2021 EMPLOYEE BENEFITS HANDBOOK

Welcome to the 2021 Benefits Open Enrollment

The Fond Du Lac annual insurance open enrollment period is about to begin.

We recognize the importance of benefits within the overall compensation package provided to all of our eligible employees. This year when we reviewed our employee benefits options, we focused not only on providing quality medical plans but also on controlling the cost and financial risk for our employees. We offer multiple options to meet the individual needs of our employees and their dependents.

Open Enrollment runs

October 15, 2020 - November 16, 2020

Employees who are making changes MUST complete the appropriate forms:

- ⇒ Enroll / Cancel / Make changes to your current **Medical**, **Dental** or **Voluntary** coverages
- ⇒ Make your annual elections for **Flexible Spending Accounts and Transportation Benefits**
- ⇒ Review / Update you life insurance **beneficiaries**

ALL paperwork must be returned to Benefits by 4:00 PM on Monday, November, 16, 2020!

IMPORTANT REMINDERS

The annual enrollment period is the only time you are able to change benefit plans or add/drop dependents during a plan year, unless you experience a qualifying family status change. Such changes include birth, marriage, divorce, adoption, or loss of other qualifying coverage. Please remember, if you do experience a qualifying event or change in status, you must notify Insurance Services within **30 days** of the event to be eligible to make changes to your elections.

Be sure to review your January pay stubs - it is your responsibility to ensure that the deductions for your benefit elections are correct. If you find a discrepancy, notify Insurance Services immediately.

Open Enrollment is a great time to review your life insurance beneficiary information to ensure your beneficiaries are up-to-date!

This guide describes your employee benefit offerings for **January 2021 through December 2021**.

2021 BENEFITS AT A GLANCE

- Medical Plan Options with PreferredOne:
  - ►Low Deductible Plan
  - ►High Deductible Plan
- Savings Accounts with Compensation Consultants
  - ►Flexible Spending Accounts (FSA)
  - ►Transportation Benefits
- Dental Plan with Delta Dental of Minnesota
- Ancillary Benefits with Cigna
  - ► Basic Life / AD&D
  - ► Additional Life / AD&D
  - ► Long Term Disability
  - ► Short Term Disability
  - ► Voluntary Benefits
- Retirement Solutions with Transamerica
- Employee Assistance Programs (EAP) with NuVantage and Cigna

Need More Open Enrollment Information???

Watch the Fond du Lac 2021 Open Enrollment Presentation!

CONTACT INFORMATION

If you have any questions regarding your benefits, please contact Benefit Carriers or your Fond Du Lac Human Resources representative listed below:

MEDICAL

PREFERREDONE
WWW.PREFERREDONE.COM
1-800-997-1750
POLICY: PKA20381

PHARMACY

CVS CAREMARK / EMPLOYERS HEALTH
WWW.CAREMARK.COM
1-855-337-9424

DENTAL

DELTA DENTAL OF MINNESOTA
WWW.DELTADENTALMN.ORG
1-800-553-9536
POLICY: 448428

BASIC LIFE AND AD&D, OPTIONAL LIFE AND AD&D, SHORT-TERM DISABILITY, LONG-TERM DISABILITY & VOLUNTARY BENEFITS

CIGNA
WWW.CIGNA.COM
1-800-362-4462
BASIC LIFE/AD&D POLICY: FLX967005
OPTIONAL LIFE/AD&D POLICY: OK968516
LONG TERM DISABILITY POLICY: FLK960897
SHORT TERM DISABILITY POLICY: VDT961995

FLEXIBLE SPENDING ACCOUNTS & TRANSPORTATION BENEFITS

COMPENSATION CONSULTANTS
WWW.CCFLEX.COM
218-879-6725

EMPLOYEE ASSISTANCE PROGRAM

NUVANTAGE
WWW.LSSMN.COM/NUVANTAGE
1-800-577-4727

YOUR BENEFITS TEAM

FOND DU LAC INSURANCE SERVICES
WWW.FDLREZ.COM
218-878-8021

Throughout this booklet you will find video and link icons that will take you to resources that provide additional information on the benefits available to you.

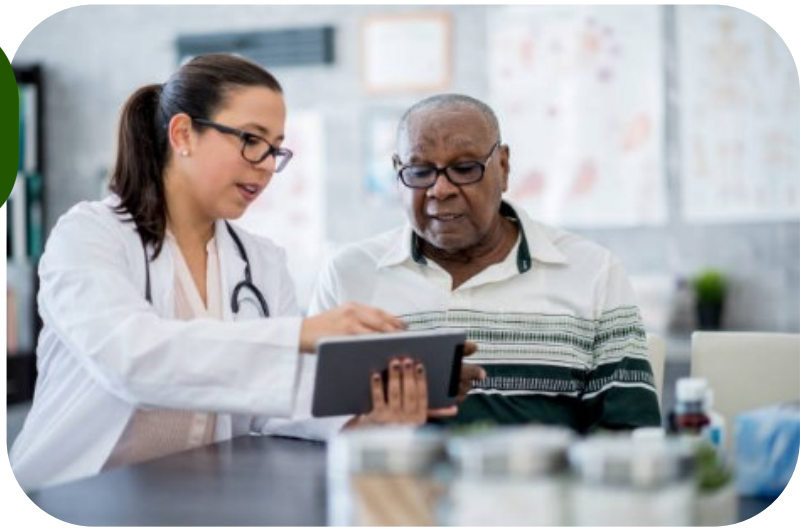
TABLE OF CONTENTS

Special Note:

The purpose of this book is to describe the highlights of your benefit program. Your specific rights to benefits under the plans are governed solely, and in every respect, by the official plan documents and insurance contracts and not by this book. If there is any discrepancy between the descriptions of the plans as described in this material and the official plan documents, the language of the documents shall govern. The employer also reserves the rights to revise, modify or terminate the plans at any time following our legal obligations.

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.

MEDICAL INSURANCE



HOW TO GET STARTED

1 SELECT YOUR MEDICAL PLAN

- ☐ **OPTION 1: Low Deductible Plan**
- ☐ **OPTION 2: High Deductible Plan**

TIP: Get the most out of your insurance by using in-network providers.

FREQUENTLY ASKED QUESTIONS

? How many hours do I need to work to be eligible for insurance benefits?

You must be a full-time employee working a minimum of 30 hours per week on a regular basis.

? Will I receive a new Medical ID card?

You will receive an ID card in the mail if you are electing medical coverage.

? Does the deductible run on a calendar year or policy year basis?

A calendar year basis.

? How long can I cover my dependent children?

Dependent children are eligible until the end of the month in which they turn age 26.

? I just got hired. When will my benefits become effective?

Your medical insurance benefit will begin after completing 90 days of employment for regular full-time employees.

YOUR HEALTH PLAN OPTIONS

All full-time employees working 30+ hours per week are eligible the day after completing 90 days of employment. Eligible dependents include your spouse and dependent children to age 26.

When enrolling in a medical plan, you will need to make two important decisions:

Step One: Pick Your Plan

You have a two plan design options to choose from:

1. **Low Plan - $1,000 Single / $2,000 Family Deductible**
2. **High Plan - $3,000 Single / $6,000 Family Deductible**

Step Two: Pick your Network

Once you select your plan, you pick which PreferredOne network best fits your needs from three options:

1. **Open Access Network** – PreferredOne's largest open access network
2. **Wilderness Health Network** – includes 10 hospitals, 35 clinics, and more than 10,000 doctors and health care professionals across Northern Minnesota. Wilderness Health includes the following health care systems: St Luke's, Community Memorial Hospital - Cloquet, Bay Area Medical Clinic, Center for America Indian Resources, Duluth Family Practice Center, Lake Superior Community Health Center – Duluth, Min No Aya Win Clinic, UMD Health Services, and more
3. **Preferred Health Network** – includes Fairview, HealthEast, and North Memorial health care systems

The Wilderness Health and Preferred Health options offer a smaller provider network, while still covering a large number of facilities and physicians. Because of this, the monthly premium cost for these two networks is less expensive than the larger open-access network. No referrals are needed when visiting an in-network provider. Visit www.preferredone.com/find-a-doctor to find in-network providers.

Note: If you are currently in or will be moving to the **Wilderness Health Network** in the upcoming plan year you **MUST** complete the Authorization form included at the end of this book. If you completed the form in the prior year you will not need to complete the form again.

▶ Medical Plans Explained

Medical Insurance Plan Options and Costs

PreferredOne	Low Deductible Plan		High Deductible Plan	
	Employee Cost Per Paycheck		Employee Cost Per Paycheck	
Open Access Network Rates				
Employee Family	$173.50 $307.50		$120.00 $254.00	
Wilderness Health and Preferred Health Network Rates				
Employee Family	$53.50 $187.50		$0 $134.00	
	In-Network	**Out of Network**	**In-Network**	**Out of Network**
Deductible (calendar year) Individual / Family	$1,000 / $2,000		$3,000 / $6,000	
Coinsurance (Member Pays)	20%	40%	20%	40%
Out-of-Pocket Maximum Individual / Family *(includes deductible, coinsurance & copays)*	$2,400 / $4,800		$4,500 / $9,000	
Office Visit Primary Care Physician / Specialist	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Preventive Care	Covered at 100%	40% after deductible	Covered at100%	40% after deductible
Urgent Care	$35 copay, then 20%	$35 copay, then 40%	20% after deductible	40% after deductible
Emergency Room	$100 copay, then 20%		20% after deductible	
Outpatient Surgery	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Inpatient Hospital Services	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Prescription Drug Retail *(at participating pharmacies)* Generic Preferred Brand Non-Preferred Specialty Drugs Mail Order *(90-day supply)* Generic Preferred Brand Non-Preferred	 $10 copay Greater of $25 or 20% Greater of $40 or 20% Greater of $40 or 20% $20 copay Greater of $50 or 20% Greater of $80 or 20%		 $10 copay Greater of $25 or 20% Greater of $40 or 20% Greater of $40 or 20% $20 copay Greater of $50 or 20% Greater of $80 or 20%	

Medical premiums are deducted from your paycheck on a pre-tax basis.

This is only a summary, review your Summary of Benefits & Coverages (SBC) or contact PreferredOne for additional information.

Care Options

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting **www.preferredone.com**.

PRIMARY CARE

- Routine, primary/ preventive care
- Non-urgent treatment
- Chronic Disease Management

VIRTUAL CARE

- Cold/flu
- Diarrhea
- Fever
- Rash
- Sinus Problems

CONVENIENCE CARE

- Common infections (Ear infections, pink eye, strep throat & Bronchitis)
- Flu shots
- Pregnancy tests
- Vaccines
- Rashes
- Screenings

URGENT CARE

- Sprains
- Small cuts
- Strains
- Sore throats
- Minor infections
- Mild Asthma Attacks
- Back Pain or strains

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 911, even if your symptoms are not described here.

CALL 9-1-1

PRIMARY CARE

For routine, primary/ preventive care or non-urgent treatment, we recommend going to your doctor's office. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out of pocket.

VIRTUAL CARE

Virtual care allows you to receive care from your mobile device or computer without an appointment, anytime and anywhere 24/7. Virtuwell, OnCare & MDLive are available through PreferredOne to bring you care from the comfort and convenience of your home or wherever you are. See **Page 7** for more details.

CONVENIENCE CARE

These providers are a good alternative when you are not able to get to your doctor's office and your condition is not urgent or an emergency.

They are often located in malls or retail stores (such as CVS Caremark, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary. Outside regular office hours—or if you can't be seen by your doctor immediately—you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster and at a lower out of pocket cost than at an emergency room.

EMERGENCY ROOM

An emergency medical condition is any condition (including severe pain) which you believe that, without immediate medical care, may result in serious injury or is life threatening.

Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in- network facility once your condition has been stabilized.

Primary Care vs. Urgent Care vs. ER

ADDITIONAL PROGRAMS AND RESOURCES WITH PREFERREDONE

MEMBER DISCOUNT PROGRAM

PreferredOne's has partnered with a variety of organizations to provide discounted programs and services to help you on the road to better health. Enjoy discounts, rewards and perks on thousands of the brands you love in a variety of categories:

- ⇒ Travel
- ⇒ Auto
- ⇒ Electronics
- ⇒ Apparel
- ⇒ Local deals
- ⇒ Education
- ⇒ Entertainment
- ⇒ Restaurants
- ⇒ Health & Wellness
- ⇒ Beauty & Spa
- ⇒ Tickets
- ⇒ Sports & Education

ONLINE VISITS

PreferredOne partners with the following online providers:

- ✓Virtuwell—**www.virtuwell.com**
- ✓OnCare—**www.oncare.org**
- ✓MDLive—**www.mdlive.com**

Available 24 hours a day / 7 days a week, online visits are a great alternative to primary and urgent care visits. Best of all online visits are fast, convenient and less expensive!!!

Conditions commonly treated through an online visit:

- Bladder infection/ urinary tract infection
- Bronchitis
- Cold/flu
- Diarrhea
- Fever
- Migraine/ headaches
- Pink eye
- Rash
- Sinus problems
- Sore throat

HEALTHY MOM & BABY

Expecting mothers receive free maternity support through a PreferredOne nurse, as well as pregnancy manuals when you enroll. Participants who complete the program will receive a $25 gift card.

PREFERREDONE EMPLOYEE PORTAL

PreferredOne.com is your personalized member website to help you access and manage your medical plan information 24/7. The website allows you to:

- Quick access to ID Cads
- Monitor health plan account balances
- Verify coverage information
- Locate and research network providers and facilities
- Compare the cost of your care

MEDICAL COST COMPARISON TOOLS

PreferredOne's medical cost tools allow you to compare the costs between different clinics, facilities, and imaging centers to help you find the lowest cost providers in your area. The "reprice my claims" tool allows you to see what your medical costs would have been had you received care from a different provider.

QUIT FOR LIFE PROGRAM

PreferredOne partners with Quit for Life to provide a tobacco cessation program for members. The program is telephonic (1-866-784-8454) and web (**www.quitnow.net**) based. The program provides expert coaches who will support you through the process 24/7 (excluding holidays).

How to Stretch Your Healthcare Dollars

CVS CAREMARK
PHARMACY BENEFIT MANAGER

Prescription Drug Benefits Overview

ACCESS IN THE PALM OF YOUR HAND

Now you can manage your prescription benefits anytime, anywhere. Download the CVS Caremark app for on- the-go access to helpful tools and resources. Easily refill your prescriptions, view your pharmacy ID details, fill new prescriptions, locate an in-network pharmacy, and so much more. Register today at Caremark.com/mobile or download on Google Play and iOS App Store.

Download on the App Store

Get it on Google play

NO-COST DIABETES ACCU-CHECK BLOOD GLUCOSE METER

To qualify for this offer you must be enrolled in the prescription benefit plan, have diabetes, and have a valid prescription for Accu-Check blood glucose test strips. If you don't already have a prescription for blood glucose test strips, we may be able to help get one from your doctor.

- To learn more about this offer contact the CVS Caremark Member Services Diabetic Meter Team at 1-800-588-4456
- For tools and resources to help you manage your diabetes, visit Caremark.com/managingdiabetes.

SPECIALTY MEDICATIONS

If you have a complex or chronic condition (such as rheumatoid arthritis, multiple sclerosis or psoriasis) then you need to obtain your prescription through our specialty pharmacy. **CVS Specialty** offers more than just medication. We're specialists in medications that treat your condition and that expertise allows us to get you the medication you need, along with personalized, clinical support. Highlights of CVS Specialty:

⇒ **Specialized support:** You'll have a dedicated CareTeam led by a pharmacist and nurse who are specialists in your condition. They can help with everything from getting started and managing side effects to injection training or finding financial assistance. This support is what will help you safely and effectively stay on track with your therapy.

⇒ **Convenient choices:** We're the only specialty pharmacy that lets you choose how you get your medication:

- You can pick it up at any CVS Pharmacy (including those inside Target stores), OR
- Have it delivered by mail anywhere that's convenient – even your doctor's office.

⇒ **Digital tools:** You'll be able to manage your medications and more at CVSspecialty.com and with the CVS Specialty mobile app.

- Order refills and track orders
- Set medication and treatment reminders
- Securely message your CareTeam
- Manage payments

How to Manage Your Prescription Drug Cost

FLEXIBLE SPENDING ACCOUNTS

2 SELECT FSA ACCOUNTS

- ☐ **Health Care Flexible Spending Account**
- ☐ **Dependent Care Expense Account**

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

This account enables you to pay medical, dental, vision, and prescription drug expenses that may or may not be covered under your insurance program (or your spouse's) with pre-tax dollars. You can also pay for dependent health care, even if you choose single (vs. family) coverage. The total amount of your annual election is available to you up front, reducing the chance of having a large out-of-pocket expense early in the plan year. Be aware—any unused portion of the account at the end of the plan year is forfeited.

Eligible Expenses Examples

- Coinsurance and copayments
- Contraceptives
- Crutches
- Dental expenses
- Dentures
- Diagnostic expenses
- Eyeglasses, including exam fee
- Handicapped care and support
- Nutrition counseling
- Hearing devices and batteries
- Hospital bills
- Deductible Amounts
- Laboratory fees
- Licensed practical nurses
- Orthodontia
- Orthopedic shoes
- Oxygen
- Prescription drugs
- Psychiatric care
- Psychologist expenses
- Routine physical
- Seeing-eye dog expenses

Prescribed vitamin supplements (medically necessary)

Full list of Eligible Examples

How the Health Care Flexible Spending Account Works

When you have out-of-pocket expenses (such as copayments and deductibles), you can either use your FSA debit card to pay for these expenses at qualified providers or submit an FSA claim form with your receipt to Fond DU Lac Reimbursement is issued to you through direct deposit into your bank account, or if you prefer, a check can be issued to you.

What is a Flexible Spending Account?

2020 Maximum Contributions

Health Care Flexible Spending Account	$2,750 max
Dependent Care Expense Account	$5,000 max

DEPENDENT CARE EXPENSE ACCOUNT

This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Care centers which qualify include dependent care centers, preschool educational institutions, and qualified individuals (as long as the caregiver is not a family member and reports income for tax purposes). Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

TRANSPORTATION BENEFITS

This program lets you set aside funds from your paycheck on a pre-tax basis to pay for qualified transportation expenses. There are two types of qualified expenses:

Parking Expenses • Parking Ramps & Lots	**Max reimbursement: $265/month**
Transit Expenses • Mass transit expenses—buses	**Max reimbursement: $265/month**

You may change your election monthly, but must do so before the month begins so that your change is effective. There is no use-it-or-lose-it, your funds will roll over from month to month and year to year. You must file for reimbursement within 6 months of the expense being incurred. You must complete an enrollment form to change your election.

Contact Information

Request a full statement of your accounts at any time by calling 218-879-6725, or log on to www.ccflex.com to review your FSA balance.

DENTAL INSURANCE

3 REVIEW YOUR DENTAL PLAN

DELTA DENTAL OF MN IS THE DENTAL CARRIER FOR 2020.

All full-time employees working 30+ hours per week are eligible the day after completing 90 days of employment. Eligible dependents include your spouse and dependent children to age 26.

Your plan utilizes the Delta Dental PPO and Premier Networks. You can choose to see a dentist in either Delta Dental network, but you will incur lower out-of-pocket expenses by choosing a dentist in the PPO network.

FIND A DENTIST

To find a Delta Dental of MN provider in your area, visit the website at www.deltadentalmn.org and click "Find a Dentist".

In-Network Providers: Provider is reimbursed based on contracted fees and cannot balance bill you.

Out-of-Network Providers: Provider is reimbursed based on Reasonable and Customary standards and balance billing is possible.

What is Dental Insurance?

Delta Dental of MN	Employee Cost Per Paycheck			
Single Family	$0 $25			
	Delta Dental PPO	Delta Dental Premier	Out-of-Network	
Deductible	$25 / person	$25 / person	$25 / person	Applied to Type B & C Services
Annual Maximum	$1,500	$1,500	$1,500	Applied to Type A, B & C Services
	Carrier Pays			
Diagnostics/ Preventive Services	Carrier pays 100%	Carrier pays 100%	Carrier pays 100%	• Oral examinations • Bitewing X-rays • Fluoride treatments • Sealants • Prophylaxis: cleanings
Basic Services	Deductible then 20%	Deductible then 20%	Deductible then 20%	• Fillings • Restorations • Endodontic Therapy • Periodontics • Oral Surgery • Major Restorative Care
Major Services	Deductible then 50%	Deductible then 50%	Deductible then 50%	• Prosthetic Repair / Adjustment • Prosthetics

This is only a summary, review your Dental Benefit Plan Summary or contact Delta Dental for additional information.

*Participants may choose to see an out-of-network dental provider, however claim payments are based on Delta's allowable charge. If your dentist charges more than Delta's allowable charge, you will pay the difference.

LIFE INSURANCE AND AD&D

5 **REVIEW YOUR LIFE INSURANCE POLICY**

- ☐ Add your spouse
- ☐ Add your dependents
- ☐ Increase your coverage

DID YOU KNOW?
Fond Du Lac provides you Basic Life and AD&D AT NO CHARGE

BASIC LIFE AND AD&D

Fond Du Lac provides a $25,000 life benefit in Basic Life and Accidental Death & Dismemberment (AD&D) insurance.

This coverage is offered through Cigna **at no cost to you.**

What is Life and AD&D Insurance?

All Full-Time employees working 32+ hours per week are eligible after 90 days of service for Basic Life and AD&D and Optional Life and AD&D. Eligible dependents include your spouse and dependent children up to age 19, or through age 22 if a full-time student.

VOLUNTARY LIFE AND AD&D AND DEPENDENT LIFE

You can purchase additional Life and AD&D Coverage beyond what Fond Du Lac provides. Cigna guarantees issues coverage during your initial enrollment period—which means you can't be turned down for coverage based on medical history.

- **Voluntary Employee Life & AD&D:** Elect up to $200,000 of life coverage in $25,000 increments. Guarantee issue up to $200,000.
- **Optional Dependent Life & AD&D for spouse:** Elect up to $100,000 of life coverage in $25,000 increments. Guarantee issue up to $100,000.
- **Optional Dependent Life & AD&D for children:** Choose a flat benefit or either $5,000 or $10,000, but no more than 50% of employee Guarantee issue up to $10,000. Children age 14 days to 6 months have a max benefit of $500.
- If you don't enroll in the Voluntary Life and AD&D plan during your initial enrollment period, you'll be required to complete an Evidence of Insurability form and be approved by Cigna before you're able to get coverage in the future.
- You must be enrolled in Voluntary Life and/or Voluntary Life / AD&D coverage in order for your spouse, and/or eligible dependent children to enroll.

Voluntary Life and AD&D and Dependent Life Options and Costs

	Employee and Spouse Life cost per $1,000		
Cigna	**Age**	**Non-Tobacco**	**Tobacco**
Voluntary Life	<25	$0.08	$0.10
	25-29	$0.08	$0.10
	30-34	$0.11	$0.14
	35-39	$0.15	$0.19
	40-44	$0.23	$0.30
	45-49	$0.34	$0.44
	50-54	$0.59	$0.83
	55-59	$0.98	$1.47
	60-64	$1.51	$2.42
	65-69	$2.90	$4.93
	70+	$4.71	$9.42
	Child(ren)	$1.00 for $5,000 of coverage $2.00 for $10,000 of coverage	
Voluntary AD&D	$0.040 per $1,000		

Please note: If you elect Voluntary Life for yourself, you may choose whether or not to include a matching AD&D benefit. Spouse election cannot exceed voluntary employee coverage amount.

DISABILITY COVERAGE

6

REVIEW YOUR DISABILITY COVERAGE

- ☐ Short Term Disability
- ☐ Long Term Disability

All Full-Time employees working 32+ hours per week are eligible after 90 days of service for long term disability benefits. All Full-Time employees working 32+ hours per week are eligible to purchase short term disability benefits, excluding Management Inc. employees.

LONG TERM DISABILITY INSURANCE

CORE PLAN

Fond du Lac pays the premium cost for a benefit of 60% of your total monthly earnings, up to a maximum of $500 per month. You must be continuously disabled for a period of 90 days or the end of your short term disability period (whichever comes first) in order for the benefit to be payable. Long term disability benefits will continue until you are no longer disabled, or until normal social security retirement age, whichever comes first.

EMPLOYEE BUY-UP OPTION

You may purchase additional long-term disability coverage up to a monthly benefit of 60% of your total monthly earnings to a maximum of $4,500 per month.

Guarantee Issue Amount: $4,500 per month

SHORT TERM DISABILITY INSURANCE

MANAGEMENT INC. EMPLOYEES

Following a one year waiting period, Management Inc employees are covered by an employer paid Short Term Disability plan through the Fond du Lac Insurance Company. You must be continuously disabled for a period of 7 days in order for the benefit to be payable. Short term disability benefits will continue until you are no longer disabled, or 11 weeks, whichever comes first.

ALL OTHER EMPLOYEES

You may purchase voluntary short term disability coverage of 60% of your total weekly earnings, up to a maximum of $1,000 per week. You must be continuously disabled for a period of 14 days in order for the benefit to be payable. Short term disability benefits will continue until you are no longer disabled, or 11 weeks, whichever comes first.

Guarantee Issue Amount: $1,000 per week

What is Disability Insurance?

PLAN COSTS

To calculate the employee cost of short-term disability and buy-up long term disability:

SHORT TERM DISABILITY	LONG TERM DISABILITY
Take your average weekly salary, multiply by 0.60. This is your **weekly benefit**. Divide this by 10 and multiply by the appropriate rate for your age. This is your monthly cost. Divide by 2 to approximate your cost per paycheck.	Take your annual salary and divide by 12. This is your monthly **covered pay**. Divide this by 100, then multiply by the rate to get your monthly cost. Divide by 2 to approximate your cost per paycheck. Your monthly benefit is your monthly covered pay multiplied by 0.60.

SHORT TERM DISABILITY				LONG TERM DISABILITY
Age	**Per $10 of Weekly Benefit**	Age	**Per $10 of Weekly Benefit**	**Per $100 of covered payroll ($60 of benefit)**
Under 29	**$0.779**	50-54	**$0.559**	**$0.477**
30-34	**$0.672**	55-59	**$0.681**	
35-39	**$0.557**	60-64	**$0.808**	
40-44	**$0.433**	65-69	**$0.922**	
45-49	**$0.461**	70+	**$1.103**	

VOLUNTARY COVERAGE

7 **PROTECT YOUR FINANCES**

- ☐ **Elect Critical Illness coverage**
- ☐ **Elect Accident insurance**

CRITICAL ILLNESS INSURANCE

Critical illness Insurance can help protect your finances from the expense of a serious health condition, such as a heart attack, cancer or stroke. Treatment for these conditions can be very expensive, so Critical Illness Insurance can help by paying a lump sum directly to you at the first diagnosis of a covered condition. You can purchase coverage for yourself and your spouse. Rate information can be found in the Cigna Benefit Summary.

Employee election options: $5,000, $10,000, or $20,000.

⇒ Coverage of up to $20,000 for an employee is guaranteed without evidence of insurability (medical underwriting) if elected within 30 days from the initial date of eligibility or during the 2019 open enrollment. Coverage elections made outside of these enrollment periods will be subject to medical underwriting.

The spouse election will be 50% of your employee election.

⇒ Spouse coverage is guaranteed without medical underwriting if purchased within 30 days from the initial date of eligibility or during the 2019 open enrollment. Coverage elections made outside of these enrollment periods will be subject to medical underwriting.

The dependent child(ren) election will be 25% of your employee election.

⇒ Dependent child(ren) elections are guaranteed.

▶ What is Critical Illness Insurance?

Cigna

All full-time employees working 30+ hours per week are eligible the day after completing 90 days of employment. Eligible dependents include your spouse and dependent children to age 26.

ACCIDENT INSURANCE

Accident Insurance pays you money based on the injury and the treatment you receive, whether it's a simple sprain or something more serious like a broken bone. The plan pays benefits for emergency room treatment, stitches, crutches, injury-related surgery and a list of other accident-related expenses. The money is paid directly to you and you decide how to spend it. You can also purchase coverage for your spouse and dependent children.

Coverage Level	Employee Paycheck Premium Cost
Employee Only	**$2.16**
Employee + Spouse	**$3.32**
Employee + Child(ren)	**$4.20**
Family	**$5.36**

▶ What is Accident Insurance?

EMPLOYEE ASSISTANCE PROGRAM

8 REVIEW YOUR EAP

What is an Employee Assistance Program?

OUR EMPLOYEE ASSISTANCE PROGRAM IS OFFERED THROUGH NUVANTAGE & CIGNA FOR 2021

Are you looking for help for a personal or family concern? Looking for a resource to assist you with a substance abuse problem or stressful situation at work? Need someone to talk to about financial issue or legal troubles? Your employer offers you two separate Employee Assistance programs through NuVantage and Cigna. Both provide excellent resources and counseling to help you through. You and your family members each have up to three face to face visits per year, per program.

You and your family members each get three free face-to-face visits per year to discuss:

- Family issues
- Marital concerns
- Stress/Anxiety
- Depression/Mental Health
- Alcohol or Drug Abuse
- Gambling Problems
- Work/Life Balance

You can reach out for in-person financial counseling, including:

- Budget planning
- Credit report review
- Debt management – waiver of setup fee
- Housing – Foreclosure prevention, reverse mortgages
- Pre-bankruptcy counseling
- College loan reviews

Also offered through NuVantage is a free 30-minute legal consultation for matters involving family law, criminal charges (including DUI), estate planning/wills, guardianship and consumer matters.

Call 24 hours / day, 7 days / week!

NuVantage Employee Resource

1-800-577-4727

lssmn.org/nuvantage/member-services

Cigna

1-800-538-3543

my.cigna.com

VIDEO LIBRARY

MEDICAL PLANS

- Medical Plans Explained
- Primary Care vs. Urgent Care vs. ER
- PPO Overview
- Medical Plan FAQs
- How to Manage Stress and Mental Health

INSURANCE 101

- Benefits Key terms Explained
- How to Read an EOB
- What is a Qualifying Event?
- What is a Telehealth?
- What is a Flexible Spending Account?
- How to Stretch Your Healthcare Dollars
- Prescription Drug Overview
- How to Manage Your Prescription Drug Cost

OPEN ENROLLMENT RUNS:

THURSDAY, OCTOBER 15, 2020– MONDAY, NOVEMBER 16, 2020

ANCILLARY BENEFITS

- What is Dental Insurance?
- What is Life and AD&D Insurance?
- What is Accident Insurance?
- What is Critical Illness Insurance?

GLOSSARY OF MEDICAL TERMS

Coinsurance—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays—A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

Emergency Room—Services you receive from a hospital for any serious condition requiring immediate care.

Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

Medically Necessary—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

Network Provider—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-pocket Maximum—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.

Preauthorization—A process by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

Prescription Drugs—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Preventive Services—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

UCR (Usual, Customary and Reasonable)—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

Urgent Care—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

IMPORTANT NOTICES

NOTE: Details regarding Fond Du Lac plans can be found in the Summary Plan Description/ Summary of Benefits and Coverage documents. To request these documents please contact Fond du Lac Insurance Services at www.fdlrez.com or call 218-878-8021.

MEDICARE PART D CREDITABLE COVERAGE

Applies to all Medicare-eligible individuals including employees, former employees, and Medicare-eligible dependents covered by Fond Du Lac group health plan or who become eligible to enroll in group health plan.

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. If you are eligible for Medicare, the following information can help you decide whether or not you want to join a Medicare drug plan. You should consider comparing your current coverage through our medical plan with the costs of plans offering Medicare prescription drug coverage in your area. Two important things you need to know about your current coverage and Medicare prescription drug coverage:

Medicare prescription drug coverage is available if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan.

All Medicare drug plans provide at least a standard level of coverage set by Medicare. More coverage may be offered at a higher premium.

Fond Du Lac has determined that the prescription drug coverage offered by Fond Du Lac 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 this coverage is Creditable Coverage, you can keep it and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you lose your current creditable prescription drug coverage through no fault of your own, you will be eligible for a two-month Special Enrollment Period to join a Medicare drug plan.

If you decide to join a Medicare drug plan, your current coverage may not be affected. This plan will coordinate with Part D coverage. If you drop your current coverage, be aware that you and your dependents may be able to get this coverage back.

If you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

This information is provided for the Medicare open enrollment period which begins on October 15. If you want more information about Medicare plans that offer prescription drug coverage, you will find it in the "Medicare & You" handbook or you can visit **medicare.gov** or call 800.MEDICARE (800.633.4227).

TTY users: 800.486.2048. If you have limited income and resources, visit Social Security at **socialsecurity.gov**, or call 800.772.1213 (TTY users call 800.325.0778).

Keep all Creditable Coverage notices. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of the 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).

This notice is intended as a brief outline; please see Human Resources for more information.

SPECIAL ENROLLMENT NOTICE

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

To request special enrollment or obtain more information, contact the Fond du Lac Insurance Services at www.fdlrez.com or call 218-878-8021.

Two additional special enrollment events are available to you and your eligible dependents. They are:

1. **Becoming ineligible for Medicaid or the Children's Health Insurance Program (CHIP).** If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the Fond du Lac Health Plan. You must request enrollment within 60 days.
2. **Becoming eligible for Premium Assistance through Medicaid or CHIP.** If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the Fond du Lac Health Plan. You must request enrollment within 60 days.

IMPORTANT INFORMATION REGARDING 1095 FORMS

As an employer with 50 or more employees, we are required to provide 1095-C forms to all employees who were eligible for coverage under our group health plan in 2019. If you were eligible for coverage under our group plan, you'll receive a personalized 1095-C form. We are also required to send a copy of your 1095-C form to the IRS. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit. You'll need 1095 form to complete your Federal tax return.

NOTICE OF PRIVACY PRACTICES

Fond Du Lac is subject to the HIPAA privacy rules. In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices by contacting Human Resources.

WOMENS HEALTH AND CANCER RIGHTS ACT OF 1998

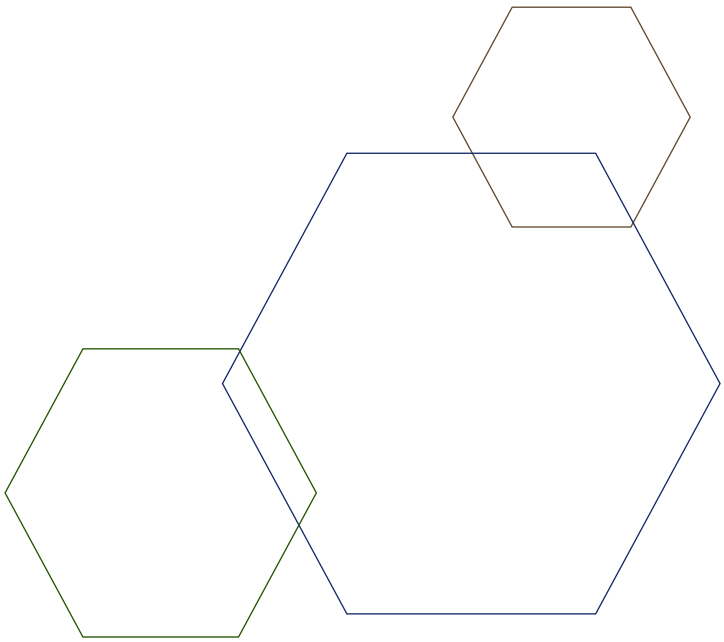
Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? Call your Plan Administrator 218-878-8021 for more information.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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
- 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. See the plan summary for details. If you would like more information on WHCRA benefits, call your Plan Administrator 218-878-8021.



MEDICAID CHIP NOTICE

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1- 877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: myalhipp.com Phone: 855.692.5447	Website: flmedicaidtplrecovery.com/hipp Phone: 877.357.3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: myakhipp.com Phone: 866.251.4861 Email: customerservice@myakhipp.com Medicaid Eligibility: dhss.alaska.gov/dpa/pages/medicaid/default.aspx	Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678.564.1162, ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: myarhipp.com Phone: 1.855.MyARHIPP (855.692.7447)	Healthy Indiana Plan for Low-Income Adults 19-64 Website: www.in.gov/fssa/hip Phone: 877.438.4479 All Other Medicaid Website: www.indianamedicaid.com Phone: 800.403.0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: www.healthfirstcolorado.com Health First Colorado Member Contact Center: 800.221.3943, state relay 711 CHP+: www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 800.359.1991, state relay 711	Website: dhs.iowa.gov/hawki Phone: 800.257.8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.kdheks.gov/hcf Phone: 785.296.3512	Website: www.dhhs.nh.gov/oii/hipp.htm Phone: 603.271.5218 HIPP Phone: 800.852.3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: chfs.ky.gov Phone: 800.635.2570	Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid Medicaid Phone: 609.631.2392 CHIP Website: www.njfamilycare.org/index.html CHIP Phone: 800.701.0710

LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 888.695.2447	Website: www.health.ny.gov/health_care/medicaid Phone: 800.541.2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 800.442.6003 TTY: Maine relay 711	Website: medicaid.ncdhhs.gov Phone: 919.855.4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: www.mass.gov/eohhs/gov/departments/masshealth Phone: 800.862.4840	Website: www.nd.gov/dhs/services/medicalserv/medicaid Phone: 844.854.4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 800.657.3739	Website: www.insureoklahoma.org Phone: 888.365.3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: www.dss.mo.gov/mhd/participants/pages/hipp. htm Phone: 573.751.2005	Website: healthcare.oregon.gov/pages/index.aspx www.oregonhealthcare.gov/index-es.html Phone: 800.699.9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: dphhs.mt.gov/montanahealthcareprograms/hipp Phone: 800.694.3084	Website: www.dhs.pa.gov/provider/medicalassistance/he althinsurancepremiumpaymenthippprogram/index.htm Phone: 800.692.7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: www.accessnebraska.ne.gov Phone: 855.632.7633 Lincoln: 402.473.7000 Omaha: 402.595.1178	Website: www.eohhs.ri.gov Phone: 855.697.4347, or 401.462.0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: dhcfp.nv.gov Medicaid Phone: 800.992.0900	Website: www.scdhhs.gov Phone: 888.549.0820
SOUTH DAKOTA – Medicaid	**WASHINGTON – Medicaid**
Website: dss.sd.gov Phone: 888.828.0059	Website: www.hca.wa.gov Phone: 800.562.3022, ext 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: gethipptexas.com Phone: 800.440.0493	Website: mywvhipp.com Toll-Free Phone: 1.855.MyWVHIPP (855.699.8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: medicaid.utah.gov CHIP Website: health.utah.gov/chip Phone: 877.543.7669	Website: www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 800.362.3002
VERMONT – Medicaid	**WYOMING – Medicaid**
Website: www.greenmountaincare.org Phone: 800.250.8427	Website: wyequalitycare.acs-inc.com Phone: 307.777.7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 800.432.5924 CHIP Website: www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 855.242.8282	

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:
U.S. Department of Labor
Employee Benefits Security Administration
Www.dol.gov/agencies/ebsa
1.866.444.EBSA (3272)

U.S. Department of health and Human Services
Centers for Medicare & Medicaid Services
Www.cms.hhs.gov
1.877.267.2323, Menu Option 4, Ext 61565

PAPERWORK REDUCTION ACT STATEMENT

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

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

The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the plans as described in this material and official plan documents, the language of the documents shall govern.