AGRA Industries

# 2023 BENEFIT GUIDE

Your Benefits, Your Choice

AVERGENT

# WELCOME TO YOUR 2023 BENEFIT GUIDE

## EMPLOYEE ELIGIBILITY

All full-time employees working **30 or more hours per week** will be eligible for benefits. All coverages will take effect on the first of the month following 60 days of employment.

These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

## DEPENDENT ELIGIBILITY

Medical, Dental, Vision:

Employees enrolled in Medical, Dental, and Vision coverages also have the option to enroll their Dependent Spouse and Dependent Children on these plans. See below for a definition of an "eligible dependent" under these plans.

## CURRENT EMPLOYEES

Once Open Enrollment ends, you will not have another opportunity to make changes until next year unless you experience a qualifying life event like a birth, adoption, marriage, or divorce before that time.

### BENEFIT HIGHLIGHTS

- Eligibility & Enrollment
- Contact List
- Medical Plan
- Collaborative Care
- Dr. on Demand
- Pharmacy
- Dental
- Vision
- Life and AD&D
- Voluntary Life & ADD
- Whole LIfe
- Short Term Disability
- Critical Illness and Accident Coverage
- Required Notices

## NEW EMPLOYEES

This is your chance to elect benefits and enroll yourself and your eligible dependents. Some benefits have "guarantee issue" at your first opportunity only, so please carefully consider this before you decline any coverages. If you take no action now, you will have no benefits and you will not have another chance to elect them until next year's open enrollment—unless you experience a qualifying life event like a birth, adoption, marriage, or divorce before that time.

## DEFINITION OF "ELIGIBLE DEPENDENTS"

The below definitions refer to Medical, Dental, and Vision Coverages.

- Your legal spouse who is a resident of the same country in which the Employee resides. Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. Domestic Partners, as defined by Federal Law are also covered.
- The employee's dependent children at the end of the month, in which, they attain age 26, legally adopted children from the date the employee assumes legal responsibility, foster children that live with the employee and for whom the employee is the primary source of financial support, children for whom the employee assumes legal guardianship and stepchildren.
- Also included are the employee's children (or children of the employee's spouse) for whom the employee has legal responsibility resulting from a valid court decree. Children who are mentally or physically disabled and totally dependent on the employee for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the employer or from the claims administrator and may be required periodically. You must notify the claims administrator and/or the employer if the dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

# CONTACTS

## INSURANCE CARRIERS AND ADMINISTRATORS

| Coverage | Carrier | Contact Information |
|---|---|---|
| Virtual Enrollment | EP6ix | 1.866.706-3537 |
| Collaborative Care | Avergent | 1.866-247-5415<br>help@avergent.com |
| Care Transitions | Avergent | 1.866-247-5415<br>help@avergent.com |
| Medical Coverage<br>TPA-billing, claims | Aither Health | 1.866.291.6099 |
| Prescription | Ventegra | 1.877.867.0943<br>ventegra.com |
| Dental | Delta Dental | 1.800.236.3712<br>deltadentalwi.com |
| Vision | NVA (National Vision Administrators | 1.800.672.7723<br>e-nva.com |
| Group Whole Life | Mass Mutual | 1.800.272.2216<br>massmutual.com |
| Short Term Disability<br>Voluntary | Mutual of Omaha | 1.800.228.7104<br>mutualofomaha.com |
| Long Term Disability | Mutual of Omaha | 1.800.228.7104<br>mutualofomaha.com |
| Voluntary Life & AD&D | Mutual of Omaha | 1.800.228.7104<br>mutualofomaha.com |
| Accident Coverage | AFLAC | 1.800.992.3522<br>aflac.com |
| Critical Illness | AFLAC | 1.800.992.3522<br>aflac.com |
| Hospital | AFLAC | 1.800.992.3522<br>aflac.com |

For questions about enrolling or making changes to the benefits, please contact:

Michelle Archerd
HR Manager
Agra Industries
715-536-9584
marcherd@agraind.com

# OPTIONS COPAY HEALTH PLAN

***Using Collaborative Care may waive or reduce copay**

| Preventive Services Paid at 100% |
|---|
| Adult & Child Annual Well Exam |
| Immunizations |
| Colorectal Cancer Screenings (age 50 and older, every 5 years) |
| Prostate Screenings - Age 40 and older |
| Mammograms |

| Physician Services | |
|---|---|
| **VALUE LEVEL** | $0 Copay |
| Preventative Care | Virtual Care |
| Routine Chiropractic** | Chronic Disease Management |
| **BASIC LEVEL** | $75 Copay |
| Primary Care* | Virtual Care |
| Chiropractic Exam* | |

| Hospital and Facility | | | |
|---|---|---|---|
| **MINOR LEVEL** | **$250 Copay** | **MAJOR LEVEL** | **$1,000 Copay** |
| Emergency Room<br>Facility Urgent Care<br>Ambulance (Air or Ground)<br>Durable Medical Equipment | | Labor & Delivery<br>Inpatient Residential Treatment<br>Impatient Room & Board*<br>Facility Lab & Radiology*<br>Advanced Diagnostics<br>Outpatient Surgery<br>Skilled Nursing<br>***Using Collaborative Care may waive or reduce copay** | |

## MEDICAL EMPLOYEE CONTRIBUTIONS BI-WEEKLY

| | |
|---|---|
| Employee Only | $60.00 |
| Family | $180.00 |

Out of Pocket Maximum:
$5,000 Individual
$10,000 Family

Please review the full summary plan documents for a list of your exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

# YOUR HEALTH PLAN INCLUDES



Your own Care Advocate just a click away

What do I do?
Where do I go?
What will it cost?

Collaborative Care Nurse to help research and coordinate care

Access to the nations best: Physicians, surgeons, pharmacists, physical and mental health therapists

RIGHT CARE

RIGHT PLACE

RIGHT PLACE

RIGHT PRICE

sponsored by

AVERGENT
independent health benefit advisors

avergent.com | 866-247-5415 | help@avergent.com


*When healthcare is frustrating and difficult to navigate*

# COLLABORATIVE CARE

**Who are my Team Advocates?**
Your health plan comes with a team of dedicated benefit experts – called Advocates – who know your benefit plan and can help guide you to answers, about coverage and claims, or resources for care, including your Collaborative Care team.

**What is my Collaborative Care team?**
Your plan gives you access to this team of benefit and clinical experts who will work together to help you assess and plan your care along with your existing providers.

**How do I access the Collaborative Care team?**
Simply call the Member Services number on your ID card or in your app

**Does Collaborative Care replace my Primary Care Physician or Specialist(s)?**
Your PCP or Specialists play a key role in your care. The Collaborative Care team is here to support existing relationships and ensure you're getting the most from those relationships. If you're not, or you need a referral, the team will assist in coordinating.

**Does this cost me anything?**
Medical opinions, care coordination and research and condition management over and above existing treatments are no cost to you. Should you choose to continue planned care or treatment, your benefits remain the same.

**Do I have to follow the advice of the Collaborative Care team?**
Your Collaborative Care Nurse will provide you with options. You can choose how you want to proceed. These options will always have the intent of providing you with the high quality, affordable care.

**What can my Collaborative Care team help me with?**
- Non-urgent care (if you need it a care issue resolved within 24 hours, we cannot support; utilize your telehealth option within your Member app or your local Urgent Care clinic)
- Planning for routine lab work, prescriptions and condition management
- Surgical second opinions through independent, board-certified specialists
- Alternative non-surgical therapy options
- And more…

**Will my Collaborative Care Nurse ever proactively contact me?**
Yes, they may. Our clinical team works proactively to identify opportunities for better access to care or benefits based on specific conditions. In the event you are contacted, you can be certain it will be to provide assistance.

**What information is shared with my employer?**
Your Health Plan and the Collaborative Care team follow all HIPAA guidelines and take the utmost care in securing data and information. Claim information is de-identified to your employer. Individual health record information is available to the Collaborative Care team in conjunction with their efforts to assist you in coordinating your care needs and accessing the best benefits.

**When should I NOT contact Collaborative Care?**
When you are experiencing a medical emergency, always dial 911 or get to the nearest Emergency Room. For non-emergent, but urgent matters, your plan offers you 3 ways to access to 24/7 telehealth.

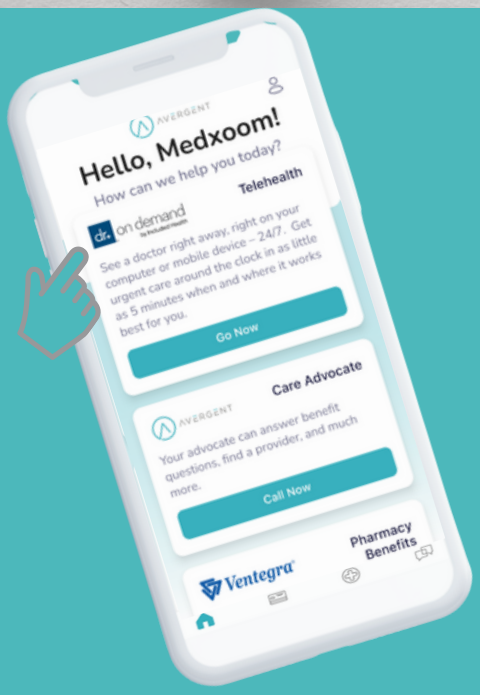
Call the number on the back of your card, go through your Member portal at www.avergent.com
Download on App Store or download the Avergent App powered by Medxoom. GET IT ON Google Play

AVERGENT

WHEN "LIFE" HAPPENS, YOU CAN'T ALWAYS GET TO A CLINIC.
BUT YOU CAN GET TOP QUALITY CARE

# dr. on demand

***FREE***
***Available 24/7 every day of the year***




## Personalized care in 2 easy steps

Go to your Avergent App powered by Medxoom

Select Dr. on Demand. You'll be connected with a board certified doctor or online therapist in minutes.

DIAGNOSIS AND TREATMENT SUGGESTIONS RIGHT FROM YOUR SMARTPHONE, TABLET OR COMPUTER.

| | | |
|---|---|---|
| Urinary Tract Infections | Cold, flu and COVID 19 | PTSD |
| Sinus infections | Headache and migraines | Prescription Refills |
| Skin conditions and rashes | Anxiety and Depression | and more |

AVERGENT

avergent.com | 866-247-5415 | help@avergent.com

*Information shared is privileged, confidential and protected by HIPPA*

# PHARMACY BENEFITS

## Pharmacy Benefits

| | Ventegra |
|---|---|
| Generic<br>(Preferred Pharmacy/Non-Preferred Pharmacy) | Retail: $5 Copay Mail Order: $20.00 Copay |
| Formulary Preferred<br>(Preferred Pharmacy / Non-Preferred Pharmacy) | $40.00 Copay |
| Formularly Non-Preferred*<br>(Preferred Pharmacy / Non-Preferred Pharmacy) | $80.00 Copay |
| Specialty*<br>(Preferred Pharmacy / Non-Preferred Pharmacy) | $250.00 Max Copay |

- *$0 must be coordinated through Collaborative Care
- Preferred pharmacy determined geographically based on pricing
- Go to your Member App or Portal to view Drug Formulary List
- Out of Pocket Max: $5,000 Individual / $10,000 Family

# DENTAL INSURANCE

## DELTA DENTAL - EMPLOYER PAID

In addition to protecting your smile, dental insurance helps pay for dental care. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

| Dental Plan of Wisconsin | PPO Provider | Premier & Non-Contracted Provider |
|---|---|---|
| Annual Maximum (Diagnostic/Prev. not included) | $1,500 | See PPO |
| Individual Deductible | $0 | See PPO |
| Family Annual Deductible | $0 | See PPO |
| Wellness Services | 100% | 100% |
| Diagnostic Services | 100% | 100% |
| Basic & Major Service | 75% / 50% | 75% / 50% |
| Orthodontic Service | 50% | 50% |
| Lifetime Orthodontic Maximum | $1,500 | $1,500 |
| Children (to age 19) | Yes | Yes |

# VISION INSURANCE

## NVA VISION - EMPLOYER PAID

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

| National Vision Administrators (NVA) | In Network | Non Network |
|---|---|---|
| Exam once per calendar year | $30 copay, then paid 100% | Reimbursed up to $42 |
| Frames once every 2 calendar years | Paid up to $100<br>20% discount off balance | Reimbursed up to $55 |
| Lenses once every 2 calendar years<br>Single Vision<br>Bifocal<br>Trifocal<br>Lenticular<br>Standard Scratch Coating | $30 copay, then paid 100% | <br>Reimbursed up to $40<br>Reimbursed up to $60<br>Reimbursed up to $80<br>Reimbursed up to $100 N/A |
| Conventional Contract Lenses<br>In lieu of frames and lenses | Paid up to $100<br>15% discount conventional<br>10% discount disposable | Reimbursed up to $80 |
| Medically necessary Contact lenses<br>Once every 2 calendar years | Covered at 100% | Reimbursed up to $210 |

This is a summary of benefits and features offered by AGRA Industries, Inc. and National Vision Administrators. All benefits are subject to the limitations, and exclusions set forth in the Summary Plan Description

# LIFE & ADD INSURANCE

MUTUAL OF OMAHA

Life insurance can help provide for your loved ones if something were to happen to you.
**Agra Industries provides a $15,000 Life and AD&D policy for all full-time employees.**

## Voluntary Supplemental Term Life and ADD

You are also able to purchase extra life and AD&D insurance coverage. **If you enroll when you are first eligible (within 90 days of date of hire), you will be able to enroll for amounts of coverage up to the Guarantee Issue amount, without having to prove good health**. If you enroll for coverage after this time, you will need to answer medical questions to be considered for coverage, and there is no guarantee that your application will be accepted. You pay for the full cost of the Optional Life and AD&D Benefit.

| | **OPTIONAL TERM LIFE AND AD&D** |
|---|---|
| Optional Life Coverage Amount | Available in increments of $10,000;<br>You can apply for up to the lesser of 5 times your annual earnings or $500,000. |
| Spouse Coverage Amount | You can apply for coverage for your spouse, in $5,000 increments, up to $100,000 |
| Children Coverage Amount | You can apply for coverage for your children in $5,000 increments, up to $10,000 |
| Guarantee Issue<br>(when 1st eligible only) | Employee: $100,000 \| Spouse: $35,000 \| Children: $10,000 |
| Age Reductions | Basic Life and AD&D insurance coverage amounts reduce by 35% at age 65, and by 50% at age 70. |

Beneficiary Designation

Please make sure you keep your beneficiaries up to date. It's important to consider beneficiaries annually, especially when you have a life event, such as marriage, divorce, birth, death or adoption. You should list a beneficiary for the Life and AD&D plans

# LIFE & ADD INSURANCE

## MUTUAL OF OMAHA

### Voluntary Supplemental Term Life and ADD

Employee or Spouse (premium for spouse based on Employees age)

| Age of Employee | Monthly Premium |
|---|---|
| | Rate per $1,000 |
| <25 | $0.08 |
| 25-29 | $0.08 |
| 30-34 | $0.08 |
| 35-39 | $0.10 |
| 40-44 | $0.14 |
| 45-49 | $0.21 |
| 50-54 | $0.33 |
| 55-59 | $0.54 |
| 60-64 | $0.82 |
| 65-69 | $1.40 |
| 70-74 | $2.64 |
| 75-79 | $5.34 |
| 80-84 | $5.34 |
| 85-89 | $5.34 |
| 90-100 | $5.34 |

Dependent Child(ren)

The monthly premium for all Depended children is $0.10 for each $1,000 of life insurance

Beneficiary Designation

Please make sure you keep your beneficiaries up to date. It's important to consider beneficiaries annually, especially when you have a life event, such as marriage, divorce, birth, death or adoption. You should list a beneficiary for the Life and AD&D plans

# LIFE & ADD INSURANCE

MASS MUTUAL

**Voluntary Group Whole Life**

## Group whole life insurance at-a-glance

| | |
|---|---|
| **Description:** | Permanent, participating life insurance coverage with built-in guarantees. |
| **Built-in guarantees:** | • Guaranteed death benefit<br>• Guaranteed cash-value growth<br>• Guaranteed fixed premium |
| **Dividend eligible[2]:** | Eligible to receive dividends each year, beginning on the certificate's second anniversary. |
| **Terminal illness provision:** | As the certificateowner, you can receive an advance, or acceleration, of a portion of your death benefit. This would happen if you are diagnosed, after the certificate is in effect, with a terminal illness expected to result in death within 12 months (this period may be 24 months in some states). |

### Consider the advantages

- It's conveniently available to you, right at work.
- Portable coverage and cash value you can keep even if you leave the company.
- No medical exams are required. Applying is easy, and can be done online or via a paper application. Employees just answer a few questions to determine eligibility.
- A simple payment option with premiums automatically deducted from your paycheck.

**So how much does it cost for a tobacco-free employee to be covered with $50,000 worth of Massmutual@WORK℠ Group Whole Life Insurance:**

| Age | 25 | 45 | 55 |
|---|---|---|---|
| Cost per week* | $7.39 | $18.81 | $33.00 |
| Guaranteed cash value at age 65 | $20,017.11 | $15,428.60 | $9,028.77 |

Þ Dividends are not guaranteed.

* This is for illustrative purposes only and is not binding. Additional policy features, or riders, are not included in the examples above and may be available at an additional cost. Rates may vary based on age, tobacco status and state.

# SHORT TERM DISABILITY

## MUTUAL OF OMAHA

A short-term disability plan will help with day-to-day expenses - housing, food, car payments, and even additional medical costs - if an illness or accident disables you away from the workplace.
This coverage is available to you at your own expense:

| SHORT TERM DISABILITY - Voluntary | |
|---|---|
| Weekly Benefit | 60% of regular pre-disability earnings |
| Maximum Weekly Benefit | $1,000 |
| Maximum Duration | 12 Weeks, as long as your remain sick or disabled |
| Benefit waiting period | 7 days |

### SHORT-TERM DISABILITY INSURANCE PREMIUMS

The monthly premium for short-term disability insurance is as follows:

| Attained Age of Employee | per $10 of Total Weekly Benefits |
|---|---|
| < 20 | $0.207 |
| 20 - 24 | $0.207 |
| 25 - 29 | $0.196 |
| 30 - 34 | $0.294 |
| 35 - 39 | $0.454 |
| 40 - 44 | $0.569 |
| 45 - 49 | $0.627 |
| 50 - 54 | $0.645 |
| 55 - 59 | $0.921 |
| 60 - 64 | $1.172 |
| 65 - 69 | $0.861 |
| 70 - 99 | $0.349 |

*Total Weekly Benefits* means the total amount of benefits for which all Employees are insured under the Policy.

# ACCIDENT | CRITICAL ILLNESS INSURANCE

## Accident Insurance

Prepare for anything life may bring with Accident Expense Insurance. It pays a benefit for the most common accidents and procedures to help bridge the gap between medical costs and existing coverage—in a straightforward, easy way.

### Group Accident Insurance

#### Premium Rates

**Semimonthly Premiums**

| Coverage | Premium |
|---|---|
| Employee | $9.58 |
| Employee and Spouse | $16.22 |
| Employee and Child(ren) | $22.06 |
| Family | $28.70 |

## Critical Illness Insurance

If you're diagnosed with a covered, serious condition you'll have additional funds to help keep your budget on track and savings intact while you work toward recovery.

### Group Critical Illness Insurance

#### Premium Rates

**Employee Uni-Tobacco Semimonthly Premiums**

| Age | $5,000 | $10,000 | $15,000 | $20,000 |
|---|---|---|---|---|
| 18-29 | $2.18 | $3.57 | $4.96 | $6.35 |
| 30-39 | $3.20 | $5.61 | $8.02 | $10.43 |
| 40-49 | $5.59 | $10.38 | $15.18 | $19.97 |
| 50-59 | $10.28 | $19.78 | $29.27 | $38.76 |
| 60+ | $18.86 | $36.93 | $54.99 | $73.06 |

**Spouse Uni-Tobacco Semimonthly Premiums**

| Age | $5,000 | $7,500 | $10,000 |
|---|---|---|---|
| 18-29 | $2.18 | $2.88 | $3.57 |
| 30-39 | $3.20 | $4.41 | $5.61 |
| 40-49 | $5.59 | $7.98 | $10.38 |
| 50-59 | $10.28 | $15.03 | $19.78 |
| 60+ | $18.86 | $27.89 | $36.93 |

## Hospital Indemnity Insurance

A trip to the hospital could significantly set back your finances. Hospital Indemnity insurance helps cover out-of-pocket expenses like groceries, medical bills, or whatever else you need.

### Group Hospital Indemnity Insurance

#### Premium Rates

**Semimonthly Premiums**

| Coverage | Premium |
|---|---|
| Employee | $10.47 |
| Employee and Spouse | $21.06 |
| Employee and Child(ren) | $16.77 |
| Family | $27.36 |

# IMPORTANT NOTICES

This Benefit Guide provides a brief summary of your benefits. It does not contain all of the details described in the official plan documents and contracts. If there is any discrepancy between what is summarized here or any verbal descriptions of the plan and the official plan documents and contracts, the plan documents and contracts will govern. The employer reserves the right to change, amend, suspend, or terminate any or all of the plans described in the guide at any time and for any reason.

This Benefit Guide is not a contract, and participation in any of the plans does not guarantee employment.

**IMPORTANT NOTICES – 2023 Plan Year**

## MICHELLE'S LAW

Michelle's Law was enacted in 2008 to ensure that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law allows seriously ill or injured college students, who are covered dependents under group health plans, to continue coverage for up to one year while on medically necessary leaves of absence.

When Michelle's Law was enacted, many health insurance plans required adult children to have full-time student status to be eligible for dependent coverage. However, due to the Affordable Care Act's (ACA) reforms, most group health plans no longer impose a full-time student status requirement for dependent eligibility.

Under the ACA, group health plans or insurers that provide coverage for dependent children must continue to make coverage available until a child attains age 26, regardless of student status. Thus, Michelle's Law will generally apply only to health plans that provide coverage to dependent full-time students who are age 26 or older.

### Coverage Requirements

Michelle's Law allows seriously ill or injured college students, who are covered dependents under group health plans, to continue coverage for **up to one year while on medically necessary leaves of absence**. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status.

Under Michelle's Law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.



## NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

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

## WOMEN'S HEALTH AND CANCER RIGHTS ACT

***Enrollment Notice***

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, deductibles and coinsurance apply. If you would like more information on WHCRA benefits, call your plan administrator.

***Annual Notice***

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at for more information

## HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

We are committed to the privacy of your health organization. The administrators of the medical plans use strict privacy standards to protect your health information from unauthorized use or disclosure. The plan's policies protecting your privacy rights and your rights under the law are described in the plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources

## HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

**Loss of Other Coverage**

If you are declining coverage 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).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

**Marriage, Birth or Adoption**

If you have a new dependent as a result of a 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, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

**Medicaid or CHIP**

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

# General Notice of COBRA Continuation Coverage Rights

***Introduction***

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

***What is COBRA continuation coverage?***

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.



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

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

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

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

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

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

***When is COBRA continuation coverage available?***

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

**Michelle** Archerd
HR Manager | **AGRA INDUSTRIES**

OFFICE: 715.536.9584 x320 | FAX: 715.536.9587
MERRILL, WISCONSIN | www.agraind.com



***How is COBRA continuation coverage provided?***

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

**Disability extension of 18-month period of COBRA continuation coverage**

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

**Second qualifying event extension of 18-month period of continuation coverage**

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

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

***Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?***
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

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

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

***Plan contact information***
**Michelle** Archerd
HR Manager | **AGRA INDUSTRIES**

OFFICE: 715.536.9584 x320 | FAX: 715.536.9587
MERRILL, WISCONSIN | www.agraind.com

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

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

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

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

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

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

| ALABAMA – Medicaid | COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) |
|---|---|
| Website: http://myalhipp.com/ Phone: 1-855-692-5447 | Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health- plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442 |
| **ALASKA – Medicaid** | **FLORIDA – Medicaid** |
| The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx | Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecove ry.com/hipp/index.html Phone: 1-877-357-3268 |
| **ARKANSAS – Medicaid** | **GEORGIA – Medicaid** |
| Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447) | Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp Phone: 678-564-1162 ext 2131 |

| CALIFORNIA – Medicaid | INDIANA – Medicaid |
|---|---|
| Website:<br>Health Insurance Premium Payment (HIPP) Program<br>http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Email: hipp@dhcs.ca.gov | Healthy Indiana Plan for low-income adults 19-64<br>Website: http://www.in.gov/fssa/hip/<br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website:<br>https://www.in.gov/medicaid/ Phone<br>1-800-457-4584 |

| IOWA – Medicaid and CHIP (Hawki) | MONTANA – Medicaid |
|---|---|
| Medicaid Website:<br>https://dhs.iowa.gov/ime/members<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website:<br>http://dhs.iowa.gov/Hawki<br>Hawki Phone: 1-800-257-8563 HIPP<br>Website:<br>https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp<br>HIPP Phone: 1-888-346-9562 | Website:<br>http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 |
| **KANSAS – Medicaid** | **NEBRASKA – Medicaid** |
| Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884 | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **KENTUCKY – Medicaid** | **NEVADA – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br>https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.asp x<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br><br>KCHIP Website:<br>https://kidshealth.ky.gov/Pages/index.aspx<br>Phone: 1-877-524-4718<br><br>Kentucky Medicaid Website: https://chfs.ky.gov | Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 |
| **LOUISIANA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP) | Website:<br>https://www.dhhs.nh.gov/oii/hipp.htm Phone:<br>603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext 5218 |

| MAINE – Medicaid | NEW JERSEY – Medicaid and CHIP |
|---|---|
| Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003<br>TTY: Maine relay 711<br><br>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740.<br>TTY: Maine relay 711 | Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 |
| **MASSACHUSETTS – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Website: https://www.mass.gov/info-details/masshealth- premium-assistance-pa<br><br>Phone: 1-800-862-4840 | Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **MINNESOTA – Medicaid** | **NORTH CAROLINA – Medicaid** |
| Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and- services/other-insurance.jsp<br>Phone: 1-800-657-3739 | Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 |
| **MISSOURI – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 | Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/<br>Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **UTAH – Medicaid and CHIP** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669 |
| **OREGON – Medicaid** | **VERMONT– Medicaid** |
| Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html<br>Phone: 1-800-699-9075 | Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427 |
| **PENNSYLVANIA – Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx<br>Phone: 1-800-692-7462 | Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp<br>Medicaid Phone: 1-800-432-5924<br>CHIP Phone: 1-800-432-5924 |
| **RHODE ISLAND – Medicaid and CHIP** | **WASHINGTON – Medicaid** |
| Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line) | Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 |

| SOUTH CAROLINA – Medicaid | WEST VIRGINIA – Medicaid |
|---|---|
| Website: https://www.scdhhs.gov Phone: 1-888-549-0820 | Website: http://mywvhipp.com/<br>Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |

| SOUTH DAKOTA - Medicaid | WISCONSIN – Medicaid and CHIP |
|---|---|
| Website: http://dss.sd.gov Phone: 1-888-828-0059 | Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002 |
| **TEXAS – Medicaid** | **WYOMING – Medicaid** |
| Website: http://gethipptexas.com/ Phone: 1-800-440-0493 | Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and- eligibility/ Phone: 1-800-251-1269 |
| | |

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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

**Paperwork Reduction Act Statement**

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

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

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

## EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS. While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.



ELIGIBILITY REQUIREMENTS An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite. *Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer. The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights