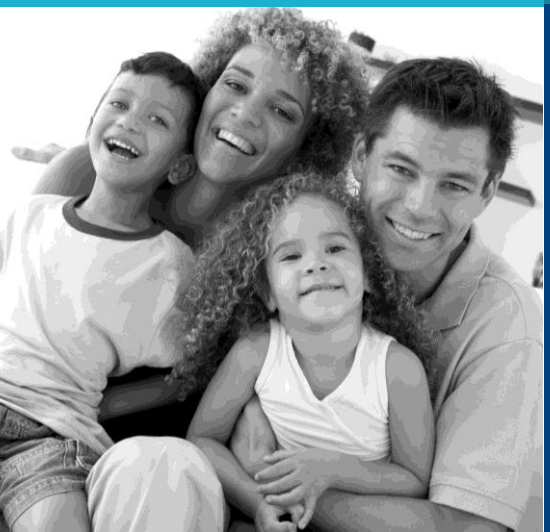
HEALTH DIMENSIONS GROUP

2023 BENEFITS GUIDE



Your Health & Wellness

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Medicare Part D
Creditable Coverage Notice

Important Notice from BlueCross and BlueShield of MN
About Your Prescription Drug Coverage and Medicare

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

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

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

2. **BlueCross and BlueShield of MN has determined that the prescription drug coverage offered by available health plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan while enrolled in BlueCross and BlueShield of MN coverage as an active employee, please note that your BlueCross and BlueShield of MN coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in BlueCross and BlueShield of MN coverage as a former employee.

You may also choose to drop your BlueCross and BlueShield of MN coverage. If you do decide to join a Medicare drug plan and drop your current BlueCross and BlueShield of MN coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with BlueCross and BlueShield of MN 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 below 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 BlueCross and BlueShield of MN changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date: 10/12/2022
Name of Entity/Sender: Health Dimensions Group
Contact--Position/Office: Tae Drake, Director of Payroll & Benefits
Address: 12900 Whitewater Drive, Minneapolis, MN 55343
Phone Number: 763-210-6721
Email: taed@hdgi1.com

WELCOME TO YOUR 2023 BENEFITS!

HDG & HDRP is pleased to provide you and your family with a wide range of competitive benefits. Your benefits are an important part of your total compensation. You have the flexibility to choose the benefits that are right for you and your family — to keep you physically and financially healthy now and in the future.

This benefits guide provides important information about your benefits and how to use them to your best advantage. Please review this information carefully, ask questions if needed, and make sure to enroll by the deadline.

ELIGIBILITY

If you are regularly scheduled to work at least 30 hours per week, you are eligible for the HDG & HDRP benefits program. For newly hired individuals, your benefits are effective the first day of the month following your hire date. You may also enroll your eligible dependents for coverage. Eligible dependents include:

- Your legal spouse;
- Children under the age of 26, regardless of student, dependency or marital status;
- Children past the age of 26 who are fully dependent on you for support due to a mental or physical disability (and are indicated as such on your federal tax return).

For details on eligibility and when your benefits begin and end, refer to your summary plan documents.

Benefits End

Your medical, dental and vision benefits end the last day of the month in which your employment ends. Your company-sponsored Life and Disability benefits end on your date of termination.

Changing Benefits After Enrollment

During the year, you cannot make changes to your medical, dental, vision, or Health Care or Dependent Care Flexible Spending Accounts unless you experience a Qualified Life Event, such as marriage or the birth of a child. If you experience a Qualified Life Event (examples below), you should contact Human Resources within 30 days of the event, or you will have to wait until the next annual open enrollment period to make changes (unless you experience another Qualified Life Event).

Qualified Life Event	Possible Documentation Needed
Change in marital status	
Marriage	Copy of marriage certificate
Divorce/Legal Separation	Copy of divorce decree
Death	Copy of death certificate
Change in number of dependents	
Birth or adoption	Copy of birth certificate or copy of legal adoption papers
Step-child	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
Death	Copy of death certificate
Change in employment	
Change in your eligibility status (i.e., full-time to part-time)	Notification of increase or reduction of hours that changes coverage status
Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

HOW TO ENROLL

Open enrollment for the 2023 plan year is 11/7/2022 – 11/18/2022. If you are a new hire, you have 30 days to enroll from your date of hire. You must complete your enrollment to receive benefit coverage for the plan year.

Before You Enroll

- Carefully review the benefits listed in this guide and determine the medical, dental, vision and other coverage that's best for you and your family.
- Ensure family members meet the eligibility requirements.
- Understand the cost of the plans you selected.
- Log in (if you have an account) or Register (new users) at https://n34.ultipro.com/Login.aspx.
- Select, review and submit your desired coverage.
- Be sure to complete beneficiary information for Life and AD&D benefits.

Check with Human Resources if you have questions.

To enroll, simply follow these steps:

- Log on to https://n34.ultipro.com/Login.aspx.
- Your username is: The first initial of your first name+your last name+Company code (e.g. John Smith=JsmithHDG or JsmithHDRP)
- If this is your first time logging in your password is your date of birth (e.g. 05/20/1984= 05201984). If you have logged in before but forgot your password please reach out and we can reset you password.

MEDICAL

HDG & HDRP's medical coverage provides you and your family the protection you need for everyday health issues or unexpected medical expenses.

How Medical Coverage Works

When you enroll in medical coverage, you pay a portion of your health care costs when you receive care and the plan pays a portion, as detailed below. Note that preventive care — like physical exams, flu shots and screenings — is always covered 100% when you use in-network providers. The key difference between the plans is the amount of money you'll pay each pay period and when you need care. The plans have different:

- **Deductibles** — the amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay a portion of the costs.
- **Copays** —a fixed amount you pay for a health care service. Copays do not count toward your annual deductible but do count toward your annual out-of-pocket maximum.
- **Coinsurances** — Once you've met your deductible, you and the plan share the cost of care, which is called coinsurance. For example, you pay 20% for services and the plan pays 80% of the cost until you reach your annual out-of-pocket maximum.
- **Out-of-pocket maximums** — the most you will pay each year for eligible in- or out-of-network services, including prescriptions. After you reach your out-of-pocket maximum, the plan pays the full cost of eligible health care services for the rest of the year.

Before You Enroll

Consider this:

1. Think about the per-pay-period cost and out-of-pocket expenses you will incur and your possible future medical expenses. The option that has the highest per-pay-period cost typically has a lower deductible, pays more and/or copays when you need care.
2. Want to stay with your doctor? Ensure they are in the plan's network by visiting the www.bluecrossmnonline.com. If they're out of network, services may not be covered or may be more expensive.
3. Consider the cost of services and prescription drugs you expect to receive during the year.
4. Evaluate how your out-of-pocket expenses may fluctuate and consider adding accident and/or critical illness insurance to help offset your out-of-pocket medical costs.

The table below summarizes the key features of the medical coverage. Please refer to the official plan documents for additional information on coverage and exclusions.

	Option 1 $1,000-$25	Option 2 $1,500-$25	Option 3 $3,000-100% HDPH	Option 4 $1,500-$25	Option 5 $3,000-100% HDHP
	Aware	Aware	Aware	High Value	High Value
	In-Network	In-Network	In-Network	In-Network	In-Network
Calendar Year Deductible					
Individual	$1,000	$1,500	$3,000	$1,500	$3,000
Family	$3,000	$4,500	$6,000	$4,500	$6,000
Calendar Year Out-of-Pocket Maximum (Includes Deductible)					
Individual	$3,000	$4,000	$3,000	$4,000	$3,000
Family	$6,000	$8,000	$6,000	$8,000	$6,000
	You pay	You pay	You pay	You pay	You pay
Coinsurance	20%	20%	0%	20%	0%
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Telemedicine	5 visits free, then $20 copay	5 visits free, then $20 copay	0% after deductible	5 visits free, then $20 copay	0% after deductible
Primary Care Physician	$25 copay	$25 copay	Deductible then 0%	$25 copay	Deductible then 0%
Specialist	$25 copay	$25 copay	Deductible then 0%	$25 copay	Deductible then 0%
Urgent Care	$25 copay	$25 copay	Deductible then 0%	$25 copay	Deductible then 0%
Emergency Room	Deductible then 20%	Deductible then 20%	Deductible then 0%	Deductible then 20%	Deductible then 0%
Lab & X-ray	Deductible then 20%	Deductible then 20%	Deductible then 0%	Deductible then 20%	Deductible then 0%
Hospitalization	Deductible then 20%	Deductible then 20%	Deductible then 0%	Deductible then 20%	Deductible then 0%
Diagnostic Imaging (MRI/CT)	Deductible then 20%	Deductible then 20%	Deductible then 0%	Deductible then 20%	Deductible then 0%
Pharmacy					
Retail Rx (up to 30-day supply)					
Tier 1	$15 copay	$15 copay	Deductible then 0%	$15 copay	Deductible then 0%
Tier 2	$50 copay	$50 copay	Deductible then 0%	$50 copay	Deductible then 0%
Tier 3	$70 copay	$70 copay	Deductible then 0%	$70 copay	Deductible then 0%
Tier 4	$120 copay	$120 copay	Deductible then 0%	$120 copay	Deductible then 0%
Specialty	20%, up to $500 per month	20%, up to $500 per month	Deductible then 0%	20%, up to $500 maximum	Deductible then 0%

The table below summarizes your per payroll deductions (24) for each of the plan options. Please refer to the official plan documents for additional information on coverage and exclusions.

	Option 1 $1,000-$25	Option 2 $1,500-$25	Option 3 $3,000-100% HDPH	Option 4 $1,500-$25	Option 5 $3,000-100% HDHP
	Aware	Aware	Aware	High Value	High Value
Medical Biweekly Payroll Deductions (24)					
Employee Only	$214.02	$188.04	$148.21	$134.00	$98.36
Employee + 1	$449.46	$394.88	$311.24	$281.41	$206.57
Employee + Family	$596.90	$514.10	$386.37	$340.72	$226.48
Monthly HSA Contributions from HDG	N/A	N/A	EE: $100 per month EE+ Dependents: $200 per month	N/A	EE: $100 per month EE+ Dependents: $200 per month

BlueCross BlueShield Minnesota

2023

AWARE® NETWORK

Open access to quality care

Your best choice for easy access to the largest selection of healthcare providers across Minnesota.

With 98 percent of doctors and 100 percent of hospitals in Minnesota, this broad, open-access network makes it easy to get the care you need. Small group plans are paired with BlueAccess℠ products.

TRAVEL WITH CONFIDENCE

When you travel outside the state, you have access to 1.7 million providers spanning every U.S. ZIP code through the national BlueCard® PPO network.* In addition, Blue Cross Blue Shield Global® Core gives you access to care in 190 countries and territories worldwide.

*The Aware Network includes providers one county into the neighboring states of Iowa, South Dakota, North Dakota and Wisconsin. When seeking care in these counties, search for providers using Aware Network (not BlueCard PPO).

Each healthcare provider is an independent contractor and not our agent. It is up to the member to confirm provider participation in their network prior to receiving services. Each Blue Cross and/or Blue Shield plan is an independent licensee of the Blue Cross and Blue Shield Association. Blue Cross Blue Shield Global Core is a registered mark of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and/or Blue Shield plans.

A NETWORK THAT FITS YOU

AWARE NETWORK

176 HOSPITALS

19,378 PRIMARY CARE PROVIDERS

43,568 SPECIALTY CARE PROVIDERS

Numbers are subject to change and are reflective of signed contracts as of June 2022.

Network matters

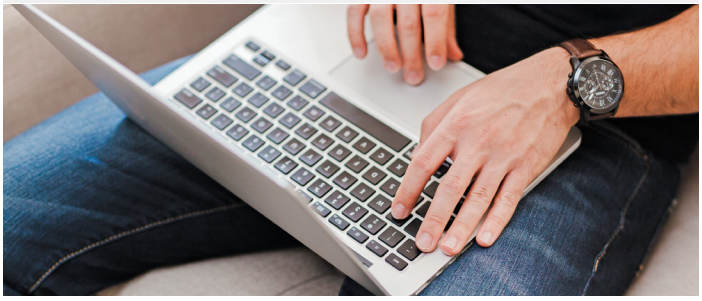
To make sure your doctor participates:

- Visit **bluecrossmn.com**
  - Click on "Find a Doctor"
  - Select "Aware Network"
  - Complete the search fields

Or call the number on the back of your member ID card.

QUESTIONS?

- Talk with your plan administrator or agent
- Visit **bluecrossmn.com/shop-plans**



Key in-network providers and hospitals

Choose from a broad selection of providers throughout Minnesota. **It's important to make sure your doctor or hospital is in the network before you receive care.**

Key providers

Allina Clinics
Alomere Health
Avera Clinics
Center for Diagnostic Imaging
Children's Clinics
Entira Clinics
Essentia Health Clinics
HealthPartners Clinics
M Health Fairview Clinics
Mayo Clinics
Minnesota Gastroenterology
Minnesota Oncology Hematology, PA Associates
North Clinic
North Memorial Health Clinics
Park Nicollet Clinics
Sanford Health Clinics
St. Luke's Clinics
St. Paul Radiology/Midwest Radiology
Summit Orthopedics
Twin Cities Orthopedics
University of Minnesota Physicians
Winona Health

Key hospitals

Abbott Northwestern Hospital
Avera Hospitals
Carris Health – Rice Memorial Hospital
Children's Hospitals
Essentia Health Hospitals
Hennepin County Medical Center
Lakeview Hospital
Maple Grove Hospital
Mayo Clinic Hospitals
Mercy Hospital
Park Nicollet Methodist Hospital
North Memorial Health Hospitals
Regions Hospital
Sanford Hospitals
St. Cloud Hospital
St. Francis Regional Medical Center
St. John's Hospital
St. Joseph's Hospital
St. Luke's Hospitals
United Hospital
University of Minnesota Medical Center
Woodwinds Hospital

Provider listings are not all-inclusive and are subject to change.

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MEDICAL

Staying In-Network

If you choose to see an out-of-network provider or pharmacy, you will still be able to use insurance, however, your costs will be *substantially* higher and your deductible and out-of-pocket maximums will be higher.

Your medical network is made up of:

- convenience care (quick) clinics
- physicians
- facilities (urgent care, emergency room)
- nurse practitioners
- specialists
- pharmacies

tip

When possible, choose urgent care facilities over the emergency room to save time and money.

When you see an in-network provider, you will:

- Have lower health care costs for medical services and prescription drugs.
- Not need to obtain pre-authorization before a procedure such as surgery, your in-network provider will handle this on your behalf.
- Not have to worry about paying for balance-billed charges and charges above the usual, reasonable, and customary.
- Not have to fill out forms to send to the insurance carrier in order to receive reimbursement, your in-network provider will handle this on your behalf.

How to find an in-network provider

- Visit BlueCross BlueShield of MN website at www.bluecrossmnonline.com
  - Click on “Find a Doctor”
  - Select “Aware” or “High Value Network”
  - Complete the search fields
- If living outside of Minnesota, change the city, state or zip code at the top.
- Call 866-873-5943 (Monday – Friday, 7am to 8pm CST)
- Check the BlueCross BlueShield of MN mobile app

HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account (HSA) is a personal savings account that you own and can use to pay for qualified out-of-pocket medical expenses. Your contributions to the HSA are taken out of your paycheck and are tax-free. Once you enroll in the HSA, you'll receive a debit card to pay for qualified out-of-pocket medical expenses. Your HSA can be used to pay for your health care expenses and those of your spouse and dependents, even if they are not covered by the High Deductible Health Plan (HDHP).

How a Health Savings Account (HSA) Works

Eligibility
Anyone who is:
- Covered by a High Deductible Health Plan (HDHP);
- Not covered under another medical plan that is not an High Deducible Health Plan (HDHP);
- Not entitled to Medicare benefits; or
- Not eligible to be claimed on another person's tax return

Your Contributions
You choose how much to contribute from each paycheck on a pretax basis.
You can contribute up to the IRS maximum of $3,850/individual or $7,750/family.
You can make an additional "catch-up" contribution of up to $1,000 per year if you are age 55 or older.

HDG & HDRP's Monthly Contribution
- $100 for employee only coverage
- $200 for employee + dependent coverage

Eligible Expenses
You can use your HSA to pay for medical, dental, vision and prescription drug expenses incurred by you and your eligible family members. *Please note: Funds available for reimbursement are limited to the balance in your HSA.*

Using Your Account
Use the debit card linked to your HSA to cover eligible expenses — or pay for expenses out of your own pocket and save your HSA dollars for future health care expenses.

Your HSA is always yours – no matter what
One of the best features of an HSA is that money left over at the end of the year remains in the account so you can use it the following year or at any time in the future. And if you leave the Company or retire, your HSA goes with you.

The Triple Tax Advantage

HSAs offer three significant tax advantages:

1. You can use your HSA funds to cover qualified medical expenses, including dental and vision expenses — tax-free.
2. Unused funds grow and can earn interest over time — tax-free.
3. You can save your HSA dollars to use for your health care when you leave HDG & HDRP or retire — tax-free.

If you want to pay less per paycheck for health care coverage and save tax-free money for future medical expenses, consider enrolling in the HDHP with HSA.

How a High Deductible Health Plan (HDHP) and a Health Savings Account (HSA) Work Together

Year 1 Example: You enroll in the HDHP with HSA during enrollment		Year 2 Example: You enroll in the HDHP plan again next year
You contribute $3,550 for a total of $3,550		$2,850 rolls over from last year and you contribute $3,550 for a total of $6,400
You use the HSA to pay $700 of eligible expenses		You use the HSA to pay $1,250 of eligible expenses
You have $2,850 in the HSA to roll over to next year!		**You have $5,150 in the HSA to roll over to next year!**

FLEXIBLE SPENDING ACCOUNTS (FSA)

Flexible Spending Accounts (FSAs) allow you to pay for eligible health care and dependent care expenses using tax-free dollars. There are three types of FSAs — the Health Care FSA, the Limited Purpose Health Care FSA and the Dependent Care FSA:

- **Health Care FSA** — Used to pay for out-of-pocket expenses associated with your medical, dental or vision plan such as copayments, coinsurance deductibles, prescription expenses, lab exams and tests, contact lenses and eyeglasses.
- **Limited Purpose Health Care FSA** — Used if you are enrolled in the HDHP medical plan. It works the same way as the standard Health Care FSA; however, you may only use it to pay for eligible vision and dental expenses.
- **Dependent Care FSA** — Used to pay for day care expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time.

You cannot use your Health Care FSA to pay for dependent care expenses, and you cannot use your dependent care FSA to pay for health care expenses.

Important: The IRS has a “use it or lose it” rule. If you do not spend all of the money in your FSA by the annual deadline, any unused dollars in your account(s) will be forfeited.

How the Health Care/Limited Purpose Health Care FSA Works	How the Dependent Care FSA Works
You may contribute up to $3,050 per year, pretax	You may contribute up to $5,000 per year, pretax, or $2,500 if married and filing separate tax returns
You receive a debit card to pay for eligible medical expenses (funds must be available in your account)	You submit claims for reimbursement; no debit cards are provided
Eligible expenses include medical copays, coinsurance, deductibles, eyeglasses and over-the-counter medications prescribed by your doctor	Can be used to pay for eligible dependent care expenses including day care, after-school programs and elder care programs
Submit claims up to March 31 of the following year for expenses from January 1 to December 31	Submit claims up to March 31 of the following year for expenses from January 1 to December 31
If you do not spend all the money in this FSA by March 31, unused dollars will be forfeited per IRS regulations	If you do not spend all the money in this FSA by March 31, unused dollars will be forfeited per IRS regulations

It’s important to note that if you participate in a Health Savings Account (HSA), you may not participate in the Health Care FSA reimbursement account.

How You Can Save on Taxes with FSAs

Here's an example of how much you can save when you use the FSAs to pay for your predictable health care and dependent care expenses.

	Health Care FSA		Dependent Care FSA	
	Without FSA	With FSA	Without FSA	With FSA
Your taxable annual income	$50,000	$50,000	$50,000	$50,000
Account deposit (before taxes)	N/A	$2,750	N/A	$5,000
Taxable wages	$50,000	$47,250	$50,000	$45,000
Federal and Social Security taxes	$14,325	$13,609	$14,325	$12,894
Expense (after taxes)	$2,750	N/A	$5,000	N/A
Take home (net)	$32,925	$33,641	$30,675	$32,106
Annual tax savings with the FSAs	$0	$716	$0	$1,431

DENTAL

Taking care of your oral health is not a luxury; it is necessary for optimal long-term health. With a focus on prevention, early diagnosis and treatment, dental coverage can greatly reduce the cost of restorative and emergency procedures. Preventive services at in-network providers are generally covered at no cost to you and include routine exams and cleanings. You pay a small deductible and coinsurance for basic and major services.

You may enroll yourself and your eligible dependents — or you may waive dental coverage. You do not have to be enrolled in medical coverage to elect a dental plan.

HDG & HDRP offers dental coverage through Delta Dental of MN. For information on finding a dental provider, visit https://www.deltadentalmn.org and click on Members then Find a Dentist.

Before You Enroll

Consider this:

1. Most in-network preventive cleanings and exams are covered at 100%.
2. You may receive dental care in- or out-of-network. However, when you go out of network, the provider can charge more and the plan will only reimburse up to the reasonable and customary rates.

The table below summarizes the key features of the dental plan. Please refer to the official plan documents for additional information on coverage and exclusions.

	Low	High
	Premier	Premier
	In-Network	In-Network
Calendar Year Deductible		
Individual	$50	$25
Family	$150	$75
Annual Plan Maximum		
Per Individual	$1,000 per individual	$2,000 per individual
	You pay	You pay
Preventive Care		
Exams, Cleanings, X-rays, Fluoride Treatments	0%	0%
Basic Services		
Fillings, Space Maintainers, Sealants, Extractions, Emergency Exams	20%	20%
Major Services		
Crowns, Inlays/Outlays, Dentures and Bridgework, Repairs, Oral Surgery, Endodontics, Periodontics, Emergency Exams	50%	50%
Orthodontia		
Children (up to 19th birthday)	N/A	50% up to $1,000 lifetime maximum
Dental Bi-weekly Payroll Deduction (24)		
Employee Only	$2.07	$5.20
Employee + 1	$3.21	$8.41
Employee + Family	$4.83	$12.90

VISION

Healthy eyes and clear vision are an important part of your overall health and quality of life. You may enroll yourself and your eligible dependents — or you may waive vision coverage. You do not have to be enrolled in medical coverage to elect a vision plan.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

HDG & HDRP offers vision coverage through EyeMed. For information on finding a vision provider, visit https://www.eyemed.com/en-us and click on Find an Eye Doctor.

	Vision Plan	
	In-Network	Out-of-Network
	You pay	Reimbursement
Cost		
Exam	$10 copay	Up to $40
Covered Services – Lenses		
Single Lenses	$25 copay	Up to $30-$70
Bifocals	$25 copay	Up to $30-$70
Trifocals	$25 copay	Up to $30-$70
Frames	$150 allowance	Up to $105
Covered Services - Contacts in lieu of Frames/Lenses		
Contacts - Medically Necessary	$150 allowance	Up to $150
Contacts - Elective	$150 allowance	Up to $150
Benefit Frequency		
Exams	Once every 12 Months	
Lenses	Once every 12 Months	
Frames	Once every 24 Months	
Contacts	Once every 12 Months	
Vision Bi-Weekly Payroll Deductions (24)		
Employee Only	$3.41	
Employee + Spouse	$6.48	
Employee + Child(ren)	$6.82	
Employee + Family	$10.03	

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Life insurance, provided by MetLife, pays a lump-sum benefit to your beneficiaries to help meet expenses in the event you pass away. Accidental death and dismemberment (AD&D) insurance pays a benefit if you die or suffer certain serious injuries as the result of a covered accident. In the case of a covered accidental injury (such as loss of sight or the loss of a limb), the benefit you receive is a percentage of the total AD&D coverage you elected based on the severity of the accidental injury.

Life / AD&D Insurance - For You		
	Life and AD&D	Voluntary Life and AD&D
Coverage Amount	$50,000	Increments of $10,000 not to exceed 5 times to your salary or $500,000.
Evidence of Insurability / Proof of Good Health	Not required.	Required if electing coverage over the Guaranteed Issue amount.
Age Reduction Schedule	Benefits reduce to 65% at age 65 then to 50% at age 70.	N/A

Guaranteed Issue (GI) and Evidence of Insurability (EOI)

Employees and spouses who elect coverage when they are first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). For Voluntary Life, any coverage over the GI amount requires an EOI form for medical underwriting approval.

Imputed Income

Under current tax laws, imputed income is the value of your basic life insurance that exceeds $50,000 and is subject to federal income, Social Security and state income taxes, if applicable. This imputed income amount will be included in your paycheck and shown on your W-2 statement.

VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

Voluntary life and AD&D insurance allow you to tailor coverage for your individual needs and provide financial protection for your beneficiaries in the event of your death or accidental serious injury.

Voluntary life insurance for you and your dependents, also provided by MetLife, can help protect your family during difficult times.

Life / AD&D Insurance - For Your Dependents			
	Employee	Spouse	Child(ren) up to age 26
Coverage Amount	Increments of $10,000 not to exceed 5 times to your salary or $500,000.	Increments of $5,000 up to $100,000 – not to exceed 50% of Employee coverage.	You can elect amounts of $1,000, $2,000, $4,000, $5,000 or $10,000 for children
Guaranteed Issue	$150,000	$30,000	N/A
Evidence of Insurability/ Proof of Good Health	Required if electing coverage over the Guaranteed Issue amount.	Required if electing coverage over the Guaranteed Issue amount.	Not required.

Before You Enroll

Consider this:

1. Typically, the right amount of coverage will depend on your age, your family situation, and any personal savings you may have.
2. It's important to understand any EOI rules that apply. If you enroll when you first become eligible, Voluntary Term Life Insurance for you and your spouse is guaranteed up to the amounts shown in the table. If you initially waive this coverage but want to enroll at a later date, you will need to provide satisfactory EOI before any coverage can take effect.
3. Think about who you want to designate as beneficiaries and make sure to name them as beneficiaries on your policy.

DISABILITY

Disability insurance can help you remain financially stable by providing a portion of your income if you become disabled and are unable to work. These benefits are provided through MetLife.

Short-Term Disability Benefits at a Glance	
Weekly Benefit	60% of weekly earnings
Weekly Maximum	$500 per week
Benefit Duration	11 weeks
Elimination Period	14 days
Pre-Existing Limitation	3/12*
**Benefits may not be paid for any condition treated within three months prior to your effective date until you have been covered under this plan for 12 months.*	

Long-Term Disability Benefits at a Glance	
Monthly Benefit	60% of monthly earnings
Monthly Maximum	$6,000 per month
Benefit Duration	to age 65 or SSNRA
Elimination Period	90 days
Pre-Existing Limitation	3/12*
**Benefits may not be paid for any condition treated within three months prior to your effective date until you have been covered under this plan for 12 months.*	

Pre-Existing Conditions

A pre-existing condition is an injury or illness for which you have received advice or treatment from a doctor within three months of the effective date of your insurance plan.

Evidence of Insurability

If you decline coverage when first eligible or if you elect coverage and wish to increase your benefit amount at a later date, Evidence of Insurability (EOI) — proof of good health — may be required before coverage is approved.

A qualifying disability is a sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training or experience.

Professional support and guidance for everyday life

Life doesn't always go as planned. And while you can't always avoid the twists and turns, you can get help to keep moving forward.

We can help you and your family, those living at home, get professional support and guidance to make life a little easier. Our Employee Assistance Program (EAP) is available to you in addition to the benefits provided with your MetLife insurance coverage. This program provides you with easy-to-use services to help with the everyday challenges of life — at no additional cost to you.

Help is always at your fingertips.

Our mobile app makes it easy for you to access and personalize educational content important to you.

Search "LifeWorks" on iTunes App Store or Google Play. Log in with the user name: **metlifeeap** and password: **eap**

Expert advice for work, life, and your well-being

The program's experienced counselors provided through LifeWorks — one of the nation's premier providers of Employee Assistance Program services — can talk to you about anything going on in your life, including:

- **Family:** Going through a divorce, caring for an elderly family member, returning to work after having a baby
- **Work:** Job relocation, building relationships with co-workers and managers, navigating through reorganization
- **Money:** Budgeting, financial guidance, retirement planning, buying or selling a home, tax issues
- **Legal Services:** Issues relating to civil, personal and family law, financial matters, real estate and estate planning
- **Identity Theft Recovery:** ID theft prevention tips and help from a financial counselor if you are victimized
- **Health:** Coping with anxiety or depression, getting the proper amount of sleep, how to kick a bad habit like smoking
- **Everyday Life:** Moving and adjusting to a new community, grieving over the loss of a loved one, military family matters, training a new pet

Convenient and confidential help when you want it, how you want it

Your program includes up to 5 phone or video consultations with licensed counselors for you and your eligible household members, per issue, per calendar year. You can call **1-888-319-7819** to speak with a counselor or schedule an appointment, 24/7/365.

When you call, just select "Employee Assistance Program" when prompted. You'll immediately be connected to a counselor.

If you're simply looking for information, the program offers easy to use educational tools and resources, online and through a mobile app. There is a chat feature so you can talk with a consultant to guide you to the information you are looking for or help you schedule an appointment with a counselor.

Log on to metlifeeap.lifeworks.com, user name: metlifeeap and password: eap

MetLife

Navigating life together

Answers to important questions

Are Employee Assistance Program services confidential?
Yes. Any personal information provided to LifeWorks stays completely confidential.*

How do I get help?
Getting professional help is just a phone call away. Simply call 1-888-319-7819 to speak with a counselor or to schedule a phone or video conference appointment. These services are available 24 hours a day, 7 days a week.

When is the right time to call?
That's up to you. Counselors are here whenever you need them —whether you simply need to talk or want guidance on something you are going through.

Is my Employee Assistance Program included with my MetLife coverage?
Yes. There is no cost to you because your employer pays for the services provided within our program. While we offer a broad range of services, there may be some assistance that's not included. You can still work with counselors for these services by arranging to pay for them directly.

Does the program have any limitations?
While we offer a broad range of services, we may not cover all services you may need. Your Employee Assistance Program does not provide:

- Inpatient or outpatient treatment for any medically treated illness
- Prescription drugs
- Treatment or services for intellectual disability or autism
- Counseling services beyond the number of sessions covered or requiring longer term intervention
- Services by counselors who are not LifeWorks providers
- Counseling required by law or a court, or paid for by Workers' Compensation

When you need some support, we're here to help.

Phone
1-888-319-7819

Web
metlifeeap.lifeworks.com
user name: metlifeeap
and password: eap

Mobile App
user name: metlifeeap
and password: eap

*MetLife and LifeWorks abide by federal and state regulations regarding duty to warn of harm to self or others. In these instances, the consultant may have a duty to intervene and report a situation to the appropriate authority.

MetLife

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166
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Accident Insurance

Coverage that helps offset costs that may not be covered under your medical plan.

Health Dimensions Consulting

Accident Insurance Benefits

With MetLife, you'll have a choice of one plan (called the "Plan) that provide payment in addition to any other insurance payment you may receive. Here are just some of the covered events/services.[1]

Benefit Type	Plan MetLife Accident Insurance Pays YOU
Injuries	
Fractures[2]	$100 – $6,000
Dislocations[2]	$100 – $6,000
Second- and Third- Degree Burns	$100 – $10,000
Concussions	$400
Cuts/Lacerations	$50 – $400
Eye Injuries	$300
Medical Services & Treatment[1]	
Ambulance	$300 – $1,000
Emergency Care	$50 – $100
Non-Emergency Care	$50
Physician Follow-Up	$75
Therapy Services (including physical therapy)	$25
Medical Testing Benefit	$200
Medical Appliances	$100 – $1,000
Inpatient Surgery	$200 – $2,000
Hospital[3] Coverage (Accident)	
Admission	$1,000 (non-ICU) – $2,000 (ICU) per accident
Confinement	$200 a day (non-ICU) — up to 31 days $400 a day (ICU) — up to 31 days
Inpatient Rehabilitation (paid per accident)	$200 a day, up to 15 days

MetLife

Accident Insurance

Benefit Type	Plan MetLife Accident Insurance Pays YOU
Accidental Death	
Employee receives 100% of amount shown, spouse receives 50% and children receive 20% of amount shown.	$50,000 $150,000 for common carrier[4]
Dismemberment, Loss & Paralysis	
Dismemberment, Loss & Paralysis	$500 - $50,000 per injury
Other Benefits	
Lodging[5] — Pays for lodging for companion — up to 31 nights per calendar year	$200 per night — up to 31 nights
Health Screening Benefit (Wellness)[6] benefit provided if the covered insured takes one of the covered screening/prevention tests	$50 **Payable 1x per calendar year**

Benefit Payment Example

Kathy's daughter, Molly, plays soccer on the varsity high school team. During a recent game, she collided with an opposing player, was knocked unconscious and taken to the local emergency room (ER) by ambulance for treatment. The ER doctor diagnosed a concussion and a broken tooth. He ordered a CT scan to check for facial fractures too, since Molly's face was very swollen. Molly was released to her primary care physician for follow-up treatment, and her dentist repaired her broken tooth with a crown. Depending on her health insurance, Kathy's out-of-pocket costs could run into hundreds of dollars to cover expenses like insurance co-payments and deductibles. MetLife Group Accident Insurance payments can be used to help cover these unexpected costs.

Covered Event[1]	Benefit Amount
Ambulance (ground)	**$300**
Emergency Care	**$100**
Physician Follow-Up ($75 x 2)	**$150**
Medical Testing	**$200**
Concussion	**$400**
Broken Tooth (repaired by crown)	**$200**
Benefits paid by MetLife Group Accident Insurance	**$1,350**

Accident Insurance

Questions & Answers

Q. Who is eligible to enroll for this accident coverage?

A. You are eligible to enroll yourself and your eligible family members![7] You need to enroll during your Enrollment Period and to be actively at work for your coverage to be effective.

Q. How do I pay for my accident coverage?

A. Premiums will be paid through payroll deduction, so you don't have to worry about writing a check or missing a payment.

Q. What happens if my employment status changes? Can I take my coverage with me?

A. Yes, you can take your coverage with you.[8] You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.

Q. Who do I call for assistance?

A. Contact a MetLife Customer Service Representative at Monday through Friday from 8:00 a.m. to 8:00 p.m., EST.

Insurance Rates

MetLife offers group rates and payroll deduction, so you don't have to worry about writing a check or missing a payment! Your employee rates are outlined below.

Accident Insurance	Bi-Weekly Cost to You
Coverage Options	**High Plan**
Employee	$4.31
Employee & Spouse	$8.20
Employee & Child(ren)	$8.93
Employee & Spouse/Child(ren)	$11.18

[1] Covered services/treatments must be the result of an accident or sickness as defined in the group policy/certificate. See your Disclosure Statement or Outline of Coverage/Disclosure Document for more details.
[2] Chip fractures are paid at 25% of Fracture Benefit and partial dislocations are paid at 25% of Dislocation Benefit.
[3] Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
[4] Common Carrier refers to airplanes, trains, buses, trolleys, subways and boats. Certain conditions apply. See your Disclosure Statement or Outline of Coverage/Disclosure Document for specific details. Be sure to review other information contained in this booklet for more details about plan benefits, monthly rates and other terms and conditions.
[5] The lodging benefit is not available in all states. It provides a benefit for a companion accompanying a covered insured while hospitalized, provided that lodging is at least 50 miles from insured's primary residence.
[6] The Health Screening Benefit is not available in all states. For Texas sitused policies and Texas residents covered under policies sitused in other states, when the Health Screening Benefit is included in an Accident-only plan, the covered screening measures are:physical exam, blood chemistry panel, complete blood count (CBC), chest x-rays, electrocardiogram (EKG), and electroencephalogram (EEG).
[7] Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas. Children may be covered to age 26. There are benefit reductions that may begin at age 65.
[8] Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

METLIFE'S ACCIDENT INSURANCE IS A LIMITED BENEFIT GROUP INSURANCE POLICY. The policy is not intended to be a substitute for medical coverage and certain states may require the insured to have medical coverage to enroll for the coverage. The policy or its provisions may vary or be unavailable in some states. There are benefit reductions that begin at age 65, if applicable. Like most group accident and health insurance policies, policies offered by MetLife may include waiting periods and contain certain exclusions, limitations and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP12-AX or contact MetLife. Benefits are underwritten by Metropolitan Life Insurance Company, New York, NY. Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details

Critical Illness Insurance

Benefits that may help cover costs such as those not covered by your medical plan.

Health Dimensions Consulting

Critical Illness Insurance

Eligible Individual	Initial Benefit	Requirements
Coverage Options		
Employee	**$5,000, $10,000, $15,000, $20,000, $25,000, $30,000**	Coverage is guaranteed provided you are actively at work. [1]
Spouse/Domestic Partner[2]	**50% of the Employee's Initial Benefit**	Coverage is guaranteed provided the employee is actively at work and the spouse/domestic partner is not subject to a medical restriction as set forth on the enrollment form and in the Certificate. [1]
Dependent Child(ren)[3]	**50% of the Employee's Initial Benefit**	Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate. [1]

Benefit Payment

Your **Initial Benefit** provides a lump-sum payment upon the first verified diagnosis of a Covered Condition. Your plan pays a Recurrence Benefit[4] for the following Covered Conditions: Heart Attack, Stroke,[5] Coronary Artery Bypass Graft,[6] Full Benefit Cancer[7] and Partial Benefit Cancer.[7] A Recurrence Benefit is only available if an Initial Benefit has been paid for the Covered Condition. There is a Benefit Suspension Period between Recurrences.

The maximum amount that you can receive through your Critical Illness Insurance plan is called the **Total Benefit** and is 3 times the amount of your Initial Benefit. This means that you can receive multiple Initial Benefit and Recurrence Benefit payments until you reach the maximum of 300% or $15,000 or $30,000 or $45,000 or $60,000 or $75,000 0r $90,000.

Please refer to the table below for the percentage benefit amount for each Covered Condition.

Covered Conditions	Initial Benefit	Recurrence Benefit
Full Benefit Cancer	100% of Initial Benefit	50% of Initial Benefit
Partial Benefit Cancer	25% of Initial Benefit	12.5% of Initial Benefit
Heart Attack	100% of Initial Benefit	50% of Initial Benefit
Stroke	100% of Initial Benefit	50% of Initial Benefit
Coronary Artery Bypass Graft	100% of Initial Benefit	50% of Initial Benefit
Kidney Failure	100% of Initial Benefit	Not applicable
Alzheimer's Disease[8]	100% of Initial Benefit	Not applicable
Major Organ Transplant Benefit	100% of Initial Benefit	Not applicable
22 Listed Conditions	25% of Initial Benefit	Not applicable

MetLife

Critical Illness Insurance

22 Listed Conditions

MetLife Critical Illness Insurance will pay 25% of the Initial Benefit Amount when a covered person is diagnosed with one of the 22 Listed Conditions. A Covered Person may only receive one benefit payment for one Listed Condition in his/her lifetime. The Listed Conditions are Addison's disease (adrenal hypofunction); amyotrophic lateral sclerosis (Lou Gehrig's disease); cerebrospinal meningitis (bacterial); cerebral palsy; cystic fibrosis; diphtheria; encephalitis; Huntington's disease (Huntington's chorea); Legionnaire's disease; malaria; multiple sclerosis (definitive diagnosis); muscular dystrophy; myasthenia gravis; necrotizing fasciitis; osteomyelitis; poliomyelitis; rabies; sickle cell anemia (excluding sickle cell trait); systemic lupus erythematosus (SLE); systemic sclerosis (scleroderma); tetanus; and tuberculosis.

Example of Initial & Recurrence Benefit Payments

The example below illustrates an employee who elected an Initial Benefit of $30,000 and has a Total Benefit of 3 times the Initial Benefit Amount or $90,000.

Illness – Covered Condition	Payment	Total Benefit Remaining
Heart Attack — first verified diagnosis	Initial Benefit payment of $30,000 or 100%	$60,000
Heart Attack — second verified diagnosis, two years later	Recurrence Benefit payment of $15,000 or 50%	$45,000
Kidney Failure — first verified diagnosis, three years later	Initial Benefit payment of $30,000 or 100%	$15,000

This example is for illustrative purposes only. The MetLife Critical Illness Insurance Policy and Certificate are the governing documents with respect to all matters of insurance, including coverage for specific illnesses. The specific facts of each claim must be evaluated in conjunction with the provisions of the applicable Policy and Certificate to determine coverage in each individual case.

In most states there is a preexisting condition limitation. If advice, treatment or care was sought, recommended, prescribed or received during the three months prior to the effective date of coverage, we will not pay benefits if the covered condition occurs during the first six months of coverage. The preexisting condition limitation does not apply to heart attack or stroke.

Supplemental Benefits

MetLife provides coverage for the Supplemental Benefits listed below. This coverage would be in addition to the Total Benefit Amount payable for the previously mentioned Covered Conditions.

Health Screening Benefit[9]

MetLife will provide an annual benefit of $50 per calendar year for taking one of the eligible screening/prevention measures. MetLife will pay only one health screening benefit per covered person per calendar year.

Critical Illness Insurance

Questions & Answers

Q. How do I enroll?

A. Enroll for coverage at mybenefits.metlife.com

Q. Who is eligible to enroll?

A. Regular active full-time employees who are actively at work along with their spouse/domestic partner and dependent children can enroll for MetLife Critical Illness Insurance coverage.[1]

Q. How do I pay for coverage?

A. Coverage is paid through payroll deduction.

Q. What is the coverage effective date?

A. The coverage effective date is 01/01/2020.

Q. If I Leave the Company, Can I Keep My Coverage?[10]

A. Under certain circumstances, you can take your coverage with you if you leave. You must make a request in writing within a specified period after you leave your employer. You must also continue to pay premiums to keep the coverage in force.

Q. Who do I call for assistance?

A. Contact a MetLife Customer Service Representative at 1 800-GET-MET8 (1-800-438-6388), *Monday through Friday from 8:00 a.m. to 8:00 p.m., EST.*

Insurance Rates

MetLife offers group rates and payroll deductions, so you don't have to worry about writing a check or missing a payment! Your employee rates are outlined below.

Semi-Monthly Premium for $1,000 of Coverage

Attained Age	Employee Only	Employee + Spouse	Employee + Children	Employee + Spouse + Children
<25	$0.34	$0.59	$0.58	$0.83
25 - 29	$0.35	$0.62	$0.59	$0.86
30 - 34	$0.42	$0.71	$0.66	$0.95
35 - 39	$0.46	$0.78	$0.70	$1.02
40 - 44	$0.50	$0.86	$0.74	$1.10
45 - 49	$0.66	$1.12	$0.90	$1.36
50 - 54	$0.88	$1.48	$1.12	$1.72
55 - 59	$1.16	$1.96	$1.40	$2.20
60 - 64	$1.51	$2.55	$1.75	$2.79
64 - 69	$2.02	$3.42	$2.26	$3.66
70+	$2.93	$4.88	$3.17	$5.12

Rates are based on 5-year age bands and will increase when a Covered Person reaches a new age band. Rates are subject to change. Please refer to the Disclosure Statement or Outline of Coverage/Disclosure Document for more information including the exclusions and limitations which apply to coverage.

Pet insurance from Nationwide®

With two budget-friendly options, there's never been a better time to protect your pet.

Our popular My Pet Protection® pet insurance plans now feature more choices and more flexibility

- **Get cash back on eligible vet bills:** Choose your reimbursement level of 50% or 70%[1]
- **Available exclusively for employees:** Plans with preferred pricing only offered through your company
- **Use any vet, anywhere:** No networks, no pre-approvals

Choose your level of coverage with My Pet Protection®

50% reimbursement

$20-$35/month[2]

70% reimbursement

$27-$47/month[2]

How to use your pet insurance plan

1 Visit any vet, anywhere.

2 Submit claim.

3 Get reimbursed.

Get a fast, no-obligation quote today at **PetsNationwide.com**

[1]Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions. Reimbursement options may not be available in all states. [2]Starting prices indicated. Final cost varies according to plan, species and ZIP code.

Nationwide®

Nationwide® pet insurance

My Pet Protection® plan summary

Nationwide pet insurance helps you cover veterinary expenses so you can provide your pets with the best care possible without worrying about the cost. Simply pay for coverage through a convenient after-tax payroll deduction.

My Pet Protection coverage highlights

We offer a choice of reimbursement options so you can find coverage that fits your budget. All plans have a $250 annual deductible and $7,500 maximum annual benefit. Coverage includes*:

- Accidents
- Illnesses
- Hereditary and congenital conditions
- Cancer
- Dental diseases
- Behavioral treatments
- Rx therapeutic diets and supplements
- And more

Plus, every My Pet Protection policy includes these additional benefits to maximize your value:

- Lost pet advertising and reward expense
- Emergency boarding
- Loss due to theft
- Mortality benefit

Included with every policy

vethelpline®

- 24/7 access to veterinary experts ($110 value)
- Available via phone, chat and email
- Unlimited help for everything from general pet questions to identifying urgent care needs

PetRxExpress℠

- Save time and money by filling pet prescriptions at participating in-store retail pharmacies across the U.S.
- Rx claims submitted directly to Nationwide
- More than 4,700 pharmacy locations

Additional highlights

- Exclusive product for employer groups only
- Preferred pricing for employees
- Multiple-pet discounts
- Guaranteed issuance

Get a fast, no-obligation quote today.

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*Some exclusions may apply. Certain coverages may be excluded due to pre-existing conditions. See policy documents for a complete list of exclusions.

Nationwide®

PLANNING FOR RETIREMENT

When you are ready to retire, will your finances be ready too? What you save today for retirement helps determine how comfortably you can live in the future.

The HDG & HDRP 401(k) Retirement Plan helps you save automatically by deducting the amount you choose from each paycheck on a pre-tax basis and depositing it into your own retirement account.

To help you reach your retirement goals, HDG & HDRP offers the Safe Harbor basic-tiered match. This match allows an employee to receive 100% of their salary deferral percentage up to 3% and then an additional 50% of their additional salary deferral percentages up to 5%. The maximum employer match is 4% when employees contribute 5% into the retirement plan.

Employee Contribution	Employer Match
1%	1%
2%	2%
3%	3%
4%	3.5%
5%	4%

tip

HDG & HDRP provides an employer match of 4% when you contribute 5% into the retirement plan

As a New Hire…

As a new hire of HDG & HDRP, you will be eligible to participate in the 401K plan the 1st of the month following 60 days of employment.

A 401K enrollment packet will be mailed to your home from our plan administrator, FuturePlan. This packet will provide you plan information including your online enrollment instructions and the pin required for enrollment. If you do not receive this packet within 60 days of employment, please see Human Resources.

HOLIDAYS & PAID TIME OFF

Paid Time Off

Paid Time Off (PTO) is provided to full-time and part-time employees (regularly scheduled for 20 or more hours a week). PTO can be used for vacations, holidays, personal time or illness.

Years of Service	PTO Earned per Hour	Annual Accrual
0 to 3 years	0.0923	192 hours
3 to 5 years	0.1115	232 hours
5+ years	0.1308	272 hours

Holidays

HDG & HDRP recognizes a core set of commonly observed holidays, during which the corporate office will be closed. If an employee wants to be paid for taking off an official holiday, the hours are to be counted as paid time off (PTO).

Holiday
Martin Luther King Day
Good Friday
Memorial Day
Independence Day
Labor Day
Thanksgiving Day
The day after Thanksgiving
Christmas Eve
Christmas Day
New Year's Day

IMPORTANT CONTACTS

Coverage	Administrator	Contact	
Medical	BlueCross and BlueShield of MN	651-662-8000	www.bluecrossmnonline.com
Health Spending Account	Benefit Extras	952-435-6858	www.benefitextras.com
Flexible Spending Accounts	Benefit Extras	952-435-6858	www.benefitextras.com
Dental	Delta Dental of MN	800-448-3815	www.deltadentalmn.org
Vision	EyeMed	866-723-0513	www.eyemedvisioncare.com
Life and AD&D	MetLife	800-438-6388	www.metlife.com
Disability	MetLife	800-438-6388	www.metlife.com
Accident Insurance	MetLife	800-438-6388	www.metlife.com
Critical Illness Insurance	MetLife	800-438-6388	www.metlife.com
401(k) Retirement	Empower Retirement	855-756-4738 TTY 800-482-5472	www.empower-retirement.com/participant
Pet Insurance	Nationwide	877-738-7874	www.petinsurance.com/healthdimensionsgroup

GLOSSARY

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing)

Annual Maximum Benefit: A cap on the benefits your insurance company will pay in a year while you’re enrolled in a particular benefit plan. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Balance Billing: When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A provider who balance bills is typically known as an out-of-network provider. An in-network provider cannot balance bill you for covered services.

Coinsurance: The percentage of costs of a covered health care service you pay (20%, for example) after you’ve paid your deductible.

Copayment (copay): A fixed amount ($20, for example) you pay for a covered health care service after you’ve paid your deductible. Copays can vary for different services within the same plan, like drugs, lab tests, and visits to specialists.

Deductible: The amount you pay for covered health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. After you pay your deductible, you usually pay only a copayment or coinsurance
for covered services. Your insurance company pays the rest. Your deductible starts over each plan year.

Guarantee Issue Amount: The amount of coverage you can be automatically approved for. If you apply for more coverage than the guarantee issue amount, you will have to complete an Evidence of Insurability form and be approved for your coverage amount. Usually only available at your first enrollment opportunity.

In-Network: Providers who contract with your insurance carrier. In-network coinsurance and copayments usually cost you less than out-of-network providers.

Out-of-Network: Providers who don’t contract with your insurance carrier. Out-of-network coinsurance and copayments usually costs you more than in-network coinsurance. In addition, you may be responsible for anything above the allowed amount (see Balance Billing).

Out-of-Pocket Maximum: The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your plan pays 100% of the costs of covered benefits. The out-of-pocket limit doesn’t include your monthly premiums. It also doesn’t include anything you may spend for services your plan doesn’t cover.

Prescription Drug Formulary: A list of prescription drugs covered by a prescription drug plan. Also called a drug list.

Prior Authorization: Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Preventive Care: Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

APPENDIX – IMPORTANT NOTICES

HIPAA Special Enrollment Rights Notice

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

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

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

HIPAA Notice of Availability of Notice of Privacy Practices

The Health Dimensions Group, LLC Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resource.

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator for more information.

Newborns' And Mothers' Health Protection Act (NMHPA) Notice

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740 TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345,ext 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT – Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone:1-800-432-5924 CHIP Phone:1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

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

Your Rights and Protections Against Surprise Medical Bills

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

What is “balance billing” (sometimes called “surprise billing”)?

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

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You **can’t** be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

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

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

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

If you believe you've been wrongly billed, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to learn more about protections from surprise medical bills and for contact information for the state department of insurance or other similar agency/resource in your state to learn if you have any rights under applicable state law. Please click on your state in the map for contact information to appear.

MarshMcLennan Agency