FB Society

2024 Benefits Enrollment Guide

Benefits effective January 1, 2024 - December 31, 2024

Welcome to Your Benefits

Your health and the health of your family are important to us. This is the reason we offer comprehensive health care coverage with ancillary benefit options to eligible employees and their families. Our benefits package is designed to focus on your total well-being. Please read through all of your materials carefully. You have many resources available for any questions related to your plans as you enroll and throughout the year. Take advantage of these resources to be sure you receive the full benefits you need. The health care coverage you elect begins with your initial eligibility date and continues through the end of the enrollment year. FB Society' health care benefit year begins January 1st and ends December 31st.

Benefit Highlights

- **There will be NO INCREASE to your medical premiums.**
- **You must elect or waive coverage electronically through the website or mobile app.**

Enrollment

Open Enrollment will occur November 6, 2023 through November 17, 2023 with changes effective January 1st. The choices you make during Open Enrollment will remain in effect through December 31, 2024. Once you elect your benefits, you will not be able to change them until the next Open Enrollment, unless you experience a qualifying life event. See page 7 for more information.

Your responsibilities:

- Carefully review this guide and determine the right coverage level, such as individual or family, and complete your enrollment online or in the mobile app via MyPay. Instructions are included on **page 20** of this guide.
- Visit each carrier's website for additional information and review the provider directory to see if your physician or doctor's office is in-network.
- Gather the information for each dependent you wish to enroll including Social Security numbers and birth dates.
- Make sure your address and personal information is current. If your information is not up-to-date, you may miss out on receiving your insurance cards, plan documents, health notices, and more.
- Review your beneficiary information and update if necessary. You may update this information any time during the year by contacting Benefits or logging into MyPay.

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MEXICAN SUGAR COCINA Y CANTINA
SIXTY VINES Wine & Dine
IDA CLAIRE South of Ordinary
WHISKEY CAKE KITCHEN & BAR
ASSEMBLY FOOD HALL
HAYWIRE
THE RANCH
Son of a Butcher SLIDER BAR
THE FOOD HALL CO.
LEGACY HALL

Benefits Overview & Contributions

Medical

Medical coverage will continue to be through Blue Cross Blue Shield. Medical contributions will be remaining the same for 2024.

Weekly Rates	HDHP Plan	PPO1 Plan	PPO2 Plan
	Your Cost	Your Cost	Your Cost
Employee Only	$17.31	$48.46	$60.92
Employee + Spouse	$106.31	$152.60	$167.19
Employee + Child(ren)	$76.58	$120.58	$145.96
Employee + Family	$153.18	$196.73	$228.46
Bi-Weekly Rates	**HDHP Plan**	**PPO1 Plan**	**PPO2 Plan**
	Your Cost	Your Cost	Your Cost
Employee Only	$34.62	$96.92	$121.85
Employee + Spouse	$212.61	$305.19	$334.38
Employee + Child(ren)	$153.17	$241.15	$291.92
Employee + Family	$306.36	$393.46	$456.92

Supplemental

Critical Illness and Accident coverage will continue to be through MetLife.

Weekly Rates	Hospital Indemnity		Accident	LifeLock	
	Low Plan	High Plan	Low Plan	Standard Plan	Advantage Plan
Employee Only	$3.52	$7.18	$3.65	$1.96	$3.92
Employee + Spouse	$5.81	$11.87	$5.60	$3.92	$7.84
Employee + Child(ren)	$5.81	$11.87	$6.04	$3.43	$5.88
Employee + Family	$8.45	$17.25	$8.49	$5.39	$9.84
Bi-Weekly Rates	**Hospital Indemnity**		**Accident**	**LifeLock**	
	Low Plan	High Plan	Low Plan	Standard Plan	Advantage Plan
Employee Only	$7.03	$14.36	$7.30	$3.92	$7.84
Employee + Spouse	$11.62	$23.73	$11.19	$7.84	$15.68
Employee + Child(ren)	$11.62	$23.73	$12.08	$6.86	$11.76
Employee + Family	$16.90	$34.50	$16.99	$10.78	$19.68

Disability

Disability coverage will continue to be through OneAmerica.

Employee Only: $0.50 per month

1. To calculate, divide annual earnings by 52: $________
2. Multiply times 0.60: $________
3. Divide by 10: $________
4. Multiply times 0.50: $________
5. Multiply times 12: $________
6. Divide by 26 or 52: $________

This is your bi-weekly or weekly cost.

Taxes and Your Benefits

Your cost for many coverage's under the benefits plan will be paid on a before-tax basis through payroll deductions. This means that your benefit deductions go farther because you save the federal income tax that would otherwise be required on these contributions.

Voluntary Life

Life coverage will continue to be through OneAmerica.
Please note that these are monthly rates.

Employee Options - Weekly Rates

Life & AD&D	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+
$10,000	$0.32	$0.32	$0.32	$0.34	$0.38	$0.55	$0.82	$1.47	$2.28	$2.67	$4.72	$8.88	$24.06	$55.01
$20,000	$0.63	$0.63	$0.63	$0.67	$0.77	$1.09	$1.64	$2.94	$4.55	$5.34	$9.44	$17.75	$48.12	$110.01
$40,000	$1.25	$1.25	$1.25	$1.34	$1.53	$2.17	$3.28	$5.86	$9.09	$10.66	$18.88	$35.49	$96.23	$220.02
$60,000	$1.87	$1.87	$1.87	$2.01	$2.29	$3.26	$4.92	$8.80	$13.64	$16.00	$28.32	$53.24	$144.35	$330.03
$80,000	$2.49	$2.49	$2.49	$2.68	$3.05	$4.34	$6.56	$11.72	$18.19	$21.32	$37.76	$70.99	$192.46	$440.03
$100,000	$3.12	$3.12	$3.12	$3.35	$3.81	$5.43	$8.20	$14.66	$22.74	$26.66	$47.20	$88.74	$240.58	$550.04
$140,000	$4.37	$4.37	$4.37	$4.69	$5.33	$7.60	$11.47	$20.52	$31.83	$37.32	$66.07	$124.23	$336.81	$770.06
$160,000	$4.99	$4.99	$4.99	$5.35	$6.09	$8.68	$13.11	$23.45	$36.37	$42.65	$75.51	$141.97	$384.92	$880.06
$180,000	$5.61	$5.61	$5.61	$6.03	$6.86	$9.76	$14.75	$26.38	$40.92	$47.98	$84.95	$159.72	$433.04	$990.07
$200,000	$6.23	$6.23	$6.23	$6.69	$7.62	$10.85	$16.39	$29.31	$45.46	$53.31	$94.39	$177.46	$481.15	$1,100.08

Spouse Options - Weekly Rates

Life & AD&D	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+	75+
$5,000	$0.16	$0.16	$0.16	$0.17	$0.19	$0.27	$0.41	$0.73	$1.14	$1.33	$2.36	$4.44	$12.03	$27.50
$10,000	$0.32	$0.32	$0.32	$0.34	$0.38	$0.55	$0.82	$1.47	$2.28	$2.67	$4.72	$8.88	$24.06	$55.01
$15,000	$0.47	$0.47	$0.47	$0.50	$0.57	$0.82	$1.23	$2.20	$3.41	$4.00	$7.08	$13.31	$36.09	$82.51
$20,000	$0.63	$0.63	$0.63	$0.67	$0.77	$1.09	$1.64	$2.94	$4.55	$5.34	$9.44	$17.75	$48.12	$110.01
$30,000	$0.94	$0.94	$0.94	$1.00	$1.14	$1.63	$2.46	$4.40	$6.82	$8.00	$14.16	$26.62	$72.17	$165.01

Child Options - Weekly Rates

Life & AD&D	Child(ren) 6 months to age 26	Child(ren) live birth to 6 months	Deduction amount
Option 1:	$10,000	$1,000	$0.57

Employee Options - Bi-Weekly Rates

Life & AD&D	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+
$10,000	$0.63	$0.63	$0.63	$0.67	$0.76	$1.09	$1.64	$2.93	$4.55	$5.33	$9.44	$17.75	$48.12	$110.01
$20,000	$1.25	$1.25	$1.25	$1.34	$1.53	$2.17	$3.28	$5.87	$9.10	$10.67	$18.88	$35.50	$96.24	$220.02
$40,000	$2.49	$2.49	$2.49	$2.68	$3.05	$4.34	$6.55	$11.72	$18.18	$21.32	$37.75	$70.98	$192.46	$440.03
$60,000	$3.74	$3.74	$3.74	$4.02	$4.57	$6.51	$9.83	$17.59	$27.28	$31.99	$56.63	$106.48	$288.70	$660.05
$80,000	$4.98	$4.98	$4.98	$5.35	$6.09	$8.68	$13.11	$23.44	$36.37	$42.64	$75.51	$141.97	$384.92	$880.06
$100,000	$6.23	$6.23	$6.23	$6.70	$7.62	$10.85	$16.39	$29.31	$45.47	$53.31	$94.39	$177.47	$481.16	$1,100.08
$140,000	$8.73	$8.73	$8.73	$9.37	$10.66	$15.19	$22.94	$41.03	$63.65	$74.63	$132.14	$248.45	$673.62	$1,540.11
$160,000	$9.97	$9.97	$9.97	$10.70	$12.18	$17.35	$26.21	$46.89	$72.74	$85.29	$151.01	$283.94	$769.84	$1,760.12
$180,000	$11.22	$11.22	$11.22	$12.05	$13.71	$19.52	$29.49	$52.76	$81.83	$95.96	$169.89	$319.43	$866.08	$1,980.14
$200,000	$12.46	$12.46	$12.46	$13.38	$15.23	$21.69	$32.77	$58.61	$90.92	$106.61	$188.77	$354.92	$962.30	$2,200.15

Spouse Options - Bi-Weekly Rates

Life & AD&D	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+	75+
$5,000	$0.31	$0.31	$0.31	$0.33	$0.38	$0.54	$0.82	$1.46	$2.27	$2.66	$4.72	$8.87	$24.05	$55.00
$10,000	$0.63	$0.63	$0.63	$0.67	$0.76	$1.09	$1.64	$2.93	$4.55	$5.33	$9.44	$17.75	$48.12	$110.01
$15,000	$0.93	$0.93	$0.93	$1.00	$1.14	$1.63	$2.46	$4.39	$6.82	$7.99	$14.16	$26.62	$72.17	$165.01
$20,000	$1.25	$1.25	$1.25	$1.34	$1.53	$2.17	$3.28	$5.87	$9.10	$10.67	$18.88	$35.50	$96.24	$220.02
$30,000	$1.87	$1.87	$1.87	$2.00	$2.28	$3.25	$4.91	$8.79	$13.64	$15.99	$28.31	$53.24	$144.34	$330.02

Child Options - Bi-Weekly Rates

Life & AD&D	Child(ren) 6 months to age 26	Child(ren) live birth to 6 monhts	Deduction amount
Option 1:	$10,000	$1,000	$1.13

Terms To Know

Plan Year: January 1st through December 31st each year.

Coinsurance: The percent of eligible charges that the plan pays.

Copay: The amount paid by a covered person to a network provider at the time services are rendered. Co-payments for covered services are not applied to your deductible.

Annual Deductible: The amount you must pay for covered health services based on contracted rates (also referred to as eligible charges/expenses) in a year before the plan will begin paying certain benefits in that year.

Eligible Employee: Eligibility is defined as a hourly team member who has averaged 30 or more hours per week, over a 3 month time frame initially, and over a 12 month time frame going forward.

Guarantee Issue: The amount of coverage pre-approved by the Life Insurance Company regardless of health status. Applies to Supplemental Life/AD&D.

Medical Emergency: A sudden, serious, unexpected and acute onset of an illness or injury where a delay in treatment would cause irreversible deterioration resulting in a threat to the patient's life or body part.

Network Benefits: The benefits applicable for the covered services of a network provider.

Non-Network Benefits: The benefits applicable for the covered services of a non-network provider.

Open Enrollment: The period during which existing employees and their dependents are given the opportunity to enroll in or change their current elections.

Out-of-Pocket Maximum: The most a covered person can pay in coinsurance in a calendar year for covered health care expenses.

Affordable Care Act: Means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, and the authoritative guidance issued thereunder by the appropriate governmental entities.

Preferred Provider Organization (PPO): A network of health care providers contracted to provide medical services to covered employees and dependents at negotiated rates. You may seek care from either a network or non-network provider, but network care is covered at a higher benefit level and the employee is responsible for a greater portion of the cost when using a non-network provider.

Usual and Customary Rates (UCR): Non-network health plan expenses are considered for reimbursement at usual and customary (U&C) rates. U&C rates are determined to be the prevailing charge made for a service by a similar provider in the same geographic area. Charges above U&C are not covered by the plan and are the responsibility of the participant.

Eligibility

New employees hired on or after October 1st will be eligible on first day of the following month after 3 months of employment only if they are averaging minimum 30 hours of work per week. Employees will have to meet the hourly requirement every 12 months to requalify for benefits.

Eligible employees may also enroll the following dependents in our group benefit plans:

- Your legal spouse
- Your natural, adopted or stepchildren up to age 26
- A child for whom legal guardianship has been awarded
- Unmarried children of any age if disabled and claimed as a dependent on your federal income taxes

Please keep in mind proof of dependency is optional, however it can be requested at any time throughout the plan year.

Spouse:

- A copy of your marriage certificate OR
- Front page of your jointly filed federal tax return.

Child (Ages 0-26):

- A copy of the child's birth certificate issued by the state, naming you or your spouse as the child's parent, or appropriate court order/adoption decree naming you or the most recently filed federal tax return confirming this child is a legal dependent.
- In addition, a stepchild requires copy of the front page of the most recently filed federal tax return confirming the child as a dependent, or other documentation such as a divorce decree or custody arrangement confirming the stepchild resides with you.

Making Changes to Your Benefits

Outside of your initial new hire or the annual Open Enrollment period changes to your benefits can only be made throughout the year within 30 days of a qualifying life event, such as:

- Marriage, divorce, legal separation
- Birth or adoption
- Change in your or your spouse's work status that affects your benefits or an eligible dependent's benefits
- Change in health coverage due to your spouse's annual Open Enrollment period
- Change in eligibility for you or a dependent for Medicaid or Medicare
- Receipt of a Qualified Medical Child Support Order or other court order

To see a full list , or to report a life event, contact Human Resources.

You must notify Benefits at benefits@fbrest.com of the requested change within 30 days of the event., and documentation must be provided.

Please keep in mind that the change in coverage you wish to make must be consistent with the qualifying life event.

Medical Benefits

FB Society employees have the choice between three medical plans offered through BlueCross BlueShield of Texas: two traditional PPO plans and a High Deductible Health Plan (HDHP). With the traditional plans, you pay a copay for office visits and other covered services are paid by the plan coinsurance once you reach your deductible.

All plans offer preventive care covered at 100%, an out-of-pocket maximum to protect you should a catastrophic event occur, and out-of-network coverage when needed. Although out-of-network coverage is available, using network providers will save you money. You can find BCBS network providers online at bcbstx.com or by calling 800-521-2227.

Prescription Drug Benefits

When you enroll in BCBS medical plan, you are automatically enrolled in prescription drug coverage. Prescription drug coverage is one of the most valuable, but also one of the most expensive, benefits offered. Always discuss lower cost alternatives with your physician and check the insurance company's website for a complete drug list at bcbstx.com.

If you regularly take the same medications, a mail order program may allow you to get a three-month supply for a lower cost, saving you trips to the pharmacy and time waiting in line. In addition, many chain pharmacies offer certain generic medications at deep discounts, and some will dispense certain antibiotics for free. Check with your pharmacy to determine if any special programs are available.

Preventive Care

We encourage you and your dependents to have annual wellness exams. Most preventive exams and well-child exams (including immunizations) are covered at 100% under the plans. Preventive exams can detect if you are at risk for, or already have, a chronic disease that may be preventable. Talk to your health care provider to find out which screenings are recommended for you and when you need them.

Medical Plan Comparison

In-Network	HDHP Plan	PPO1 Plan	PPO2 Plan
Deductible	$5,000 Individual/$10,000 Family	$5,000 Individual/$10,000 Family	$2,500 Individual/$5,000 Family
Out-of-Pocket Max	$5,000 Individual/$10,000 Family	$7,150 Individual/$14,300 Family	$5,000 Individual/$10,000 Family
Preventive Care	Covered at 100%, no deductible	Covered at 100%, no deductible	Covered at 100%, no deductible
Primary Care Visit	Plan pays 100% after deductible	$40 copay	$25 copay
Specialist Visit	Plan pays 100% after deductible	$40 copay	$25 copay
Urgent Care Visit	Plan pays 100% after deductible	$65 copay	$50 copay
Emergency Room	Plan pays 100% after deductible	$100 copay then plan pays 70% after deductible	$100 copay then plan pays 80% after deductible
Inpatient & Outpatient Hospital	Plan pays 100% after deductible	Plan pays 70% after deductible	Plan pays 80% after deductible
Mental Health/ Substance Abuse	Inpatient & Outpatient: Plan pays 100% after deductible	In & Outpatient: Plan pays 70% after deductible/$40 copay	Inpatient/Outpatient: Plan pays 80% after deductible/$25 copay
Retail Rx *74 days*			
» Generic	Plan pays 100% after deductible	$20 copay	$20 copay
» Preferred	Plan pays 100% after deductible	$40 copay	$35 copay
» Non-Preferred	Plan pays 100% after deductible	$60 copay	$50 copay
» Specialty	Plan pays 100% after deductible	$20/$40/$60 copay	$20/$35/$50 copay

Out-of-Network	HDHP Plan	PPO1 Plan	PPO2 Plan
Deductible	$10,000 Individual/$20,000 Family	$10,000 Individual/$20,000 Family	$5,000 Individual/$10,000 Family
Out-of-Pocket Max*	$20,000 Individual/$40,000 Family	$20,000 Individual/$60,000 Family	$10,000 Individual/$20,000 Family
Preventive Care	Plan pays 70% after deductible	Plan pays 70% after deductible	Plan pays 70% after deductible
Primary Care Visit	Plan pays 70% after deductible	Plan pays 70% after deductible	Plan pays 70% after deductible
Specialist Visit	Plan pays 70% after deductible	Plan pays 70% after deductible	Plan pays 70% after deductible
Urgent Care Visit	Plan pays 70% after deductible	Plan pays 70% after deductible	Plan pays 70% after deductible
Emergency Room	Plan pays 70% after deductible	$100 copay then plan pays 70% after deductible	$100 copay then plan pays 80% after deductible
Inpatient/Outpatient Hospital	Plan pays 70% after deductible	Plan pays 50% after deductible	Plan pays 60% after deductible
Mental Health/ Substance Abuse	Inpatient & Outpatient: Plan pays 70% after deductible	Inpatient & Outpatient: Plan pays 50% after deductible	Inpatient & Outpatient: Plan pays 60% after deductible
Retail Rx *74 days*			
» Generic	Plan pays 70% after deductible	$20 copay plus 20% coinsurance	$20 copay plus 20% coinsurance
» Preferred	Plan pays 70% after deductible	$40 copay plus 20% coinsurance	$40 copay plus 20% coinsurance
» Non-Preferred	Plan pays 70% after deductible	$60 copay plus 20% coinsurance	$60 copay plus 20% coinsurance

This is meant to be a brief summary only. For full plan details refer to the Summary Plan Description (SPD).

**Includes calendar year deductible*

Medical Plan Resources

Blue Access for Members

Register or log in to your secure member site — Blue Access for Members^{SM} (BAM^{SM}) — to view coverage details, access identification (ID) cards, check claims status, manage your user profile, and view health and wellness information.

Download the BAM mobile app to access your ID cards and plan information anytime, anywhere when you are on the go. Visit bcbstx.com to register. Download the app on Google Play or the App Store, or text BCBSTXAPP to 33633.

Personal Health Manager

You and your family members can take advantage of important health and wellness online tools and resources with Personal Health Manager. Explore how the Personal Health Manager features can help you achieve your wellness goals.

Discover

- Take the confidential *Health Risk Assessment* to better understand your current health condition, identify potential issues, and reinforce what you're doing right.
- Get health and wellness questions answered via secure email through *Ask A Nurse, Ask A Dietitian, Ask A Trainer* and *Ask A Life Coach*.

Plan

- Visit the For Your Health section for helpful information and suggestions on exercise, nutrition, and lifestyle issues.
- Create customized plans for you and your family members to follow.

Track

- Stay motivated and track your *Get Fit, Eat Right*, and *Live Well* plan goals and activity progress.
- Set up a personal health record to keep track of and manage your and your family's health information in one secure location.

Reward

- Stay motivated to reach your goals—when you use many of the features of the *Personal Health Manager*, you automatically earn Blue Points that can be redeemed for reward items.

Log in to Blue Access at bcbstx.com and click the Personal Health Manager icon to get started.

MDLive Virtual Visits

Visit independently contracted board-certified doctors with MDLive for treatment of non-emergency medical and pediatric health issues, and even get a prescriptions sent to a nearby pharmacy (when appropriate). Instead of going to the ER or urgent care for non-emergency visits, schedule a virtual visit to save time and money.

Common reasons for choosing virtual care:

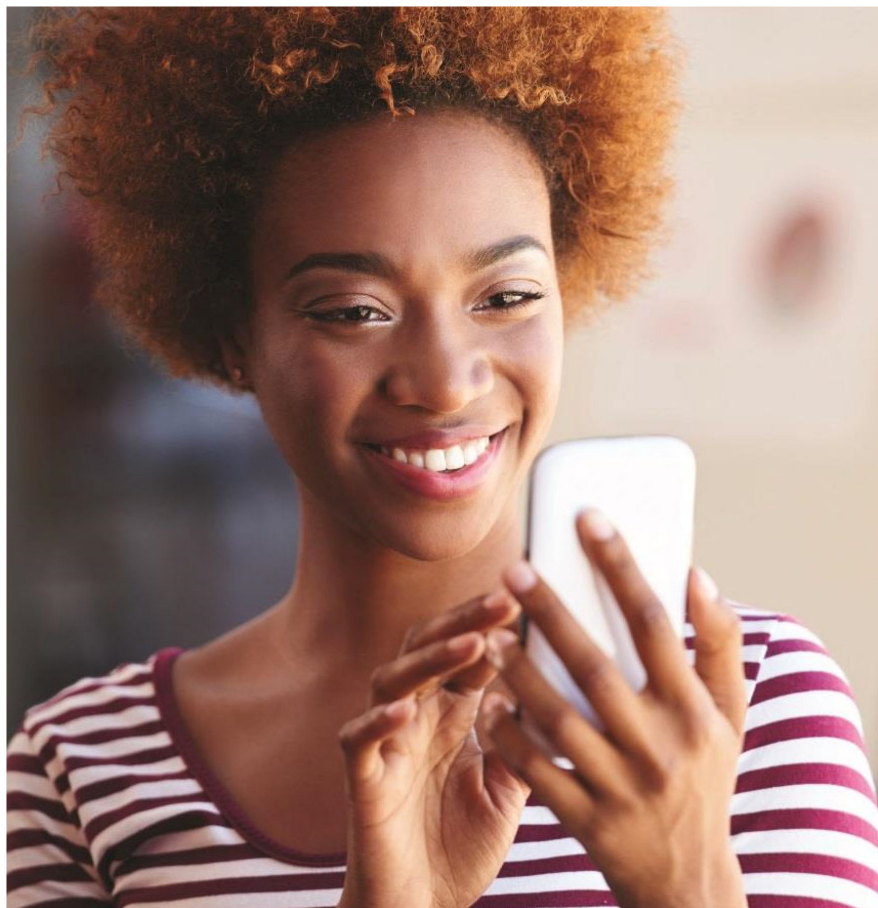
- Allergies
- Cold & Flu
- Cough
- COVID-19
- Ear Pain
- Headache
- Insect Bites
- Medication Refills
- Pink Eye
- Rash
- Sinus Problems
- Sore Throat
- UTI (Adults Females, 18+)
- Yeast Infections
- And more

To get started, visit members.mdlive.com/bcbstx and register so you'll be ready to receive care when you need it, and download the MDLive mobile app on Google Play or the App Store.

Additional Resources

Visit bcbstx.com for more information on a wealth of tools and resources, including:

- 24/7 Nurse Line - Call 877-351-8392
- Special Beginnings Maternity Program
- Complementary Alternative Medicine
- Blue Care Connection
- Curves Membership Discounts
- Well-Woman Exams Benefit
- Jenny Craig Membership Discounts



BlueCross BlueShield of Texas

Start Saving Money on High-Cost Medications with FlexAccess™

FlexAccess is a cost assistance program designed to help you lower your costs if you take certain high-cost medications. This program is part of the Blue Cross and Blue Shield of Texas (BCBSTX) health plan your employer offers.

Get the Most From the FlexAccess Program

- If you or your dependents take one or more of the medications in our program, you may get a letter or, in some cases, a phone call from the FlexAccess team to help you get started.
- The team will review your cost share (what you pay when you buy your prescription) at the pharmacy you use now. The new amount you would pay may be as low as $0.
- You should speak with FlexAccess, even if you are using a drug manufacturer's coupon now, to make sure you are paying the lowest cost.
- Participating in this program is your choice. If you don't take part, you may pay up to the full price of your medications.

Call FlexAccess at **888-302-3618**, M-F, 7 a.m. to 7 p.m. CT, or email FlexAccess Member Services at **member.services@flexaccessrx.com** to ask any question or find out if your prescription drug is part of this program.

Prescription drugs included in the program may change without notice. If at any time your medications are no longer part of the program, your out-of-pocket prescription cost will be based on your plan benefits.

FlexAccess is a trademark of Prime Therapeutics LLC. FlexAccess is a product owned by Prime Therapeutics, which is a separate pharmacy benefit management company contracted by Blue Cross and Blue Shield of Texas (BCBSTX) to provide pharmacy benefit management and related other services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.

Blue Cross®, Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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Where To Go For Care

24/7 Nurseline

If an unexpected medical situation arises, a nurse can help you decide if you should call your doctor, visit the ER or urgent care, or treat the problem yourself. A nurse can also let you know if you can wait to see the doctor the next day.

Doctor's Office

Your primary care physician (PCP) should be your first choice for non-emergency care and ongoing health conditions. Your PCP knows your medical history and can help manage chronic conditions and recommend specialists or other medical care.

MDLive Virtual Visit

If your doctor isn't available, you are out of town, or you need care after hours for a simple condition try an virtual visit. Go online or access the app to make an appointment with a physician anytime, 24/7 wherever you are.

Urgent Care and Retail Clinics

If your doctor isn't available, or you need care after hours for a non life threatening issue, visit an urgent care or retail health clinic for simple conditions such as a cold or the flu. Urgent care centers can provide a greater range of care including x-rays.

Emergency Room

Only visit the ER for serious, life threatening medical care. If you feel you are dealing with a health emergency, call 911 or go to the ER right away. Do not visit for routine care or minor ailments.

Health Savings Account

When you elect to enroll in the High Deductible Health Plan (HDHP), you are eligible to open a Health Savings Account through the bank or financial institution of your choice to have pre-tax dollars deducted from your paycheck and deposited to pay for eligible out-of-pocket health care expenses. You are the owner of this bank account, and unlike a traditional Flexible Spending Account, your funds can roll over from year-to-year and build over time.

HSA Advantages

- Pre-tax savings – never pay federal government taxes on your HSA funds as long as you spend the money on eligible IRS 213(d) medical, dental, and vision expenses.
- Unused funds carry over from year to year and can build over time.
- You have complete control over how and when funds are used.
- Balances over a certain amount may have investment opportunities.
- Funds remaining in your account after you reach the age of 65 can be used for non-medical expenses with ordinary taxes paid, similar to a 401(k).
- HSAs are portable; if you leave FB Society you can take the account with you.

Maximum Contributions

The 2024 IRS annual maximum contribution into your account:

- Single coverage : $4,150
- Family coverage: $8,300
- Persons aged 55 and above may set aside an additional $1,000 in catch-up contributions each year

Voluntary Life and AD&D Insurance

Voluntary Life Insurance

Life insurance provides a lump sum cash benefit to surviving dependents to cover immediate costs such as funeral expenses or ongoing living expenses to help survivors adjust to the loss of income related to the death of a wage earner, or funds for college or retirement for the survivors.

Voluntary Life
Employee: $10,000 increments up to $300,000 max. **Guarantee Issue:** $200,000
Spouse: $5,000 increments up to $150,000 max. **Guarantee Issue:** $30,000
Child: Birth - 6 months: $1,000 **Child: 6 months - 26 years:** $10,000 **Guarantee Issue:** Full amount

Benefits reduce by 35% of the original amount at age 65; and further reduce by: 60% of the original amount at age 70; 75% of the original amount at age 75. Refer to the Plan Certificate for details.

Eligible employees have the option to purchase Voluntary Life coverage through OneAmerica. Coverage may also be purchased to cover a spouse and/or child(ren) after electing coverage for yourself. The Guarantee Issue (GI) amount is the highest amount of coverage that you or your dependents may elect without completing an Evidence of Insurability (EOI) form. If you elect an amount of coverage above the GI limit, or elect to increase your benefit amount at a future date, the benefit amount over the GI level will not go into effect until your EOI has been approved.

Voluntary AD&D

AD&D insurance provides a specified benefit for a covered accidental death or covered accidental bodily injury that directly caused dismemberment (the loss of a hand, foot, or eye). In the event of death, the amount of AD&D insurance is equal to your amount of life insurance.

Voluntary AD&D
Loss of Life: Pays 100%
Loss of Both Hands, Feet or Eyes: Pays 100%
Loss of Hand, Foot or Eye: Pays 50%

Refer to the Plan Certificate for details.

Short-Term Disability

Short-Term Disability (STD) insurance pays a weekly benefit for the short duration that you are unable to work due to a non work-related accident or illness. It is designed to help replace a portion of your lost income enabling you to maintain your way of life and protect your savings.

Eligible FB Society employees may elect Voluntary STD coverage through

Short-Term Disability*	
Elimination Period	Illness/Injury: 14 days
Benefit Amount	60% of weekly earnings up to $1,000/week
Maximum Benefit Duration	Up to 11 weeks
Pre-existing Conditions	3/6

Benefits begin on the first of the month following 60 days.

Disability Benefit Calculator

Weekly earnings = $__________________

Multiply times 0.60 = $__________________
Estimated weekly benefit with a maximum, not to exceed $1,000 a week

*Coverage excludes Preexisting conditions.- any condition for which a Person received medical advice or treatment during the 3 months immediately prior to a Person's Individual Effective Date of Insurance.

Supplemental Insurance

Supplemental benefits can help offset costs caused by accident or hospitalization. They can also cover some non-medical expenses that your current insurance might not. These plans are provided through MetLife and you pay for the coverage elected through convenient payroll deductions.

Hospital Indemnity Insurance

Even with a quality medical plan, extra expenses can add up if you have an unexpected medical need. Hospital Indemnity insurance through MetLife helps you cover your out-of-pocket expenses (like deductibles and coinsurance) when you are admitted to the hospital. Payments are made directly to you, not to the doctors, hospitals or other health care providers. Two individual hospital plan choices are available for you to purchase: a Low Option and a High Option. The High Option offers a higher benefit in exchange for a higher per-paycheck cost.

Hospital Indemnity	Low Plan	High Plan
Accident/Illness Hospital Admission	$500	$1,000
Accident/Illness Hospital Confinement	Non-ICU: $100/day, up to 365 days ICU: $200/day, up to 30 days	Non-ICU: $200/day, up to 365 days ICU: $400/day, up to 30 days
Accident Inpatient Rehab*	$100/day, up to 15 days/accident and 30 days/calendar year	$200/day, up to 15 days/accident and 30 days/calendar year

This is meant to be a brief summary. Refer to the Plan Summary for details.

**Immediately following a hospital confinement within 365 days of accident*

Accident Insurance

Accident insurance through MetLife provides a financial cushion by helping you pay for costs that aren't covered by your medical plan. It provides you with a lump-sum payment for extra cash to help you focus on getting back on track, without worrying about finding the money to help cover the costs of treatment.

Accident	Low Plan
Fractures	$50 - $3,000 per injury
Initial Hospitalization Benefit	Non-ICU: $500/ICU: $1,000
Accident/Illness Hospital Confinement	Non-ICU: $100/ICU: $200
Accidental Death	Employee: $25,000/Spouse: $12,500/Child: $5,000
Dismemberment, Loss & Paralysis	$250 - $10,000 per injury

This is meant to be a brief summary. Refer to the Plan Summary for details.

Additional Benefits

401(k) Retirement Plan

We are partnering with Principal® to provide services for our new retirement plan. Your benefits are important to us, which is why we selected Principal as our service provider. They are committed to your success and making this move as simple as possible.

- Eligibility: 21 years of age and one year of service in which worked 1,000 hours. Semi-annual entry. Keep in mind that the 401(K) plan is for ALL employees if they meet these eligibility requirements.
- Match: 100% of first 3% plus 50% of the next 2% that you contribute to the plan. Immediate vesting (Safe Harbor contribution). That means that the employer contribution to the plan belongs to the participant immediately.
- Contributions: Pre-tax (tax-deferred) and after- tax (Roth).
- Maximum contribution amount (2024): $24,000. If 50 years of age or older, additional catch up of $7,500 is allowed. Participants can choose to save from 1% to 90% of their pay into the 401(K).
- Deferral Changes (or changing your savings percentage) frequency: Semi-annual. May stop anytime.
- Bonus: Separate election. May change the amount anytime.
- Default investment option: Principal LifeTime Hybrid Portfolios (Target Date Fund) or build your own portfolio using the individual investment options available.

Please call Principal's Participant Contact Center at 800-547-7754 with any questions or ask your manager.

LifeLock Identity Theft Protection

Identity fraud can damage your finances, credit and reputation. Thieves can get a new home, car or line of credit in your name. At LifeLock, our job is to help protect against identity fraud and handle things for you if it occurs.

LifeLock Standard Membership

- Privacy Monitor
- Dark Web Monitoring
- Stolen Wallet Protection
- Identity Alert System
- Stolen Funds Reimbursement
- One-Bureau Credit Monitoring
- USPS Address Change Verification
- Coverage for Lawyers and Experts
- Restoration Specialists

LifeLock Advantage Membership

Includes Standard services plus...

- Bank & Credit Card Activity Alerts
- Court Records Scanning
- Fictitious Identity Monitoring
- Data Breach Notifications

Provide your information during enrollment and your LifeLock coverage will begin upon your effective date. You will receive a welcome email with instructions how to take full advantage of your membership.

Benefit Contacts

Benefit	Phone	Web/Email
Medical BlueCross BlueShield	800-521-2227 Nurseline: 877-351-8392	bcbstx.com
Virtual Visits MDLive	888-680-8646	members.mdlive.com/bcbstx
Dental	800-244-6224	mycigna.com
Vision EyeMed	866-804-0982	eyemed.com
Voluntary Life & Disability OneAmerica	800-553-5318	oneamerica.com
Supplemental Benefits MetLife	800-438-6388	metlife.com
Identity Theft Protection LifeLock	800-607-9174	lifelock.com
Benefits FB Society		benefits@fbrest.com

Your Benefit Resources

More details about the benefits offered to you can be found by:

- Logging into MyPay
- Registering on the insurance company websites
- Downloading the insurance company smartphone apps
- Calling the insurance company directly

If you have questions or need assistance enrolling, contact Human Resources.

Online Enrollment Instructions

Our online payroll and benefits portal, MyPay, enables you to make your benefit elections whenever and wherever it is most convenient for you. This site will guide you through the enrollment process. For each benefit you will be able to review your choices and select your coverage level to include any dependents.

Follow these steps to make your benefit elections:

1. Gather the personal information for the dependents you wish to cover including Social Security numbers and birth dates.
2. When it is time for you to enroll, you will receive an email from MyPay with your username and a temporary password. Go to https://www.hralliance.net/ee/login.aspx and input your login information.
3. Go to the “Benefits” tab and click on your enrollment.
4. After reading the Welcome Page, please check the “I Agree” Box, press “Submit,” and then click the next page.
5. Review your personal information and request any changes by clicking the “Request Change” button and then click “Next Page.”
6. Verify all of your dependent’s personal information is included and correct. Otherwise, click “Add Dependent,” and enter the information. Click to move to the next page.
7. Select your benefit plans keeping in mind that each one may require additional selections such as confirming dependent coverage or selecting an amount. Click “Next Page” when finished.
8. Review and verify your selected plans. If correct, select “Submit.” If any “Warnings” appear, please return to the corresponding Plan’s page to correct any missing information.
9. Verify the amounts that will be deducted from your paycheck and print a copy of your selections for your records.
10. Click “I have reviewed my benefit elections above and am ready to submit them.”
11. Complete the electronic signature, which will allow for your enrollment to be submitted to Benefits for processing.

Important Notices

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator as identified at the end of these notices.

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

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, 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). To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefit 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

Coverage After Termination (COBRA) - Health Coverage: If you or your dependents have coverage at the time of a qualifying event, you may be eligible to elect continuation of coverage under one or more of the following:

- Medical Plan, Dental Plan, and Vision Plan

You have a legal right under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to purchase a temporary extension of your coverage at group rates. However, you must pay the full cost of the coverage, plus a 2% administrative fee.

What is COBRA Continuation Coverage? COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary."

You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect. COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

COBRA & Retirement: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to **FB Society,** and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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

- The end of employment or reduction of hours of employment;
- Death of the employee or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided? Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. **There are also ways in which this 18-month period of COBRA continuation coverage can be extended.**

Disability extension of 18-month period of COBRA continuation coverage: If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage: If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage e if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

(HIPAA) Employee Health Plan Summary Notice of Privacy Practices: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Uses and Disclosures of Health Information: FB Society uses health information about you for treatment, to pay for treatment, and for other allowable healthcare purposes. Health care providers submit claims for payment for treatment that may be covered by the group health plan. Part of payment includes ascertaining the medical necessity of the treatment and the details of the treatment or service to determine if the group health plan is obligated to pay. Information may be shared by paper mail, electronic mail, fax, or other methods. Subject to certain requirements, **FB Society** may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. **FB Society** provides information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and distribute the new notice. You can also request a copy of our full notice at any time. For more information about our privacy practices, contact the Office of the Privacy Officer or the Human Resources Department.

Your Health Information Rights: In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you the normal copy fees that reflect the actual costs of producing the copies including such items as labor and materials. You also have the right to receive a list of instances where **FB Society** has disclosed health information about you for reasons other than treatment, payment, healthcare operations, related administrative purposes, and when you explicitly authorized it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that **FB Society** correct the existing information or add the missing information. You have the right to request that **FB Society** restrict the use and disclosure, then **FB Society** must abide by the request and may only reverse the position after you have been appropriately notified. You have the right to request an alternative means of communication with FB Society and are not required to explain why you want the alternative meansof communication.

Privacy Complaints: If you are concerned **FB Society** has violated your privacy rights, or you disagree with a decision FB Society has made about access to your records, you may address them to the Privacy Contact listed in this notice. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

The FB Society Responsibilities: FB Society is required by law to protect the privacy of your information, provide this notice about **FB Society Restaurant's** information practices, follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this notice.

Detailed Notice of Privacy Practices: For further details about your rights and the federal Privacy Rule, refer to the detailed statement of this Notice. You can ask for a written copy of the detailed Notice by contacting the Privacy Contact listed in this notice.

Privacy Contact: Address any questions about this notice or how to exercise your privacy rights to the Human Resources Department at 626-673-9909.

Notice Of Opportunity To Enroll In Connection With Extension Of Dependent Coverage To Age 26: Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in **FB Society**. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to January 1, 2024. If you would like more information, contact your Plan Administrator.

Notice Lifetime Limit No Longer Applies/ Enrollment Opportunity: The lifetime limit on the dollar value of benefits under FB Society benefit Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan.

Individuals have 30 days from the date of this notice to request enrollment. If you would like more information, contact your Plan Administrator.

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 **FB 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 e 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. **FB Society** has determined that the prescription drug coverage offered by **BLUE CROSS BLUE SHIELD** 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 coverage with **FB Society** will not be affected. You and/or your dependents can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with **FB 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 n 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 plan administrator. 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 **FB 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).

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information: When key parts of the health care law took effect in 2014, this created a new way to buy health insurance:

the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace? The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2023 for coverage starting as early as January 1, 2024.

Can I Save Money on my Health Insurance Premiums in the Marketplace? You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.*

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer- offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information? For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost.

Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer: This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Here is some basic information about health coverage offered by this employer: Eligible employees are Fulltime employees who work 30 hours per week and have completed the newly eligible 60 day waiting period.

Eligible dependents include the employee's spouse and eligible dependent children up to age 26.

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace.
The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

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.

Finally, if you or an eligible dependent has coverage under a state Medicaid or child health insurance program and that coverage is terminated due to a loss of eligibility, or if you or an eligible dependent become eligible for state premium assistance under one of these programs, you may be able to enroll yourself and your eligible family members in the Plan. However, you must request enrollment no later than 60 days after the date the state Medicaid or child health insurance program coverage is terminated or the date you or an eligible dependent is determined to be

eligible for state premium assistance.

To request special enrollment or obtain more information, contact the plan administrator listed below: Benefits: benefits@fbrest.com

Notice Informing Individuals About Non Discrimination and Accessibility Requirements Discrimination is against the law: FB Society complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. **FB Society** does not exclude people or treat them differently because of race, color, national origin, age, disability, orsex.

FB Society:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Benefits at benefits@fbrest.com. If you believe that **FB Society** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: TWC's Civil Rights Division at https://www.twc.texas.gov/jobseekers/how-submit-employment-discrimination-complaint#:~:text=TWC's%20Civil%20Rights%20Division's%20programs,against%20in%20an%20employment%20transaction.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

Consolidated Appropriations Act (CAA) No Surprises Act

Your Rights and Protections Against Surprise Medical Bills When you get emergency care or get treated by an out-of-network provider at an in -network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")? When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit. "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for: Emergency services If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services. [Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language as appropriate] Certain services at an in-network hospital or ambulatory surgical center when you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network. When balance billing isn't allowed, you also have the following protections: You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly. Your health plan generally must cover emergency

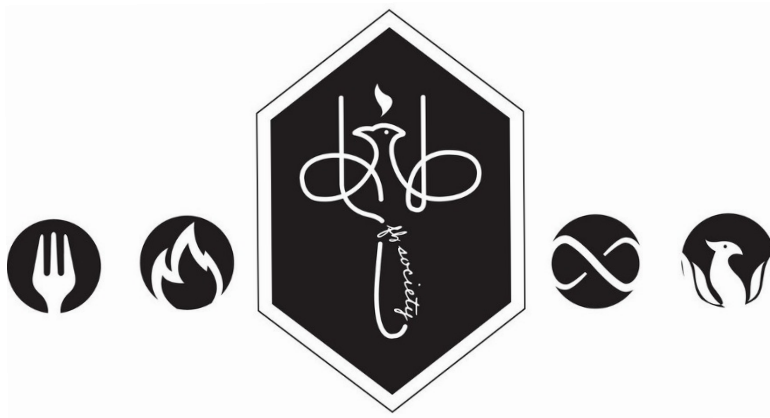
services without requiring you to get approval for services in advance (prior authorization). Cover emergency services by out-of-network providers. Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits. Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit. If you believe you've been wrongly billed, you may contact Human Resources at FB Society.

If you believe you've been wrongly billed, you may contact your Human Resources Department. In addition, if you have questions about a provider's network status or you believe you've been wrongly billed, please contact the BLUE CROSS BLUE SHIELD help line.

Visit www.cms.gov/nosurprises for more information about your rights under federal law.

Visit www.tdi.texas.gov for more information about your rights under state law.

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by FB Society. 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.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