

FOUNDATION FOR THE CAROLINAS

2025 Employee Benefits

FOUNDATION FOR
THE CAROLINAS

220 North Tryon Street
Charlotte, NC 28202
704.973.4500



This summary is not a legal document and does not replace or supersede the “Evidence of Coverage,” Plan Document or the Summary Plan Description. Please refer to these documents for a complete description of the coverage, eligibility criteria, controlling term, exclusions, limitations and conditions of coverage.

Foundation For The Carolinas reserves the right to terminate, suspend, withdraw, reduce or modify the benefits described in the Evidence of Coverage/Plan Document/Summary Plan Description in whole or in part, at any time. No statement in this or any other document and no oral representation should be construed as a waiver of this right. This summary is the confidential property of Foundation For The Carolinas.



This document is intended for the internal use of FFTC and FFTC’s staff only and should not be distributed or reproduced externally in any form without express written permission from the Human Resources Department.

TABLE OF CONTENTS

Eligibility & Open Enrollment	4
Medical Coverage	5
Wellness	8
Health Savings Account	9
Health Reimbursement Account	10
Flexible Spending Account	11
Basic Dental	13
Vision	14
Basic Group Life and AD&D	15
Voluntary Life and AD&D	16
Disability	17
Accident	18
Critical Illness	20
Employee Assistance Program	22
Retirement	23
Paid Time Off	24
Additional Programs	25
Benefit Resource Center (BRC)	26
Mobile App	27
My Benefit Advisor	28
Cigna Healthy Rewards	29
Legal Notices	31
Contact Information	51

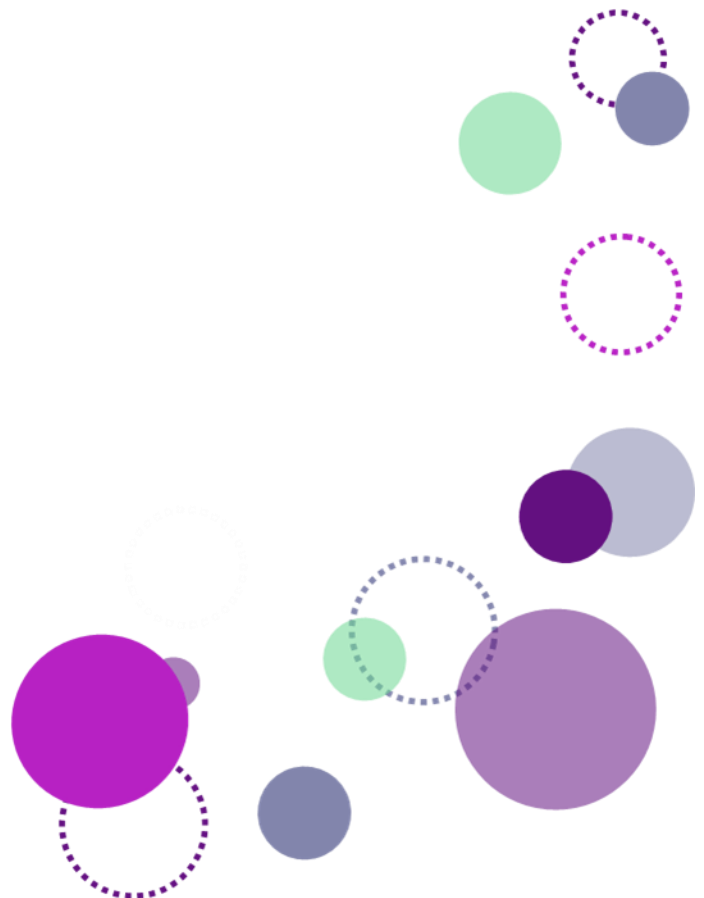
Welcome

We are so excited to have you as part of our Foundation For The Carolinas team! As an organization that has served our community since 1958, we strive to offer our employees a best-in-class benefits program that attracts and retains our best-in-class team.

This guide provides a detailed overview of our extensive offerings. We've contracted with market leaders to provide excellent coverage, top-notch customer service and a comprehensive plan for you and your family.

With gratitude,

Your Human Resources Team



Eligibility & Open Enrollment

Who is Eligible?

Foundation employees who meet the minimum requirements are eligible. For new employees, coverage begins the first day of the month after completing a full calendar month of employment. **New employees take note:** After the initial enrollment period ends, changes can only be made during Open Enrollment or when a Qualifying Life Event occurs (*see below*).

Enrollment Information

Your eligible dependents include your legal spouse or domestic partner and children up to age 26. If you're covering a dependent for Medical, Dental, Vision and/or Voluntary Life, you need to provide their name, birthdate and social security number.

Premiums/contributions for Medical, Dental, Vision, Health Savings Account and Flexible Spending Accounts are made on a "pre-tax" basis.

Remember: Open Enrollment is your opportunity to obtain coverage or make changes. Once it ends, changes can only be made if a Qualifying Life Event occurs. Examples include:

- Loss/gain of coverage through spouse's employer
- Birth or adoption of a child
- Divorce
- Marriage

Dependent Coverage Details

Coverage	Dependent Age Minimum	Termination of Coverage Date
Medical	To age 26	End of the month
Dental	To age 26	End of the month
Vision	To age 26	End of the month

Affordable Care Act (ACA) 1095 – C

We value you and are committed to providing you and your family with affordable benefits that meet or exceed the requirements of "minimum essential coverage" under the Affordable Care Act. Our medical plan is considered acceptable under the ACA guidelines.

You will receive a 1095-C form annually along with your W-2. This is proof of the health coverage we offer to you and your family. Only one form is provided for all individuals listed on your policy. Please note that the Medical plan coverage is currently non-taxable. If you have any questions, please contact Human Resources.



Medical Coverage

The Foundation offers robust medical coverage for qualified employees and their families. Please refer to the summary plan description for complete details.

	CIGNA HDHP		CIGNA PPO	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Annual Deductible				
Individual	\$3,500	\$7,000	\$3,500	\$7,000
Family	\$7,000	\$14,000	\$7,000	\$14,000
Coinsurance (Member)	20%	50%	30%	50%
Maximum Out-of-Pocket				
Individual	\$7,000	\$14,000	\$5,500	\$11,000
Family	\$14,000	\$28,000	\$11,000	\$22,000
Physician Office Visit				
Primary Care	20% after deductible	50% after deductible	\$25 copay	50% after deductible
Specialty Care	20% after deductible	50% after deductible	\$50 copay	50% after deductible
Preventive Care				
Adult Periodic Exams	100%	50% after deductible	100%	50% after deductible
Well-Child Care	100%	50% after deductible	100%	50% after deductible
Diagnostic Services				
X-ray and Lab Tests	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Complex Radiology	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Urgent Care Facility	20% after deductible	50% after deductible	\$50 copay	50% after deductible
Emergency Room Facility Charges	20% after deductible	80% after deductible	\$300 copay	\$300 copay
Inpatient Facility Charges	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Outpatient Facility and Surgical Charges	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Mental Health				
Inpatient	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Outpatient	20% after deductible	50% after deductible	\$10 copay	50% after deductible
Substance Abuse				
Inpatient	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Outpatient	20% after deductible	50% after deductible	30% after deductible	50% after deductible
Other Services				
Chiropractic	20% after deductible	50% after deductible	\$50 copay	50% after deductible
Retail Pharmacy (30 Day Supply)				
Generic (Tier 1)	20% after deductible	80% after deductible	\$10 copay	N/A
Preferred (Tier 2)	20% after deductible	80% after deductible	\$50 copay	N/A
Non-Preferred (Tier 3)	20% after deductible	80% after deductible	\$100 copay	N/A
Preferred Specialty (Tier 4)	20% after deductible	80% after deductible	\$100 copay	N/A
Mail Order Pharmacy (90 Day Supply)				
Generic (Tier 1)	20% after deductible	N/A	\$30 copay	N/A
Preferred (Tier 2)	20% after deductible	N/A	\$150 copay	N/A
Non-Preferred (Tier 3)	20% after deductible	N/A	\$300 copay	N/A
Preferred Specialty (Tier 4)	NoHome delivery	N/A	No Home delivery	N/A

Telehealth Through MDLive

Important benefit to remember: Telehealth provides an easy way to access a physician by video consultation – anywhere, anytime, including holidays. It’s convenient for minor health problems after hours or when you’re away from home. Here’s how to get started:

1. Go to www.mycigna.com and click “Talk to a doctor” or call MDLive at 888.726.3171.
2. Select the type of care you need: medical care or counseling; cost will be displayed on myCIGNA and MDLive.
3. Follow the prompts for an on-demand, urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care.

Appointments are available via video or phone, whenever it’s most convenient for you. Virtual dermatology doesn’t require an appointment.

Some common health problems treated by MDLive physicians are:

Primary Care

- Preventive care/screenings
- Receive orders for biometrics or blood work at local facilities

Behavioral Care

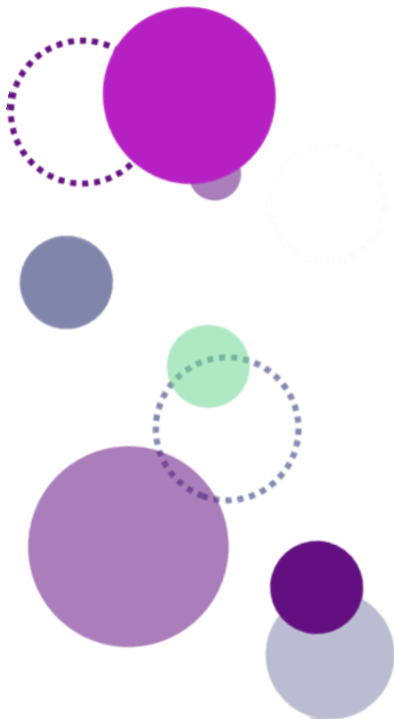
- Access to psychiatrists and therapists
- Option to select the same provider every session

Urgent Care

- On demand care ANY time, including holidays
- Convenient, affordable alternative to urgent care and ER
- Prescriptions available, if appropriate

Dermatology

- Board certified dermatologists review pictures and symptoms
- Diagnosis and treatment plan usually within 24 hours; can be longer if testing required



Medical Coverage Premiums

Foundation For The Carolinas pays a significant portion of the cost of your medical plan, putting both employee premiums and plan design first and foremost. Our medical coverage will continue to be with CIGNA, which offers a broad network of providers nationwide at mycigna.com.

Due to the Health Care Reform legislation, services considered “preventive” could be different than what you may have seen in the past. You now have preventive care covered at 100% with no copay or deductible for ACA-mandated services. It’s a good idea to build a profile on mycigna.com where you can check coverage, review claims and obtain valuable benefit information.

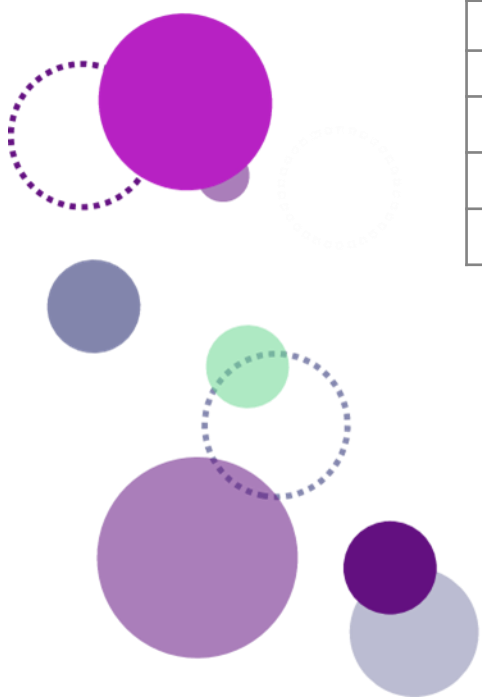
Did you know: You can play a part in keeping the cost of healthcare down? Here are some ways you can become an effective healthcare consumer:

- Practice prevention and know what to do for early detection.
- Talk with your doctors and share in decisions.
- Pursue a healthy lifestyle. Maintain and improve health with wellness.
- Choose providers from the CIGNA network to enjoy reduced rates.
- The actual cost of a procedure or service can be obtained from your doctor or healthcare facility. It’s good to consider the full cost and not just your portion of the payment when making decisions.

Bi- Weekly Employee Payroll Deductions		
Plan	HDHP with HSA	PPO with HRA
Employee	\$35.19	\$39.67
Employee & Spouse	\$137.46	\$156.94
Employee & Child(ren)	\$115.52	\$135.60
Employee & Family	\$325.85	\$375.84



FFTC Paid Premiums		
Plan	HDHP with HSA	PPO with HRA
Employee	\$316.74	\$357.01
Employee & Spouse	\$549.83	\$627.76
Employee & Child(ren)	\$462.07	\$542.42
Employee & Family	\$760.33	\$876.97



The Foundation wants you to stay healthy, which is why we encourage employees to participate in our wellness program. Employees and covered spouses/domestic partners are encouraged to get an annual physical and schedule preventive screenings. Find out more: www.mycigna.com/preventive.

Employees and covered spouses/domestic partners who completed their required physical in 2024 are eligible for the wellness incentive in January 2025.

Employees and covered spouses/domestic partners have from Jan. 1, 2025, to Dec. 31, 2025, to obtain their annual physical for the wellness incentive in the following plan year.

Employees and covered spouse/domestic partners who do not complete their annual physicals within the 2025 plan year will not receive their wellness incentive in 2026.

New Hires will receive the wellness incentive in January of the following plan year upon completion of the annual physical during the current plan year.

Information on how to obtain and submit eligibility forms from WellWorks is outlined below.

Login Instructions:

New Members:

1. Go to www.wellworksforyoulogin.com
2. Click the link to create an account as a New Member
3. Enter your Company ID: 12295
4. Select Yes to confirm the company name listed is correct
5. Create a Username, Password, and enter the required personal information
6. Select Create Account
7. Accept the terms of the Consent Form

Current Participants:

MEMBER TYPE	USERNAME FORMAT	PASSWORD FORMAT	EXAMPLE
Employee	Employee email	Birthdate in MMDDYYYY	UN: thunter@fftc.org PW: 03061976
Spouse	Employee email + S	Birthdate in MMDDYYYY	UN: thunter@fftc.orgS PW: 04131978

Submission Instructions:

1. Download the Physician Results form and take it with you to your annual physical.
2. Some doctor's offices will submit the form for you; other offices will complete the form and send to you to submit to WellWorks.
3. You can submit the form several ways:
 - Upload via the Wellness Portal
 - Scan and email to forms@wellworksforyou.com
 - Mail to WellWorks, Attn: Forms Department, 1615, West Chester Pike, Suite 104, West Chester, PA 19382

Please allow 7 – 10 business days for processing. You will receive a confirmation email when your form has been processed.

Contact WellWorks with any questions: 800.425.4657.

Health Savings Account

How Much Can I Contribute?	2025 HSA Contributions	
	Individual	Individual + Dependents
Total Contribution Limit	\$4,300	\$8,550
If over age 55	Additional \$1,000	Additional \$1,000
Employee Contribution	\$3,100	\$6,150
*Employer Contribution	\$1,200	\$2,400

FFTC Wellness contributions are made in January 2025.

HSA enrolled employees who complete the wellness activity in the prior year will receive an employer contribution. Please reference the chart below for maximum employer contribution limits:

	HSA Plan - FFTC Pays (January 2025)
First Member	\$1,200 (\$600 initial eligibility + \$600 Wellness adherence)
Additional Member	\$1,200 (\$600 initial eligibility + \$600 Wellness adherence)

Additional members include any dependent covered under the FFTC medical plan; up to two contributions maximum per year including the employee.

Employees whose start date is during the plan year will receive a prorated initial eligibility employer contribution. For example, if benefits are effective March 1, the employee receives an initial eligibility contribution of \$500.

What are the Advantages of an HSA?

Any money deposited into your Health Savings Account is 100% yours – whether you withdraw funds within a month, a year or 10 years! It is the only IRS-supported vehicle to allow tax-free contributions and distributions for qualified medical services and/or products.

Funds can be used for qualified medical, dental, and vision expenses, long-term care insurance premiums, COBRA premiums, health care coverage while receiving unemployment compensation, and Medicare if age 65 or older.

Note: You will be subject to account maintenance fees if you are no longer an active High Deductible Plan participant. Please refer to the Optum Deposit Agreement and Disclosure. Please see Human Resources for a copy.

Questions and for a list of eligible expenses:

Please visit online at: www.optumbank.com Or call at: 866.234.8913

Who is Eligible?

You are eligible if you:

- Are covered by a High Deductible Health Plan.
- Are not covered under a medical health plan that is not a High Deductible Health Plan.
- Are not covered under a Medical FSA.
- Are not receiving Medicare benefits.
- Are not claimed on another person's tax return.

How Does It Work?

- Employee and/or employer funds HSA account.
- Employee will be mailed an HSA Debit Card.
- Employee seeks medical services.
- Medical services are paid by the High Deductible Health Plan (subject to a deductible).
- Employee can use debit card or seek reimbursement from their HSA account for any eligible expense.
- To maximize catch-up contributions, the employee and covered spouse must be 55 or older and open separate HSAs.

Health Reimbursement Account

HRA Information

FFTC's Health Reimbursement Account reimburses employees for deductible expenses – up to the full amount of the qualified expenses once you meet the deductible threshold.

You do not take the HRA money with you if you leave the Foundation. Any unused money in your HRA does not rollover into subsequent policy years. Any claims must be submitted by Dec. 31 for eligible services incurred within the same plan year.

You are able to obtain up to \$2,500 with wellness adherence or \$1,500 without wellness adherence.

Who Is Eligible?

You are eligible if you:

- Are covered by the Company's PPO Plan.
- Can be covered under a Medical FSA.
- Can be entitled to Medicare benefits.



How Does It Work?

- Employer funds HRA account.
- Employee seeks medical services.
- Employee requests reimbursement from the HRA account by contacting Flores & Associates.
- Upload your Explanation of Benefits from CIGNA showing your deductible expenses, and Flores will process the appropriate reimbursement.
- Please see page 10 for more information on how to submit a claim.

For new hires and employees who complete their wellness adherence, *refer to Table 1.*

For employees who do not complete their wellness adherence in the prior year, *refer to Table 2.*

	HRA Plan <u>with</u> Wellness Adherence		
Table 1	Deductible	Member Meets	FFTC Pays
First Member	\$3,500	\$1,000	\$2,500
Additional Member*	\$3,500	\$1,000	\$2,500

	HRA Plan <u>without</u> Wellness Adherence		
Table 2	Deductible	Member Meets	FFTC Pays
First Member	\$3,500	\$2,000	\$1,500
Additional Member*	\$3,500	\$2,000	\$1,500

*Additional members include any dependent covered under the FFTC medical plan, up to two reimbursements maximum per year including the employee.

Questions?

Please visit online at: www.flores247.com

Or call at: 800.532.3327

Flexible Spending Account

Limited Purpose Flexible Spending Account (LPFSA) - HDHP Only

Who is eligible?

- Any regular employee enrolled in the HDHP/HSA who works 30 hours or more per week.

How does it work?

- Employees can put aside pre-tax dollars (via payroll deduction) up to \$3,300 per year for reimbursement of qualified dental and vision expenses (no medical).
- Deferral amounts are subject to non-discrimination testing. You will be notified prior to the beginning of the plan year if your deferral amount needs to be adjusted.

Flexible Spending Account (FSA) – PPO Only

Who is eligible?

- Any regular employee enrolled in the PPO plan who works 30 hours or more per week.
- Employees who decide not to enroll in FFTC medical plans may still elect to participate in the FSA.

How does it work?

- Employees can put aside pre-tax dollars (via payroll deduction) up to \$3,300 per year for reimbursement of qualified medical, prescription drug, dental or vision expenses. Deferral amounts are subject to non-discrimination testing. You will be notified prior to the beginning of the plan year if your deferral amount needs to be adjusted.

Dependent Care Flexible Spending Account (DCFSA) – HDHP or PPO

Who is eligible?

- Employees with dependents less than age 13.
- Employees whose parents are listed as dependents on their tax return.

How does it work?

- Employees can use pre-tax dollars (via payroll deduction) up to \$5,000 per year (\$2,500 if married and filing separately) for reimbursement of eligibility of child/elder care expenses.
- Debit card not available for Dependent Care FSA.

Plan Year for Flexible Spending Accounts is Jan. 1, 2025 – Dec. 31, 2025

- The dollars in your FSA must be used for expenses incurred during the plan year.
- You have a grace period of 74 days after the plan year ends (through **March 15, 2026**) to incur claims that counts towards the current year's FSA expenses.
- You have until **March 31, 2026** to file for reimbursement on your Jan. 1, 2025 - Dec. 31, 2025 expenses.

Questions?

Visit online at: www.flores247.com

Or call at: 800.532.3327



FSA Debit Card Frequently Asked Questions

What expenses are eligible for payment with my Debit Card?

You can use your Flores Debit Card to pay for expenses incurred during your active enrollment period in the current plan year. If a provider or merchant does not accept Debit Cards, you do have the option to file a manual request for reimbursement of your eligible out-of-pocket cost. Please visit www.flores247.com for a guide to allowable expenses. If you terminate employment during the plan year, the card will be turned off at that time. Only expenses incurred while you are an active participant will be considered as reimbursable.

How can I use my Debit Card to pay for my eligible out-of-pocket expenses?

Although the Flores Debit Card is a debit card with a cash balance loaded onto it, you should select “credit” as the transaction type, and sign for purchases at authorized merchants. Please keep in mind that the Flores Debit Card will decline if you try to swipe it for an amount greater than your available balance.

How should I send my documentation to Flores?

Many transactions will be auto-approved at the point of sale and will not require further documentation. Flores will notify you by email or a mailed letter if additional information is needed to verify the eligibility of a particular transaction. You may submit your documentation by upload on the participant website, www.flores247.com, using the e-Receipt mobile application, or by fax or mail.

I used my card for an ineligible expense. How do I correct this?

You may send a refund check to Flores for the ineligible amount which will be credited back to your Debit Card to be used toward other eligible expenses you incur later in the year. You may also submit documentation that verifies you have paid out-of-pocket for an eligible expense, which Flores will use to offset the ineligible amount paid with your Debit Card.

Will I receive a new card each plan year?

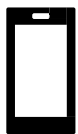
Your Debit Card is valid for five years from its issue date. Do not discard your card prior to its expiration date. At the start of each new plan year, your Debit Card will be reloaded with your new election amount. A new card will be mailed to you when your expiration date is approaching.

How do I obtain my account details?



WEBSITE

Visit www.flores247.com and log in using Participant ID or User Name and password



MOBILE WEBSITE

Visit our mobile website at m.flores247.com



PID & PASSWORD ASSISTANCE

Dial 800.840.7684

How do I submit documents to Flores?

ONLINE

Visit www.flores247.com and upload scanned documents securely

MOBILE

Download e-Receipt smart phone app. Available for Apple or Android devices.

MAIL

Flores & Associates, LLC
PO Box 31397
Charlotte, NC 28231

FAX

800.726.9982 or 704.335.0818

CUSTOMER SERVICE 1.800.532.3327

Dental Coverage

Benefits Coverage	In-Network	Out-Of-Network
Annual Deductible		
Individual	\$50	\$50
Family	\$150	\$150
Waived for Preventive Care?	Yes	Yes
Annual Plan Maximum		
Per Covered Individual	\$1,500	\$1,500
Lifetime Orthodontic Maximum Per Member	\$1,000	\$1,000
Plan Benefits – insurance covers this amount		
Preventive <ul style="list-style-type: none"> • Examinations • X-rays • Cleanings • Fluoride Treatments (children to age 16) • Sealants • Palliative Treatment (Emergency) 	100%	100% of the Usual & Customary allowance
Basic <ul style="list-style-type: none"> • Basic Restorative • Space Maintainers • Repairs • Simple Extractions • General Anesthesia • Simple Endodontics 	<ul style="list-style-type: none"> • Simple Periodontics • Surgical Endodontics and Periodontics • Amalgam and Composite Fillings 	80%
Major <ul style="list-style-type: none"> • Inlays/Onlays • Crowns/Bridges • Dentures • Implants • Orthodontics (Children up to age 19) 	50%	50% of the Usual & Customary allowance

Questions?

Online: www.mycigna.com

- To find a Preferred Dentist near you, simply click on the Find a Dentist link then search for a “Dental Preferred Provider Organization” dentist. You can even map directions directly to their office.
- Register to use www.mycigna.com for secure access to your benefit information including eligibility, benefit, claim details, payment information, procedure history and more.

Phone: 800.244.6224 (Option 1)

- Call to speak with a customer service representative Monday through Friday or use the automated system available 24/7.

Dental Premiums (per bi-weekly pay period)		
	Employee Pays	FFTC Pays
Employee Only	\$ 2.71	\$24.39
Employee + Spouse	\$ 10.45	\$41.81
Employee + Child(ren)	\$ 10.63	\$42.53
Employee + Family	\$ 25.20	\$58.79

Easy Benefit Access

With Cigna Dental, you are able to visit any provider you choose, but you maximize your savings when you visit a network provider. The average network discount is 20%!

Vision Coverage

Foundation For The Carolinas offers vision insurance for you and your family through Cigna.

You can find providers and more information by calling 800.244.6224 or on the website at www.mycigna.com. Cigna uses the EyeMed network for vision providers.

Comprehensive Plan	
The Benefit (per enrolled individual)	<ul style="list-style-type: none"> • One routine eye exam annually • \$130 allowance for eyewear annually (including contactlens exam) • A contact lens fitting, re-fit, or evaluation annually
Co-Payment	<ul style="list-style-type: none"> • Exam: \$10; Eyewear:\$25
Eyewear Allowance	
<p>If you exceed the annual allowance for frames and lenses, you will obtain a 20%-25% discount on the excess amount. You receive a 20% discount off the cost of additional pairs of prescription glasses and non-prescription sunglasses. There is also an average 15% discount for LASIK or PRK from participating providers.</p>	

Vision Premiums (per bi-weekly payperiod)		
	Employee Pays	FFTC Pays
Employee Only	\$1.01	\$2.35
Employee + Spouse	\$2.02	\$4.71
Employee + Child(ren)	\$2.04	\$4.75
Employee + Family	\$3.25	\$7.59



Basic Life and AD&D

Foundation For The Carolinas Pays 100% of This Benefit

The Foundation provides each employee who works 30 hours or more per week a Basic Life Insurance and Accidental Death & Dismemberment policy – 3x annual earnings up to a guaranteed issue maximum of \$425,000.

If death is the result of an accident, your beneficiary will receive an amount equal to your basic life insurance coverage. If you are dismembered (such as loss of sight in an eye, loss of a hand, foot, limb, hearing, speech, etc.), benefits will be paid to you as a percentage of the basic life amount. When you turn 65, the benefit amounts will follow a pre-determined reduction schedule. Please view the benefit summaries for more details.

Symetra	
Life & AD&D Benefit Amount	Three times annual salary
Employee Non-Medical Guarantee Issue	\$425,000
Age Reductions	Benefits reduce to 67% at age 65, then to 34% at age 70



Voluntary Life and AD&D

Optional Term Life and AD&D Insurance - Symetra

Foundation For The Carolinas provides each regular employee who works 30 hours or more per week the opportunity to purchase additional life insurance.

Employee

Employees are eligible for \$10,000-\$100,000 of coverage with no medical questions asked if you apply when you are first eligible. Total coverage is up to \$300,000 with medical evidence of insurability. Employees must be actively at work and not confined to a hospital or disabled on the effective date of the coverage.

Spouse

Spouses are eligible for increments of \$5,000 up to 50% of the employee's benefit, if the employee is electing coverage. Spouses can obtain up to \$25,000 with no medical questions if applying when first eligible and up to \$150,000 with medical evidence of insurability.

Children

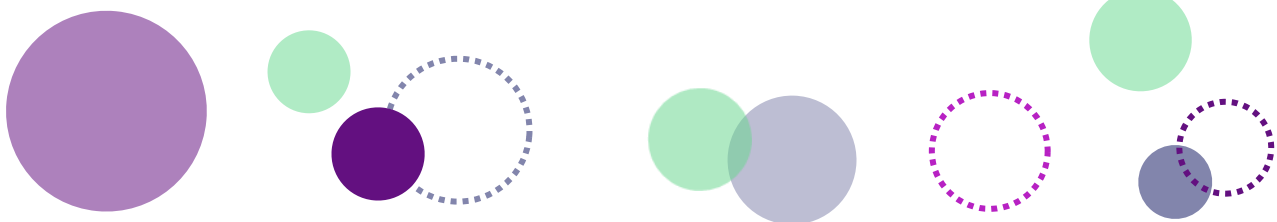
Children aged 15 days to 26 years can obtain a benefit of \$10,000. The employee must also elect coverage before the child can be covered. The cost per pay period is \$0.42 regardless of how many children are being covered.



Voluntary Life Premiums for Employee/Spouse (per bi-weekly pay period)							
Age	Rate	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000	Up to \$100,000
under30	\$0.11	\$0.51	\$1.02	\$1.52	\$2.03	\$2.54	\$5.08
30-34	\$0.11	\$0.51	\$1.02	\$1.52	\$2.03	\$2.54	\$5.08
35-39	\$0.14	\$0.65	\$1.29	\$1.94	\$2.58	\$3.23	\$6.46
40-44	\$0.20	\$0.92	\$1.85	\$2.77	\$3.69	\$4.62	\$9.23
45-49	\$0.30	\$1.38	\$2.77	\$4.15	\$5.54	\$6.92	\$13.85
50-54	\$0.53	\$2.45	\$4.89	\$7.34	\$9.78	\$12.23	\$24.46
55-59	\$0.81	\$3.74	\$7.48	\$11.22	\$14.95	\$18.69	\$37.38
60-64	\$0.92	\$4.25	\$8.49	\$12.74	\$16.98	\$21.23	\$42.46
65-69	\$1.64	\$7.57	\$15.14	\$22.71	\$30.28	\$37.85	\$75.69

Benefits reduce to 65% at age 65, then to 50% at age 70.

Evidence of insurability (medical questions) will be required if an employee elects an amount over the guaranteed issue limit or elect coverage after the initial eligibility period.



Disability

Foundation For The Carolinas Pays 100% of This Benefit

Disability coverage is an important employee benefit that provides income replacement for an employee in the event he or she becomes sick, injured or otherwise disabled and cannot work.

When Am I Considered Disabled?

You are considered disabled when, because of injury or sickness, you are unable to perform your job, and you are under the regular care of a doctor.

Short-Term Disability

Short-Term Disability is a company-paid benefit that provides partial income protection if a serious illness or injury causes you to be on medical leave from work for more than eight days.

- The benefit provides you with 60% of your earnings during your approved disability period up to a maximum of \$2,000 (taxable income) per week. The benefit remains in effect for up to 13 paid weeks, based on continued disability status.
- You are not covered for a disability caused by war or any act of war, declared or undeclared, an intentionally self-inflicted injury, active participation in a riot, and commission of a crime for which you have been convicted. Benefits are not payable for any period of incarceration as a result of a conviction.
- Disability benefits must be approved by a physician and the disability provider.
- You must be employed by Foundation For The Carolinas for 12 months before you're eligible for short-term disability.

Questions?

Visit online at: www.symetra.com

Or call at: 800.796.3872

Long-Term Disability

The cost of Long-Term Disability plan coverage is currently paid entirely by the Foundation. The LTD premiums are paid in a "gross-up and deduct" manner, where Foundation For The Carolinas increases the employee's salary by an amount equal to the cost of the premium, and then takes a payroll deduction for the premium. This results in a benefit that is tax-free to the employee since they pay for the premium with their after-tax dollars that were "bonused" to them by FFTC.

Foundation For The Carolinas provides regular employees who work 30 hours or more per week a Long-Term Disability policy.

- Long-Term Disability coverage protects an employee from loss of income in the event that he or she is unable to work due to illness, injury, or accident for a long period of time.
- This benefit will pay 60% of your monthly salary to a maximum payment of \$10,000 less deductible sources of income and disability earnings (benefits from statutory plans, unemployment benefits and salary continuation).
- Benefits begin after 90 days (three (3) months) of disability.
- Your benefits will be non-taxable.
- You are not covered for a disability caused by war or any act of war, declared or undeclared, an intentionally self-inflicted injury, active participation in a riot, and commission of a crime for which you have been convicted. Benefits are not payable for any period of incarceration as a result of a conviction.

Voluntary Accident

Foundation For The Carolinas provides each regular employee who works 30 hours or more per week the opportunity to purchase accident insurance from Symetra, which offers financial support in case of an accidental injury.

You decide how to use the cash benefits:

- To pay for travel expenses related to treatment.
- To pay for deductible and coinsurance charges on medical plan.
- To make any repairs or renovations to your home to assist with care.
- To help pay living expenses.
- Choose one of three levels of benefit: Base, Classic or Premier.

Here's an example on how accident coverage can help:

Your child breaks a wrist playing soccer:

If you have the Classic level benefit, you might receive:

\$1,250 (fracture) + \$200 for ER and \$50 for X-ray = \$1,500

You fall off a ladder at home and are treated at the ER.

If you have the Classic level benefit, you might receive:

\$200 for ER visit; \$50 for X-ray = \$250

Accident Premiums (per bi-weekly pay period)			
	Base	Classic	Premier
Employee Only	\$4.38	\$6.08	\$7.95
Employee + Spouse	\$7.32	\$10.20	\$13.38
Employee + Child(ren)	\$8.64	\$12.13	\$16.00
Employee + Family	\$12.18	\$17.14	\$22.62



Voluntary Accident

Emergency Care & Diagnostics	Base	Classic	Premiere
Ambulance – Ground	\$100 pp/pa	\$250 pp/pa	400pp/pa
Ambulance – Air	\$1,000 pp/pa	\$1,500 pp/pa	\$2,000 pp/pa
Emergency Room	\$150 pp/pa	\$200 pp/pa	\$300 pp/pa
Major diagnosis Testing (MRI, CT, CAT, EEG) 1 Benefit covered per accident	\$75 pp/pa	\$150 pp/pa	\$300 pp/pa
X-Ray	\$40 pp/pa	\$50 pp/pa	\$60 pp/pa
Pain Management/Epidural (one per accident covered)	\$50 pp/pa	\$75 pp/pa	\$100 pp/pa
Accident Hospitalization & Surgical Benefits			
Hospital Admission	\$1,000 pp/pa	\$1250 pp/pa	\$1,500 pp/pa
ICU Admission	\$2,000 pp/pa	\$2,500 pp/pa	\$3,000 pp/pa
Hospital Confinement Up to 365 days per accident	\$150 per day	\$250 per day	\$300 per day
ICU Up to 30 days per accident	\$300 per day	\$500 per day	\$600 per day
Rehabilitation/Skilled Nursing Facility	\$75 per day	\$125 per day	\$150 per day
Blood/Plasma/Platelets	\$300 pp/pa	\$400 pp/pa	\$500 pp/pa
Surgery – Open Abdominal, Thoracic	\$1,000 per surgery	\$2,000 per surgery	\$3,000 per surgery
Surgery – Cranial	\$1,000 per surgery	\$2,000 per surgery	\$3,000 per surgery
Surgery – Hernia	\$500 per surgery	\$1,000 per surgery	\$1,500 per surgery
Surgery – Exploratory or Without Repair	\$200 per surgery	\$300 per surgery	\$400 per surgery
Outpatient/Misc. Surgery	\$200 pp/pa	\$300 pp/pa	\$400 pp/pa
Transportation Up to 3 trips per accident	\$300 per trip	\$400 per trip	\$500 per trip
Family lodging After 7 day duration	\$4,000 pp/pa	\$6,000 pp/pa	\$8,000 pp/pa
Coma After 7 day duration	\$4,000 pp/pa	\$6,000 pp/pa	\$8,000 pp/pa
Follow-Up Care			
Follow-up Doctor’s Visit	\$50 pp/pa	\$75 pp/pa	\$100 pp/pa
Physical Therapy Up to 10 visitsper accident	\$30 per visit	\$50 per visit	\$75 per visit
Chiropractic Visit Up to 10 visitsper accident	\$30 per visit	\$50 per visit	\$75 per visit
Medical Equipment	\$150 pp/pa	\$250 pp/pa	\$400 pp/pa
Prosthetic Device	\$1,500 pp/pa	\$2,000 pp/pa	\$2,500 pp/pa

Voluntary Critical Illness

If you are a Foundation employee who works 30 hours or more per week, the Foundation provides the opportunity to purchase Critical Illness insurance from Symetra for you and your family. This coverage will offer financial support if you are diagnosed with a covered critical illness. There is a pre-existing condition limitation of 12 months for any condition for which treatment was received in the 12 months prior to the effective date.

Benefits can be used any way you like:

- To pay for travel expenses related to treatment.
- To pay for deductible and coinsurance charges on medical plan.
- To make any repairs or renovations to your home to assist with care.
- To help pay living expenses.
- Premiums based on attained age.

Initial Benefit	
Heart Attack	\$10,000
Stroke	\$10,000
Coronary Artery Bypass Surgery	\$ 2,500
Major Organ Failure	\$10,000
End Stage Renal Failure	\$10,000
Invasive Cancer	\$10,000
Cancer in Situ	\$ 2,500

Covered Conditions Include

- Heart Attack
- Stroke
- Major Organ Transplant
- End Stage Renal Failure
- Coronary Artery Bypass Surgery
- Invasive Cancer – Carcinoma in Situ (excludes skin cancer and early prostate cancer)

Wellness Benefit

You will receive an annual \$50 benefit when you or a covered spouse has a covered wellness screening test.



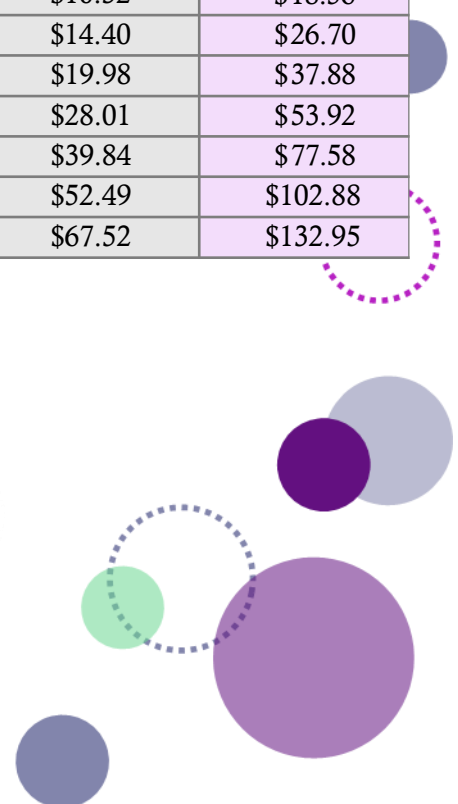
Voluntary Critical Illness

Employee Only Premiums (per bi-weekly pay period)		
	\$10,000	\$20,000
under 24	\$ 1.68	\$2.32
25-29	\$ 1.88	\$2.71
30-34	\$ 2.28	\$3.50
35-39	\$ 2.65	\$5.19
40-44	\$ 4.55	\$8.05
45-49	\$ 6.43	\$11.81
50-54	\$ 9.14	\$17.23
55-59	\$12.87	\$24.69
60-64	\$18.23	\$35.40
65-69	\$26.11	\$51.17
70-74	\$34.56	\$68.08
75-79	\$44.58	\$88.11

Employee + Spouse Premiums (per bi-weekly pay period)		
	\$10,000	\$20,000
under 24	\$ 3.05	\$ 4.00
25-29	\$ 3.34	\$ 4.59
30-34	\$ 3.94	\$ 5.78
35-39	\$ 5.20	\$ 8.30
40-44	\$ 7.35	\$12.60
45-49	\$10.17	\$18.24
50-54	\$14.23	\$26.38
55-59	\$19.83	\$37.57
60-64	\$27.84	\$53.58
65-69	\$39.68	\$77.27
70-74	\$52.40	\$102.70
75-79	\$67.43	\$132.76

Employee + Child(ren) Premiums (per bi-weekly pay period)		
	\$10,000	\$20,000
under 24	\$ 1.85	\$2.65
25-29	\$ 2.05	\$3.05
30-34	\$ 2.44	\$3.83
35-39	\$ 3.29	\$5.52
40-44	\$ 4.71	\$8.38
45-49	\$ 6.59	\$12.13
50-54	\$ 9.30	\$17.55
55-59	\$13.03	\$25.02
60-64	\$18.38	\$35.71
65-69	\$26.27	\$51.49
70-74	\$34.73	\$68.41
75-79	\$44.74	\$88.44

Family Premiums (per bi-weekly pay period)		
	\$10,000	\$20,000
under 24	\$ 3.21	\$ 4.33
25-29	\$ 3.51	\$ 4.92
30-34	\$ 4.09	\$ 6.09
35-39	\$ 5.36	\$ 8.62
40-44	\$ 7.50	\$12.92
45-49	\$10.32	\$18.56
50-54	\$14.40	\$26.70
55-59	\$19.98	\$37.88
60-64	\$28.01	\$53.92
65-69	\$39.84	\$77.58
70-74	\$52.49	\$102.88
75-79	\$67.52	\$132.95



Employee Assistance Program

Did You Know?

Foundation For The Carolinas pays 100% of our Employee Assistance Program benefit, which is administered through ComPsych.

We All Need Help Every Now and Then

Problems are just a part of everyday life. You and your household members now have access to our Employee Assistance Program to help with the everyday challenges of life that may affect your health, family life and desire to excel at work.

1) Consultation and Support

You and your household members are entitled to up to five sessions with a licensed counselor. You also have access to phone assistance where an advocate can assess your needs, develop a solution, and direct you to community resources and online tools.

2) Work and Life Services

Telephonic consultations are available in the following areas:

- **Legal consultation** Unlimited capabilities to speak with advisors and lawyers; first 30 minutes free, then 25% off entire bill.
- **Parenting** Guidance on child development, sibling rivalry, separation anxiety, etc.
- **Senior Care** Learn how to solve the challenges of caring for an aging loved one
- **Childcare or PetCare** Referral services
- **Financial Services & Referral** Retirement planning, taxes, budgeting, debt counseling

GUIDANCE RESOURCES

Your ComPsych Guidance Resources program offers someone to talk to and resources to consult whenever and wherever you need them.

Call: **800.272.7255** | Online:
guidanceresources.com Web
ID: COM589
TTY: 800-697-0353
App: GuidanceNow

**All EAP Services are
CONFIDENTIAL.**

For more information, please contact Human Resources.

Retirement Savings

Foundation For The Carolinas Programs – FFTC Retirement Plan

The Foundation offers all employees a 403(b) retirement savings plan with TIAA. The plan includes the ability for every employee to make contributions to the plan, as well as a Foundation contribution to eligible employees.

The Foundation also provides free independent financial advice through CAPTRUST. They can assist you with a broad range of retirement plan related questions including your investment allocation, savings rate and Roth. CAPTRUST can also assist you if you would like help transferring your assets from the “old” plan to the “new” plan. You can reach them by calling 1.800.967.9948 or scheduling an appointment on their website: www.captrustadvice.com.

Employee Contributions

Employees can contribute to the plan by electing a percentage of pay per pay period. Employees can choose to contribute on a pre-tax basis (which defers federal and state income tax until distribution) or on a Roth after-tax basis (amounts are taxed when contributed to the plan but eligible distributions are tax-free).

Employees that do not make a voluntary election to contribute will be automatically enrolled in the plan at a pre-tax deferral rate of 2% of pay. Employees have the option at any time to elect a different deferral rate, choose Roth instead of pre-tax, or elect not to contribute to the plan at all.

Employee contributions are made as a percentage of pay each pay period. Once a year, the deferral rate automatically will increase by 1%, until the employee’s contribution rate reaches 6%. At any time, the employee can elect to opt out of the automatic increase amount.

The IRS sets annual limits for employee contributions to the plan. For current limits, visit www.IRS.gov.

Employer Contributions

Regular employees who complete a year of service and who work a minimum of 1,000 hours are eligible to receive employer contributions.

The Foundation will contribute a percentage of your salary, based on your age, to the plan. This is an employer-paid benefit; there is no cost to the employee and no employee contributions to the plan are required. Contributions are made each payroll period and are 100% vested after completion of three years of service.

Contributions are as follows:

- Under 40 years of age: 6% of pay
- Age 40 – 49: 12% of pay
- Age 50 and above: 18% of pay

Employees can manage their plan accounts through TIAA at www.tiaa.org. Additional information is available through the Summary Plan Description and other important documents can be found on the TIAA website.

Questions?

Please visit online at: www.tiaa/fftc Or
call at: 800.842.2252



If you would like to schedule a phone consultation with CAPTRUST,

Please visit online at: www.captrustadvice.com Or
call at: 800.967.9948

Paid Time Off

PTO

The Foundation provides each regular, full-time and regular part-time employees who work 1,000 hours or more per year, paid time off for Holidays, Special Leave, Personal Leave, Vacation, and more. These hours are categorized into individual time off buckets.

Holidays

Employee are paid for holidays as they occur. The following holidays will be observed by The Foundation in 2025:

2025 Holidays	
New Year's Day	Wednesday, January 1 st
Martin Luther King Jr. Day	Monday, January 20 th
President's Day	Monday, February 17 th
Memorial Day	Monday, May 26 th
Juneteenth	Thursday, June 19 th
Independence Day	Friday, July 4 th
Labor Day	Monday, September 1 st
Indigenous Peoples' Day	Monday, October 13 th
Veterans Day	Tuesday, November 11 th
Thanksgiving Holiday	Thursday, November 27 th Friday, November 28 th
Christmas Holiday	Wednesday, December 25 th Thursday, December 26 th

Special Leave

The Foundation provides paid time off for employees to use throughout the year for minor personal illness, dependent care, bereavement, doctor visits, dentist appointments, and special religious/ethnic holidays not recognized by the Company. On January 1st, employees are granted 10 days, equivalent to 80 hours, of Special Leave.

Personal Leave

On January 1st, employees are granted 16 hours of Personal time. In addition, non-exempt employees will receive an additional 16 hours of Personal time. These hours may be used for personal business that cannot be accomplished during regular, non-working hours. These hours can also be utilized as additional self-wellness days.

Floating Holiday

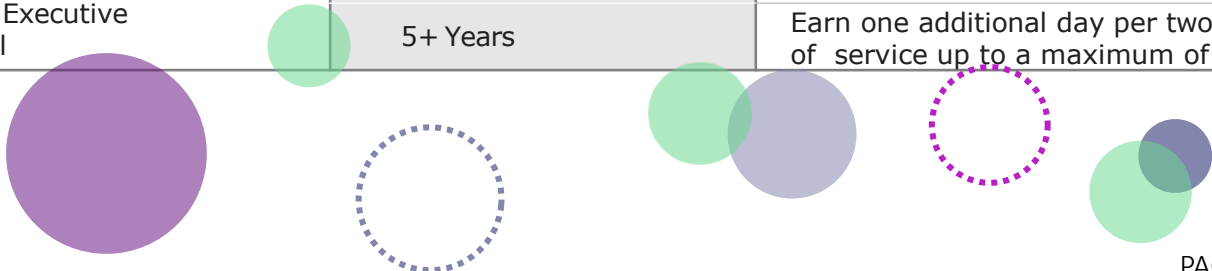
Employees will receive 2 Floating Holidays, 16 hours, that can be used for various reasons of the employees' own choosing. The Floating Holiday is paid time off to observe a holiday or event, such as a religious holiday that is not scheduled by The Foundation.



Vacation

Paid vacation time off is intended to provide employees the opportunity to spend discretionary time away from work. All employees whose regular work schedule is 1,000 hours or greater per year are eligible for vacation benefits. The amount of vacation time available to each employee grows with years of service. Vacation is accrued from the start of employment at a set rate per pay period based on the following schedule:

	Length of Service	Annual Accrual Days (prorated for part-time employees)
Nonexempt positions, Manager and AVP level	0-3 Years	15 days
	3+ Years	Earn one additional day per year of service up to a maximum of 20 days
Director, VP, SVP and Executive level	0-3 Years	15 days
	3-5 Years	20 days
	5+ Years	Earn one additional day per two (2) years of service up to a maximum of 25 days



Additional Programs

Matching Gift Program

The Foundation will match eligible employees' gifts of \$25 or more to a qualified charitable organization. The maximum matched for any one employee per year is \$5,000.

Donor Advised Fund

Eligible employees may establish a Donor Advised Fund through FFTC with a minimum gift of \$1,000. While an active employee, there will be no minimum balance to maintain or fees to administer the fund.

Parking/Transportation

FFTC provides parking for all regular full-time employees in a designated parking garage/lot. In lieu of a parking space, FFTC will pay for an employee's bus or light rail pass.

Fitness Device Subsidy Program

Wearable fitness devices are great tools to help bring awareness to your level of physical activity. Employees may purchase a wearable fitness device of their choice and be reimbursed \$20 by FFTC. Please present receipt for the current plan year.

Eligibility: All staff are eligible to participate

Maximum Amount Paid by FFTC: \$20/device

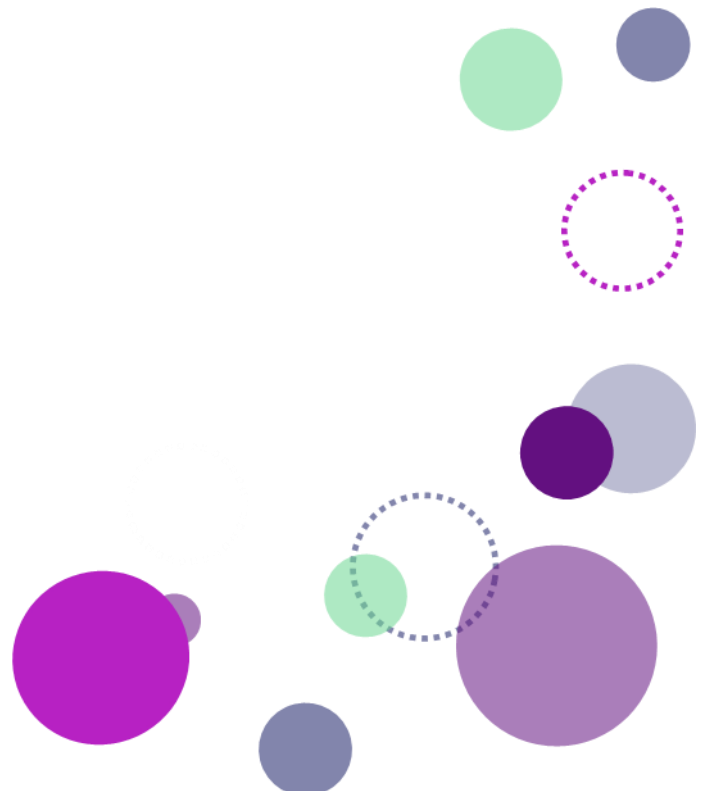
Parental Leave Program

Employees who meet the eligibility requirements of the Family and Medical Leave Act, and who plan and signify their intent in advance to return to their job, are eligible to receive a maximum amount of 12 work weeks of paid parental leave during their FMLA-approved leave for the birth of a child of the employee, or to care for a newborn child or a child placed with the employee for adoption or foster care (within 12 months of the birth or placement).

Requests for time off in accordance with this policy must be approved by and coordinated with the Human Resources Department and your immediate supervisor.

Catastrophic Medical Donation Program

Foundation For The Carolinas' Catastrophic Medical Donation Program allows employees to voluntarily donate accrued paid vacation time to a donated bank for the benefit of qualifying, fellow employees who have exhausted their accrued paid vacation and special and/or personal leave and are in need of income while out of work on a Foundation-authorized and approved unpaid leave of absence (e.g. unpaid Family and Medical Leave Act leave) due to a serious medical condition or emergency involving (1) the employee, and/or (2) an immediate family member for whom the employee has caregiver responsibilities.



Benefit Resource Center

Why won't they pay my claim?

Services denied?!

How can my claim still be "in process"?

It's been two months!

I called my insurance carrier, but now I'm just more confused.

Do I have mail-order prescription benefits?



Call the Benefit Resource Center, We're Here To Help!

The Benefit Resource Center will serve as your guide and advocate for navigating the healthcare system and claims issues. All benefit eligible employees and dependents are eligible. As an independent third party, Benefit Advocates can confidentially resolve complicated and sensitive benefit issues you may not feel comfortable discussing with your employer or others. Your privacy is protected, and your identity is kept confidential.

Benefit advocacy services include:

- Answering your benefit questions.
- Resolving health, dental, drug, vision, disability claims or billing errors.
- Helping you find lower cost medications or medical treatments.
- Appealing claim denials.
- Finding in-network doctors and hospitals.
- Providing a dedicated advocate to guide you from start to finish – a benefits pro on an experienced benefit team.

Advocates are available Monday-Friday 8 a.m.-5 p.m. by calling 855.874.0835 or email brcsouth@usi.com.

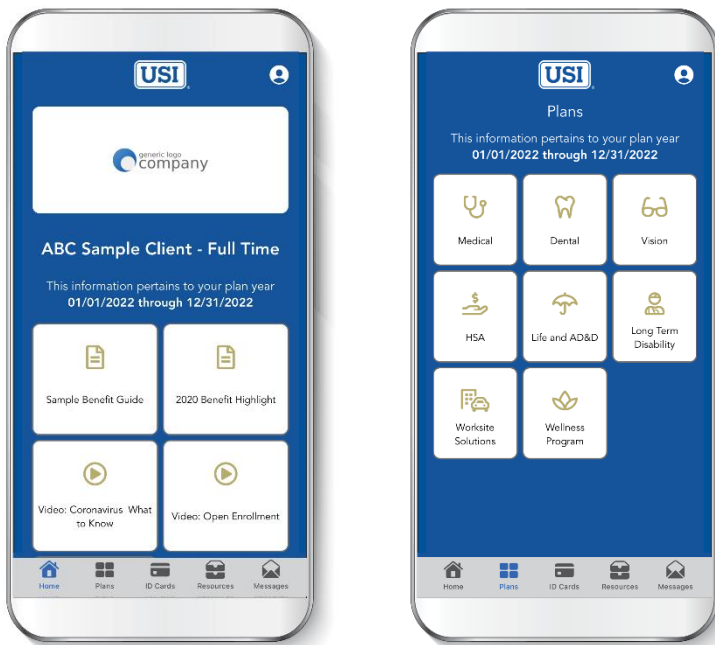
Benefits Information At Your Fingertips

Foundation For The Carolinas

Have you downloaded **MyBenefits2GO**? Access key coverage details and contact information from anywhere.

Search *MyBenefits2GO* and when prompted, enter code:

Y21443



Available for iPhone and Android



Eco-friendly. No more sifting through paper packets!



Store and share your ID cards, view group ID numbers, and click-to-dial contacts.



Available to the whole family.



Find health coverage details when you need it.



We Make Medicare Easier for You

You Can Count On Us



Education

We take the time to help you understand Medicare and listen to your specific needs before making any recommendations.



Review Plan Options

We have access to a wide variety of insurance providers and plan types to help you select the best policy for your specific needs, including Medigap Plans, Medicare Advantage Plans, Prescription Drug Plans, and more.



Simplifying Enrollment

We reduce the stress of the enrollment process with step-by-step guidance, eliminating the need paper for forms whenever possible.

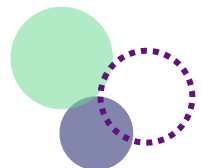
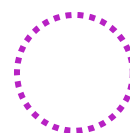
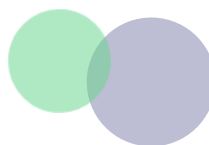
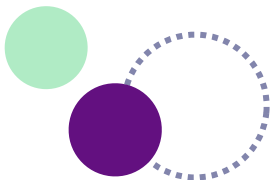
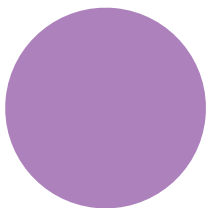


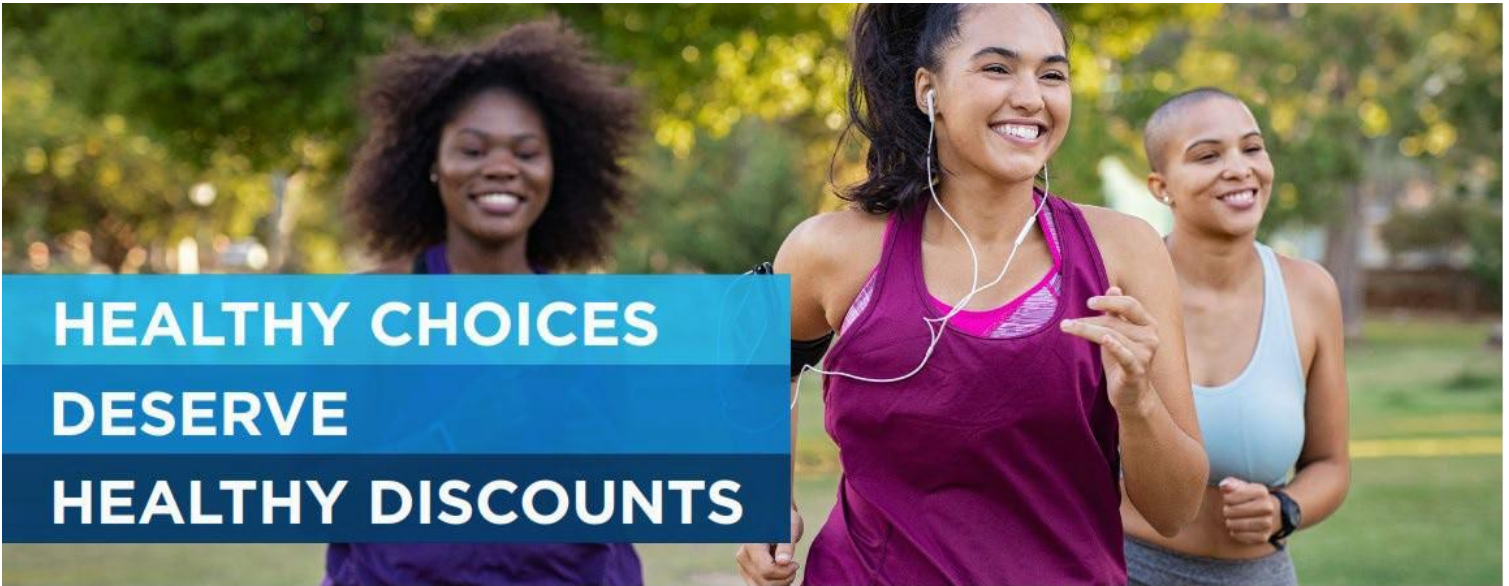
Annual Review

Each year, we review your unique situation and help you identify whether your current coverage needs to be expanded, reduced, or changed to a more effective option. We are here to serve you, year after year.

If you have any questions about Medicare or need help reviewing your options, please contact Karen Coia at 856.334.4326.

My Benefit Advisor This document is designed to highlight various employee benefit matters of general interest to our readers. It is not intended to interpret laws or regulations, or to address specific client situations. You should not act or rely on any information contained herein without seeking the advice of an attorney or tax professional. ©2018 My Benefit Advisor. All Rights Reserved. CA Insurance License #0G33244





Start saving today with Cigna Healthy Rewards

Just use your Cigna ID wallet card when you pay and let the savings begin. Get discounts on the health products and programs you use every day for:

- Nutritional Meal Delivery Service
- Fitness Memberships and Devices**
- Vision Care, Lasik Surgery, Hearing Aids
- Alternative medicine
- Yoga Products and Virtual Workouts**

Real brands. Real discounts. Realeasy.

Log into **myCigna.com** and navigate to Healthy Rewards Discount Program or call **800.870.3470**.

*Healthy Rewards is a discount program. Some Health Rewards programs are not available in all states and programs may be discontinued at any time. If your health plan includes coverage for any of these services, this program is in addition to, not instead of, your plan Benefits. Healthy Rewards programs are separate from your plan Benefits. **A discount program is NOT insurance, and you must pay the entire discounted charge.** All goods, services and discounts offered through Healthy Rewards are provided by third parties who are solely responsible for their products, services and discounts.

Fitness Membership and Devices along with Yoga Products and Virtual Workouts can only be accessed by login into **myCigna.com and navigating to Healthy Rewards Discount Program.

Together, all the way.

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates. All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, a Behavioral Health, Inc., and Cigna Health Management, Inc. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc. All models are used for illustrative purposes only.



For Cigna customers who don't have access to **myCigna.com** and want an Active&Fit Direct™ gym membership:

- Call **800.870.3470**; and
- Press 3 to be transferred to a customer service agent.



QR CODE FORM TECHNOLOGY

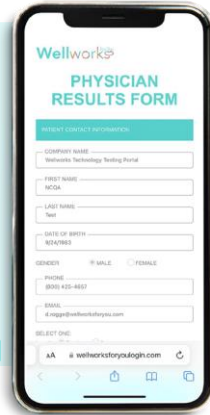
PROGRAM FORM SUBMISSION MADE EASY

Wellworks For You form submission technology makes it easier than ever to submit program forms right on the Wellworks For You Mobile App.

EARN INSTANT PARTICIPATION

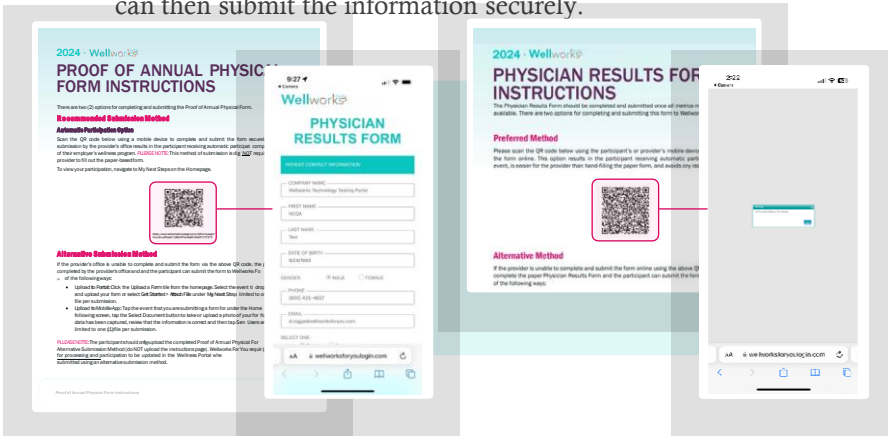
We understand the importance of accuracy and security in today's fast-paced digital landscape. That's why we have crafted a cutting-edge solution that not only guarantees 100% accuracy but also ensures unparalleled security, leaving behind the days of paper-based vulnerabilities.

mobile app



QR SUBMISSION

1. **Print with Ease:** The member can print the form and instruction sheet directly from the Wellness Portal.
2. **Scan and Go:** Whether you're a member or a PCP, enjoy the simplicity of scanning the QR code using a smartphone or tablet.
3. **Enter Metrics with Confidence:** As a PCP, inputting the required metrics is simple.
4. **Sign and Submit:** Complete the process seamlessly by entering the screening date and PCP signature. The member or PCP can then submit the information securely.



The new QR Code technology instantly allows PCPs to submit results in real time via a secure QR Code link. This QR code is specific to the participant whose Wellness Locker it was downloaded from and cannot be used by anyone else.

Seamless Incentive Credit: Credit is instantly awarded once the PCP enters the metric values and taps Submit.

Effortless, Secure Data Capture: Our system works behind the scenes to capture member data values securely. Rest assured, individual data will be available to display the way it does in the portal today!



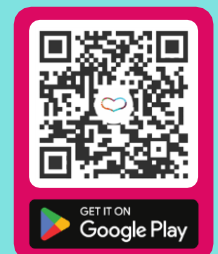
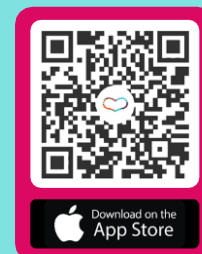
Available forms to submit using the Wellworks QR Code Technology:

- PHYSICIAN RESULTS FORM
- PROOF OF VISIT FORM

Visit the Wellness Locker for the updated form **AVAILABLE TODAY!**

This QR code is specific to the participant whose Wellness Locker it was downloaded from and cannot be used by anyone else.

Download the Wellworks For You Mobile App Today!



[Watch a demo for Mobile here](#)

[Watch a demo for Desktop here](#)

Legal Notices

Fixed Indemnity Insurance – Notice Requirement

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit [HealthCare.gov](https://www.healthcare.gov)** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website ([naic.org](https://www.naic.org)) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

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 following pages for more details.

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the plan descriptions.

NEWBORNS ACT DISCLOSURE – FEDERAL

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).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

IMPORTANT NOTICE: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.



In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed
to: Jose Rivas, Human Resources Executive
220 N. Tryon Street, Charlotte, NC 28202 jrivas@fftc.org

Your Information. Your Rights. Our Responsibilities.

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.***

Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

IMPORTANT NOTICE: *This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.*



Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases, we never share your information unless you give us written permission:
 - Marketing purposes
 - Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

IMPORTANT NOTICE: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.



Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

Response to lawsuits and legal actions: Employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.



We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Effective Date of this Notice: January 1, 2025
- Name of the privacy official: Jose Rivas | Human Resources Executive | jrivas@fftc.org | 704-973-4500

Important Notice from Foundation for the Carolinas 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 Foundation for the Carolinas 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. Foundation for the Carolinas has determined that the prescription drug coverage offered by the Foundation for the Carolinas Health Plan for the plan year January 1, 2025 to December 31, 2025 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, the following options may apply:

- You may stay in the Foundation for the Carolinas Health Plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
 - During the Medicare prescription drug annual enrollment period, or
 - If you lose Foundation for the Carolinas Health Plan creditable coverage.
- You may stay in the Foundation for the Carolinas Health Plan and also enroll in a Medicare prescription drug plan. The Foundation for the Carolinas Health Plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Foundation for the Carolinas Health Plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Foundation for the Carolinas Health Plan, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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 Foundation for the Carolinas 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 Foundation for the Carolinas changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date: January 1, 2025
Name/Entity of Sender: Foundation for the Carolinas
Contact Position/Office: Jose Rivas | Human Resources Executive
Address: 220 N. Tryon Street, Charlotte, NC 28202
Phone Number: 704-973-4500

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+)

IMPORTANT NOTICE: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.



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.flmedicaidtprecovery.com/flmedicaidtprecovery.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

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: KIHIPPP.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: 1-800-657-3739

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: HSHIPPPProgram@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
Medicaid 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

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 \(CHIP\) \(pa.gov\)](http://www.pa.gov/en/services/dhs/childrens-health-insurance-program-chip)
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 Rlte 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](http://www.texas.gov/health-insurance-premium-payment-program)
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](http://www.vermont.gov/health-insurance-premium-payment-program)
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>

IMPORTANT NOTICE: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.



<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)



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 Employment-Based 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%¹ 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.²

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 these factors in determining whether to purchase a health plan through the Marketplace.

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

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.

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:

Name of Entity/Sender:	Foundation for the Carolinas
Contact--Position/Office:	Jose Rivas Human Resources Executive Address:
Office:	220. N. Tryon Street, Charlotte, NC 28202
Phone Number:	704-973-4500

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.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 Foundation for the Carolinas		4. Employer Identification Number (EIN) 56-6047886	
5. Employer address 220 N. Tryon Street		6. Employer phone number 704-973-4500	
7. City Charlotte	8. State NC	9. ZIP code 28202	
10. Who can we contact about employee health coverage at this job? Jose Rivas			
11. Phone number (if different from above)		12. Email address jrivas@fftc.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:

All full time eligible employees working 30 hours or more per week
 - Some employees. Eligible employees are:
- With respect to dependents:
 - We do offer coverage. Eligible dependents are:

Legal spouse/domestic partner, and married and unmarried full time student children to age 26.
 - 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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

Contact Information

Additional information regarding benefit plans can be found on provider websites. Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

BENEFIT	CARRIER	PHONE NUMBER	WEBSITE
Medical and Prescription Rx	CIGNA	(800)244-6224	www.mycigna.com
Dental and Vision	CIGNA	(800) 244-6224	www.mycigna.com
Life and Disability Plans	Symetra • Life • LTD • STD	(800)-796-3872	www.symetra.com
Health Reimbursement Account / Flexible Spending Plan	Flores & Associates – HRA / FSA	(800)532-3327	www.flores247.com
Health Savings Account	Optum Bank – HSA	(866)234-8913	www.optumbank.com
Accident and Critical Illness	Symetra	(800) 497-3699	www.symetra.com
Defined Contribution Plan	TIAA - Plan Administrator CAPTRUST – Financial Advisor	(800)842-2252 (800)967-9948	www.tiaa.org/fftc www.captrustadvice.com
Employee Assistance Plan	ComPsych • Web ID COM589	(800)272-7255	www.guidanceresources.com
Monica Jennings - Payroll and Benefits Manager		704-973-4521	mjennings@fftc.org

