2022
Enrollment Guide

CEREALS & GRAINS ASSOCIATION

APS

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Contact Information

If you have specific questions about a APS's benefit plan, please contact the administrator listed below, or your local human resources department.

Benefit	Administrator	Phone	Website/Email
Medical	HealthPartners	952.883.5000	www.healthpartners.com
Health Reimbursement Arrangement - HRA	HR Simplified	Cust. Service: 888.318.7472 option 1 Claims Fax: 877.723.0146	www.hrsimplified.com
Dental	HealthPartners	952.883.5000	www.healthpartners.com
Vision	EyeMed Vision Care	1.866.9EYEMED	www.eyemedvisioncare.com
Basic Life and AD&D Insurance	Lincoln Financial Group	800.423.2765	www.lfg.com
Supplemental Life and AD&D Insurance	Lincoln Financial Group	800.423.2765	www.lfg.com
Long Term Disability	Lincoln Financial Group	800.423.2765	www.lfg.com
Flexible Spending Accounts - FSA	HR Simplified	Cust. Service: 888.318.7472 option 1 Claims Fax: 877.723.0146	www.hrsimplified.com
Health Savings Accounts	Optum Bank	866.234.8913	www.optumbank.com
American Phytopathological Society Human Resources Department	Kim Flanegan Kris Benjamin	651.994.3826 651.994.3825	kflanegan@scisoc.org kbenjamin@scisoc.org

Benefits Overview

Your Benefits

When you think about your total compensation package, don't forget about your benefits. Along with your pay, American Phytopathological Society has provided a benefit program with real financial value. Your benefits package will improve your life and the lives of your family members. A great deal of time and effort has been invested in designing, funding, and maintaining a quality benefit plan. But you and your family can also play an important role in getting the most from your benefits by making sure that you understand them.

Select your benefits carefully

When possible, you are offered options so that you can select the plan that best fits your needs. To get the most value from your benefits, carefully consider which options are right for you and your family. Because your premiums are generally deducted on a pre-tax basis, IRS regulations may prohibit you from making enrollment changes until the end of the plan year, unless you experience a family status change. For instance, you may not be able to cancel your coverage should you decide you would no longer be using the plan for the rest of the year. Please check with Human Resources if you are considering enrolling and terminating in a plan before the plan year ends.

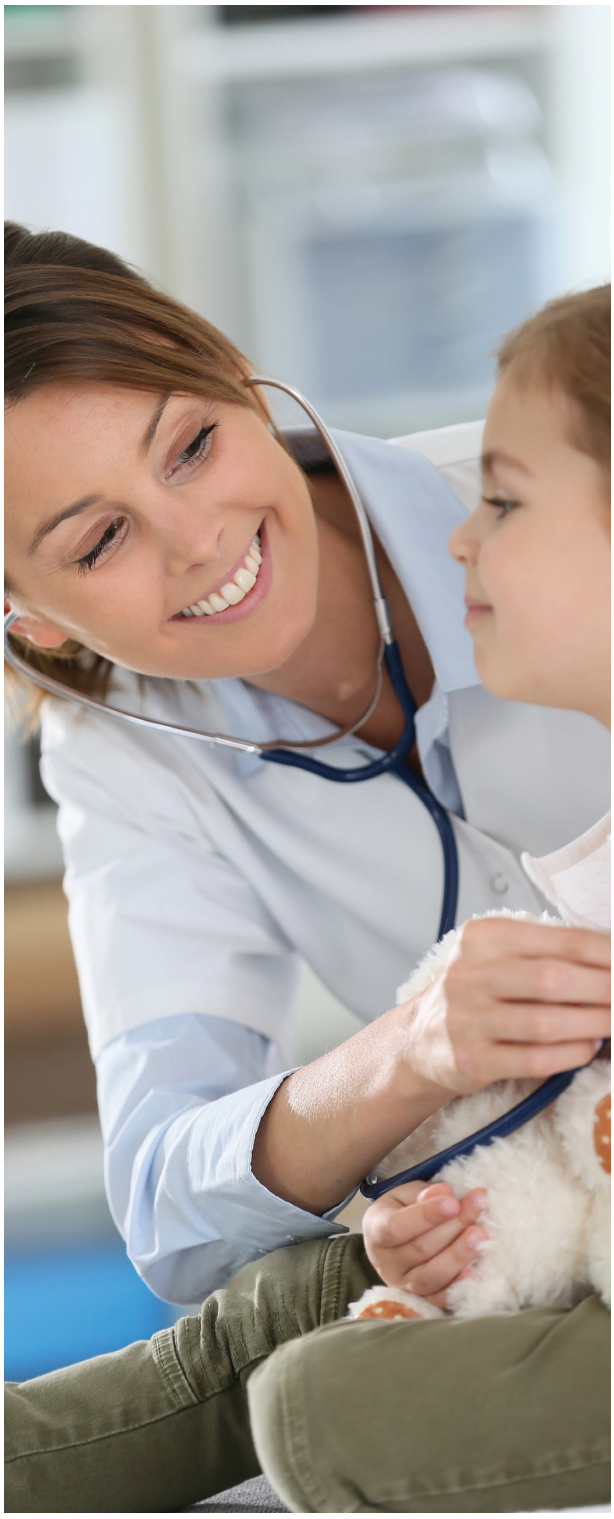
In the event of divorce or legal separation, or the loss of dependent child status under the plan, you must notify Human Resources within 30 days to maintain the right to continue coverage. At that time, Human Resources will provide enrollment materials to you or your covered dependent.

Inside this booklet

This booklet describes your employee benefits. For each benefit plan, you will find a description of your coverage, as well as information about eligibility, enrollment, costs and contact information. This booklet is intended to provide a summary of each of your benefit plans. Although care was taken to correctly describe these plans, you should consult your actual certificate for full details.

Important notice regarding dependent eligibility

Healthcare Reform legislation passed in 2010 has changed the definition of an eligible dependent under your employer's group medical plan. With this legislation, the group medical plan must allow coverage for dependent children under the age of 26, regardless of full-time student status, marital status or tax-dependent status.



Medical Benefits

Administered by HealthPartners

Health Insurance is designed to provide protection for you and your dependents in the event that you require medical care. Remember that you can help to keep your plan costs low. Although you are not required to see a network provider, your expenses will be less when you seek care within the network. Most importantly, make sure you understand your plan so that you can use your medical benefits wisely.

Eligibility

All active employees working more than 30 hours per week are eligible for medical plan benefits the 1st of the month following 30 days of full-time employment. If you are an active employee and elect medical coverage for yourself, you may also cover your eligible dependents. Eligible dependents include your spouse and children under age 26.

Plan Networks

Your medical plan choices with HealthPartners consists of two network options: Open Access Network and Achieve Network.

Open access network you can choose from more than 950,000 doctors and 6,000 hospitals in the United States. Simply go to your network doctor when you need care. No need to select a primary care clinic. And you don't need referrals to see specialists.

Achieve network you can choose from a network comprised of HealthPartners and Park Nicollet clinics along with a selection of other independent clinics Members are not required to designate a primary care clinic and do not need referrals to see an in-network specialist.

Current provider listings are available at **www.healthpartners.com**.

Benefit Summary by Plan				
Plan Features	Plan 1 -$1,500 HRA Open Access Network	Plan 2 - $2,000-100 HSA Open Access Network	Plan 3 - $1,500 HRA Achieve Network	Plan 4 - $2,000-100 HSA Achieve Network
In-Network Benefits				
Deductible	$1,500 Single; $3,000 Family	$2,000 Single; $4,000 Family	$1,500 Single; $3,000 Family	$2,000 Single; $4,000 Family
Out-of-Pocket Maximum	$3,500 Single; $7,000 Family	$2,000 Single; $4,000 Family	$3,500 Single; $7,000 Family	$2,000 Single; $4,000 Family
Coinsurance	Plan pays 80%; You pay 20%	Plan pays 100%; You pay 0%	Plan pays 80%; You pay 20%	Plan pays 100%; You pay 0%
Office Visit	Deductible, then you pay 20%	100% after Deductible	Deductible, then you pay 20%	100% after Deductible
Preventive Care	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Prescription Drug Coverage Generic Formulary Brand Formulary Generic Non-formulary Brand	$15 copay $50 copay $100 copay	100% after Deductible	$15 copay $50 copay $100 copay	100% after Deductible
Out-of-Network Benefits				
Deductible	$3,500 Single; $7,000 Family	$4,000 Single; $8,000 Family	$3,500 Single; $7,000 Family	$4,000 Single; $8,000 Family
Out-of-Pocket Maximum	$10,500 Single; $21,000 Family	$6,000 Single; $12,000 Family	$10,500 Single; $21,000 Family	$6,000 Single; $12,000 Family
Coinsurance	Plan pays 50%; You pay 50%	Plan pays 50%; You pay 50%	Plan pays 50%; You pay 50%	Plan pays 50%; You pay 50%

Employee Costs Per Pay Period				
Tier	Plan 1 -$1,500 HRA Open Access Network	Plan 2 - $2,000-100 HSA Open Access Network	Plan 3 - $1,500 HRA Achieve Network	Plan 4 - $2,000-100 HSA Achieve Network
Employee Only	$84.00	$84.00	$65.00	$65.00
Employee + 1	$295.00	$295.00	$255.00	$255.00
Family	$393.00	$393.00	$337.00	$337.00

Note: Employee contributions are deducted from your paycheck before taxes. This means that you do not pay federal or state income taxes on the cost of your insurance. Be sure to read your insurance policy Summary Plan Description.

HealthPartners Plan Features

The following programs are offered at no additional cost by HealthPartners.

www.HealthPartners.com

Access helpful and personalized information on your health plan, review your benefits and manage plan payments, like your deductible usage. You can also order ID cards and access additional information on the resources below. Register your member ID today to take control of you and your family's health plan. You can also download a helpful app for your smartphone.

Wellbeats Fitness Program

Wellbeats is an easy-to-use, on-demand fitness platform to help you workout wherever, whenever, and however you like. For more details visit **www.healthpartners.com**.

CareLine Service

CareLine services are available 24/7, 365 days a year. You will reach skilled nurses who are specially trained to assess medical conditions and answer questions of all kinds.

Call 612-339-3663 or 1-800-551-0859. TTY: 952-883-5474

BabyLine Phone Service

BabyLine helps expectant and new parents up to six weeks after the baby is born. Nurses help answer questions about mood swings, morning sickness, healthy eating, safe medications and more. Available 24/7, 365 days a year.

Call 612-333-2229 or 1-800-845-9297.

HealthPartners Nurse Navigator Program

When you need help sorting out health and insurance issues, call our Nurse Navigators. They can help guide you through difficult decisions like choosing treatment options. Nurse Navigators will also research and coordinate healthcare based on you benefits and coverage. Available Monday through Friday, 7 a.m. to 7 p.m., CST.

Call 952-967-7985 or 888-324-9722. TTY: 952-883-5127.

Behavioral Health Personalized Assistance Line

Talk to professionals who can help when you have questions about mental and chemical health network, benefits and services. Available Monday through Friday, 7:30 a.m. to 5 p.m., CST.

Call (952) 883-5811 or 1-888-638-8787.

Partners in Quitting

Thinking about quitting smoking or smokeless tobacco? Today is the day to turn those thoughts into action! Access a confidential smoking cessation program that is free to HealthPartners members. For more information or to begin registration, call **952-883-7800 or 1-800-311-1052. TTY: 952-883-7498.**

Virtuwell Online Clinic

Getting sick is no fun. It means feeling rotten and taking time away from work. But getting better is easy with Virtuwell, a 24/7 online clinic. It treats common conditions like cold, flu, sinus infection, pinkeye and bladder infection. Plus, you can use it for yourself or your kids!

H.R.A. / H.S.A. Accounts

Healthcare Reimbursement Arrangement (HRA) Details

Your Healthcare Reimbursement Arrangement (HRA) is a combination of: 1) a savings account to pay for routine care and 2) an insurance plan to pay for major medical claims. Together these create the complete Medical plan for you and your families. This first-dollar, cash-saving medical plan is designed to put people back in control of their health care by giving them ownership of their health care spending dollars. With HRAs, people have the opportunity to spend their health care dollars the way they choose. When good health care decisions are made, employees benefit medically and financially.

The Healthcare Reimbursement Arrangement is to be used for health care costs. This account pays for expenses such as: office visits, chiropractic care and hospital claims that count towards your deductible and coinsurance. Prescription expenses, dental and vision expenses are not eligible. You may use your HRA to pay for providers not participating in your approved health plan provider network. At the end of the year 100% of any remaining funds up to the out-of-pocket maximum amount in the Healthcare Reimbursement Account will transfer to the next year. The plan year is January 1 – December 31.

HRA reimburses for medical expenses (not including prescriptions) first before FSA dollars. Once HRA dollars are depleted, medical expenses can be submitted to your FSA, if enrolled. In summary, the objective of the HRA is to use the same money paid to HealthPartners in a way that better benefits the employee both medically and financially.

Annual Employer Contributions	
Health Reimbursement Account	
Employee Coverage	$1,000
Employee + 1 Coverage	$1,500
Family Coverage	$2,000

Health Saving Account (HSA) Details

Important Note: To be eligible to open an HSA, you must meet the eligibility requirements set forth by the IRS. Please contact your Human Resources Department for specific HSA eligibility rules.

If you are covered under your spouse's medical plan, if you and/or your spouse participate in a medical reimbursement flexible spending account plan (unless this plan is limited to dental and vision care expenses only) and/or if you are currently on Medicare, you are not eligible to contribute to an HSA and your employer may not contribute to an HSA on your behalf. Please contact your Human Resources Department if you fall into any of the situations outlined above.

The HSA is funded via voluntary employee contributions on a pre-tax basis via payroll deduction. The 2022 maximum contribution limit to the HSA is $3,650 for single coverage and $7,300 for family coverage. You may also qualify to contribute an additional amount $1,000 to your HSA if you are age 55 or older. Even though your employer may contribute to an HSA, the HSA is fully owned by the employee and stays with the employee, even at termination of employment. Funds accumulate year after year; there is no "use it or lose it" rule.

Annual Contributions - Health Savings Account				
	2022 IRS Maximum Limits	Employer Contributions	Possible Employee Contributions	Age 55+ 'Catch-up' Contributions
Employee Coverage	$3,650	$1,000	$0- $2,650	$0-$3,650
Employee + 1 Coverage	$7,300	$1,500	$0- $5,800	$0- $6,800
Family Coverage	$7,300	$2,000	$0- $5,300	$0-$6,300

Dental Benefit

Administered by HealthPartners

Dental Coverage is designed to provide protection to you and/or your family in the event that you require dental services during the year. Your plan is designed to encourage regular visits to your dentist which is essential to maintaining oral health, and to provide coverage for basic diagnostic and preventative dental needs.

Eligibility

All active employees working more than 30 hours per week are eligible for dental plan benefits the 1st of the month following 30 days of full-time employment.

If you are an active employee and elect dental coverage for yourself, you may also cover your eligible dependents. Eligible dependents include your spouse and unmarried dependent children under age 26.

Below is a brief summary of the key elements of your dental plan. Please refer to the benefit plan booklet(s) for specific benefits, limitations and exclusions.

Plan Information

Carrier: **HealthPartners**

Group Number: **23192**

Plan: **Distinctions**

Effective Date: **January 1, 2022**

Plan Networks:

Level 1: features two of Minnesota's most respected dental groups - HealthPartners Dental & Park Dental.

Level 2: includes more than 2,400 dentists in the Twin Cities & throughout Minnesota.

Search Providers

You can search and locate participating providers online @: www.healthpartners.com/dentaldistinctions

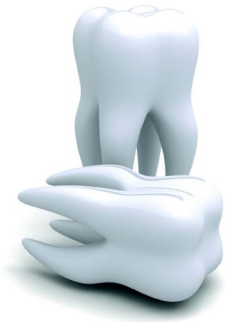
HealthPartners is partnering with Cigna to provide nationwide dental coverage. You have access to over 120,000 providers nationwide with this relationship.

	Level 1	Level 2	Out-of-Network
Deductible (per person/per family, calendar year)	None	$25/$75	$50/$150
Annual Maximum	$2,500	$2,000	$1,000
Diagnostic and Preventive (Cleanings, X-Rays, Fluoride Treatments, Sealants)	100%	100%	100%
Basic 1 Services (Amalgam fillings, simple extractions, composite fillings)	100%	80%	80%
Non-Surgical Periodontics & Endodontics	80%	80%	50%
Basic 2 Services (Periodontics & Other oral surgery)	80%	80%	50%
Major Services (Crown and crown repair, Removable and fixed bridges and dentures and repairs)	50%	50%	50%
Orthodontic Maximum	$1,000	$1,000	$750
Little Partners—Kids 12 and under	Covered at 100% at in-network dentists—No deductible, no coinsurance & no annual maximum.		

Plan Cost

Employee Costs Per Pay Period	
Employee Only	$10.00
EE + 1 Dependent	$19.50
Family	$34.00

Note: Employee contributions are deducted from your paycheck before taxes. This mean that you do not pay federal or state income taxes on the cost of your insurance.



Vision Benefit

Administered by EyeMed Vision Care

Vision coverage provides coverage for specific vision materials, including preferred pricing on a large selection of brand-name, designer frames, lenses, and lens options.

Plan Information

Carrier: **EyeMed Vision Care**

Effective Date: **January 1, 2022**

Plan Networks: Receiving your vision benefit is as easy as visiting your EyeMed provider. To locate providers, call 1.866.299.1358 and use EyeMed's locator service or speak with an EyeMed Customer Service Representative or visit www.eyemedvisioncare.com.

Vision Benefit Summary		
Plan Features	In-Network	Out-of-Network
Eye Exam w/ Dilation (every 12 months)	$10 Copay	Up to $30
Retinal Imaging Benefit	Up to $39	N/A
Standard Contact Fit/Follow-Up	Up to $40	N/A
Premium Contact Fit/Follow-Up	10% off Retail	N/A
Frames (every 24 months)		
Any available frame at a provider location	$0 Copay, $200 Allowance, 20% off balance over $200	Up to $100
Standard Plastic Lenses (every 12 months)		
Single Vision	$25 copay	N / A
Bifocal	$25 copay	
Trifocal	$25 copay	
Lenticular	$25 copay	
Standard Progressives	$90	
Premium Progressives	$90, then 80% of charge after $120 allowance	
Lens Options (Paid by the member and added to the base price of the lens)		
UV Treatment	$15	N / A
Tint (Solid and Gradient)	$15	
Standard Scratch-Resistance	$15	
Standard Polycarbonate	$40	
Standard Anti-Reflective Coating	$45	
Polarized	20% off retail price	
Other Add-ons and Services	20% off retail price	
Contact Lenses (allowance Covers Materials Only)		
Conventional	$200 Allowance; 15% off balance over $200	Up to $160
Disposables	$200 Allowance; plus balance over $200	Up to $160
Medically Necessary	$0 Copay, Covered in full	Up to $200
Additional Pairs Benefit	Members receive a 40% discount off complete pair eyeglasses and a 15% discount off conventional contact lenses once the funded benefit has been used.	

Plan Cost

The voluntary vision plan rates are 100% employee paid.

Biweekly Vision Premiums	
Coverage Tier	Employee Cost Per Paycheck
Employee	$4.18
Employee + Spouse	$7.94
Employee + Child(ren)	$8.36
Family	$12.29

Eligibility

All active employees regularly scheduled to work 30 or more hours per week are eligible for this coverage on the 1st of the month following date of hire.

If you are an active employee and elect coverage for yourself, you may also cover your eligible dependents. Eligible dependents include your legal spouse and dependent children to age 26. Dependent children are eligible, regardless of financial dependence, student status, residence or marital status.

Life and Accident & Dismemberment Benefit

Insured by Lincoln Financial

What would happen to your family or financial obligations if something happened to you? Life insurance is designed to provide protection for your dependents or to enable your beneficiary to settle your affairs in the event of your death. Regardless of your age, income, or health status, Life Insurance may help secure the future or your survivors.

Eligibility

All active employees working more than 30 hours per week are eligible for group life insurance benefits the 1st of the month following 30 days of full-time employment.

Plan Information

Carrier: **Lincoln Financial Group**

Group Number: **000010104381-0000**

Effective Date: **January 1, 2022**

When you enroll in a Life Insurance policy you need to designate a beneficiary. Since the most current beneficiary form determines who will receive your benefit, it is important to review your designation from time to time. You can change your beneficiary at any time by filling our a new beneficiary form and returning it to Human Resources.

Plan Cost

APS contributes 100% of the employee cost. Below is a brief summary of the key elements of your basic life and AD&D plan.

Benefit Summary	
Basic Life	1.5 times your salary to a maximum of $50,000
Basic AD&D	Matching AD&D benefit

Voluntary Life and AD&D Benefit

Insured by Lincoln Financial

Voluntary life insurance can provide additional protection and security for you, your spouse or your children.

Eligibility

If you are an active full-time employee working 30 or more hours per week, you are eligible for coverage on the first day of the month following 30 days of full-time employment.

If you are an active employee and elect voluntary life coverage for yourself, you may also cover your eligible dependents. Eligible dependents include your spouse and unmarried dependent children under age 26.

Plan Information

Carrier: **Lincoln Financial Group**

Group Number: **000400104382**

Below is a brief summary of the key elements of your voluntary life and AD&D plan. Please refer to the benefit plan booklet(s) for specific benefits, limitations and exclusions.

Benefit	Employee	Spouse	Dependent
Amount	Choice of $10,000 increments May not exceed 5 times your base annual salary You may purchase AD&D coverage for yourself regardless of whether you purchase Term Life coverage.	Choice of $5,000 increments 50% of employee amount *Employee must elect coverage, in order to elect coverage for spouse and/or dependent child(ren).*	Flat $10,000 Applies to multiple children
Minimum Amount	$10,000	$5,000	Not applicable
Maximum Amount	$300,000	$150,000	Not applicable
Guarantee Issue	$50,000	$50,000	$10,000

Plan Cost

This benefit is 100% employee paid.

Monthly Voluntary Life Rates					
Age Band	Smoker Employee per $1,000	Non-Smoker Employee per $1,000	Smoker Spouse Per $1,000	Non-Smoker Spouse per $1,000	Child Per $10,000
<24	$0.12	$0.07	$0.12	$0.07	$2.00
25-29	$0.12	$0.07	$0.12	$0.07	**Note:** The premium paid for child coverage is based on the cost of coverage for one child, regardless of how many children you have.
30-34	$0.12	$0.07	$0.12	$0.07	
35-39	$0.16	$0.08	$0.16	$0.08	
40-44	$0.31	$0.14	$0.31	$0.14	
45-49	$0.47	$0.23	$0.47	$0.23	
50-54	$0.68	$0.38	$0.68	$0.38	
55-59	$0.98	$0.60	$0.98	$0.60	
60-64	$1.68	$1.01	$1.68	$1.01	
65-69	$2.79	$1.80	$2.79	$1.80	
70-74	$2.79	$1.80	$2.79	$1.80	
75+	$2.79	$1.80	$2.79	$1.80	

Monthly AD&D Coverage Rates			
	Employee per $1,000	Spouse per $1,000	Child per $1,000
Employee	$0.035	$0.035	$0.035

Note: Your rate will increase as you age and move to the next age band. The change will become effective on January 1st of each year.

Long Term Disability Benefit

Insured by Lincoln Financial

Long-term disability coverage provides a reasonable replacement of monthly earnings to an employee who becomes disabled for extended periods of time due to an accident or sickness.

Eligibility

All active employees working more than 30 hours per week are eligible for the long-term disability plan benefits the 1st of the month following 1 year of full-time employment. Dependents are not eligible to participate in the long-term disability coverage.

Plan Information

Carrier: **Lincoln Financial Group**

Group Number: **000010126270-00000**

Below is a brief summary of the key elements of your long-term disability plan. Please refer to the benefit plan booklet(s) for specific benefits, limitations and exclusions.

Benefit Summary	
Benefits Payable after	90 days of disability
Maximum Benefit Duration	SSNRA
Percent of Income Replacement	66.67% of monthly pay
Maximum Monthly Benefit Payable	$6,000
Own Occupation Period	3 years

Plan Cost

APS contributes 100% of the employee cost.

Note: Since your employer pays for the Long-Term Disability premium pretax, any benefits you receive under the Long-Term Disability plan are subject to federal and state taxes.

Preexisting Conditions Limitation

Benefits may not be payable if the disability is due to a Preexisting Condition. See your certificate of coverage booklet for more information on this and other LTD provisions.

FLEXIBLE SPENDING ACCOUNT (FSA)

Insured by HR Simplified

Under a Section 125 Plan (also referred to as a Flexible Spending Account or FSA), you may pay your portion of the premium for specific employer-sponsored benefit plans with pretax dollars. You can also pay for eligible medical, dental and vision expenses not covered by your (or your spouse's) health, dental or vision plans and dependent care expenses with pretax dollars under a Section 125 Plan. Your choices will depend upon factors such as a your marital status, income level, dependent status, and/or duplicate coverage under a spouse's plan.

Your elections under this plan may fall into two categories:

- Healthcare Reimbursement FSA
- Dependent care Reimbursement FSA

Information regarding each of these two categories is outlined in detail below.

Eligibility

All active employees working more than 30 hours per week are eligible to participate the 1st of the month following 30 days of full-time employment.

Plan Information

Administrator: **HR Simplified**

Plan Year: **January 1 through December 31**

"Use It or Lose It" Rule

Federal tax laws require that a Section 125 Plan operate on a "use it or lose it" basis. This means that if you do not use the entire amounts available for reimbursement under your Health Care Reimbursement FSA or Dependent Care Reimbursement FSA for a Plan Year, you will forfeit the unused amount and have no further claim to those monies after the Plan Year (and any run-out period) ends.

HEALTHCARE REIMBURSEMENT FSA

You can set aside up to $2,750 in a Health Care Reimbursement FSA each year to help pay for out-of-pocket medical, dental and vision expenses for you, your spouse and your dependent child(ren). Below is a brief list of such expenses:

1. Deductibles, coinsurance and/or co-pays under a health, dental or vision plan
2. Over the Counter (OTC) medications (with prescription only)
3. Eye glasses, contact lenses, cleaning & wetting solutions
4. Orthodontia expenses
5. Lasik eye surgery or radial keratotomy
6. Prescription Drugs

Federal tax rules define which health expenses are eligible for reimbursement from a Health Care Reimbursement FSA. For more information, refer to the list of eligible expenses insert or the Flexible Benefit Plan Summary Plan Description.

Orthodontia Expenses

Typically, a portion of an Orthodontia contract (25% to 35%) is for expenses incurred immediately to complete initial orthodontia work. The remainder of the contract balance is divided over the remaining months of treatment. Under some contracts, the remaining months may span over a two or three-year period. You may only receive reimbursements under your Health Care Reimbursement FSA for expenses you incur during that plan year.

FLEXIBLE SPENDING ACCOUNT (FSA)

LIMITED SCOPE FSA

If you are participating in the HSA, you are not eligible to contribute to a traditional health care reimbursement FSA. The Limited Purpose Health Care Reimbursement FSA allows you to set aside pre-tax dollars to pay for eligible dental and vision expenses incurred during the calendar year.

You can set aside up to $2,750 in a Limited Purpose Health Care Reimbursement FSA each year to help pay for out-of-pocket dental and vision care services. Your FSA remains limited to dental and vision care services until you have incurred the minimum required out-of-pocket deductible expenses. Once the minimum deductible amount has been satisfied for the high deductible health plan, you may be reimbursed for any medical expenses incurred during the remainder of the plan year.

DEPENDENT CARE REIMBURSEMENT FSA

You can set aside up to $5,000 (up to $2,500 if you're married and filing separate tax returns) in a Dependent Care Reimbursement FSA each year to help you pay for your eligible dependent care expenses, such as day-care for your child or elder care.

If, in order to maintain employment, you are paying for child care or elder care services, you may be eligible to request reimbursement for some or all of those expenses through this program. Child care or elder care services may qualify for reimbursement if they meet these requirements:

1. The child must be under 13 years old or, if older, mentally or physically incapable of caring for him or her self
2. Must be provided by a facility or caretaker with a registered tax ID number
3. The services may be provided inside or outside your home, but not by someone who is your dependent for income tax purposes, such as an older child, your spouse, or a grandparent who lives with you

The following illustrates how Flexible Spending Accounts work:

EXAMPLE: An employee's annual gross pay is $24,000. The employee's election to the FSA totals $2,750 for the year.

	Without FSA	With FSA
Gross Pay	$24,000	$24,000
Less FSA Contributions	$0	-$2,750
Taxable Income	$24,000	$21,250
Less Taxes (Federal, State and FICA estimated at 30%)*	-$7,200	-$6,375
Less Out-of-Pocket Expenses	-$2,700	-$2,750
Plus Reimbursement from FSA	$0	+$2,750
Take-Home Pay	**$14,100**	**$14,875**

*Taxes are illustrated for example purposes only. Reduced Social Security Tax (FICA) may result in less Social Security benefit.

The annual difference of $810 shows the value of paying for insurance premiums and other out-of-pocket expenses with pretax dollars. In this example, the employee has an additional $810 "in-pocket" throughout the year, versus having paid that amount in taxes.

Plan participation requirements

Since the premiums and any money set aside in these programs are done so on a pretax basis, the ability to add or drop coverage or change your elections under these programs is limited to either an Annual Open Enrollment Period as determined by your employer, or due to a change in family status that affects your eligibility for benefits.

Qualified Status Changes may include the following and apply to you, your spouse or your eligible dependent:

- Legal marital status
- Number of dependents
- Employment status Work schedule
- Dependent status
- Residence or worksite

FLEXIBLE SPENDING ACCOUNT (FSA)

FLEXIBLE SPENDING ACCOUNT ELIGIBLE EXPENSES

Below is a brief list of example eligible expenses for reimbursement from a flexible spending account. Actual reimbursement may require proof of medical necessity.

Insurance

Eligible

- Deductible and copayments for medical, dental and vision plans
- Coinsurance
- Amounts not reimbursed

Ineligible

- All premiums for insurance
- Expenses reimbursed by other insurance

Drugs and Medications

Eligible

- Prescription drugs
- Birth control drugs
- Insulin

Ineligible

- Prescription and over-the- counter drugs for cosmetic purposes

Vision Care

Eligible

- Optometrist or ophthalmologist fees
- Eyeglasses
- Contact lenses and cleaning solutions
- Prescription sunglasses
- LASIK eye surgery
- Radial keratotomy

Ineligible

- Lens replacement insurance
- Warranties
- Protection plans

Dental/Orthodontic

Eligible

- Dental care
- Artificial teeth/dentures
- Fluoridation of home water supply advised by dentist
- Braces, orthodontic services incurred within plan year+

Ineligible

- Teeth bleaching
- Tooth bonding that is not medically necessary

+Special rules apply to Orthodontia contracts. Expenses can only be paid if incurred within the plan year. Most contracts span several years.

Treatments/Therapies

Eligible

- Weight loss programs prescribed to treat a medical condition
- X-ray treatments
- Smoking cessation
- Treatment for drug or alcohol dependency
- Acupuncture
- Vaccinations
- Physical therapy

Ineligible

- Physical treatments unrelated to specific health problems or diagnosis

Fees/Services

Eligible

- Physicians fees
- Routine exams
- Obstetrical expenses
- Hospital services
- Nursing services for a specific condition
- Cost of a nurse's room and board and nurse's services
- Surgical or diagnostic services
- Legal sterilization
- Cosmetic surgeries or treatment that treat deformity caused by an accident or trauma or disease, or an abnormality from birth
- Services of chiropractors or osteopaths
- Anesthesiologist fees
- Dermatologist fees
- Gynecologist fees

Ineligible

- Cosmetic surgeries or procedures that improve patient's appearance, but do not meaningfully promote the proper function of the body or prevent or treat an illness or disease
- Payments to domestic help, companion, babysitter, chauffeur, etc., who primarily render services of a nonmedical nature.
- Nursemaids or practical nurses who render general care for healthy infants
- Payments for child care (eligible under the Dependent Care FSA)

Medical Equipment

Eligible

- Wheelchair (includes cost of operating and maintaining)
- Crutches (purchased or rented)
- Oxygen equipment and oxygen used to relieve breathing problems that result from a medical condition
- Artificial limbs
- Support hose (if medically necessary)
- Wigs (where necessary for mental health of individual who loses hair because of disease)
- Testing equipment, i.e., blood sugar monitors

Ineligible

- Wigs, when not medically necessary for mental health
- Vacuum cleaner purchased by an individual with dust allergy

Psychiatric Care

Eligible

- Services of psychotherapists, psychiatrists and psychologists
- Legal fees directly related to commitment of a mentally ill person

Ineligible

- Psychoanalysis undertaken to satisfy curriculum requirements of a student
- Marriage counseling

Assistance for the Disabled

Eligible

- Cost of guide for a blind person
- Cost of note-taker for a deaf child in school
- Cost of Braille books and magazines in excess of cost of regular editions
- Seeing-eye dog (cost of buying, training and maintaining)
- Hearing-trained cat or other animal to assist deaf person (cost of buying, training and maintaining)
- Household visual alert system for deaf person
- Excess costs of specifically equipping automobile for a disabled person over the cost of ordinary automobile; device for lifting a disabled person into automobile

Miscellaneous

Eligible

- Sales tax associated with an eligible expense
- Hearing aids, batteries for operation of hearing aids, hearing aid repairs
- Bandages/dressings
- Expenses connected with donating an organ
- Cost of computer storage of medical records
- Cost of special diet, but only if it is medically necessary and only to the extent that costs exceed that of a normal diet
- Transportation expenses primarily for, and essential to, medical care, including car mileage, bus, taxi, train, plane fares, ambulance services, parking fees and tolls
- Lodging expenses (not provided in a hospital or similar institution) not to exceed $50 per night per individual while away from home if the lodging is primarily for and essential to medical care provided by a doctor

Ineligible

- Expenses of divorce when doctor or psychiatrist recommends divorce
- Cost of toiletries, cosmetics and sundry items
- Cost of specialized foods taken as a substitute for regular diet, when the special diet is not medically necessary or cost is not in excess of a normal diet
- Maternity clothes
- Diaper service
- Distilled water purchased to avoid drinking fluoridated city water supply

Legal Notices

1. HIPAA Special Enrollment Rights
2. Women's Health & Cancer Rights Act
3. HIPAA Notice of Privacy Practices Reminder
4. Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
5. Annual Medicare Part D Certification (Notice of Creditable Coverage)
6. Summary of Benefits (SBC's) for all plans are available.

Please take time to familiarize yourself with this information. If you have dependents that are enrolled in the plan(s), please make sure they also have the opportunity to review this information.

HIPAA Special Enrollment Rights

American Phytopathological Society Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the American Phytopathological Society Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Kris Benjamin - Benefits Manager at 651.994.3825 or kbenjamin@scisoc.org.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Legal Notices

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: $1,500 HRA Open Access Network (Individual: 80% / 20% coinsurance and $1,500 deductible; Family: 80% / 20 coinsurance and $3,000 deductible)

Plan 2: $2,000-100 HSA Open Access Network (Individual: 100% / 0% coinsurance and $2,000 deductible; Family: 100% / 0% coinsurance and $4,000 deductible)

Plan 3: $1,500 HRA Achieve Network (Individual: 80% / 20% coinsurance and $1,500 deductible; Family: 80% / 20% coinsurance and $3,000 deductible)

Plan 4: $2,000-100 HSA Achieve Network (Individual: 100% / 0% coinsurance and $2,000 deductible; Family: 100% / 0% coinsurance and $4,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 651.994.3825 or kbenjamin@scisoc.org.

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

American Phytopathological Society is committed to the privacy of your health information. The administrators of the American Phytopathological Society Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Kris Benjamin - Benefits Manager at 651.994.3825 or kbenjamin@scisoc.org.

Legal Notices

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	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 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: http://dhss.alaska.gov/dpa/Pages/medicaid/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**
Website: https://medicaid.georgia.gov\health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840

Legal Notices

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
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/oii/hipp.htm 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

Legal Notices

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**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ 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, 2021, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

Legal Notices

Annual Medicare Part D Certification Important Information

Applies if you or one of your dependents is on Medicare or becomes covered under Medicare while you remain an active employee.

Medicare offers insurance coverage for prescription drugs through Medicare Part D. APS Medical Plan will continue to offer prescription drug coverage as a benefit under these plans for active employees and their covered dependents. APS coverage is considered 'creditable coverage', which means APS Medical Plans' prescription drug benefits provide cover-age at least as good as or better than Medicare Part D. If you or one of your dependents is on Medicare or becomes covered under Medicare while you remain an active employee, please print the Certificate of Creditable Coverage, and keep it in your records. This Certificate of Creditable Coverage will allow you and your dependents to join Medicare Part D in the future without paying late enrollment fees.

During your employment, you have the option to choose to continue your prescription drug coverage through APS Medical Plan or to elect Medicare Part D. However, if you choose to elect Medicare Part D, you will not be eligible to participate in APS Medical Plan that provide both medical and prescription drug coverage. Please read materials sent to you from Medicare or other Medicare Part D providers carefully before making your decision.

Notice of Creditable Coverage

Important Notice from American Phytopathological Society

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

When Can You Join a Medicare Drug Plan?

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

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Company coverage will not be affected. The $500-$40 and $25-95% medical plans offer the following prescription drug coverage for a 1-month supply: 100% coverage after a $15 copay for Generic Formulary drugs, a $150 copay for Generic Non-Formulary drugs, a $60 copay for Brand Formulary Drugs or a $150 copay for Brand Non-Formulary. The HSA Health Plan offers the following prescription drug coverage for a 1-month supply: 100% coverage after the deductible. Members may keep this coverage if they elect part D and this plan will coordinate with Part D coverage. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the pre-scription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current North Lakes Academy coverage, be aware that you and your dependents may be able to get this coverage back.

Legal Notices

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 American Phytopathological Society 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 American Phytopathological Society 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:	**January 01, 2022**
Name of Entity/Sender:	**American Phytopathological Society**
Contact—Position/Office:	**Kris Benjamin - Benefits Manager**
Office Address:	**3340 Pilot Knob Road,**
	Eagan, St. Paul, Minnesota 55121-2097
	United States
Phone Number:	**651.994.3825**

Notes

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting