



FOUNDATION FOR THE CAROLINAS

2026 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 Foundation for the Carolinas' staff only and should not be distributed or reproduced externally in any form without express written permission from the Human Resources Department.

Welcome

We're so excited to have you as part of our Foundation For The Carolinas team! Whether you're a new employee or have been with us for a while, we thank you for joining us on our mission to create remarkable impact.

As a community foundation that has served our region for nearly 70 years, we strive to offer a top-notch benefits program that attracts and retains top-notch talent. This guide provides a detailed overview of all that we offer. We've contracted with market leaders to provide great coverage, stellar customer service and a comprehensive plan for you and your family.

If you have any questions, please contact someone on the HR team. Thank you again for all that you do for your community, this region and the Foundation!

With gratitude,
Your Human Resources Team

Table of Contents

OPEN ENROLLMENT		FINANCIALS	
Eligibility & Open Enrollment	5	Basic Group Life and AD&D	21
HEALTH		Voluntary Life and AD&D	22
Medical Coverage	6	Disability	23
Wellness	9	Retirement	24
Dental	10	Paid Time Off	25
Vision	11	BENEFIT RESOURCES	
Health Savings Account	12	Additional Programs	26
Health Reimbursement Account	13	Benefit Resource Center (BRC)	28
Flexible Spending Account	14	Mobile App	29
Employee Assistance Programs (EAP)	16	My Benefit Advisor	30
Accident	17	Cigna Healthy Rewards	31
Critical Illness	19	LEGAL	
		Legal Notices	32
		CONTACTS	
		Contact Information	49

Eligibility & Open Enrollment

Who is Eligible?

Foundation for the Carolinas periodically reviews the benefit programs and may make modifications at its sole discretion.

All regular employees are eligible for employer paid benefits provided the employee meets the minimum requirements set forth by law and the benefit plans. The effective date of coverage for the various insurance plans in which you enroll is typically the first day of the month after completing one full calendar month of employment. After this initial enrollment period ends, changes can only be implemented during Open Enrollment or when a Qualifying Life Event occurs.

Coverage	Dependent Age Minimum	Terminated 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

Enrollment Information

Your eligible dependents include your legal spouse/domestic partner, and children to age 26. If you're covering a dependent for Medical, Dental, Vision, and/or Voluntary Life, you will need to provide their name, date of birth, 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 that Open Enrollment is your chance to obtain coverage or make changes to your coverage. You cannot change your election during the plan year without a Qualifying Event. Examples of qualifying events include:

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

Affordable Care Act (ACA) 1095-C

At Foundation for the Carolinas, we value our employees 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



Foundation for the Carolinas will continue to offer medical coverage. The below chart is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

	CIGNA — HDHP		CIGNA — PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible				
Individual	\$3,500	\$7,000	\$3,500	\$7,000
Family (2 deductibles per 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
Virtual Care (MD Live)	\$0	n/a	\$0	n/a
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/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	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 & 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	N/A	\$10 copay	N/A
Preferred (Tier 2)	20% after deductible	N/A	\$50 copay	N/A
Non-Preferred (Tier 3)	20% after deductible	N/A	\$100 copay	N/A
Preferred Specialty (Tier 4)	20% after deductible	N/A	\$100 copay	N/A
Mail Order Pharmacy (90 Day Supply)				
Generic (Tier 1)	20% after deductible	N/A	\$10 copay	N/A
Preferred (Tier 2)	20% after deductible	N/A	\$50 copay	N/A
Non-Preferred (Tier 3)	20% after deductible	N/A	\$100 copay	N/A
Preferred Specialty (Tier 4)	No Home delivery	N/A	No Home delivery	N/A

Telehealth Through MD Live



The telehealth benefit provides an easy way to access a physician by video consultation 24/7/365 days a year from anywhere you are each day - even holidays. This is convenient for minor health problems after hours or when you're away from home, and it's FREE for urgent and preventive care. Here's how to get started:

Go to www.mycigna.com and click "Talk to a doctor" or call MDLive at 888-726-3171

Select the type of care you need: medical care or counseling; cost will be displayed on myCIGNA and MDLive

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:

Primary Care

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

Urgent Care

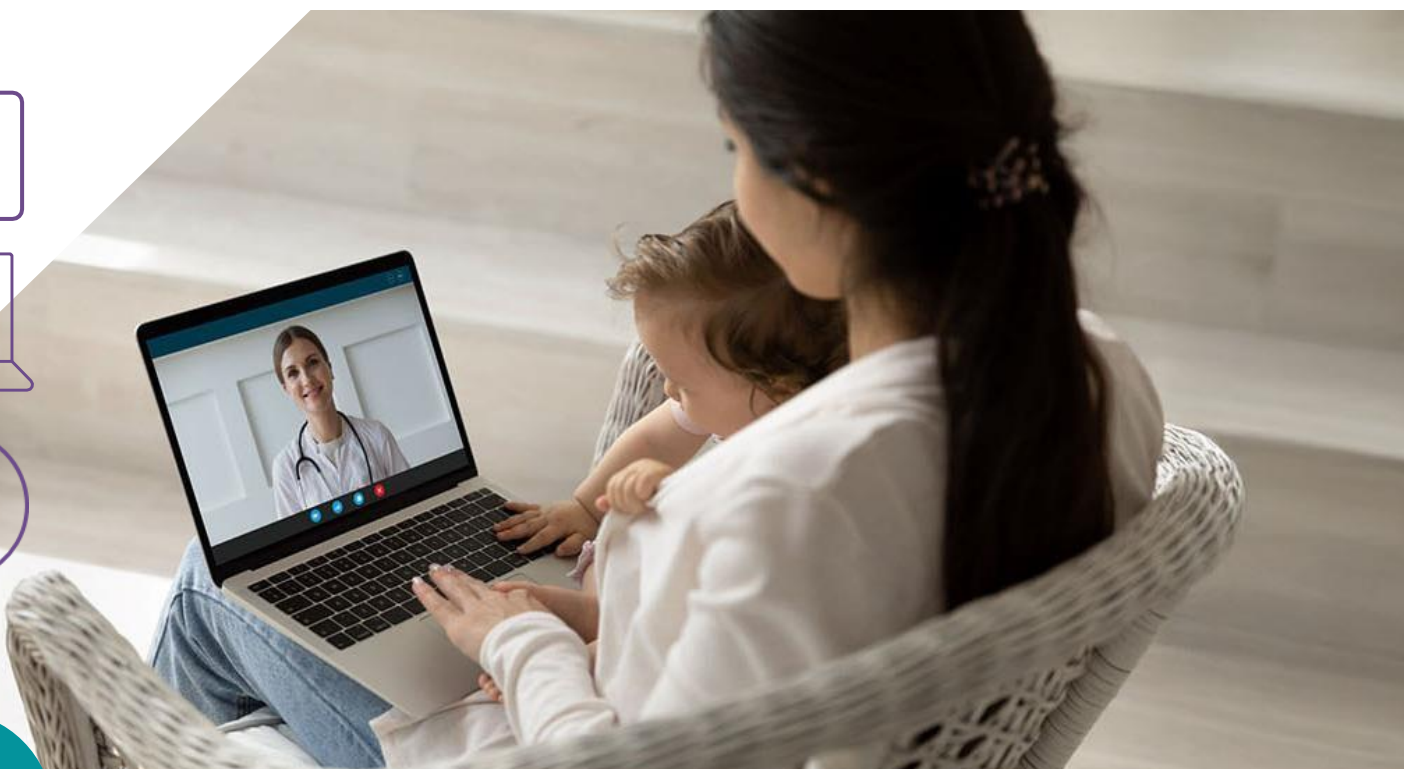
- On demand care 24/7/365, including holidays
- Convenient, affordable alternative to urgent care and ER
- Prescriptions available, if appropriate

Behavioral Care

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

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 for a significant portion of the cost of the medical plan(s) and remains competitive in both employee premiums and plan design. Our medical coverage will continue to be with CIGNA. CIGNA offers a broad network of providers nationwide.

You can search for a network provider at: mycigna.com.

Please note that 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.

We encourage you to do your part to keep the cost of healthcare down. Here are some ways you can become an effective healthcare consumer:

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

Bi-Weekly Employee Payroll Deductions

Plan	HDHP with HSA	PPO with HRA
Employee	\$38.64	\$43.55
Employee & Spouse	\$150.92	\$172.30
Employee & Child(ren)	\$126.83	\$148.88
Employee & Family	\$357.75	\$412.63

Foundation for the Carolinas Paid Premiums – Per Pay Period

Plan	HDHP with HSA	PPO with HRA
Employee	\$335.18	\$440.58
Employee & Spouse	\$604.95	\$806.61
Employee & Child(ren)	\$524.00	\$693.99
Employee & Family	\$859.04	\$1,163.21



Wellness

In an effort to further our culture of health and well-being, Foundation for the Carolinas encourages employees to participate in our wellness program. Employees and covered spouses/domestic partners are asked to get an annual physical and obtain the required preventive screenings for your age and gender. A list of these can be found at www.mycigna.com/preventive.

- Employees and covered spouses/domestic partners who completed their required physical in 2025 are eligible for the wellness incentive in January 2026.
- Employees and covered spouses/domestic partners have from January 1, 2026 to December 31, 2026 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 2026 plan year will not receive their wellness incentive in 2027.
- New Hires will receive the wellness incentive in January of the following plan year upon completion of the annual physical within 2026 plan year parameters.



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 Cover this Amount		
Preventative <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 Simple Periodontics Surgical Endodontics and Periodontics Amalgam and Composite Fillings 	80%	80% of the Usual & Customary Allowance
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

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. You will receive an ID card for your dental coverage.

Dental Premiums (Per BI-Weekly Pay Period)

	Employee Pays Per Pay Period	Foundation for the Carolinas Pays
Employee Only	\$2.79	\$25.12
Employee + Spouse	\$10.77	\$43.08
Employee + Child(ren)	\$10.96	\$43.82
Employee + Family	\$25.96	\$60.56

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.

Vision Coverage



Foundation for the Carolinas is offering 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 every 12 months • \$130 allowance for eyewear every 12 months (including contact lens exam) • A contact lens fitting, re-fit, or evaluation every 12 months
Co-Payment	<ul style="list-style-type: none"> • Exam: \$10, Eyewear: \$25
Eyewear Allowance	

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.

Vision Premiums (Per Bi-Weekly Pay Period)		
	Employee Pays	Foundation for the Carolinas 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



Health Savings Account (HSA)



What Are The Advantages of an HSA?

Any money deposited into your Health Savings Account is 100% yours – whether you withdraw funds within 1 month, 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 (HDHP) participant. Please refer to the Flores Deposit Agreement and Disclosure. A copy of the document is on the benefits website.

Who Is Eligible?

You are eligible if you:

- Are covered by a High Deductible Health Plan (HDHP);
- 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; and
- 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 HDHP (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.

How Much Can I Contribute?

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

Additional members include any dependent covered under the Foundation for the Carolinas' medical plan.

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

	2026 HSA Contributions	
	Individual	Individual + Dependents
Total Contribution Limit	\$4,400	\$8,750
If Over Age 55	Additional \$1,000	Additional \$1,000
Employee Contribution	\$3,200	\$6,350
*Employer Contribution	\$1,200	\$2,400

Foundation for the Carolinas' Wellness contributions are made in January 2026.

HSA Plan	
First Member	\$1,200 (\$600 Initial Eligibility + \$600 Wellness Adherence)
Additional Member	\$1,200 (\$600 Initial Eligibility + \$600 Wellness Adherence)

**Foundation for the Carolinas pays in January 2026; reflects wellness contribution*

Questions?

Visit: www.flores247.com

Website login help: 800-840-7684

General Customer Service: 800-532-3327 or email hsa@flores247.com

Health Reimbursement Account (HRA)



HRA Information

Foundation for the Carolinas' HRA reimburses employees for deductible expenses incurred. You can be reimbursed up to the full amount of the qualified expenses at any point in the year given you first meet the applicable deductible threshold.

The HRA is not an individual account, but rather a "promise to pay." You do not take the HRA money with you if you leave Foundation for the Carolinas. Any unused money in your HRA does not rollover into subsequent policy years. Any claims must be submitted by December 31st for eligible services incurred within the same plan year.

You may 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

Table 1

HRA Plan Without Wellness Adherence			
	Deductible	Member Meets	Foundation for the Carolinas Pays
First Member	\$3,500	\$2,000	\$1,500
Additional Member*	\$3,500	\$2,000	\$1,500

Table 2

HRA Plan With Wellness Adherence			
	Deductible	Member Meets	Foundation for the Carolinas Pays
First Member	\$3,500	\$1,000	\$2,500
Additional Member*	\$3,500	\$1,000	\$2,500

*Additional members include any dependent covered under the' Foundation for the Carolinas' medical plan.

- 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 (EOB) 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 employees who do not complete their wellness adherence, refer to Table 1.

For employees who complete their wellness adherence in the prior year, refer to Table2.

Questions?

Visit: www.flores247.com or

Call: 800-532-3327

Flexible Spending Account (FSA)



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 \$3,400 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 Foundation for the Carolinas' 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 \$3,400 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 \$7,500 per year (\$3,750 if married and filing separately) for reimbursement of eligible child/elder care expenses.

Debit card not available for Dependent Care FSA.

Plan year for Flexible Spending Accounts is 1/1/2026 – 12/31/2026

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 15th of the following year) to incur claims that counts towards the current year's FSA expenses.

You have until March 31, 2026 to file for reimbursement on your January 1, 2025 - March 31, 2026 expenses.



Questions?

Visit: www.flores247.com or

Call: 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

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. What do I need to do to 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.

The content of this handout has been prepared by Flores & Associates, LLC for informational purposes only and does not constitute legal or tax advice. This information is an interpretation of selected portions of the Internal Revenue Code (IRC) as of 9/1/2015 and is subject to continual revisions.

How Do I Obtain Account Details?



WEBSITE

Visit www.flores247.com and Log in using Participant ID or Username 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-Reception smart phone app
Available for Apple or Android devices

MAIL

Flores & Associates, LLC
PO Box31397 | Charlotte, NC28231

FAX

800.726.9982 or 704.335.0818

**Customer
Service**

1 800-532-3327

Employee Assistance Program

Did You Know?

Employee Assistance Program (EAP) administered through ComPsych

Foundation for the Carolinas pays 100% of this benefit

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 (EAP) 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:

Telephonic Consultations	
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 Pet Care	Referral services
Financial Services and 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](https://www.guidanceresources.com)
Web ID: COM589
TTY: 800-697-0353
App: GuidanceNow

All EAP services are CONFIDENTIAL.
For more information, please contact Human Resources.

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. This coverage will offer financial support if you or a covered dependent is treated for 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:

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

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

\$300 for ER visit; \$75 for X-ray = \$375

Accident Premiums (Per Bi-weekly PayPeriod)

	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



Accident



Emergency Care & Diagnostics	Base	Classic	Premiere
Ambulance – Ground	\$200 pp/pa	\$300 pp/pa	\$400 pp/pa
Ambulance – Air	\$1,000 pp/pa	\$2,000 pp/pa	\$3,000 pp/pa
Emergency Room	\$200 pp/pa	\$300 pp/pa	\$400 pp/pa
Major diagnosis Testing (MRI, CT, CAT, EEG) 1 Benefit covered per accident	\$200 pp/pa	\$300 pp/pa	\$400 pp/pa
X-Ray	\$50 pp/pa	\$75 pp/pa	\$100 pp/pa
Pain Management/Epidural (one per accident covered)	\$100 pp/pa	\$150 pp/pa	\$200 pp/pa
Accident Hospitalization & Surgical Benefits			
Hospital Admission	\$1,000 pp/pa	\$1,500 pp/pa	\$2,000 pp/pa
ICU Admission	\$2,000 pp/pa	\$3,000 pp/pa	\$4,000 pp/pa
Hospital Confinement Up to 365 days per accident	\$200 per day	\$300 per day	\$400 per day
ICU Up to 30 days per accident	\$400 per day	\$600 per day	\$800 per day
Rehabilitation/Skilled Nursing Facility	\$100 per day	\$150 per day	\$200 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 Up to 30 nights	\$100 per night	\$150 per night	\$200 per night
Coma After 7 day duration	\$5,000 pp/pa	\$7,500 pp/pa	\$10,000 pp/pa
Follow-Up Care			
Follow-up Doctor's Visit	\$100 pp/pa	\$150 pp/pa	\$200 pp/pa
Physical Therapy Up to 10 visits per accident	\$30 per visit	\$50 per visit	\$75 per visit
Chiropractic Visit Up to 10 visits per 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

Critical Illness



Foundation for the Carolinas provides each regular employee who works 30 hours or more per week the opportunity to purchase Critical Illness insurance from Symetra. This coverage will offer financial support if you are diagnosed with a covered critical illness. Coverage is guaranteed issue and is available for spouses and children.

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

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.

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



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

(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

Basic Life and AD&D



Foundation for the Carolinas Pays 100% of This Benefit

Foundation for the Carolinas provides each regular employee who works 30 hours or more per week a Basic Life Insurance and Accidental Death & Dismemberment policy based on 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 (3) 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
Evidence of Insurability	Required for any amount over \$425,000

The cost of group insurance coverage is currently paid entirely by Foundation for the Carolinas. The Internal Revenue Service provides an exclusion for the first \$50,000 of group term life insurance coverage provided by Foundation for the Carolinas. The premiums paid to provide any additional life insurance coverage in excess of the first \$50,000 of coverage 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 this portion of the premium with their after-tax dollars that were “bonused” to them by Foundation for the Carolinas.



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 for themselves or their dependents. In order to obtain coverage for dependents, the employee must obtain coverage for him/herself. The spouse's benefit cannot exceed 50% of the employee's benefit.

Employee

Employees are eligible for increments of \$10,000 up to \$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. The employee 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 of age 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 elects 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 the material and substantial duties of your regular occupation, and you are under the regular care of a doctor.

Short-Term Disability

Short-Term Disability (STD) is a company-paid benefit that provides partial income protection if a serious illness or injury causes you to be on a medical leave of absence from work more than 8 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.

Long-Term Disability

The cost of Long-Term Disability (LTD) plan coverage is currently paid entirely by Foundation for the Carolinas. 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 Foundation for the Carolinas.

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.

Questions?

Visit online at: www.symetra.com

or call at: 800-796-3872



Retirement Savings



Foundation for the Carolinas Retirement Plan

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

Foundation for the Carolinas also provides a free service of 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: <http://www.captrustadvice.com/>.

Employee Contributions

Employees are able to 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 payroll 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 2026, participants may contribute up to \$24,500, with an additional \$8,000 annual catch-up contribution for participants who are age 50 or older by the end of the year. Special catch-up contributions of \$11,500 is allowed for participants age 60 - 63.

Employer Contributions

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

Foundation for the Carolinas 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 and documents can be found on our Benefits Microsite and the TIAA website.

Additional information is available through the Summary Plan Description and other important documents can be found on our Benefits Microsite and the TIAA website.



Questions?

Visit online at: www.tiaa.org/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 800-967-9948



Paid Time Off

PTO

Foundation for the Carolinas provides regular, full-time and regular part-time employees who work 1,000 hours or more per year, paid time off for Holidays, Vacation, Personal days, sick days and more. These hours are categorized into three Buckets: FFTC Holidays, Vacation Days and General PTO Days.

Holidays

Employee are paid for holidays as they occur. The following holidays will be observed by Foundation for the Carolinas in 2026:

2026 Holidays	
New Year's Day	Thursday, January 1 st
Martin Luther King Jr. Day	Monday, January 19 th
President's Day	Monday, February 16 th
Memorial Day	Monday, May 25 th
Juneteenth	Friday, June 19 th
Independence Day	Friday, July 3 rd
Labor Day	Monday, September 7 th
Indigenous Peoples' Day	Monday, October 12 th
Veteran's Day	Wednesday, November 11 th
Thanksgiving Holiday	Thursday, November 26 th Friday, November 27 th
Christmas Holiday	Thursday, December 24 th Friday, December 25 th

Vacation

Paid vacation time off is intended to provide employees the opportunity to spend planned 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 available to each employee is based on corporate title and tenure with the Foundation as outlined in the table below. Unused vacation expires at the end of each year.

General PTO

The Foundation provides paid time off for employees to use throughout the year at their discretion to manage minor personal illnesses, dependent care, bereavement, doctor visits, personal wellness, special holidays not recognized by the Foundation and other approved absences as determined in coordination with your supervisor/HR. On January 1, eligible employees have access to 15 days of general PTO. Unused PTO time expires at the end of the year.

Time Off Bucket	All Roles up to AVP		VP, Director, SVP, Executive		
	Tenure	Up to 7 yrs	7+ yrs	Up to 10 yrs	10+ yrs
Vacation		15	20	20	25
Paid Time Off		15	15	15	15
FFTC Holidays		13	13	13	13
Total Max (Days)		43	48	48	53

Additional Programs

Matching Gift Program

Foundation for the Carolinas will match on a dollar-for-dollar basis eligible employee's 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. This provision remains in place for employees with five (5) years of service or more upon their separation.

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 and keep you accountable to your fitness goals. Employees are able to purchase a wearable fitness device of their choice and be reimbursed \$20 by FFTC. Please present a receipt for the current plan year (1/1/2026 – 12/31/2026).

Eligibility for Fitness Device Subsidy

All staff are eligible to participate in the subsidy:

Maximum Amount Paid by Foundation for the Carolinas is \$20 per device

Parental Leave Program

Employees who meet the eligibility requirements under the Family and Medical Leave Act (FMLA), have completed at least one year of employment, and who provide advance notice of their intent to return to work following their leave, are eligible to receive up to 12 workweeks of paid parental leave. This leave must be taken during an FMLA-approved absence for one of the following qualifying events:

- The birth of a child, or to care for a newborn child;
- The placement of a child with the employee for adoption or foster care.

To qualify for paid parental leave, the birth or placement of the child must occur after the employee has completed one full year of employment. Leave must be taken within twelve months of the birth or placement.

All requests for parental leave under this policy must be coordinated with and approved by both the Human Resources Department and the employee's immediate supervisor.



Additional Programs (Con't)

Foundation for the Carolinas Financial Legacy Program

Our financial well-being program is through Truist Momentum. Our Foundation for the Carolinas Financial Legacy Program or Legacy for short is a company paid benefit that provides employees and their family members with tools and resources to help better manage finances through an online educational training comprised of 8 self-paced learning courses on topics such as budgeting, saving, investing strategies and more.

While it is easy to feel like money controls us instead of the other way around, the new Legacy program offers a solution that is based on tried-and-true strategies which make taking control of your finances easier than one might think by helping match your money to your values and your finances to your life goals. This program aims to help you not only save more and plan better but to also manage your finances more intuitively and with more confidence.

Bright Horizons

We're pleased to offer a partnership with Bright Horizons which will provide employees with back-up discounted and reimbursable childcare options, family support, elder care and college coach services. You'll have access to a website full of resources such as podcasts and videos. This partnership enhances our commitment to support our employees and their families.

We'll be sharing more information on this service through our benefits website.

Get Started Today!

Use the QR code provide below or by visiting www.TruistMomentum.com and using the Registration Code: FFTC



USI Benefit Resource Center (BRC)



**Insurance is Complicated.
We Understand.**

We're Here to Help!

The Benefit Resource Center (BRC) is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals, and their primary responsibility is to assist you.

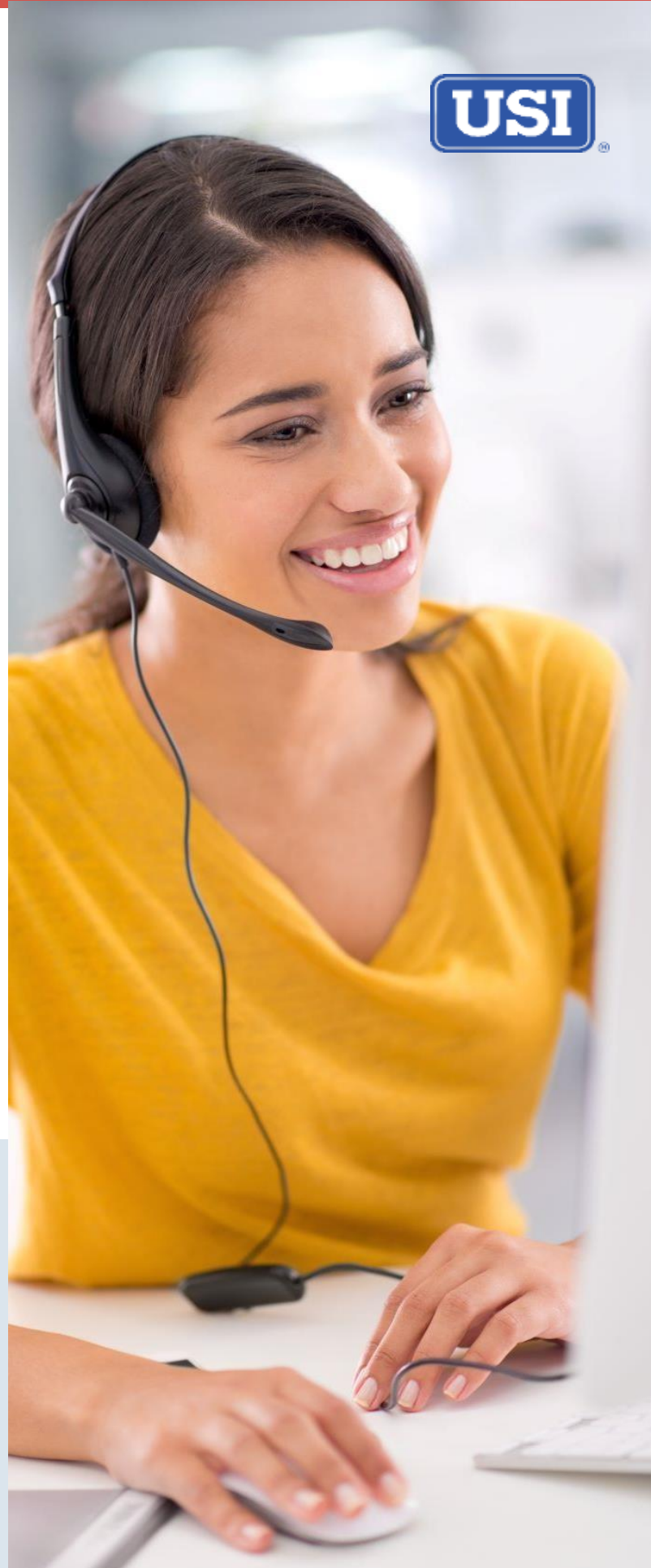
We speak insurance. Our Benefits Specialists can help you with:

- Deciding Which Plan is the Best For You
- Benefit Plan and Policy Questions
- Eligibility and Claim Problems with Carriers
- Information About Claim Appeals and Process
- Allowable Family Status Election Changes
- Transition of Care When Changing Carriers
- Claim Escalation, Appeal and Resolution
- Medicare Basics with Your Employer Plan
- Coordination of Benefits
- Finding In-Network Providers
- Access to Care Issues
- Obtaining Case Management Services
- Group Disability Claims

We Respond. We Act. We Help.

The specialists in the Benefit Resource Center are available Monday through Friday 8:00 am to 5:00 pm Eastern & Central Standard Time via Phone or Email.

855-874-0835 | BRCSouth@usi.com



Benefit Information When You Need It Most



Foundation for the Carolinas Have you Downloaded MyBenefits2Go?

Find It In The App Store

Search for 'MyBenefits2GO' and download our free app.

Enter this code when prompted: **H41604**

Highlights of the MyBenefits2GO App

- Access Benefits Information On the Go
- Convenient Contact Information for Carriers and HR
- Organized Plan Information in One Place
- View the Most Updated Plan Information
- Store Your ID Cards In the App



MyBenefits2GO:

Free Mobile Benefits App for Android and iPhone

The MyBenefits2GO app gives you on-the-go access to your benefit and insurance policy details, HR contact information and more!

The app is a quick and simple way for you and your enrolled dependents to access benefit summaries and other important information about our group plans. Store photos of ID cards in the app and easily locate carrier and HR contact information—all in one place. The MyBenefits2GO app is free for iPhone and Android.



Getting In Touch

The app provides employees and their enrolled dependents single-point contact information for benefits resources and insurance carriers.

Keeping Up-to-Date

The app automatically connects you with the most updated plan information and allows for message reminders from your employer.

Lightening Wallets

The app allows you to store and share images of your ID cards, freeing up space and giving you access when you need it.

Staying Organized

The app gives you access to benefit plan information and ID cards—all in one place.



We Make Medicare Easier for You

Medicare often leaves people confused with its complicated rules and a wide array of choices. My Benefit Advisor can help you sort through the complexities and the tough decisions to find the solution that is right for you.

Our licensed advisors will compare the price and coverage options that are available to you in the Medicare marketplace. We help guide your decisions in order to save you time and money. Best of all, there is no charge for this service and your rates are the same as buying directly from the insurance carrier.

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 for paper 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.

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

If you have any questions about Medicare or need help reviewing your options, please reach out to the Medicare team [here](#).

Cigna Healthy Rewards



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:

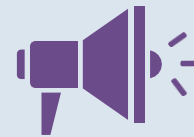
- Nutritional Meal Delivery Service
- Fitness Memberships and Devices**
- Vision Care, Lasik Surgery, Hearing Aids
- Alternative medicine
- Yoga Products and Virtual Workouts **

Real Brands. Real Discounts. Real Easy.

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.



For Cigna customers who don't have access to www.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.

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.

Together, all the way.®



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 deductible 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.

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.



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.

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.

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.



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:
Travis Bole, CHRO and COO
200 N. Tryon Street
Charlotte, NC 28202
tbole@fftc.org

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.



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?

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.



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

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'

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

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.



- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

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, 2026
- Name of the privacy official: Travis Bole, CHRO and COO, tbole@fftc.org

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.



MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

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, 2026 to December 31, 2026 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.

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.



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, 2026
 Name/Entity of Sender: Foundation for the Carolinas
 Contact Position/Office: Travis Bole – CHRO and COO
 Address: 220 N. Tryon Street, Charlotte, NC 28202
 Phone Number: 704-973-4500

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.



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, 2025. 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

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.



COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: <https://www.healthfirstcolorado.com/>
 Health First Colorado Member Contact Center:
 1-800-221-3943/State Relay 711
 CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>
 CHP+ Customer Service: 1-800-359-1991/State Relay 711
 Health Insurance Buy-In Program (HIBI): <https://www.mycohibi.com/>
 HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidprecovery.com/flmedicaidprecovery.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: KIHIPP.PROGRAM@ky.gov
 KCHIP Website: <https://kynect.ky.gov>
 Phone: 1-877-524-4718
 Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

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.



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: HSHIPPProgram@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://dhcnp.nv.gov>
 Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
 Phone: 603-271-5218
 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
 Phone: 1-800-356-1561
 CHIP Premium Assistance Phone: 609-631-2392

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.



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 \(CHIP\) \(pa.gov\)](#)

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](#)

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/>

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.



CHIP Website: <https://chip.utah.gov/>

VERMONT – Medicaid

Website: [Health Insurance Premium Payment \(HIPP\) Program | Department of Vermont Health Access](#)
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>
<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: <https://dhhr.wv.gov/bms/>
<http://mywvhipp.com/>
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, 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)

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 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:	Travis Bole, CHRO and COO
Address:	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 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? Travis Bole			
11. Phone number (if different from above)		12. Email address tbole@ffc.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 the Cigna website. Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

Medical and Prescription Rx		(800) 244-6224	www.mycigna.com
Dental and Vision		(800) 244-6224	www.mycigna.com
Life and Disability Plans		(800) 796-3872	www.symetra.com
Health Reimbursement Account / Flexible Spending Plan		(800) 532-3327	www.flores247.com
Health Savings Account		(800) 532-3327	www.flores247.com
Accident and Critical Illness		(800) 497-3699	www.symetra.com
Defined Contribution Plan	 Plan Administrator  CAPTRUST Financial Advisor	(800) 842-2252 (800) 967-9948	www.tiaa.org/FFTC www.captrustadvice.com
Employee Assistance Plan	 <small>GuidanceResources® Worldwide</small> Web IDC0M589	(800) 272-7255	www.guidanceresources.com
Human Resources Department			hr@fftc.org



FOUNDATION FOR THE CAROLINAS

2026 Employee Benefits

**FOUNDATION FOR
THE CAROLINAS**

220 North Tryon Street
Charlotte, NC 28202
704.973.4500