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2025 ALSAC Benefits

Full-Time Employees

Dear ALSAC Employee,

Whether you are new to ALSAC or a current employee, every year during annual enrollment, employees have the opportunity to review their benefit options and make changes for the next plan year. We recognize the diverse workforce we have and strive to give you a variety of choices and flexibility in your benefit options.

Please refer to this benefits guide during annual enrollment and throughout the year so you're aware of the benefits you have available and thus, find the right "fit" for you and your family.

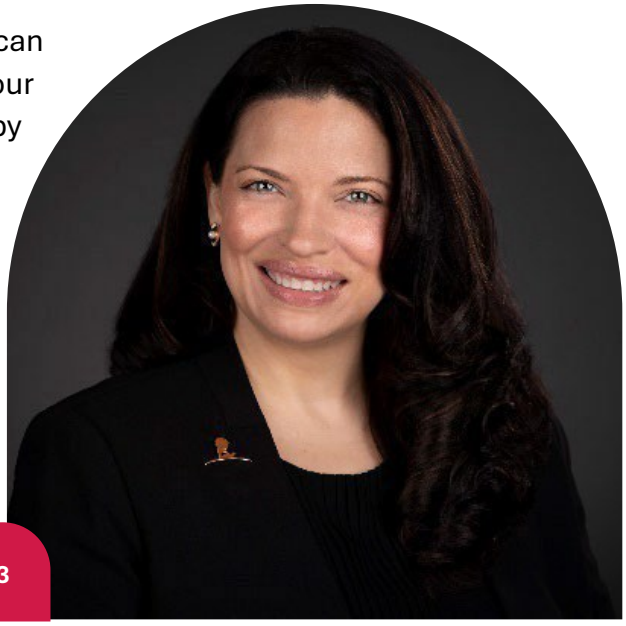
Benefits are a significant component of your overall total rewards package, and I encourage you to review your total rewards statement in Workday to see the value of this package provided to you by ALSAC. We continually review the market to ensure that we offer a comprehensive and affordable benefits package, look for benefits that support our employees, reflect the latest legislative and regulatory requirements, and keep us competitive in the marketplace.

ALSAC is continuing to provide medical coverage at no cost to you if you enroll in employee only coverage. As before, it you choose to cover dependents, you will see a reduction in cost. To continue enhancing our plans while keeping your costs at a minimum, we all have to be smart consumers of healthcare. You can help control our healthcare expense by using generic drugs instead of brand-name drugs when possible, getting your annual wellness exams and leading an active lifestyle that includes physical fitness and healthy eating. You can also be in control of your costs by staying in-network and utilizing prior authorizations when needed.

As a reminder, telemedicine services powered by MDLive are a cost-effective alternative to a convenience care clinic or urgent care center, and costs less than going to an emergency room. These allow you the flexibility of obtaining non-emergency medical care through video, voice, or mobile platforms.

Lastly, we continue to provide a very competitive 401(k) savings plan with no changes to the amount the organization contributes to it. I urge each of you to consider contributing to this retirement savings plan if you aren't already. Whether retirement is far in the distance or on your doorstep, it's never too late to start saving.

I encourage you to read the entire packet of information so you can Make the best benefit choices for you and your family. Through our partnerships with vendors and wise use of healthcare services by all of us, we can continue to provide market-competitive and affordable plans to employees.



Regards,

Annette Green
Chief People Officer, Employee Experience

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Medicare Part D Notice
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the legal notices in the back of this guide on pages 45-46 for more details.

Benefits Enrollment

As a part of ALSAC, you have a wealth of benefit options available to you. ALSAC offers you a choice of two medical plans as well as plans that provide coverage for dental, vision, life insurance and more. We encourage you to take a close look at all of the benefit information provided in this guide. Our benefit programs are just one of the many ways ALSAC helps you take care of yourself and your family.

Important Information

Enrollment in this plan is optional. Employees may choose a medical, dental and vision plan, or one of the three, or none at all.

1. Evaluate Your Benefit Options

Review all of the benefit options included in this guide.

2. Decide Your Elections

Determine what plans and coverage levels you want to elect. Consider how much of your pay, if any, you want to direct toward a Flexible Spending Account (FSA). Decide which family members are eligible to participate in the benefit plans.

3. Enroll in Your Benefits

To enter your dependent information and make your elections, access Annual Enrollment via Workday@ALSAC.

Please note: For additional information outlining benefits, directories and providers visit ALSAC's Intranet site ALSAC Resource Center (ARC). When in doubt, please contact the benefit providers or for additional questions, please submit by using the Workday@ALSAC Request Tool.

The information contained in this guide is a brief summary of benefits available to full-time ALSAC employees and is not intended to replace or amend any ALSAC benefit described. Should there be a conflict between this summary and the Plan Document, the Plan Document will be the final authority. For more information or additional questions, please use the Workday@ALSAC Request Tool.

General Information

Grandfathered Status

The ALSAC PPO medical plans are a “grandfathered health plan” under the Patient Protection and Affordable Care Act (ACA). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. As a grandfathered health plan, the ALSAC PPO medical plan may not include certain consumer provisions of the ACA that apply to other plans. However, grandfathered plans must comply with certain other consumer protections in the ACA, for example: the elimination of lifetime limits on benefits.

Effective Date of Coverage

Unless otherwise described in this guide, the effective date of coverage for new hire benefits is on the first of the month following a 30-day waiting period. For example, if you are a new hire and your first day of employment is October 13, 2024, your coverage will go into effect on December 1, 2024. Benefit changes made during annual enrollment will go into effect January 1, 2025.

When Does Coverage End?

Benefit coverage for you and any enrolled dependents will automatically end when your employment is terminated, or you are no longer eligible. Your coverage ends at midnight on your last day of active employment. Coverage for a dependent will also end when he/she no longer meets the definition of a dependent under the plan. If you are a covered dependent loses coverage, you will receive an election form which will give you the option of continuing your group health coverage for a designated period, as required by COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) law. Certain events require you to notify ALSAC within specific timeframes in order to be eligible for continued coverage. Be sure to verify that your dependents meet the eligibility requirements listed on the next page. Supporting documentation may be required.

Important Information:
To initiate a new life event, such as adding or removing dependents, as a result of a qualified life event change, you will need to initiate the change in Workday@ALSAC.

General Information

Benefit Eligibility

As an ALSAC employee, you are eligible for full-time benefits if you work at least 30 hours per week. During annual enrollment, you have the option to change plans or waive coverage. You may also drop or enroll your eligible dependents for coverage once you are eligible.

Who is Eligible?

Your family members may participate in your benefit plans if they are eligible. Eligible dependents include your spouse and your children up to age 26. Proof of dependent status is required for enrollment.

Eligible Dependents are Defined As:

- Your legal spouse as long as he or she is not legally separated from you.
- Your natural child(ren), legally adopted child(ren), or stepchild(ren) – until he or she reaches his or her 26th birthday – provided he or she is not a member of the armed services. You are required to submit written evidence of dependency upon request.
- Your natural or legally adopted child(ren) who is named in a Qualified Medical Child Support Order (QMCSO)
- Your spouse's natural or legally adopted child(ren) who is named in a Qualified Medical Child Support Order (QMCSO)
- Your foster child(ren) or legal dependent – until he or she reaches his or her 26th birthday – provided he or she is not a member of the armed services. You are required to submit written evidence of dependency upon request.
- Your naturally or legally adopted child(ren) over his or her 26th birthday who is incapable of self-support, who resides with you and depends on you for support because of a physical handicap, intellectual disability, development disability, or mental illness. Your child's handicap must have occurred prior to reaching his or her 26th birthday. Coverage is subject to approval by the Benefits Department.

The word "spouse" refers to a person of the opposite sex or same sex. A same-sex spouse is eligible for coverage if the marriage has been legalized. The word "child" refers to you and/or your spouse's biological/legally adopted child.

Qualified Life Events

Sometimes changes in your life will affect your benefits. When these changes occur, you and your dependents may be eligible for a special enrollment that allows you to adapt your benefit elections to the changes in your life.

You may enroll or make changes to your benefit elections if you experience a qualifying life event. Generally, you may change your benefit elections only during the annual enrollment period. However, the following is a list of qualified events that will allow you to change you benefit elections during the year.

Marriage	**Divorce/Legal Separation**	**Spouse Becomes Employed**	**Death of a Spouse**
Gain Dependent Child/Birth/Adoption	**Spouse Becomes Unemployed**	**Covered Dependent Child No Longer Eligible**	**Death of a Dependent Child**

The change you make must be consistent with the life event that occurred, such as adding coverage for a new spouse or baby or dropping coverage for a spouse in a divorce. In addition, if you aren't enrolled in the plan as an employee, you must enroll in the plan when you enroll any of these dependents. If your spouse is not enrolled in the plan, you may enroll him/her when you enroll a child due to birth or adoption.

New Life Event in Workday@ALSAC

To add or remove dependents because of a qualified life event, you will need to initiate change and load supporting documentation in Workday@ALSAC. Your life event change will be in pending status until all supporting documentation is reviewed and approved. If the appropriate documentation is not provided within 60 days of the date of the event, the life event transaction will be canceled.

Acceptable documentation for adding a dependent(s) includes marriage license (spouse), birth certificate or adoption placement agreement (children) or custody agreement (stepchildren).

Important Information:
If you do not initiate your change and provide supporting documentation (such as a marriage license and/or birth certificate(s) within 60 days of the event, you must wait until the next annual enrollment period to make changes to your coverage (unless you experience another qualifying life event).

Medical

ALSAC offers a choice of two PPO medical plan options through Cigna. To view details about your benefits such as claims and coverage or to verify that your provider is in-network, visit **MyCigna.com** or you can call 1-855-21ALSAC (1-855-212-5722).

Plan Provisions	Medical PPO Plan 1		Medical PPO Plan 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible				
Individual	$150	$460	$450	$1,060
Family	$450	$1,260	$1,350	$3,050
Out-of-Pocket Maximum (includes deductible)				
Individual	$1,500	$3,750	$3,000	$4,200
Family	$3,500	$8,750	$7,500	$9,220
Copayments				
Physician Office Visit	$15	30% after deductible	$20	40% after deductible
Chiropractic (36 visits/year)	$30		$35	
Telemedicine	$0		$0	
Specialist Office Visit	$30		$35	
Urgent Care Center	$35		$40	
Preventive Care	$0		$0	
ER Visit (waived if admitted)	$150	$150	$150	$150
Coinsurance				
Outpatient Surgery, Diagnostic and Therapeutic Services	10% after deductible	30% after deductible	20% after deductible	40% after deductible
Inpatient Hospital Care				
Hospice, Home Health, Mental Health/Substance Abuse				
Other Covered Services				
Infertility Treatment	Benefit provided by Progyny in coordination with your Cigna medical plan.			

The above chart outlines your medical coverage for each plan option. Additional information can be found on the ARC in the Summary of Benefits Coverage.

Medical

Cigna Open Access Plus "OAP" Network

The Cigna OAP plan gives you flexibility, by allowing you to choose your providers and hospitals from the "OAP" network. You can choose a Primary Care Physician (PCP) as your personal health advocate and to help coordinate care with other providers. It is recommended, but not required.

In-Network

See in-network doctors or other health care providers to keep your costs lower and eliminate paperwork. Please note: if you choose an out-of-network provider, your out-of-pocket costs will be higher.

Prior Authorization

Cigna must authorize some covered services in advance in order for those covered services to be paid at the maximum allowable charge without penalty. Obtaining prior authorization is not a guarantee of coverage. Services that require prior authorization include, but are not limited to:

Inpatient hospital and inpatient hospice stays (except maternity admissions)

Skilled nursing facility and rehabilitation facility admissions

Certain outpatient surgeries and/or procedures

Certain specialty Drugs

For more information, you may call Cigna at 1-855-212-5722 to find out which services require Prior Authorization.

Preventive Care

Preventive care includes the following services:

- Well childcare for children ages two and older, including routine immunizations
- Routine pap smears
- Flu Shots
- Routine Physicals
- Colonoscopy screening for ages 45 and older
- Prostate screening for men aged 45 and older or age 40 with risk factors
- Annual mammograms for women aged 40 and over for in-network providers. Out-of-network visits will be covered after the out-of-network deductible has been met and coinsurance applies.

Important Information:
In the Greater Memphis area, the OAP network includes Methodist and St. Francis networks. If you're unsure if your provider is in network, please verify by visiting MyCigna.com or by calling 1-855-21ALSAC (1-855-212-5722).

Medical

Telemedicine

When it's not an emergency, when traveling or when you are too busy to go to the doctor's office, members of ALSAC's Cigna plan can take advantage of telemedicine services through MDLIVE. MDLIVE connects members with doctors 24 hours a day, 7 days a week. As a reminder, the Telemedicine copay is $0 plus any prescriptions. Register at **MDLIVEForCigna.com** or by calling 1-888-726-3171.

Nurseline Support 24/7

Call knowledgeable nurses for answers about different medical concerns including, but not limited to sick children, sprained ankles, cut fingers, fevers and more. Nurseline Support can be reached at 1-800-CIGNA 24 (1-800-244-6224).

Healthy Babies

Enroll in Cigna Healthy Babies for help throughout your pregnancy. This program supports you in managing your pregnancy and can help keep you and your baby healthy.

- Nurses available over the phone 24/7 to help you with everything from morning sickness to maternity benefits.
- Materials on pregnancy and babies, including a kit to chart your health throughout your pregnancy.
- To enroll, call 1-855-212-5722 or visit **MyCigna.com**, select "My Health" tab, then "Programs and Services"

Progyny Infertility Treatment Benefit

ALSAC has partnered with Progyny, a leading fertility benefits solution, to provide an inclusive family-building benefit for every unique path to parenthood. Through Progyny, we hope to provide a healthy, timely and supported family-building journey.

To make your fertility benefit easier to understand and utilize, Progyny has bundled all of the individual services, tests and treatments you may need to pursue into Progyny Smart Cycles. More details on Progyny Smart Cycles and how this benefit works with your Cigna medical plan are available on the ARC.

MDLIVE: MDLIVEForCigna.com; 1-888-726-3171

Nurseline Support: 1-800-CIGNA 24 (1-800-244-6224)

Medical

Coverage Under Two Plans

Coverage under both ALSAC's and your spouse's plans does not give you extra benefits or cover charges up to 100%. When two plans cover the same person, they coordinate benefit payments.

Example

Assume that ALSAC's coverage is secondary for your spouse. When you submit the claim, the administrator will calculate what our plan would have paid if it was primary.

Let's say it was $80. The amount will be subtracted from what the other plan paid, and our plan will pay the difference. In this case, the other plan paid $80, and our plan would have paid the same amount – so the difference would be zero.

Claim: $100 → **Spouse's Plan Paid: $80** → **Our Plan Would Have Paid: $80** → **Difference Paid by Our Plan: $0**

Important Information

Cigna requests information if you or any covered dependents have other health insurance coverage (including Medicare) in addition to coverage with Cigna. If you don't respond to this request, your dependents' coverage for medical could be placed on hold and claims for medical may be held in a "pended" status awaiting your response. Contact Cigna at 1-855-212-5722 if you have questions or need to provide information on other health insurance coverage.

Knowing if you have other health insurance coverage will help Cigna work with those plans when processing your claims. When a claim is processed, Cigna checks to see if our members have other insurance and coordinates payment of the claim with the other plan.

Coordination of benefits helps keep your health care costs manageable by ensuring claims are not overpaid.

Prescription Drugs

Coverage for your prescription drugs is provided by CVS Health. Use your CVS/Caremark ID card to fill your prescription at the participating pharmacy. For more information, visit Caremark.com or call 1-866-259-0798.

Plan Provisions	ALSAC PPO Plan 1		ALSAC PPO Plan 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Retail	**31-Day Supply**		**31-Day Supply**	
Generic	$5	No Coverage	$5	No Coverage
Brand Preferred	$35		$35	
Brand Non-Preferred	$70		$70	
Copayments	**90-Day Supply**		**90-Day Supply**	
Generic	$10	No Coverage	$10	No Coverage
Brand Preferred	$70		$70	
Brand Non-Preferred	$140		$140	

Generic Drugs

Generic drugs are the most cost-effective choice because they have the same therapeutic value as their brand name drug equivalents. They are made with the same active ingredients and are available in the same strengths and dosages as their equivalents. They must also meet the same standards for safety, quality and effectiveness. The only differences are the name and the price. This translates into lower copays for you.

Brand Preferred (Formulary) Drugs

Brand Preferred (Formulary) drugs are brand name drugs with no generic equivalent that CVS Health pharmacists have chosen for the plan's preferred list, or formulary. These drugs have the same attributes for safety, effectiveness and quality as more expensive brand name drugs.

Brand Non-Preferred Drugs

Brand Non-Preferred drugs have the highest cost-share because other less expensive brand name drugs provide the same therapeutic outcomes. The CVS Health formulary will include a comparable drug from the same therapeutic class.

The above chart outlines your prescription drug coverage for each plan option. For more information, visit Caremark.com or call 1-866-259-0798.

Prescription Drugs

90-Day Prescriptions

If you or someone on the plan takes medication on an ongoing basis, CVS Health can deliver a 90-day supply for one cost and save you time and money as well. Contact CVS Health at 1-866-259-0798 or go online at **Caremark.com** for more information.

ALSAC requires certain maintenance medications to be filled as a 90-day supply via mail order or at certain retail pharmacies like CVS and Costco. Participants will receive a letter regarding this after enrollment in the plan and can opt-out of this requirement. 30-day supplies of all other medications can be obtained at any participating pharmacy in the network (Walgreens, Sam's, Kroger, etc.)

Prior Authorization

Prior Authorization is a program that helps you get the prescription drugs you need with safety, savings and – most importantly – your health in mind. It helps you get the most from your healthcare dollars with prescriptions drugs that work well for you and are covered by our pharmacy benefit. It also helps control the rising cost of prescription drugs by ensuring that covered drugs are used for treating medical problems rather than for other purposes.

The program monitors certain prescription drugs and their costs so you can get the right drug at the right cost. It works much like healthcare plans that approve certain medical procedures before they're done to make sure you're getting tests you need. If you're prescribed a certain medicine, that drug may need a "prior authorization." It makes sure you're getting a cost-effective drug that works for you.

In this program, your medical professionals are consulted. When your pharmacist tells you that your prescription needs a "prior authorization," it simply means that more information is needed to see if the plan can cover the drug. Only your doctor (or sometimes a pharmacist) can provide this information and request a prior authorization.

The Prior Authorization program was developed under the guidance and direction of independent, licensed doctors, pharmacists and other medical experts. Together with CVS Health – which manages the pharmacy benefit plan – these experts review the most current research on thousands of drugs tested and approved by the U.S. Food & Drug Administration (FDA) as safe and effective.

Non-Coordination of Benefits:
No coordination of benefits is available for the prescription drug plan; therefore, if your dependents, including your spouse, are covered under another medical plan that is considered primary coverage for them, the ALSAC prescription drug plan will not cover their prescriptions.

Dental

Dental benefits are administered by Delta Dental of Tennessee. Regular dental exams can help you and your dentist detect problems in the early stages. You will receive dental services at a discounted rate when you use a Delta PPO or Delta Premier dentist.

Plan Provisions	Dental PPO Plan 1	Dental PPO Plan 2
Deductible		
Individual	$50	$0
Family	$100	$0
Coinsurance		
Diagnostic and Preventive Care (cleanings, fluoride treatments, sealants and x-rays)	Covered 100%; no deductible	Covered 100%; no deductible
Basic Services (fillings, periodontics, scaling and root planing, and oral surgery)	You pay 20% after deductible	You pay 20%; no deductible
Major Services (crowns, bridges, full and partial dentures)	You pay 40% after deductible	You pay 40%; no deductible
Orthodontia	You pay 50% after deductible	You pay 50%; no deductible
Limits		
Lifetime Orthodontia (per member)	$1,000 (children up to age 17 only)	$1,500 (includes adults)
Annual Maximum (per member)	$1,500	$5,000

How to Find a Dentist Online

- Go to DeltaDentalTN.com
- Scroll down to the **Find a dentist** section
- Select an option from the **Specialty** drop-down list
- Select your plan type as either **Delta Dental PPO** or **Delta Dental Premier**
- Search by your current location or enter a zip code
- Click on the **Find dentists** button

The above chart outlines your dental coverage for each plan option. Additional information can be found on the ARC in the Delta Dental of Tennessee Certificate of Coverage – Benefits Summary.

Vision

Two benefit plan options for vision insurance are offered through Vision Service Plan (VSP). Exams, glasses, and frames are covered once every 12 months.

Plan Provisions	Low Option Plan 1 In-Network	High Option Plan 2 In-Network
Copayments		
Exam	$10	$10
Prescription Eyeglasses	$25	$10
Lenses • **Single lenses** • **Bifocal lenses** • **Trifocal lenses**	Covered 100% after copay	Covered 100% after copay
Contact Lenses (medically necessary)		
Allowances		
Eyeglass Frames (20% off amount over allowance)	$130	$150
Contact Lenses (in lieu of eyeglasses)		
Lasik		
Discounts Available		

Important Information

- Please see VSP plan document for additional information about out-of-network services
- No ID# is needed. Simply tell your eye care provider that you have VSP
- Visit VSP.com to find a VSP doctor near you.

The following items are excluded under this plan:

- Plano lenses (non-prescription)
- Two pairs of glasses instead of bifocals
- Replacement/repair of lost/broken lenses or frames
- Medical or surgical treatment
- Orthoptics, vision training or supplemental testing
- Expenses associated with securing materials

The above chart outlines your vision coverage for each plan option. Additional information can be found on the ARC in the Vision Certificate of Coverage.

Health Plan Rates

2025 ALSAC Medical Rates (Non-Tobacco)

PPO 1	Employee Bi-Weekly Deduction				Monthly	
	Under $50k	$50k–$150k	$151k–$250k	$250k +	Total Plan Cost	COBRA
Employee Only	$0.00	$0.00	$0.00	$0.00	$1,033.82	$1,054.50
Employee + Child(ren)	$44.31	$50.77	$55.38	$63.69	$1,809.18	$1,845.37
Employee + Spouse	$60.46	$68.77	$74.77	$85.85	$2,067.65	$2,109.00
Employee + Family	$85.85	$97.85	$105.69	$121.38	$2,584.55	$2,636.24

PPO 2	Under $50k	$50k–$150k	$151k–$250k	$250k +	Total Plan Cost	COBRA
Employee Only	$0.00	$0.00	$0.00	$0.00	$961.47	$980.69
Employee + Child(ren)	$24.46	$28.62	$30.46	$35.54	$1,682.55	$1,716.20
Employee + Spouse	$36.00	$41.54	$44.31	$52.62	$1,922.91	$1,961.37
Employee + Family	$46.62	$53.08	$57.69	$70.15	$2,403.64	$2,451.71

2025 ALSAC Medical Rates (Tobacco)

PPO 1	Employee Bi-Weekly Deduction				Monthly	
	Under $50k	$50k–$150k	$151k–$250k	$250k +	Total Plan Cost	COBRA
Employee Only	$4.62	$4.62	$4.62	$4.62	$1,033.82	$1,054.50
Employee + Child(ren)	$48.92	$55.38	$60.00	$68.31	$1,809.18	$1,845.37
Employee + Spouse	$65.08	$73.38	$79.38	$90.46	$2,067.65	$2,109.00
Employee + Family	$90.46	$102.46	$110.31	$126.00	$2,584.55	$2,636.24

PPO 2	Under $50k	$50k–$150k	$151k–$250k	$250k +	Total Plan Cost	COBRA
Employee Only	$4.62	$4.62	$4.62	$4.62	$961.47	$980.69
Employee + Child(ren)	$29.08	$33.23	$35.08	$40.15	$1,682.55	$1,716.20
Employee + Spouse	$40.62	$46.15	$48.92	$57.23	$1,922.91	$1,961.37
Employee + Family	$51.23	$57.69	$62.31	$74.77	$2,403.64	$2,451.71

Health Plan Rates

2025 ALSAC Dental and Vision Rates

Dental PPO 1	Employee Bi-Weekly Deduction	Monthly	
		Total Plan Cost	COBRA
Employee Only	$4.56	$33.98	$34.66
Employee + Child(ren)	$9.13	$67.98	$69.34
Employee + Spouse	$7.98	$59.47	$60.66
Employee + Family	$11.41	$84.97	$86.67
Dental PPO 2			
Employee Only	$9.13	$50.31	$51.31
Employee + Child(ren)	$18.26	$100.60	$102.61
Employee + Spouse	$15.97	$88.02	$89.79
Employee + Family	$22.82	$125.76	$128.28
Vision Low			
Employee Only	$2.85	$6.17	$6.29
Employee + Child(ren)	$6.11	$13.23	$13.49
Employee + Spouse	$5.71	$12.38	$12.63
Employee + Family	$9.56	$20.71	$21.12
Vision High			
Employee Only	$3.35	$7.26	$7.41
Employee + Child(ren)	$7.17	$15.53	$15.84
Employee + Spouse	$6.70	$14.52	$14.81
Employee + Family	$11.04	$23.93	$24.41

Flexible Spending Accounts

Navia Benefit Solutions administers Flexible Spending Accounts (FSAs) on behalf of ALSAC plan participants. FSAs are designed to save you money on your taxes. Each pay period, funds are deducted from your pay on a pre-tax basis and are deposited to your Health Care and/or Dependent Care FSA. You then use those funds to pay for eligible health care or dependent care expenses.

Healthcare FSA	Eligible expenses include most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses and doctor-prescribed over-the-counter medications) **Annual Contribution Limit: $3,300**
Dependent Care FSA	Eligible expenses include dependent (up to age 13 years of age) care expenses (such as day care, after school programs or elder care programs) so you and your spouse can work or attend school full-time. **Annual Contribution Limit: $5,000 ($2,500 if married and filing separate tax returns**

Important Information About FSAs

Your FSA elections will be in effect from January 1 – December 31. Claims must be filed by March 31 following the close of the Plan Year in which the expense was incurred. You will receive a debit card with enrollment in the health FSA. Please plan your contributions carefully. **This is a "use it or lose it" plan. Any unused money is forfeited.**

Period Coverage

Your period of coverage for incurring expenses is your full plan year (Jan. 1 – Dec. 31), unless you make a permitted mid-plan year election change due to a qualified life event. A mid-plan year election change will result in split periods of coverage, creating more than one period of coverage within a plan year with expenses reimbursed from the appropriate period of coverage within a plan year.

Funds from a previous period of coverage can be combined with the amount after a mid-plan year election changes. However, expenses incurred before the election change can only be reimbursed from the amount of the balance in the FSA prior to the change. Mid-plan year election changes are approved only if the extenuating circumstances and supporting documentation are within IRS regulations governing the plan.

*Split periods of coverage do not apply to Dependent Care Flexible Spending Accounts.

Use it or Lose it!
Because there is a tax advantage to using the FSAs, you forfeit any unused balance that remains in your FSA at the end of the plan year. This rule is sometimes known as "use it or lose it". To avoid this, you should carefully estimate your expected health and dependent care expenses for the upcoming plan year before you choose the amount you will deposit into each of your FSAs.

Flexible Spending Accounts

The Advantages of an FSA

With an FSA, the money you contribute is never taxed when used on eligible expenses – not when you put it in the account, not when you are reimbursed with the funds from the account and not when you file your income tax return at the end of the year. Receive your reimbursements faster by signing up for direct deposit.

Here is an example of savings when you use FSAs to pay for your health care and dependent care expenses. For a list of medical expenses eligible for reimbursement, please visit NaviaBenefits.com.

FSA Savings	With FSA	Without FSA
Your taxable income	$50,000	$50,000
Pre-tax contribution to Health Care and Dependent Care FSA	$2,000	$0
Federal and Social Security taxes	$11,701	$12,355
After-tax dollars spent on eligible expenses	$0	$2,000
Spendable income after expenses	$36,299	$35,645
Tax savings with the Medical and Dependent Care FSA	$654	N/A

Transportation Benefits Program

Commuter Benefits is a federal transportation benefit program that allows you to save on your transit costs by deducting your commute expenses pre-tax from your paycheck each month. You save money (24-40%) on transit or vanpool expenses because you don't pay taxes on the money you deduct.

When you sign up for the Transportation Benefits Program pre-tax deductions, your transit benefits card will be delivered to you within 10-14 business days. If you are currently enrolled in the FSA, you will not receive a new debit card. Funds will be credited to your existing healthcare FSA debit card to use when paying for commuting via public transit (bus, rail or ferry) or vanpool.

You are eligible for this benefit if you live in certain areas, such as San Francisco or Chicago. For more information, please contact Navia.

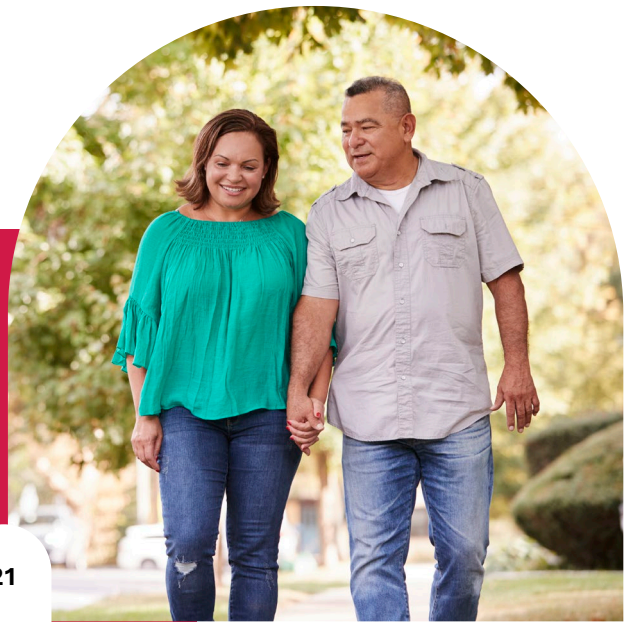
For a list of medical expenses eligible for FSA reimbursement, visit NaviaBenefits.com.

Alliant Medicare Solutions

As you near age 65, not only are you thinking about retirement, but you are also considering post-employment health insurance options. Deciding on a Medicare health plan is one of the most important decisions you will have to make. It is vitally important that you understand your coverage choices, the costs for the various plans, and when you should enroll. **Alliant Medicare Solutions** is a free, non-government entity resource available to you, your family members, and friends. Experienced representatives can answer questions such as:

- What are the Medicare insurance plans
- Which plans might work best for me?
- Am I eligible?
- How does Medicare work with my employer coverage?
- When should I enroll?
- What does Medicare NOT cover?
- How do I enroll?
- What does Medicare cost?

1. At least 3 months before your 65th birthday, or if you are already over 65, gather your current medical coverage information (plan, cost, prescriptions, preferred doctors and hospitals, etc.)
2. Call Alliant Medicare Solutions at **1-877-888-0165**
3. Talk with a licensed insurance agent about your Medicare options
4. The team can help you compare your employer plan to Medicare plans available in your area
5. Alliant Medicare Solutions helps you enroll or emails you the policy materials for you to review



For More Information:

- **Download "Your Guide to Medicare" at alliantbenefits.cld.bz/adh-medicare-guide**
- **Watch Medicare 101 at bainshark.com/alliant/medicare101**
- **Visit Alliant Medicare Solutions at AlliantMedicareSolutions.com**
- **For comprehensive information about Medicare, visit Medicare.gov**

Basic Life & Additional Life Insurance

Basic Life and AD&D Insurance

Life insurance is an important part of your financial security, especially if others depend on you for support. ALSAC provides 1 ½ times your annual salary in Basic Life and Accidental Death & Dismemberment (AD&D) insurance to all eligible employees at no cost to you.

AD&D insurance is designed to provide a benefit in the event of accidental death or dismemberment. Your Basic Life and AD&D insurance policy is underwritten by Sun Life. Please refer to plan documents on the ARC for more information.

Beneficiaries for Basic Life and AD&D

If you do not designate your beneficiaries for your life and AD&D coverage, your beneficiary will default to your spouse/registered domestic partner. If you are not married your beneficiary designation will default according to the following succession:

- Child(ren) in equal shares
- Parents in equal shares
- Your estate

Additional Life Insurance

Coverage is available through Sun Life in increments of $25,000 up to a maximum of $400,000. During the 2025 annual enrollment period, any new enrollment or increase in coverage of more than $25,000 will require Evidence of Insurability (EOI). The monthly rate of coverage per $1,000 is $0.24.

You may purchase spousal life insurance from Sun Life in increments of $12,500 up to 100% of the employee's election or $250,000 (whichever is less). During the 2025 annual enrollment period, any new enrollment or increase in coverage of more than $12,500 will require evidence of insurability. The monthly rate of coverage per $1,000 is $0.24.

You may also purchase life insurance for dependent children, from birth to 26 years, in the amount of $10,000. The monthly cost of dependent life insurance is $2.40.

Important Information:
Amounts greater than $50,000 are reported to the IRS as taxable income.

Personal Accident Insurance

You may purchase personal accident insurance to cover yourself and your family. This insurance is administered by New York Life. Personal Accident Insurance may help pay expenses in the event of a covered accident resulting in death or serious injury caused by an accident that may not be satisfied by other insurance plans such as life, disability, health, or workers' compensation.

Employees may select coverage ranging from $25,000 to $400,000. Each family member's coverage is a percentage of the benefit amount you select. The benefit amount cannot exceed $200,000 for your spouse and $25,000 for your dependent children, ages 14 days to 26 years. The monthly rate of coverage per $1,000 of personal accident insurance is $.035 for employee only or $.05 for employee and family. Evidence of Insurability (EOI) is not required. For more information, you may contact New York Life at 1-888-842-4462.

Plan Features Include:

Voluntary option is available to employees, their spouses and their child(ren)

Diverse coverage options – among the broadest in the industry – can build the right plan, with the right protection, at the right price

Provides funds for unexpected costs and fills a potential gap in your coverage program

Living benefits for accident survivors

Beneficiaries for Additional Life and/or Personal Accident Insurance

If you do not designate your beneficiaries for Additional Life Insurance and/or Personal Accident insurance, your benefit amount will be paid to the first surviving party in the following order:

- Spouse
- Child(ren) in equal shares
- Parents in equal shares
- Brothers and Sisters in equal shares
- Your estate

For more information on Personal Accident Insurance, you may contact New York Life at 1-888-842-4462.

Supplemental Insurance

Employees have access to group accident, critical illness, and hospital indemnity insurance coverage through Aflac. These group products offer preferred rates, and premiums are payroll deducted. For more information about plan benefits, call 1-800-433-3036 or visit **AflacGroupInsurance.com**.

Accident Insurance	Accident insurance helps pay for out-of-pocket costs that arise from covered accidents such as fractures, dislocations and lacerations. This plan includes a wellness benefit through which Aflac will pay you to get a qualified wellness test obtained through preventive care.
Critical Illness Insurance	Critical Illness insurance helps pay the expected and unexpected expenses that arise from diagnosis of a covered critical illness such as cancer (internal or invasive), heart attack, stroke, end-stage renal failure or a major organ transplant. This plan includes a health screening benefit, where Aflac will pay you to get a qualified health screening test while receiving preventive care.
Hospital Indemnity Insurance	Hospital Indemnity insurance helps pay the out-of-pocket costs associated with a hospital stay including benefits for hospital confinement, hospital admission, hospital intensive care and intermediate intensive care step-down unit.

Important Information:
Please review the Aflac Required Certification language document on the ARC.

Business Travel Insurance

ALSAC provides accidental death and dismemberment benefit coverage for employees while traveling on company business. This company-provided benefit is insured through the Chubb Group of Insurance Companies and also includes evacuation for business travelers if there is a medical emergency or security threat.

Coverage Also Includes:

- **24-hour business travel accident insurance to, from and during business travel**
- **Travel assistance services – manage and pay covered benefits due to medically necessary evacuation, repatriation and return of mortal remains**
- **Out-of-country medical assistance**
- **Identity theft protection for business travelers**

Position	Coverage Amount
National Executive Director, Chief Operating Officer, Vice President, Senior Vice President	$400,000
Regional Director, N.E.O. Director	$300,000
Senior Event Marketing Representative, Event Marketing Manager, Event Marketing Specialist, Donor Liaison, Gift Planning Representative, Associate Director	$100,000
All other full-time employees	$25,000

This benefit begins on the first day of employment and pays according to the above schedule.

Family Support Program

Urban Sitter

ALSAC has partnered with UrbanSitter to bring our employees a family support program. This benefit includes access to an entire network of reliable and trusted caregivers. From booking backup childcare to hiring a dog walker, UrbanSitter's array of care benefits helps you easily find top-rated, background-checked caregivers when you need them most.

All ALSAC employees will receive a free UrbanSitter membership, which gives you access to the national UrbanSitter network of caregivers who meet the needs of your schedule, budget, and family. Additionally, ALSAC is providing all employees a $500 annual care credit for you to use on care to support your family.

UrbanSitter can assist in finding and reserving family care providers to meet your needs, including backup childcare, full/part-time childcare providers, tutors/homework helpers, pet care providers, household help, and senior care providers.

Do you have a current caregiver who is not yet on the UrbanSitter Network?

- Invite them to join UrbanSitter now, so you can pay them using your $500 annual care credit starting on January 1, 2025

How can my caregiver sign up on the UrbanSitter Network?

- Your caregiver creates an account at UrbanSitter.com/signup/sitter
- Once your caregiver completes a background check and is approved by UrbanSitter, you can book them and begin using your care credit on January 1, 2025.

What types of caregivers can join the UrbanSitter Network?

- **Childcare providers** – Nannies, babysitters, mother's helpers, after-school sitters, carpool drivers
- **Tutors** – Academic tutors, music tutors, SAT tutors
- **Pet caregivers** – Pet sitters, dog walkers
- **Household helpers** – Housekeepers, household assistants, errand helpers
- **Senior care providers** – Non-medical only, errands, meal preparer

Get started today with UrbanSitter and utilize your $500 annual care credit from ALSAC. Enroll at UrbanSitter.com/ALSAC with your work email address. Then check your email to verify your account.

Additional Benefits

WorkingAdvantage

ALSAC has partnered with WorkingAdvantage to bring a comprehensive, no-cost discount program for employees and families. The best part about the discount program it's complete free to use! To get started visit **ALSAC.Savings.WorkingAdvantage.com**. WorkingAdvantage offers the country's largest employee savings program, and includes discounts on a wide range of products, including:

- Electronics
- Appliances
- Apparel
- Rental Cars/Cars
- Flowers
- Gift Cards
- Groceries
- Hotels
- Movie Tickets
- Gym/Fitness Memberships
- Special Events
- Theme Park Tickets

Group Legal Services

ALSAC employees may purchase group legal services through MetLife Legal. MetLife Legal provides you with telephone and office consultations for an unlimited number of matters including estate planning, family law, traffic offenses, defense of civil lawsuits and more.

Coverage for this benefit is $9.00 per bi-weekly pay period, and you will be enrolled in the plan for a period of one year. For more information about MetLife Legal or to search for an attorney, go to **LegalPlans.com** and enter access code **6090511**.

Identity Theft Protection

Employees have access to an identity theft benefit through IdentityForce. The benefit includes, Change of Address Monitoring, Dark Web Monitoring, Identity Threat Alerts, Smart SSN Tracker and more. Once activated and you provide your personal email address, you will receive an email from IdentityForce with instructions on how to activate your account.

This benefit is available to employees and their eligible child(ren) at no cost. Employees can add their spouse for an additional $1.00. Additional information regarding this benefit can be found on the ARC.

To get started with your FREE discount program, visit ALSAC.savings.WorkingAdvantage.com.
Legal Services: LegalPlans.com access code: 6090511
Identity Theft Protection: More information available on the ARC.

Retirement/Deferred Compensation

401(k)

Newly hired ALSAC employees are automatically enrolled, after 30 days, in the organization's 401(k) plan called the ALSAC Employee Retirement Plan. Your eligibility to make employee contributions to the Plan begins on the first day of your employment with ALSAC. New participants are automatically set up to contribute 3% of their compensation and can opt out or change their deferral at any time.

Employees can take advantage of pre-tax savings or after-tax savings (Roth) account. Pre-tax contributions are deducted before federal and state tax withholdings are calculated. With after-tax contributions, employees can enjoy tax-free withdrawals for qualified distributions.

Principal provides retirement services and investment option to employees in the plan. A variety of investment options for you to choose from are available in the plan. Additional information, as well as up-to- date investment performance, is available online at **Principal.com**. The easy-to-use site will help you review plan and investment information. In addition to explaining how to direct your investments, information is available regarding any administrative and individual expenses associated with your investment decisions. You will also be able to make changes to your contribution and investments as well.

Upon completing one year of service, ALSAC will begin making bi-weekly contributions of 7% of your salary up to the FICA limit and 12.7% over the FICA limit. To receive the ALSAC contribution, the employee must have completed 1,000 or more hours of service for the 12-month period. Employee contributions are always 100% vested; however, ALSAC contributions are vested at the following schedule:

Years of Service	Vested Amount
2 Years	30%
3 Years	60%
4 Years	100%

457(b)

Directors (People Leaders) and above are eligible to participate in ALSAC's 457(b) Plan. A 457(b) is a deferred compensation plan that allows eligible employees to set aside a portion of their salary on a before-tax basis for the purpose of saving for retirement. Similar to other deferred compensation plans such as 401(k) and 403(b) plans, the 457(b) plan allows participants to defer federal and, in many cases, state income taxes on contributions until these funds are withdrawn. There are no employer contributions in this plan.

All contributions deferred under the 457(b) Plan, including earnings on such amounts, are the sole property of ALSAC and remain subject to the claims of its general creditors until actually distributed to you. It's recommended that you consult with your tax adviser to discuss the tax treatment of the 401(k) Plan and the 457(b) Plan before enrolling in the 457(b) Plan.

Important Information

To change your contribution(s) to the 401(k) or 457(b) plans, please access **Principal.com**.

Vacation

Full-time ALSAC employees earn vacation as shown in the following table. Vacation is earned and credited to each employee's account on a monthly basis. The maximum vacation bank accrual is 240 hours.

Position	Years of Service	Annual Accrual	Monthly Accrual	Weekly Accrual
Senior Directors and above	N/A	20 days	13.33 hours	3.07 hours
Directors	Up to 5 years	15 days	10 hours	2.30 hours
	5 years or more	20 days	13.33 hours	3.07 hours
All other exempt and non-exempt employees	Up to 2 years	10 days	6.66 hours	1.31 hours
	2-5 years	15 days	10 hours	2.30 hours
	5 years or more	20 days	13.33 hours	3.07 hours

The length of service is calculated based on the employee's anniversary date. Once employees enter an eligible employment classification, they begin to earn paid vacation time according to the schedule. They can request use of vacation time after it is earned. Vacation approval is at management discretion. To take accrued vacation, employees must request advance approval from their supervisor. Requests will be reviewed based on a number of factors, including business needs and staffing requirements. Vacation time off is paid at the employee's base pay rate at the time of vacation. It does not include overtime or any special forms of compensation such as incentives, commissions, bonuses or shift differentials.

As stated above, employees are encouraged to use available paid vacation time for rest, relaxation and personal pursuits. In the event that available vacation is not used by the end of the fiscal year, employees may carry unused time forward to the next fiscal year, provided maximum hours accumulated doesn't exceed 240. If the total amount of unused vacation time reaches a cap of 240 hours, further vacation accrual will be suspended until the employee has reduced the balance below the limit; at which time vacation accrual will begin again. Vacation hours will not accrue during leave of absences.

Upon termination of employment, employees will be paid for all unused vacation time that has been earned through the last day of work.

See the Manage your Time Off job aid for reference. Employees may submit and check vacation balances by going to Workday.

Holiday and Personal Days

The following holidays are paid observances (including two personal days):

January	May	June	July	September	November	December
New Year's Day Martin Luther King, Jr. Day	Memorial Day	Juneteenth	Independence Day	Labor Day	Thanksgiving Day after Thanksgiving	Christmas

ALSAC will grant paid holiday time off to all eligible employees immediately upon assignment to an eligible employment classification. Holiday pay will be calculated based on the employee's base pay rate (as of the date of the holiday) times the number of hours the employee would otherwise have worked on that day. Only regular full-time employees are eligible for holiday pay.

If a recognized holiday falls on a Saturday, the day will be observed on the preceding Friday. If the recognized holiday falls on a Sunday, the day will be observed on the following Monday. If a recognized holiday falls during an eligible employee's Leave of Absence, the employee will be ineligible for holiday pay. For purposes of determining the amount of leave used by an employee, a holiday will count as FMLA leave in cases where the employee is using FMLA leave in increments of one week.

In cases where the employee is using FMLA leave in increments of less than one week, the holiday will not count against the employee's FMLA leave entitlement unless the employee was otherwise scheduled and expected to work on the holiday. If eligible non-exempt employees work on a recognized holiday, they will receive holiday pay plus wages at one and one-half times their straight-time rate for the hours worked on the holiday.

Veterans' Day

The State of Tennessee now allows veteran employees to take unpaid leave on Veterans' Day, the eleventh day of November, annually. ALSAC can require the employee to provide at least one-month's written notice to management that they intend to take leave on Veterans' Day and to provide proof of veteran status. The employee's absence, whether alone or with other veteran employees, can be denied if the absence will impact public health or safety or cause significant economic or operational disruption to ALSAC as determined solely by the employer.

Personal Days

In addition to the recognized holidays, eligible employees will receive two personal days each fiscal year of employment that may be used to observe religious or ethnic holidays, celebrate other days of personal significance or attend to personal business. Employees earn one personal day January 1 and another on July 1. Employees hired after July 1 are not eligible for personal days until the next calendar year. Personal days must be taken in full-day increments versus 8- hour increments and must be used during the fiscal year in which they are granted. Further, they cannot be carried over from one fiscal year to the next, and unused days cannot be exchanged for pay. Personal days must be scheduled with prior approval of the employee's supervisor. Paid time off holidays will not be counted as hours worked for the purposes of determining overtime.

Personal Sick Time

ALSAC provides sick time benefits to all eligible full-time employees for periods of temporary absence due to illnesses or injuries. You will accrue personal sick time each pay period for use in situations where you require time off due to personal health reasons.

Sick leave benefits will be calculated based on the employee's base pay rate at the time of absence and will not include any special forms of compensation such as incentives, commissions, bonuses or shift differentials.

All accumulated sick leave hours must be exhausted before an employee is eligible to receive state disability insurance benefits to supplement their pay. The combination of any such disability payments and sick leave benefits cannot exceed the employee's normal weekly earnings.

Sick hours may be accumulated up to a maximum of 192 hours. When hours reach this maximum, further accrual of sick leave benefits will be suspended until the employee has reduced the balance below the limit.

Sick Leave Accrual

Years of Service	Monthly Accrual	Weekly Accrual
5 years of service by July 1, 2016	10 hours	2.30 hours
All other employees	8 hours	1.847 hours

Sick hours may be accumulated up to a maximum of 192 hours. When hours reach this maximum, further accrual of sick leave benefits will be suspended until the employee has reduced the balance below the limit.

Personal Sick Time

Personal Sick Time Usage

Sick time benefits are intended solely to provide income protection in the event of illness or injury and may not be used for any other absence other than those specified below. Unused sick leave benefits will not be paid to employees upon termination of employment.

Personal sick time may be used in cases where employees require time off due to personal health reasons, including dental care. ALSAC may require a physician's statement concerning the reason for an employee's absence when:

- Attendance records indicate possible abuse of the sick policy
- The status of an employee's health indicates the need to determine his/her capability to satisfactorily perform his/her regular duties
- An absence lasts longer than three days – these absences must be reported to **ALSACLeave@alsac.stjude.org**.

Personal sick time may also be used for employees to voluntarily admit themselves into drug rehabilitation. Personal sick time ***may not*** be used for a W-4 dependent's admission to a drug rehabilitation facility or nursing home, outpatient surgery, etc.

Personal sick time may be used when a W-4 dependent is an inpatient in a hospital. Once the dependent has been released from the hospital, the employee may elect to use family sick (if applicable), vacation days or personal days for salary continuation.

Such leave shall run concurrently with family and medical leave to the extent the employee is eligible for such leave.

Non-exempt employees who do not have accrued time to cover hours missed will have their pay deducted. Both exempt and non-exempt employees are subject to discipline, up to and including termination, for excessive absenteeism for non-FMLA absences regardless of whether they have time in their vacation or sick leave banks to cover their absences. See Family Medical Leave Policy in the Employee Handbook for information on how FMLA absences will be handled.

Important Information:
An employee who is unable to work due to illness or injury should notify his/her direct supervisor before the scheduled start of the workday, if possible. They must notify their supervisor (not a co-worker or the receptionist) as soon as possible in advance of the anticipated tardiness or absence. If an employee cannot speak personally to his/her supervisor, he/she must leave a number where he/she can be reached.

Short Term Income Replacement

ALSAC provides short-term disability (STD) income replacement benefits (STIR) to eligible employees who are unable to work because of a qualifying personal illness or personal injury. Disability benefits are subject to applicable taxes and are offset by any other income or disability benefits you receive (or are eligible to receive), such as sick pay, state disability, Social Security and workers' compensation.

Eligibility

You are eligible for short-term income replacement coverage if you are classified by ALSAC as a full-time employee working at least 30 hours per week. If you are classified by ALSAC as working less than 30 hours per week, as a temporary/seasonal employee, intern or a contractor, you are not eligible for STIR benefits. **For new employees, eligibility for STIR benefits begins on the first day of the month following 6 months of employment with ALSAC.** Coverage is automatic for eligible employees; no enrollment is required.

ALSAC has delegated day-to-day benefits administration, including determination of eligibility, the amount and duration of STIR benefits, to a third-party short-term disability management company, Sun Life (which is also the insurer of STIR benefits). STIR benefit claims will be administered in accordance with a formal claim determination and appeal process (as required by the Employee Retirement Income Security Act of 1974 (ERISA) by Sun Life. ALSAC pays the full cost for short-term disability coverage for eligible employees.

Benefit Amount

You may qualify for STIR benefits when the same or a related illness or injury prevents you from being at work (a qualifying disability) for more than 14 calendar days "Elimination Period". STIR benefits are calculated based on the type of leave, earnings and years of service (each as determined in accordance with plan terms) on the date you become unable to work. Income replacement benefits will be payable for the Period of Disability approved by Mutual of Omaha, up to a maximum of 11 weeks. After 11 weeks, you may be eligible for long-term disability benefits subject to applicable LTD plan terms (please see the LTD Benefit Plan SPD for details). Weekly benefit payment will not exceed $3,000.

STIR benefits, if approved, will be paid according to the applicable benefit schedule on the next page.

Short Term Income Replacement

STIR Benefits Schedule – Medical Benefit*

Tier	Years of Service	Elimination Period (14 calendar days)	Sun Life STIR Benefits	Employee Pays	Maximum period of paid time (Period of Disability)
1	0 – 4	Employee uses available sick and/or vacation	60%	40%	11 weeks
2	5 – 9	Employee uses available sick and/or vacation	65%	35%	11 weeks
3	10 +	Employee uses available sick and/or vacation	70%	30%	11 weeks

*For medical benefit, employee uses available sick and/or vacation time to cover "Elimination Period" and supplement STIR benefit in order to maintain 100% pay.

STIR Benefits Schedule – Maternity Benefit**

Tier	Years of Service	Elimination Period (14 calendar days)	Sun Life STIR Benefits	ALSAC Pays	Maximum period of paid time (Period of Disability)
1	0 – 4	ALSAC continues employee's pay	60%	40%	Natural delivery: 6 weeks / Cesarean delivery: 8 weeks
2	5 – 9	ALSAC continues employee's pay	65%	35%	Natural delivery: 6 weeks / Cesarean delivery: 8 weeks
3	10 +	ALSAC continues employee's pay	70%	30%	Natural delivery: 6 weeks / Cesarean delivery: 8 weeks

**For maternity benefit (medical after delivery), ALSAC continues the employee's pay during the "Elimination Period" and provides the supplement that maintains the employee at 100% income replacement.

Remember, disability benefits are subject to applicable taxes and are offset by any other income or disability benefits you receive (or are eligible to receive), such as sick pay, state disability, Social Security and workers' compensation.

Short Term Income Replacement

Sun Life will consider income from other sources when determining the amount of the STIR benefit. Other income sources are amounts that you receives or are eligible to receive as a result of the disability or the sickness and/or injury that caused, in whole or in part, their disability.

For you to receive STIR benefits, you must be under the continuous care of a physician who, with respect to their qualifying disability, is practicing within the scope of his or her license. You must also be under a defined course of treatment appropriate for their disability. If the disability is a mental or nervous disorder, the treatment must include care by a board-certified, licensed physician who specializes in psychiatric medicine. Failure to provide the third-party disability management company with the required medical (or any other required) documentation may lead to a denial or termination of benefits.

Approved STIR benefits will continue until the earliest of the following to occur (in addition to any other events described in the plan):

1. You no longer has a qualifying disability, as determined by Sun Life
2. You exhaust the maximum 11-week STIR benefit period
3. You fail to provide the third-party disability management company with satisfactory proof of continuous disability
4. You are not under continuous and appropriate care and treatment for the illness or injury that caused the disability
5. You are able to return to work with ALSAC and does not do so

You should contact Sun Life within 24 hours of the time you know your absence will exceed the 14-calendar day elimination period (generally two scheduled work weeks).

Sun Life Contact Information
Phone: 1-800-877-5176, Monday through Friday from 7:30 a.m. to 5:00 p.m., CST
Online: SunLife.com/account
Fax: 402-997-1865

Short Term Income Replacement

Stir Claim Evaluation Process

- Sun Life will wait for receipt of objective medical information from your physician to verify the claim
- Sun Life will remain in contact with you and follow up with their physician for the duration of the Period of Disability
- Sun Life will keep the Benefits Department, and you informed of the status of your claim.
- You must contact Sun Life immediately if any information regarding your medical condition changes
- You must also contact the Benefits Department if your estimated date of return to work or your ability to work changes
- If needed, Sun Life may ask your manager to complete a Job Evaluation Summary to determine job functions and physical requirements
- You must notify Sun Life and the Benefits Department immediately of any address or telephone number changes during the course of a leave

STIR Claim Approval

Sun Life will notify you and the Benefits Department when a claim for STIF benefits is approved or denied.

Deductions

Benefit deductions will continue to be taken from any ALSAC pay you receive (e.g. sick and/or vacation pay) during the period of time you are receiving STIR benefits. Missed deductions will be automatically taken from your paycheck upon your return to work.

More details about the STIR benefits (including details about the claims determination and appeal process) are available in the summary plan description (SPD). The information contained above is only a summary of the STIR benefits and is not meant to replace or supersede the plan document (including the applicable insurance contract). In the event of a conflict between the information contained above and the formal plan document for the ALSAC/St. Jude Children's Research Hospital Employee Health and Welfare Benefit Plan, the plan document will govern.

Important Information:
It is ultimately your responsibility to ensure that your physician(s) cooperates with Sun Life and provides all medical documentation requested. If Sun Life fails to receive the appropriate medical (or any other required) documentation, it could result in a delay or denial of STIR benefits.

Long Term Disability Insurance

The goal of ALSAC's Long-Term Disability (LTD) insurance plan is to provide you with income replacement should you become disabled and unable to work. The plan provides for 60% of your monthly pre-disability earnings–up to a $15,000 monthly maximum. Benefits begin after 90-days of disability or illness and continue to recovery or your Social Security normal retirement age.

Family Sick Time

You will receive 40 hours of family sick time at 6 months from your date of hire to use for the care of a spouse, your parents, children or other W-4 dependents who are ill.

Hospitalization of the family member is not required for family sick time to be used

Hourly employees are permitted to use personal or family sick time for any part of a day, in increments of 15 minutes

Salaried employees must use family or personal sick time in one-hour increments

Important Information

An employee who is unable to report to work due to illness or injury should notify his/her direct supervisor before the scheduled start of the workday, if possible. They must notify their supervisor (not a co-worker or the receptionist) as soon as possible in advance of the anticipated tardiness or absence. If an employee cannot speak personally to his/her supervisor, he/she must leave a number where he/she can be reached.

The balance will be restored to 40 hours on July 1 each year. The maximum amount of family sick time that can be used is 40 hours per fiscal year. Sick time will not accrue during leaves of absence.

Additional Time Off

Personal Leave

ALSAC provides leaves of absence without pay to eligible employees who wish to take time off from work duties to fulfill personal obligations, and who are not eligible for paid or unpaid leave under any other policy.

Regular full-time employees are eligible to request personal leave as described in this policy. Eligible employees may request personal leave only after having completed one year of service. As soon as eligible employees become aware of the need for a personal leave of absence, they should request leave from their direct supervisor. Leave requests will be reviewed and approved by their direct supervisor, Vice President, Senior Vice President and the Senior Vice President, Employee Experience.

Personal leave may be granted for a period of up to 12 weeks every two years. If this initial period of absence proves insufficient, consideration will be given to a written request for a single extension of no more than 30 calendar days with the Senior Vice President of Employee Experience approval. An employee must take any available sick leave or vacation leave as part of the approved period of leave, as applicable.

Requests for personal leave will be evaluated based on a number of factors, including anticipated workload requirements and staffing considerations during the proposed period of absence. Subject to the terms, conditions and limitations of the applicable plans, employees will be responsible for paying their portion of the insurance premiums in order to maintain coverage during any leave period. Benefit accruals, such as vacation, sick leave, and educational assistance or holiday benefits, will be suspended during the leave and will resume upon return to active employment.

When a personal leave ends, there can be no guarantee of a position at ALSAC. However, an effort will be made to return the employee to a position within the organization when possible. If an employee fails to report to work promptly at the expiration of the approved leave period, ALSAC will assume the employee has resigned.

Paternity Leave

Eligible employees (biological father or a husband who is not the baby's biological father) are granted up to four weeks of leave with pay for paternity leave following the birth of a child or upon the initial placement or legal adoption of a child under age 18.

Paternity Leave can be taken from the day the baby is born or placed (adoption) up to 52 weeks from that date. Leave must be taken in a block of four weeks. It may not be split into smaller increments. In addition, certified documents (such as a birth or adoption certificate) will be required.

Where an employee may be eligible for both paternity and adoption paid time off due to an initial placement or legal adoption of a child under age 18, the employee will only be eligible for the paternity paid time off benefit. This benefit applies to all permanent, full-time, employees whose child was born on Jan. 1, 2022, or later, or who have adopted a child on or after Jan. 1, 2022.

Additional Time Off

Bereavement Leave

In the event of the death of an immediate family member, ALSAC provides up to three days of paid bereavement leave to full-time employees. Time required beyond three days must be taken as vacation or personal time.

Employees who wish to take time off due to the death of an immediate family member should notify their supervisor immediately. Bereavement pay is calculated based on the base pay rate at the time of absence and will not include any special forms of compensation, such as incentives, commissions, bonuses or shift differentials.

Up to three days of paid bereavement leave may be taken within one week (seven days, including weekends) of the death, or the employee will be unable to take time off due to bereavement. If a bereavement day falls during a paid holiday or regular day off, no additional payment beyond the employee's regular pay for that day will be made, nor will the three days be extended because of a paid holiday or regular day off. In no instance should there be more than one type of payment for the hours not worked. Employees on any other type of leave of absence are not eligible for bereavement leave.

Employees should request additional time off as needed from their supervisor. Bereavement leave will normally be granted unless there are unusual business needs or staffing requirements. Employees may, with their supervisor's approval, use any available paid leave for additional time off as necessary.

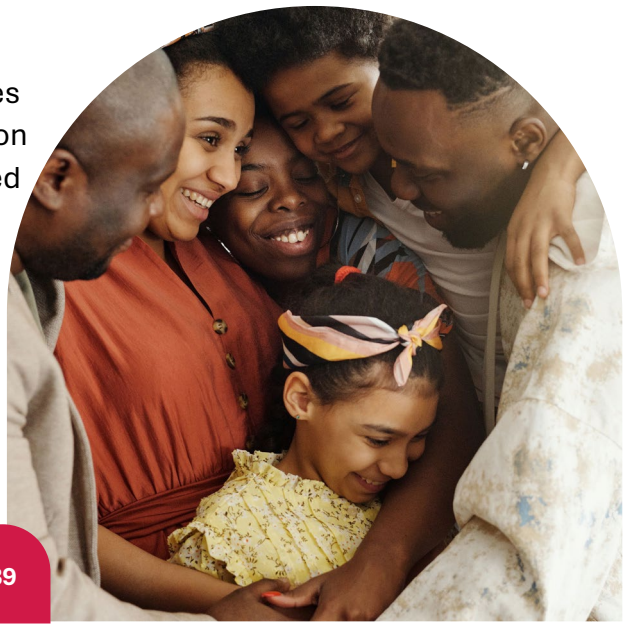
Civic Duty

Time Off to Vote

ALSAC encourages employees to fulfill their civic responsibilities by participating in elections. Employees are encouraged to find time to vote either before or after their regular work schedule. If employees are unable to vote in an election during their non-working hours, ALSAC will grant up to three hours of paid time off to vote. Employee should request time off to vote from their supervisors by noon on the day before Election Day. Advance notice is requested so that the necessary time off can be scheduled at the beginning or end of the work shift; whichever provides the least disruption to the normal work schedule.

Jury Duty

ALSAC encourages employees to fulfill their civic responsibilities by serving jury duty when required. Jury duty will be paid based on the number of hours the employee would otherwise have worked on the day of absence. All employee classifications qualify for paid jury duty leave. Employees must show the jury duty summons to their supervisor so their supervisor may make arrangements to accommodate their absence. The employee is also required to submit a copy of the summons to the payroll department. Employees are expected to report for work whenever their court schedules permit. Work time missed due to serving jury duty will be considered an excused absence. Employees are not required to submit a copy of the jury duty check to ALSAC.



Additional Time Off

Witness Duty

If employees have been subpoenaed or otherwise requested to testify as witnesses by ALSAC, they will receive paid time off for the entire period of witness duty. If employees are subpoenaed to appear in court as a witness by a party other than ALSAC, they will be granted time off to appear. Employees are free to use applicable accumulated paid leave benefit (such as vacation leave) to receive compensation for the period of this absence. If an employee is to appear in court voluntarily, either on his/her own account or on account of a third party, he/she must seek advance approval from his/her supervisor and use any accrued paid time off available to cover the absence. The subpoena should be shown to the employee's supervisor immediately after it is received so that operating requirements can be adjusted, where necessary, to accommodate the employee's absence. The employee is also required to submit a copy of the subpoena to the payroll department. The employee is expected to report for work whenever the court schedule permits.

Military Leave

A military leave of absence will be granted to employees who are absent from work because of service in the U.S. uniformed services, in accordance with the Uniformed Services Employment and Re-employment Rights Act (USERRA).

Thirty days advance notice of military service is required, unless military necessity prevents such notice or it's otherwise impossible or unreasonable. Those returning from military leave will be reinstated to the position they would have attained if they had continued working, to their former position or to a position of like seniority, status and pay, unless ALSAC's circumstances have so changed as to make re-employment impossible or unreasonable.

Those returning from military leave must notify ALSAC of their intent to return to work within fourteen (14) days for leaves of one to six months or within ninety (90) days for leaves of more than six months. Those returning from leaves of less than one (1) month must report to work on the first scheduled workday following their completion of training. Employees will receive partial pay for military leave (covered by dates specified in military orders). Upon presentation of satisfactory military pay verification data, employees will be paid the difference between their normal base compensation and the pay (excluding expense pay) received while on military duty. Employees are responsible for providing their military pay schedule, including military pay changes when incurred. Continuation of health insurance benefits is available as required by USERRA at the active employee rate, based on the length of the leave and subject to the terms, conditions and limitations of the applicable plans for which the employee is otherwise eligible.

Benefit accruals, such as vacation, sick leave or holiday benefits, will continue to accrue during the leave. Employees may, but are not required to, use available accrued sick and vacation time during military leave, as applicable, according to ALSAC's plan.

Employees returning from military leave will be reinstated to the position they would have attained had they remained actively employed, to their former position or to a position of like seniority, status and pay, unless ALSAC's circumstances have so changed as to make re-employment impossible or unreasonable. They will be treated as though they were actively employed for purposes of determining benefits based on length of service. For more information or additional questions please use the Workday@ALSAC Request Tool.

Employee Assistance Program (EAP)

ALSAC offers an Employee Assistance Program (EAP) that provides assistance to employees and their dependents at no cost. The program is sponsored through Magellan Healthcare. Magellan is confidential and gives immediate access to counselors 24 hours a day, 7 days a week. You may call for any number of reasons: crisis intervention assistance, short-term problem resolution and referrals, information, assessment, or action planning. Benefits include three face-to-face visits per issue. For assistance, call (800) 424-4039 or visit **MagellanHealthcare.com** (Member Login > Company Name: ALSAC).

Adoption Benefits

Reimbursement of adoption expenses is available to full-time employees who have completed 12 months of service and worked at least 1,250 hours during the preceding 12 months. Reimbursement will be 50 percent of eligible expenses up to a maximum of $4,000 per child plus two weeks paid time off, which runs concurrently with FMLA.

Where an employee may be eligible for both Paternity and Adoption paid time off due to an initial placement or legal adoption of a child under age 18, the employee will only be eligible for the Paternity paid time off benefit.

Eligible expenses include fees for applications, home study, psychological evaluation of parents, document and processing costs, adoption agency fees, international adoption fees, court costs, legal fees, and the child's medical or travel expenses related to the adoption process.

To access your EAP, call (800) 424-4039 or visit MagellanHealthcare.com (Member Login > Company Name: ALSAC).

Educational Assistance

ALSAC recognizes that the skills and knowledge of its employees are critical to the success of the organization. The educational assistance program encourages personal development through formal education so that employees can maintain and improve job-related skills or enhance their ability to compete for reasonably attainable jobs within ALSAC.

ALSAC will provide educational assistance to all eligible employees who have completed one year of service in an eligible employment classification. Regular full-time employees are eligible for educational assistance. To maintain eligibility, employees must remain on the active payroll and perform their job satisfactorily through completion of each course and receipt of reimbursement.

Individual courses or courses that are part of a degree, licensing or certification program must be from an accredited institution and be related to the employee's current job duties or a foreseeable future position or career opportunity in the organization in order to be eligible for educational assistance. ALSAC has the sole discretion to determine whether a course relates to an employee's current job duties or a foreseeable future position or career opportunity. Employees should contact the Benefits Department for more information or questions about educational assistance.

To guarantee reimbursement of educational costs, requests for educational assistance must be approved prior to enrollment. An Education Assistance Application form shall be submitted to the Benefits Department through the employee's department head. The department head shall recommend either approval or disapproval of the request. The final decision shall be made by the Benefits Department based on established guidelines, which include the nature and purpose of the course of study, the benefits derived by the employee and ALSAC, the level of responsibility and length of service of the employee and the estimated cost.

If employees are eligible to receive educational benefits from other sources, such as the Veterans Administration, grants, fellowships, or other scholarships, that amount will be deducted from the eligible amount offered by ALSAC. ALSAC will reimburse the employee 100% of the costs for grades of C or better, up to $5,250 per year for full-time employees and $2,625 for part-time employees. There shall be no assistance for a grade lower than C. For passing a pass-fail course, the amount of assistance shall be 100% of reimbursable costs subject to the maximum limits.

ALSAC will reimburse the employee 100% of the costs for grades of C or better, up to $5,250 per year for full-time employees and $2,625 for part-time employees.

Educational Assistance

Within 90 days of completion of the course, the employee shall submit to the Benefits Department a transcript of grades received and receipts for expenses incurred. The organization will then reimburse the employee the cost of tuition, textbooks, and registration, laboratory, and library fees, subject to the maximum limits. To apply for reimbursement, the employee must complete the following steps:

1. Upon enrollment, the employee must complete Part I of the Educational Assistance Application and return it to his/her supervisor with the class schedule.

2. The supervisor must complete Part II, the Supervisor's Evaluation section of the application, which provides the certification needed for ensuring that courses are consistent with ALSAC's educational assistance policy.

3. Part III, Replay to Employee is completed by the Benefits Department, indicating whether the application has been approved. The Benefits Department will return a copy of the approved application to the employee.

4. The employee should use the approved, signed application to initiate reimbursement action when approved courses are completed successfully.

5. Receipts for payments and certification of passing grade(s) documentation should be attached to the employee's application copy and forwarded to the Benefits Department within 90 days of successful completion of the course. The Benefits Department completes Part IV and submits for payment.

ALSAC invests in educational assistance of employees with the expectation that the investment be returned through enhanced job performance. However, if an employee voluntarily separates from ALSAC's employment within six months of completion of any course(s), the employee must repay the full amount paid by the organization for educational assistance. If the employee leaves the organization voluntarily - or is terminated for cause - between six months and one year after completing the course, one half of the amount will be repayable.

While educational assistance is expected to enhance employee's performance and professional abilities, ALSAC cannot guarantee that participation in formal education will entitle the employee to automatic advancement, a different job assignment or pay increases.

Contact Information

Benefit	Vendor	Phone Number or Email	Website
Medical	Cigna Group #3341704	855-212-5722	MyCigna.com
Medical	MDLive (Telemedicine)	888-726-3171	MDLiveForCigna.com
Medical	Nurseline Support 24/7	800-244-6224	MyCigna.com
Medical	Healthy Babies	855-212-5722	MyCigna.com
Medical	Progyny (Fertility Treatment)	833-215-4803	Progyny.com
Prescription Drugs	CVS/Caremark Group #CASLA	866-259-0798	Caremark.com
Employee Assistance Program (EAP)	Magellan Company Name: ALSAC	800-424-4039	MagellanHealthcare.com
Dental	Delta Dental Group #4143	800-223-3104	DeltaDentalTN.com
Vision	VSP Group #30023513	800-877-7195	VSP.com
Flexible Spending Accounts	Navia Benefit Solutions Company Code: AJ4	800-865-6543	NaviaBenefits.com
Medicare Assistance	Alliant Medicare Solutions	877-888-0165	AlliantMedicareSolutions.com
Basic Life and AD&D Additional Life Spousal Life Dependent Life STIR Long Term Disability	Sun Life	800-321-1780	SunLife.com/account
Personal Accident Insurance	New York Life Policy OK-818435	888-842-4462	NewYorkLife.com
Group Legal	MetLaw Group #6090511	800-821-6400	LegalPlans.com
Supplemental Insurance	Aflac	800-433-3036	AflacGroupInsurance.com
Employee Retirement Plan 401(k)	Principal	800-547-7754	Principal.com
Identity Theft	IdentityForce Code: ALSAC	844-579-1183	IdentityForce.com
Parental Support	UrbanSitter	support@urbansitter.com	UrbanSitter.com/ALSAC
Discount Program	WorkingAdvantage	800-565-3712	Alsac.Savings.WorkingAdvantage.com

Legal Notices

Important Notice from ALSAC 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 ALSAC 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. **ALSAC has determined that the prescription drug coverage offered by the ALSAC/St. Jude's Children's Research Hospital Employees Health and Welfare 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 ALSAC coverage will not be affected.

Retail Prescription Drug Benefits		Mail Order Prescription Drug Benefits	
Generic	**$5**	**Generic**	**$10**
Brand-Preferred	**$35**	**Brand-Preferred**	**$70**
Brand Non-Preferred	**$70**	**Brand Non-Preferred**	**$140**

If you do decide to join a Medicare drug plan and drop your current ALSAC coverage, be aware that you and your dependents will 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 ALSAC 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 ALSAC 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:	October 24, 2024
Name of Entity/Sender:	American Lebanese Syrian Associated Charities
Contact--Position/Office:	Lashauna Anderson, Benefits Manager
Address:	501 St. Jude Place, Memphis, TN 38105
Phone Number:	901-578-2148

Legal Notices

PLEASE READ IMPORTANT NOTICE FROM THE AMERICAN LEBANESE SYRIAN ASSOCIATED CHARITIES HEALTH AND WELFARE PLAN ANNUAL NOTICE

Notice of Choice of Providers

ALSAC generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, call the plan administrator. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from ALSAC or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator.

Women's Health and Cancer Rights Act

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

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

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

- PPO 1 – Deductibles: $150 Individual / $450 Family; Coinsurance 90%
- PPO 2 – Deductibles: $450 Individual / $1,350 Family; Coinsurance 80%

If you would like more information on WHCRA benefits, call your plan administrator.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in your employers health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in your employer's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 60 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 60 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in your employer's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for ALSAC describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting your plan administrator.

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Legal Notices

Newborns' and Mothers' Health Protection Act
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). If you would like more information on maternity benefits, call your plan administrator.

Notice of Grandfathered Plan Status
ALSAC believes the ALSAC/St. Jude's Children's Research Hospital Employee Health and Welfare plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 901-578- 2148. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Michelle's Law
The ALSAC/St. Jude's Children's Research Hospital Employee Health and Welfare plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school.
Coverage may continue for up to a year unless your child's eligibility would end earlier for another reason.
Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, the plan administrator as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

Notice of Availability of Alternative Standard for Wellness Plan
Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 901-578-2148 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

ACA Disclaimer
This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 of your modified adjusted household income.

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2
INDIANA – Medicaid
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

Legal Notices

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – 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)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

Legal Notices

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
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, 2024, 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 1/31/2026)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

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 is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[11] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[12]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact **ALSAC Benefits – Lashauna Anderson (Lashauna.Anderson@alsac.stjude.org).**

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.

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.

3. Employer name **American Lebanese Syrian Associated Charities**		4. Employer Identification Number (EIN) **35-1044585**	
5. Employer address **501 St. Jude Place**		6. Employer phone number **901-578-2148**	
7. City **Memphis**	8. State **TN**	9. ZIP code **38105**	
10. Who can we contact about employee health coverage at this job? **Lashauna Anderson**			
11. Phone number (if different from above)	12. Email address **Lashauna.Anderson@alsac.stjude.org**		

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Employees working at least 30 hours per week

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

1. The Subscriber's current spouse which includes a same-sex Domestic Partner defined by Employer; or
2. The Subscriber's or the Subscriber's spouse's: (1) Natural child; (2) legally adopted child (including children place for the purpose of adoption); (3) step-child(ren); or (4) children for whom the Subscriber or Subscriber's spouse is the legal guardian, including grandchildren of the Subscriber or Subscriber's spouse who meet eligibility criteria; who are less than 26 years old; or
3. A child of the Subscriber or Subscriber's spouse for whom a Qualifies Medical Child Support Order has been issued; or
4. An Incapacitated Child of the Subscriber or Subscriber's spouse.

☐ We do not offer coverage.

☒ If checked, 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. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☒ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $ 0
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☒ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $ _____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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This document provides an overview of your benefits only. Refer to your plan booklet for a complete description of benefits provided. The plan booklet and your eligibility for benefits will determine how your benefits are paid.