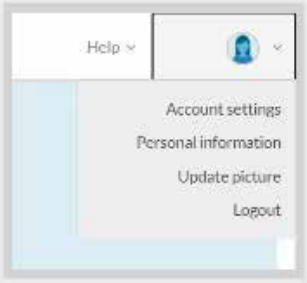
Support is more convenient than ever.

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

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

   Check sessions on your BetterHelp account

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



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

NEW DIRECTIONS® | betterhelp

Helping You Balance Your Work and Personal Life

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

BENEFITS	WHEN YOU ARE ELIGIBLE	WHAT YOU RECEIVE
PAID TIME OFF (PTO)	Immediately. Eligible full-time (AF) and part-time (PT) 0.5 to 1.0 FTE. Time may be used upon accrual.	Annual Accrual 0–4 years 132 hrs (16.5 days) 5–9 years 156 hrs (19.5 days) 10–14 years 180 hrs (22.5 days) 15–19 years 204 hrs (25.5 days) 20–24 years 228 hrs (28.5 days) 25 years + 252 hrs (31.5 days) PTO may be carried over to a max of 328 hours; part-time PTO accrual rates are prorated. (Years of service credit is determined by adjusted hire date)
PTO SELL BACK	Eligible full-time (AF) and part-time (PT) 0.5 to 1.0 FTE Annually during the sell back period.	To assist with managing PTO accrual balances, team members may elect to "sell back" future PTO accruals. The combination of PTO accruals and PTO sell back accruals will not exceed 328 hours. Hours in excess of 328 will not be paid out.
SHORT TERM DISABILITY AND/OR LEGACY EXTENDED ILLNESS TIME (EIT)	Active full time (AF) and part-time (PT) 0.5 to 1.0 FTE Eligible Team members are automatically enrolled in the short term disability benefit on the 91st day of continuous eligibility. Team members with a Legacy Extended Illness Time (EIT) balance must use the entire EIT balance prior to eligibility for short term disability benefit payment. (see important pay information)	Team members may receive a bi-weekly disability income benefit if they become disabled as a result of an injury or illness, including a pregnancy-related condition, while covered under the short term disability or Legacy EIT benefit. **Important PAY information while on a leave of absence:** If you are on a leave of absence for your own illness and are eligible for short term disability, you must return all required leave documents to Leave Administration by the due date in order to initiate your disability claim.
HOLIDAYS	Immediately. Active full-time (AF) and part-time (PT) 0.5 to 1.0 FTE	New Year's Day, Good Friday, Independence Day, Labor Day, Thanksgiving Day and Christmas Day. Part-time holiday accrual rates are prorated.
BEREAVEMENT LEAVE	Immediately. Active full-time (AF) and part-time (PT) 0.5 to 1.0 FTE	Up to 3 scheduled work days (not to exceed 24 hours) paid leave for death in team member's immediate family, defined as parent, step-parent, brother, sister, spouse, dependents (including stepchildren), parent-in-law (mother-in-law, father-in-law), grandchildren, grandparent, and great grandparent.
JURY DUTY	Immediately. All employed team members.	Time off from regularly scheduled work to serve on a local, state or federal jury in response to a jury summons, and may be eligible for jury compensation.
CONTINUING EDUCATION	Immediately	As approved.
EDUCATION ASSISTANCE	See FMOLHS policy	Financial support to further education and professional development.
EMPLOYEE HEALTH SERVICES	Immediately	Free annual influenza inoculation and Hepatitis B vaccine program.
CREDIT UNION	Immediately	Regular share savings account by payroll deduction, signature loans and new and used car loans.
FRANCISCAN SERVICE AWARD	Upon nomination	Peer-based recognition of employees who exemplify core values of the organization.
FAMILY CARE BENEFIT FMOLHS.CARE.COM	Immediately	FMOLHS covers the premium membership fee to Care.com in order to provide you with care options for your family as well as discounts on care.

BENEFITS	WHEN YOU ARE ELIGIBLE	WHAT YOU RECEIVE
FAMILY & MEDICAL LEAVE	After 1yr employed & 1,250 hrs of service	Up to 12 weeks leave for certain family and medical events. Apply for all Leave status online or contact Leave Administration: 833-4uaskHR (833-482-7547)
PERSONAL LEAVE	After 6 months	Up to 4 weeks may be granted upon manager approval
MEDICAL LEAVE	Upon date of hire	Up to 12 weeks
MILITARY LEAVE	Immediately	Leave while serving in the "Uniformed Services" including voluntary and involuntary service and time spent in active duty, inactive duty training, and full time National Guard duty.
EMPLOYEE'S BLOOD DONOR PLAN	Immediately	Employee and family blood bank program. Participate by giving one unit of blood each year.
HEALTH CENTER MEMBERSHIP	Immediately	Discounts on various memberships.
WORKERS' COMPENSATION	Immediately	Medical expenses and wage replacement for on-the-job injuries/exposures as governed by state law.
ACCESS PERKS	Immediately	Allows you to save money and earn rewards just for being a team member of FMOLHS. Team Members are automatically enrolled at no cost and are eligible to receive discounts on purchases from thousands of local and national merchants.
PAY ACTIV	Immediately	Financial wellness app that gives you access to 40% of your earned but unpaid wages before your actual payday

My Discounts

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

What is Access Perks?

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

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

Contact Access Perks at 888-433-7898 or visit the website at FMOLHS.AccessPerks.com.

How do I Access the Mobile App?

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

Advance Auto Parts · AVIS · carter's babies and kids · Foot Locker.com · CINEMARK · PAPA JOHN'S BETTER PIZZA · redbox · CHOICE HOTELS · KOHL'S · Six Flags · Walt Disney World · Target

App Store · Google Play

Merchant Locations As of 5/31/2018

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

Care Discount Program

Care can be expensive – we have discounts to help. From daycare to senior living facilities, resources on parenting and more, we've got you covered.

Whether you're planning a major purchase or just want deals on day-to-day essentials, we have ways for you to save with major brands.

- Care for children, seniors and pets
- Car buying and auto services
- Fitness, wellness, legal & financial services
- Groceries, dining out, computers & electronics
- Travel, tickets, and entertainment
- Local deals near you

$125
Average child care savings per month

$263
Average senior care savings per month

Best of all? This program is free to you!

View discounts »

Care.com

My Voluntary Benefits

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

VOLUNTARY BENEFIT PLANS		
PLAN	CURRENT ENROLLEES	NEW ENROLLEES
LINCOLN VOLUNTARY EMPLOYEE LIFE	Team members currently enrolled may add $10,000 or $20,000 coverage.	Team members who are within their first 30 days of eligibility may enroll through Lawson Employee Self-Service
LINCOLN VOLUNTARY SPOUSE LIFE LINCOLN VOLUNTARY DEPENDENT LIFE	You will have an opportunity to review and maintain coverage through Lawson Employee Self-Service.	Team members who are within their first 30 days of eligibility may enroll through Lawson Employee Self-Service
VOLUNTARY ACCIDENT	Enroll in or waive coverage.	Eligible to ENROLL in coverage.
VOLUNTARY CRITICAL ILLNESS	Maintain or term current election.	Available to new hires or newly eligible team members only.

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

Eligible dependents for these plans include your legal spouse and unmarried dependent children from birth to age 21; to age 25 if a full-time student.

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

Voluntary Critical Illness – New Hires/Newly Eligible Only

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

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

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

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

VOLUNTARY CRITICAL ILLNESS COVERAGE

BENEFIT DESCRIPTION	BENEFIT AMOUNT
MAXIMUM PRINCIPAL SUM	
EMPLOYEE	$10,000
SPOUSE	$10,000
CHILD	$5,000
LINCOLN CARECOMPASS℠ CATEGORY	
CRITICAL ILLNESS ASSESSMENT BENEFIT	$75
FAMILY CARE BENEFIT (PER INSURED DEPENDENT)	$25
	PERCENTAGE OF PRINCIPAL SUM
HEART CATEGORY	
HEART ATTACK, HEART TRANSPLANT, STROKE	100%
ARTERIOSCLEROSIS, ANEURYSM	10%
	PERCENTAGE OF PRINCIPAL SUM
ORGAN CATEGORY	
END STAGE RENAL FAILURE, MAJOR ORGAN TRANSPLANT	100%
ACUTE RESPIRATORY DISTRESS SYNDROME	25%
	PERCENTAGE OF PRINCIPAL SUM
QUALITY OF LIFE CATEGORY	
ALS/LOU GEHRIG'S, ADVANCED ALZHEIMER'S, ADVANCED PARKINSON'S	100%
ADVANCED MS, LOSS OF SIGHT, HEARING OR SPEECH	25%
INVASIVE CANCER	100%
CANCER IN SITU, BENIGN BRAIN TUMOR, BONE MARROW TRANSPLANT	25%
ACCIDENT	100% of Principal Sum
LIFETIME CATEGORY MAXIMUM (CATEGORY RECURRENCE)	100%
ADDITIONAL CATEGORY OCCURRENCE	100% payable benefit
BENEFIT WAITING PERIOD	30 days
PRE-EXISTING PERIOD	
	12/12
BENEFIT REDUCTION	
	50% at age 70

Note

If you have previously elected Critical Illness coverage, you are able to maintain that coverage. If you term that coverage, you will not have the opportunity to re-enroll.

Voluntary Accident

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

Accident Insurance

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

POLICY HIGHLIGHTS

	NONSURGICAL / SURGICAL		NONSURGICAL / SURGICAL
FRACTURES			
PER FRACTURE	$50-$2,500/$100-$5,000	CHIP FRACTURES	25% benefit
DISLOCATIONS			
PER INJURY	$50-$1,200/$100-$2,400	PARTIAL DISLOCATION	25% benefit
SPECIFIC INJURIES OR TREATMENTS			
TRANSFUSIONS	$150	EYE (REMOVAL OF FOREIGN BODY) ONCE PER EYE/ACCIDENT	$100
JOINT REPLACEMENT	$1,500-$2,000	EYE (SURGICAL REPAIR) ONCE PER EYE/ACCIDENT	$300
COMA	$2,000	LACERATION	$50-$400
CONCUSSION	$100	SURGERY	$250-$1,000
DENTAL CROWN ONCE PER ACCIDENT	$150	TREATMENT OF LIGAMENTS/ TENDONS, KNEE CARTILAGE, ROTATOR CUFF, RUPTURED DISC	$300-$400
DENTAL EXTRACTION ONCE PER ACCIDENT	$50		
TRANSITIONAL CARE BENEFITS			
CRUTCHES, WHEELCHAIR, WALKER	$25-$350	REASONABLE MODIFICATIONS TO HOME OR VEHICLE	$2,500
PROSTHESIS PER LIMB/DEVICE	$500		
ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)			
ACCIDENTAL DEATH-EMPLOYEE	$30,000	LOSS OF OR LOSS OF USE OF ANY ONE FINGER, THUMB, OR TOE	$300
ACCIDENTAL DEATH-SPOUSE	$10,000		
ACCIDENTAL DEATH-CHILD	$5,000	TRANSPORTATION OF REMAINS	$5,000
LOSS OF OR LOSS OF USE OF ONE: HAND, FOOT, ARM, LEG, EYE	$7,000	SEAT BELT/HELMET AD&D BENEFIT	10% of AD&D
		CATASTROPHIC LOSS	$50,000

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

VOLUNTARY ACCIDENT COVERAGE

	SEMI-MONTHLY RATE
EMPLOYEE ONLY	$8.01
EMPLOYEE+SPOUSE	$11.21
EMPLOYEE+CHILD(REN)	$13.56
EMPLOYEE + FAMILY	$17.96
ON THE JOB ACCIDENT COVERAGE	Included

Voluntary Term Life Insurance

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

Life insurance can help:

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

Policy highlights:

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

	VOLUNTARY EMPLOYEE LIFE	VOLUNTARY SPOUSE LIFE	VOLUNTARY DEPENDENT LIFE
WHEN YOU CAN ENROLL	Team members who are within their first 30 days of eligibility may enroll through Lawson Employee Self-Service. Team members may enroll in $10,000 increments up to a maximum of $150,000. If you are currently enrolled you may enroll in an additional $10,000 or $20,000.	Team members who are within their first 30 days of eligibility may enroll through Lawson Employee Self-Service. You may maintain or term your coverage. You must be enrolled in Voluntary Employee Life in order to elect Spouse coverage. Spouse coverage amount cannot exceed the employee's elected coverage amount.	Team members who are within their first 30 days of eligibility may enroll through Lawson Employee Self-Service. You must be enrolled in Voluntary Employee Life in order to elect Dependent coverage.
COVERAGE AMOUNT	$10,000 Increments	$10,000 Increments	$10,000
MAXIMUM BENEFIT	$150,000 initial enrollment	$30,000	$10,000

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

Note

To elect a beneficiary for your Lincoln Voluntary Life products, enter a beneficiary through Lawson Employee Self Service.

Required Notices

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

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

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2022
Name of Entity/Sender:	Franciscan Missionaries of Our Lady of Health System
Contact—Position/Office:	Human Resources
Address:	PO Box 83780 Baton Rogue, LA 70884-3780
Phone Number:	833-482-7547

Women's Health and Cancer Rights Act

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

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

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

HIPAA Privacy and Security

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

HIPAA Special Enrollment Rights

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

Loss of eligibility includes but is not limited to:

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

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

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

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

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

Important Contacts

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

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

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

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

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

Vision Plan
AlwaysCare Vision
www.AlwaysCareBenefits.com
888-729-5433 ext 2013

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

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

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

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

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

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

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

Family Care Benefits
Care.com + LifeCare
FMOLHS.care.com
855-781-1303
careteam@care.com

Notes

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

- Get your questions answered?
- Review your benefit options?
- Review and update your personal information, dependents and beneficiaries in Lawson Employee Self Service?
- Enroll in core benefits – Health, Dental, Vision, Medical FSA – by November 15th?
- Enroll/Review Voluntary Benefits by November 15th?
- Click "Keep these benefits" when you have completed your enrollment in Lawson Employee Self-Service?
- Save a printed copy of your benefit elections?
- Submit dependent verification documents to askHRdocuments@fmolhs.org by November 15th?
- Designate a beneficiary for your life insurance coverages?
- If your benefit elections are properly completed and saved, you will see a message that states:
  Congratulations! Your enrollment has been successful...
  And, you will receive an enrollment confirmation at your Team Mail address.
- If you do not receive an email confirming your elections, your elections were not properly completed and you must complete the election process again.

See page 11 for details on how to access Lawson Employee Self-Service from work or home.

askHR

Help is a phone call or click away.

Reach out using the method that works best for you:

- Submit an online request* on TeamLink, by clicking the askHR link
- Email askHR@fmolhs.org
- 833-4UaskHR (833-482-7547)

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

Franciscan Missionaries of Our Lady Health System