PATHWAY TO HEALTH

A GUIDE TO YOUR HEALTH BENEFITS

CLIENT WORKERS

2026

THE FEDCAP GROUP
The Power of Possible

PATHWAY TO HEALTH

TABLE of CONTENTS

CONTACT INFORMATION

Fedcap Benefit Service Center

Contact the Fedcap Benefit Service Center at 1-866-533-3227 if you have benefit questions or need assistance with enrollment. Benefit representatives are available Monday through Friday between 9:00 am and 5:00 pm ET. You may also send questions via email anytime at benefitservicecenter@fedcap.org.

Benefits/Carrier	Telephone	Website	Group Number
Medical Anthem	800-435-1385 800-241-6894 (TDD) 833-203-1739 (CarelonRx)	www.anthem.com	720419
24-Hour Nurse Line Anthem	877-825-5276	N/A	720419
LiveHealth Online Anthem	844-784-8409	www.livehealthonline.com	720419
Dental Anthem	877-606-3338	www.anthem.com	720419
Vision Anthem	866-723-0515	www.anthem.com	720419
Flexible Spending Account & Commuter Benefits FloresHR	800-532-3327	accounts.floreshr.com/Page/Home CustomerService@FloresHR.com Company Code = FAA20168 Employee ID = Your full SSN	FAA20168
Life/AD&D, Disability The Standard	800-552-2137 (Life) 800-232-0113 (Disability)	AL-Claims@standard.com	720419
Leave Management (FMLA & other leaves) The Standard	888-868-7046	AL-AbsenceClaims@standard.com	720419
Voluntary Benefits Anthem	800-604-5379	www.anthem.com	720419
403(b) Thrift Plan Mutual of America	212-224-2111	www.mutualofamerica.com Rainiel.Lopez@mutualofamerica.com	
Legal Plan MetLife	800-821-6400 Monday - Friday: 8am to 7pm Password: MetLaw	www.legalplans.com (access code: 1500985)	150

The material in this benefits brochure is for informational purposes only and is neither an offer of coverage nor medical or legal advice. It contains only a partial description of plan or program benefits and does not constitute a contract. In case of a conflict between your plan contracts and this information, the plan contracts will govern. While this material is believed to be accurate as of the print date, it is subject to change. If you have any questions about the benefits available to you as an eligible employee of The Fedcap Group, please feel free to contact the Benefit Service Center.

Medical, dental, vision and voluntary benefits excluding voluntary life & accidental death and dismemberment (AD&D) are administered and insured by Anthem. Core short-term disability, buy-up short-term disability, long-term disability, basic life & AD&D and voluntary life and AD&D are administered and insured by The Standard.

ELIGIBILITY & ENROLLMENT

Eligibility

For you: You are eligible for benefits if you are a full-time or regular part-time employee regularly scheduled to work at least 30 hours per week. This eligibility does not apply to paid time off accrual.

For your dependents. Your dependents become eligible for coverage on the same date you do. Eligible dependents are your:

- Legal spouse (including common law spouse)
- Children up to age 26, including stepchildren, foster children and adopted children (for medical, dental and vision)
- Disabled child of any age (with documentation) who is dependent on you for support due to a mental or physical disability that occurred before reaching age 26

Benefits are effective according to the schedule below.

Enrollment

New Hires: You will have until your effective date to enroll in your benefits.

Current Employees: You may enroll in or change your benefit elections only during the annual open enrollment period or if you experience a Qualified Life Event.

How to Enroll

- Visit www.fedcapgroup.org/oracle
- Log into your account
- From the home page, click the "Benefits" icon
- View your benefits online and make your elections

Note: You may enroll in or change your Commuter Benefits or 403(b) Thrift Plan Benefits at any time. If you need assistance with enrollment, contact the Fedcap Benefit Service Center at **1-866-533-3227** or **benefitservicecenter@fedcap.org**.

For new hires, benefits are effective:

Medical, Dental, Vision Flexible Spending Accounts Commuter Short-Term Disability Employee Assistance Plan MetLife Legal	First of the month following 30 days of employment
Life/AD&D Long-Term Disability	First of the month following 90 days of employment
403(b) Thrift Plan	Upon Enrollment and Election after hire date

When you leave Fedcap, benefits will end:

Medical, Dental, Vision	End of month after your last day of employment
Commuter	End of the following month after your last day of employment
Employee Assistance Program	90 days after last day of employment
403(b) Thift Plan	Last paycheck
Flexible Spending Accounts MetLife Legal Life/AD&D Long-Term Disability Short-Term Disability	Last day of employment

Fedcap Benefit Service Center

Agents Available Monday-Friday 9am-5pm ET:

Call Toll-Free: 1.866.533.3227

Live Chat: Go to http://myteambms.com/benefitservicecenter and click "Start Chat"

Email: benefitservicecenter@fedcap.org

Leave a Message: Go to http://myteambms.com/benefitservicecenter and click "Leave a Message"

*Inquiries received after 5pm will be answered within one business day.

ELIGIBILITY & ENROLLMENT

Making Changes During the Year

The IRS requires that benefit elections paid for on a pre-tax basis remain in effect for the full plan year. However, the IRS permits changes within 30 days of a qualifying life event. With a qualifying life event, you will be able to add or drop elected benefit coverage for you and/or your dependents. Examples of qualifying life events are:

- Your marriage, divorce, legal separation or annulment,
- The birth of your baby, adoption or placement of a child with you for adoption, or another change in the number of your dependents,
- The death of a dependent,
- Your dependent's eligibility or ineligibility for coverage (for example, he or she reaches the plan's eligibility age limit),
- A change in work location or home address for you, your spouse or your dependents,
- A change in coverage of your spouse or your dependent under another plan,
- Your qualification for a special enrollment under the Health Insurance Portability and Accountability Act of 1996 (HIPAA),
- A court order received by the plan, such as a Qualified Medical Child Support Order (QMCSO), or
- You, your spouse or your dependent's qualification for Medicare or Medicaid. For this qualifying life event only, you will have 60 days to provide supporting documentation.

If you need to make an election change during the year or have questions about what constitutes a qualifying life event, contact the Fedcap Benefit Service Center at 1-866-533-3227 **or** benefitservicecenter@fedcap.org**.**

Terms You Should Know

Deductible: A fixed dollar amount (individual or family) during the calendar year that the insured pays out-of-pocket, before the insurer begins to make payments for covered services.

Coinsurance: A form of cost sharing in an insurance plan that requires an insured person to pay a shared percentage of covered expenses after the deductible amount, if any, is paid.

Copay: A fixed amount required by a health provider to be paid by the insured for each outpatient (office) visit or prescription.

Out-of-Pocket Maximum: The maximum dollar amount an insured is required to pay "out of his/her pocket" during a plan year. After the maximum is reached, the insurance carrier pays the total cost of all eligible covered expenses.

HEALTH & WELFARE BENEFITS

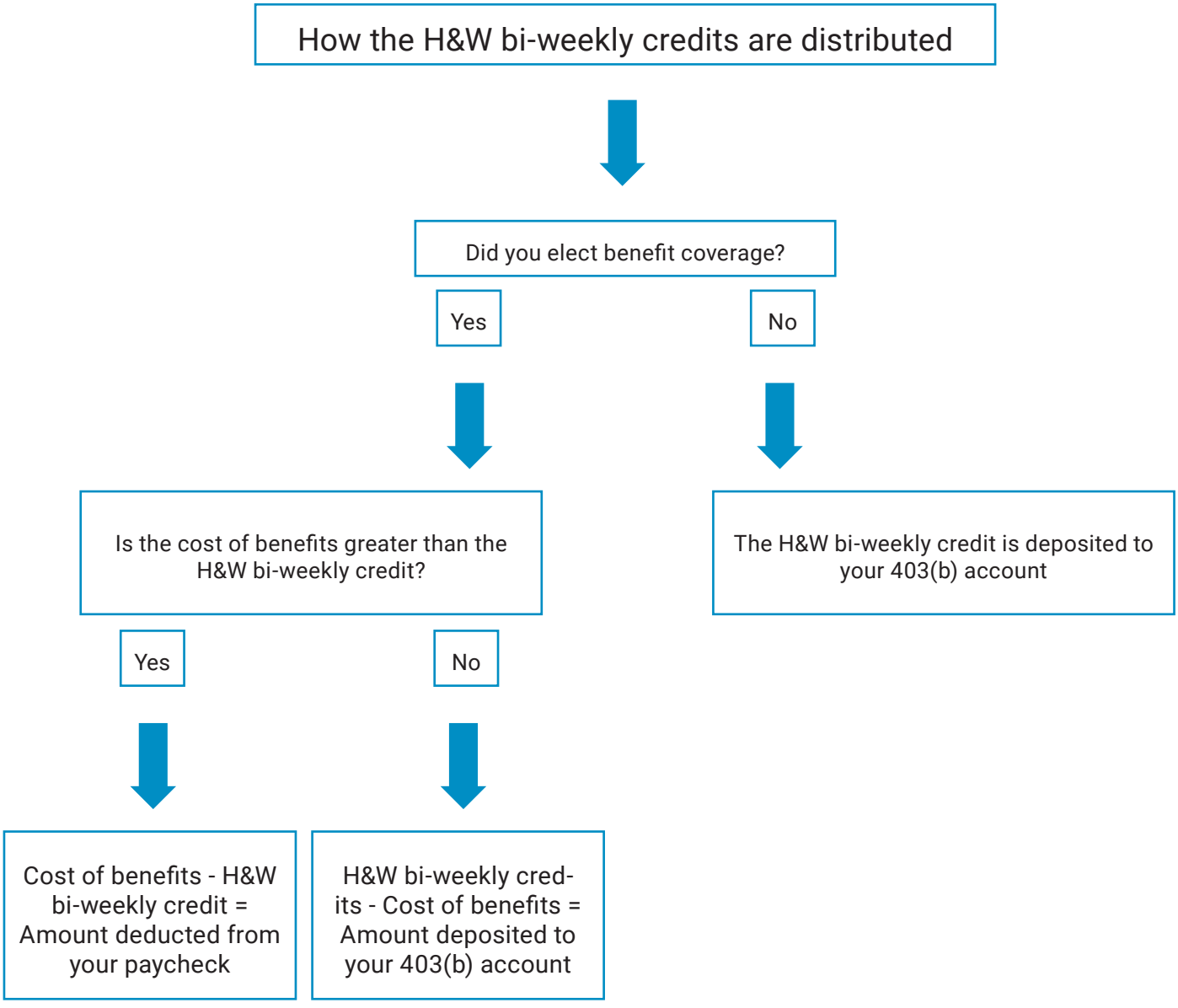
Health & Welfare Credits – How do I earn Health & Welfare credits?

The Health and Welfare (H&W) Credits are calculated based on the amount defined in your contract and the number of eligible hours you work each week. The hours used to calculate the H&W credits for any given pay period will always be a pay period behind, so only the actual hours worked are used. Some contracts include all types of paid hours, including vacation, sick, overtime and weekend hours worked, while others do not. The maximum number of hours used to calculate the H&W credit is 80 hours per payroll period.

Health & Welfare Credits – How does it work?

The cost of the benefits you elect are eligible to be deducted from your H&W credits. Eligible health benefits include medical, dental, vision, legal and life insurance costs. Depending on your benefit election, the difference will either be deducted from your paycheck or deposited into your retirement account at Mutual of America. Deposits to Mutual of America are made on a quarterly basis. Per government regulations, client workers who are 65 years and older and earn H&W credits must elect Fedcap medical coverage.

The chart below can assist you with understanding your H&W Credits.



WHAT'S NEW OR CHANGING?

What's new or changing in 2026?	
Anthem PPO Plan	• Annual deductible for In-Network will change to $1,250 (for individual) and $3,125 (for family) • Out-of-Pocket Maximum for In-Network will change to $7,150 (for individual) and $17,875 (for family) • Out-of-Pocket Maximum for Out-of-Network will change to $7,150 (for individual) and $17,875 (for family)
Anthem EPO Plan	• Annual deductible will change to $2,000 (for individual) and $4,000 (for family) • Out-of-Pocket Maximum will change to $17,875 (for family)
Commuter Benefits	• The carrier for commuter benefits will be changing to FloresHR
FSA Benefits	• The carrier for FSA benefits will be changing to FloresHR
Retirement - 403(b)	• 2026 annual maximum and catch-up contribution limits are changing

MEDICAL BENEFITS

The Fedcap Group offers three medical plans through Anthem Blue Cross Blue Shield — Exclusive Provider Organizations (EPOs) and Preferred Provider Organization (PPO). For additional information, refer to the detailed plan descriptions provided by Anthem Blue Cross Blue Shield.

Anthem Plan Features	PPO		EPO	HRA3000
Network*	**In-Network Blue Access**	**Out-of-Network**	**In-Network Only Blue Access**	**In-Network Only Blue Access**
Annual Deductible Individual/Family	**$1,250/$3,125**	$3,000/$7,500	**$2,000/$4,000**	$3,000/$6,000
Coinsurance Plan/Member	80%/20%	60%/40%	70%/30%	90%/10%
Out-of-Pocket Maximum Individual/Family	**$7,150/$17,875** (includes deductible; all in-network cost shares)	**$7,150/$17,875** (includes deductible)	$7,150/**$17,875** (all in-network cost shares)	$7,150/$14,300 (includes deductible; all in-network cost shares)
Annual Preventive Physical	Covered 100%	Covered in-network only	Covered 100%	Covered 100%
Office Visits (PCP/Specialist)	$20/$35 copay	Deductible/Coinsurance	$25/$40 copay	Deductible/Coinsurance
Live Health Online	$0 copay	Deductible/Coinsurance	$0 copay	Deductible/Coinsurance (If deductible is not met, cost is $59. If deductible is met, cost is $5.90)
Outpatient Lab & X-Ray**	Deductible/ Coinsurance	Deductible/Coinsurance	Covered 100%**	Deductible/Coinsurance
MRI/MRA, CAT, PET Scans	Deductible/ Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Urgent Care	$35 copay	$35 copay	$40 copay	Deductible/Coinsurance
Emergency Room (waived if admitted)	$250 copay	$250 copay	$250 copay	Deductible/Coinsurance
Routine Maternity Care	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Inpatient Hospital	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Surgery	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Durable Medical Equiptment	Deductible/Coinsurance	Covered in-network only	Deductible/Coinsurance	Deductible/Coinsurance
Mental Health***				
Inpatient	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Services	$20 copay	Deductible/Coinsurance	$25 copay	Deductible/Coinsurance
-Office Visits		Deductible/Coinsurance		Deductible/Coinsurance
-Other Outpatient Services	Coinsurance only		Coinsurance only	
Outpatient Short Term Rehab (exam/evaluation)	$20/$35 copay****	Covered in-network only	$25/$40 copay****	Deductible/Coinsurance

*Note: If you are outside of New York State, then the network for all plans is National PPO.
**covered in full when part of office visit on same day of service, otherwise subject to deductible/coinsurance
***mental health services include behavioral health and substance abuse services
****exam/evaluation only; other services subject to deductible/coinsurance

About LiveHealth Online

With Live Health Online, you can see a board-certified doctor from home, office or on the go at no cost to you if you are enrolled in EPO or PPO. There is a $59 charge if you are enrolled in HRA3000 plan and have not met your deductible. Once you have met your deductible, the charge is $5.90. When you sign up at www.livehealthonline.com or download the app to your smartphone or tablet, you can access doctors 24/7 for health issues like the flu, a cold, pink eye, and more. You can also talk to a licensed psychologist or therapist through video using LiveHealth Online Psychology when you're feeling stressed. Note: You can also call LiveHealth Online at 844-784-8409 from 7:00 am to 11:00 pm. Due to state laws, LiveHealth Online is not available in all 50 states and state restrictions may limit coverage in states where it is available.
Go to https://www.livehealthonline.com/ and click on FAQ for details.

Prescription Drug Coverage	PPO		EPO	HRA3000
Retail (30-day supply) Tier 1 Tier 2 Tier 3	Rx Ded: $100* $10 copay $35 copay*** 20% Rx cost*** $80 min/$400 max	Covered in-network only	Rx Ded: $100* $10 copay $35 copay*** 20% Rx cost*** $80 min/$400 max	Deductible then** $10 copay $35 copay 20% Rx cost $80 min/$300 max
Mail Order (90-day supply) Tier 1 Tier 2 Tier 3	Rx Ded: $100* $20 copay $70 copay*** 20% Rx cost*** $80 min/$400 max	Covered in-network only	Rx Ded: $100* $20 copay $70 copay*** 20% Rx cost*** $80 min/$400 max	Deductible then** $20 copay $70 copay 20% Rx cost $80 min/$300 max

* deductible per person; does not apply to Tier 1 **Combined with medical deductible ***After deductible is met

Preferred Generics Prescription Drug Program

You can save money by choosing a generic over a brand-name drug. When your doctor prescribes a brand-name drug that has a generic option, your pharmacy will automatically fill the prescription using the generic drug.
If you prefer the brand-name drug over the generic option, you will pay the generic copay plus the difference in cost between the generic and the brand-name drug.
When your doctor writes a prescription for a brand-name drug that has a generic option and writes "dispense as written", the pharmacy will fill the prescription for the brand-name drug.
Be sure to talk with your doctor about generic versus brand-name medications. For more information visit www.anthem.com.

Important Information Regarding Diabetes Medications & Supplies

If you take diabetic medications and need diabetic supplies, you will pay $0 copay.

Diabetic supplies include:

Blood sugar diagnostics	Lancets
Glucometers	Urine test strips
Insulin syringes	Alcohol swabs

For more information on medications and supplies available for $0 copay, log on to: www.anthem.com.

Mail Order Program

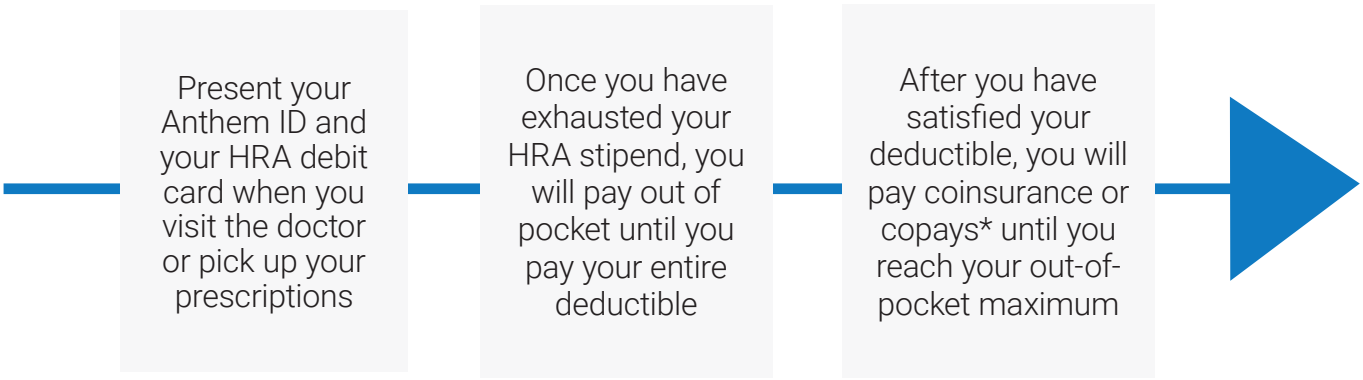
You can save money on Tier 1 and Tier 2 prescriptions you take on a routine basis for chronic conditions (e.g., asthma, high blood pressure, high cholesterol, etc.) by getting up to a 90-day supply delivered directly to your home using the Home Delivery Program. To get started, call 1-833-203-1739. Agents are available 24/7. You'll need your prescription, doctor's name, phone number, drug names and strengths, and a credit card. Once you set up your home delivery, you can order future refills easily:

- By Phone 24/7: Call 1-833-203-1739
- By Mail: Fill out an order form; then, mail it along with payment to CarelonRx Home Delivery, P.O. Box 94467, Palatine, IL 60094-4467
- Online: Visit www.anthem.com, log in and choose Pharmacy. On your personal pharmacy page, select View Your Prescriptions under Switch to a 90-Day Supply. For the drugs you want to switch to home delivery, choose Switch to a 90-day Supply and then Select Prescriber. You can also add or update your shipping address, shipping options and payment method on this page.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

The Fedcap Group provides you with a Health Reimbursement Account (HRA) through Anthem. An HRA is an employer-funded account you can use to pay for eligible health care expenses not covered by Anthem.
This Plan is an In-Network only plan; this means there is no coverage if you use an out of network provider. You must satisfy a deductible before the Plan will begin to pay benefits, except for preventive care services, which are covered at no cost to you. Once the deductible has been satisfied, the Plan provides traditional health coverage through a national network of physicians and facilities.

How the HRA Works with Anthem



*Copays apply to prescriptions only. All other services are subject to coinsurance after the deductible has been met.

The Fedcap Group will provide an HRA stipend to use towards the deductible. The amount of the HRA stipend varies with coverage tier. Effective January 1, 2026, The Fedcap Group will provide the following amount to HRA3000 participants:

Coverage Level	Stipend Amount
Employee Only	$1,000
Employee + Child(ren)	$1,250
Employee + Spouse	$1,250
Employee + Family	$1,500

In the HRA3000 Plan, the deductible is satisfied as soon as one covered individual meets the Individual deductible for Employee Only tier, or one or more individuals collectively meet the Family deductible. In other words, each covered individual is not required to meet the Individual deductible, except for individuals in Employee Only tier. The HRA3000 has an aggregate deductible; the Family deductible amount will include all combined eligible expenses that you and your covered dependents incur. The Family deductible amount may be satisfied by one member or a combination of two or more members covered under the HRA3000 Plan. For employees who elect the HRA3000 plan during the year, their HRA stipend is prorated on a monthly basis.

Anthem

The Sydney Health mobile app makes healthcare easier

Access personalized health and wellness information wherever you are

Use Sydney℠ Health to keep track of your health and benefits — all in one place. With a few taps, you can quickly access your plan details, Member Services, virtual care, and wellness resources. Sydney Health stays one step ahead — moving your health forward by building a world of wellness around you.

Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you, such as gender, languages spoken, or location. You'll be matched with the best results based on your personal needs.

My Health Dashboard

Use My Health Dashboard to find news on health topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals. It also offers a customized experience just for you, such as syncing your fitness tracker and scanning and tracking your meals.

Chat

If you have questions about your benefits or need information, Sydney Health can help you quickly find what you're looking for and connect you to an Anthem representative.

Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker or talk to a doctor via chat or video session.

Community Resources

This resource center helps you connect with organizations offering no-cost and reduced-cost programs to help with challenges such as food, transportation, and child care.

My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

¿Prefieres obtener información en español?

Tienes opciones. Si tu teléfono móvil ya está configurado en español, la aplicación Sydney Health también estará en español. Si no es así, selecciona el **menú** dentro de la aplicación Sydney Health y elige **el idioma de la aplicación**. También puedes visitar **espanol.anthem.com**.

Download the Sydney Health app today

Use the app anytime to:

- Find care and compare costs.
- See what's covered and check claims.
- View and use digital ID cards.
- Check your plan progress.
- Fill prescriptions.

Scan the QR code to download the Sydney Health app.

You can also set up an account at **anthem.com/register** to access most of the same features from your computer.

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2023 The Virtual Primary Care experience is offered through an arrangement with Hydrogen Health.

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ConditionCare

A personalized program to help you manage your health

If you have an ongoing condition that may put you at risk for future health issues, we can help. When you sign up for **ConditionCare**, a health and wellness program, we work with you to support your physical and mental health. Your health plan offers this program at no extra cost.

ConditionCare can help you or your covered family members manage conditions, such as:

- High cholesterol, high blood pressure, high blood sugar, and weight problems
- Coronary artery disease (CAD) and heart failure
- Diabetes
- Asthma and chronic obstructive pulmonary disease (COPD)
- Low back pain
- Arthritis, hip and knee replacement, and osteoporosis

An extra layer of care at no extra cost

Your health is a priority. Call us today at **866-962-0951** to learn how the ConditionCare program can help you take care of your health. Sign-up is quick and easy.

"The ConditionCare nurses are very knowledgeable and very willing to listen and offer good advice. They follow up when they say they are going to. I really appreciate that. Awesome program."

- ConditionCare participant

Support for your unique needs

Our team of healthcare professionals work closely with you to create a care plan based on your specific condition. The program offers:

- Telephone access to healthcare professionals who can answer questions and work with you to optimize your health.
- Continued guidance from care managers, nurses, pharmacists, dietitians, and other healthcare professionals who work together to help you reach your health goals.
- Educational resources and tips to help you learn more about your condition

To find out more about the ConditionCare program, call us toll free at 866-962-0951.

Anthem

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DENTAL BENEFITS

The Fedcap Group offers two Preferred Provider Organization (PPO) dental plans through Anthem Blue Cross Blue Shield. For additional information, refer to the detailed plan descriptions provided by Anthem.

Anthem Plan Features	PPO1		PPO2	
Network	**In-Network Dental Complete**	**Out-of-Network**	**In-Network Dental Complete**	**Out-of-Network**
Annual Deductible Individual/Family Waived for preventive and diagnostic services	$50/$150	$50/$150	$100/$300	$100/$300
Annual Maximum	$1,500	$1,500	$1,000	$1,000
Preventive & Diagnostic Services Oral exams Cleanings Full mouth x-rays Bitewing x-rays Fluoride treatment Sealants (children under age 16)	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Basic Services **Fillings** Amalgam (silver) fillings Simple extractions	80% after deductible	80% after deductible	60% after deductible	50% after deductible
Endodontics Root canal	80% after deductible	80% after deductible	60% after deductible	50% after deductible
Periodontics Scaling and root planing	80% after deductible	80% after deductible	60% after deductible	50% after deductible
Oral surgery Surgical extractions	80% after deductible	80% after deductible	60% after deductible	50% after deductible
Major Services Crowns, Dentures, Bridges, **Implants**	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Orthodontia Eligibility	Dependent Child(ren) Only (must be banded before age 19)		Employee and Dependent(s)	
Orthodontia	50%	50%	50%	50%
Orthodontia Lifetime Maximum	$1,500	$1,500	$1,000	$1,000

Accessing Anthem Dental ID Cards

Go to www.anthem.com from your computer or mobile browser and click Login/Register
Login with your member user name/password to access your secure member website

VISION BENEFITS

The Fedcap Group offers vision benefits through Anthem Blue Cross Blue Shield. For additional information, refer to the detailed plan descriptions provided by Anthem.

Anthem Plan Features	Anthem BCBS Vision Benefits	
	In-Network	Out-of-Network
		Reimbursed up to...
Eye Exam Once every 12 months	$5 copay	Up to $30 Allowance
Lenses Once every 12 months	$10 copay	Single: Up to $25 Bifocal: Up to $35 Trifocal: Up to $45 Lenticular: Up to $80
Frames Once every 24 months	$120 allowance, then 20% off any balance	Up to $120 Allowance
Contact Lenses (in lieu of eyeglasses) Once every 12 months Elective Conventional Elective Disposable Medically Necessary	$120 allowance, 15% off any balance $120 allowance (no additional discount) Covered in Full	Up to $120 Allowance Up to $120 Allowance Up to $200 Allowance

FloresHR

Healthcare FSA

Do you want to save 30% on health-related expenses this year? Enrolling in a Healthcare Flexible Spending Account (FSA) can save you up to $1,020 a year.

What is a Healthcare FSA?

A Healthcare FSA is an account that lets you set aside money before taxes to pay for many medical expenses for yourself, your spouse, or eligible dependents.

What can it be used for?

Eligible expenses include things like insurance copayments and deductibles, prescription drugs, vision and dental expenses.

How does it work?

1. During open enrollment, sign up for a Healthcare FSA.
2. Choose how much money you'd like to set aside for medical expenses.
3. The amount you've chosen is divided equally and deducted from your paycheck over the course of the year.
4. When paying for eligible expenses, you can use your FloresHR Benefits Payment Card to pay direct or use your personal funds and get reimbursed.

When can I use it?

Conveniently, the total amount you've chosen to put in your FSA is available to start spending on the first day of your plan.

What are the annual contribution limits?

2025: $3,300
2026: $3,400

Helpful Tips

Plan ahead to maximize your Healthcare FSA and use all your funds each year.

- Review what you paid for health-related expenses last year — are there any reoccurring items?
- Think about the upcoming year — does anyone in your family need orthodontia or vision care? Are you thinking of having a child?
- Use the information to figure out how much you'd like to have in your FSA.

Did You Know?

You can use your Healthcare FSA for:

- Medical procedures and surgeries
- Exercise and wellness expenses
- Family planning and care
- Many prescription drugs, vitamins, and probiotics

Frequently Asked Questions

Healthcare FSA

1. **What is a Healthcare FSA?**
   A Healthcare FSA is an account that lets you set aside money before taxes to pay for medical, dental and vision expenses for yourself, your spouse and eligible dependents.

2. **Who is eligible for an FSA?**
   A Healthcare FSA covers eligible expenses for you and your dependents, even if they are not covered under your primary health plan.

3. **What expenses are eligible through an FSA?**
   Health plan co-pays, deductibles, over-the-counter medications, eyeglasses, dental care, and certain medical supplies are covered. The IRS provides specific guidance regarding eligible expenses. (See IRS Publication 502).

4. **How do I contribute money to my FSA?**
   The amount you elect as your annual contribution will be divided by the number of paychecks for the year. This pay period amount will be deducted from each paycheck before taxes.

5. **How do I get the funds out of my FSA?**
   If you have a FloresHR benefits payment card, simply swipe it at the register. Otherwise, file a claim including the receipt documenting the type, amount and date of the expense. Once approved, your reimbursement check will be mailed or deposited into your bank account.

6. **How soon can I start spending my FSA funds?**
   Your entire annual election amount is available on the first day of the plan year.

7. **What happens if I don't spend all of my FSA by the end of the plan year?**
   Be sure to only allocate dollars for predictable medical expenses. Any unused funds at the end of the plan year and any applicable runout periods are forfeited, also called the use-it-or-lose-it rule. If your employer has adopted the FSA carryover, any unused balance (up to 20% of the annual maximum contribution limit) that remains in your account as of the last day of the plan year will roll forward for use in the new plan year. You will have 90 days after the end of the plan year to submit for eligible expenses with dates of service for the prior year.

8. **Can I change my election amount mid-year?**
   Elections can only be altered if you experience a change in status as defined by IRS regulations, such as marriage, divorce, birth, or death in your immediate family.

9. **What happens to my FSA if my employment is terminated?**
   Participation in your FSA is also terminated. This means that only expenses that were incurred prior to your termination date are eligible for reimbursement.

10. **Can I deduct healthcare expenses paid for by my FSA?**
    No, any expense paid for with FSA dollars cannot be claimed as a deduction.

11. **Can over the counter (OTC) medications be purchased with my FSA?**
    Yes, OTC medications are eligible to be bought with your FSA.

Revised 10/25

Sign up for a Healthcare FSA and start saving today!

FloresHR.com

PO Box 1028 • Allen Park, MI 48101 • 800.532.3327

Dependent Care FSA

What is a Dependent Care FSA?

A Dependent Care FSA is an account that lets you set aside money before taxes to pay care providers who watch your children and eligible dependents while you're at work.

What can it be used for?

Eligible expenses include before- or after-school care for children 12 or younger, custodial care for dependent adults, licensed daycare centers, a nanny or au pair, preschools, and day camps.

How does it work?

1. During open enrollment, sign up for a Dependent Care FSA.
2. Choose how much money you'd like to set aside for daycare or caregiving expenses.
3. The amount of money you've chosen will be divided equally and deducted from your paycheck over the course of the year.

When can I use it?

Reimbursement won't be processed until you have enough funds in your account.

What are the annual contribution limits?

- $5,000 per family ($2,500 for married individuals filing separately)

Helpful Tips

Plan ahead to maximize your Dependent Care FSA and use all your funds each year.

- Calculate how much you would normally spend on your dependents' care for 12 months.
- Note that there is an annual contribution limit.
- Set up direct deposit to receive reimbursements faster.
- Download the FloresHR Mobile App to check your account balance and send your claim by uploading a photo of your detailed receipt.

Did You Know?

- You can also use funds for a licensed after-school program or summer camp if your child is age 12 or younger or is disabled.
- If you experience a qualifying event, like having a baby or assuming care for an elderly person, you can sign up outside of the annual enrollment period.
- If your care provider changes rates or fees, you may also adjust the amount you set aside.

Frequently Asked Questions

Dependent Care FSA (DCFSA)

1. **What is a Dependent Care FSA (DCFSA)?**
   A Dependent Care FSA (DCFSA) is an account that lets you set aside money before taxes to pay care providers who watch your children and eligible dependents while you're at work.

2. **Why should I enroll in a Dependent Care FSA?**
   The money you put into a Dependent Care FSA is set aside from your paycheck before taxes. On average, participants enjoy a 30% tax savings on their annual contribution. This means you could be saving up to $1,500 per year on dependent care expenses!

3. **How do I contribute money to my Dependent Care FSA?**
   The amount you elect as your annual contribution will be divided by the number of paychecks for the year. This pay period amount will be deducted from each paycheck before taxes. You can then use the money in your account to pay for eligible dependent care expenses throughout the plan year.

4. **Who qualifies as a dependent?**
   Dependents are children under age 13, that you claim as dependents, as well as adults or other relatives that are incapable of caring for themselves (if you provide more than 50% of their support).

5. **When can I use my Dependent Care FSA?**
   You can use funds from your Dependent Care FSA under the following conditions:

   - To care for your qualified dependent.
   - To allow you (and your spouse if filing jointly) to work or look for work.

   Dependent Care FSA funds can cover costs for before or after school care for children aged 12 and younger, custodial care for dependent adults, licensed daycare centers, nanny or au pair services, nursery schools or preschools, late pickup fees, and summer or holiday day camps.

6. **What doesn't qualify?**
   There are certain expenses you cannot pay for using your Dependent Care FSA. These include expenses from a prior plan year, expenses for non-disabled children aged 13 and older, educational expenses (including kindergarten or private school tuition fees), food, clothing, sports lessons, field trips and entertainment, overnight camp expenses, and late payment fees for childcare.

7. **Can I use my entire Dependent Care FSA election amount at the beginning of the year?**
   No, you will only have Dependent Care FSA funds as they are equally deducted each pay cycle. Funds will accumulate in your account until you file a claim for reimbursement.

8. **Are there any rules about who can care for my dependents?**
   Yes, you cannot use funds to pay for care provided by a spouse, a person listed as a dependent on your taxes, or your child under the age of 19.

9. **How do I use my Dependent Care FSA to pay for qualified expenses?**
   You can use personal funds and then reimburse yourself with funds from your Dependent Care FSA by submitting an online claim through the FloresHR portal or via the mobile app. You'll need to provide photos of receipts when you submit a claim for reimbursement. Reimbursement won't be processed until you have enough funds in your account.

10. **What happens if I don't spend all my Dependent Care FSA funds by the end of the plan year?**
    Any unused funds that are in your account at the end of the year will be forfeited, which means you will lose that money. Plan carefully so that you use all the money in your Dependent Care FSA by the end of the plan year.

11. **Can I change my election amount mid-year?**
    You can only enroll or change your election amount mid- year if you have a special event like a birth, death or assume care for an elderly person. If your care provider changes rates or fees, or your child turns 13 you may also adjust the amount you set aside.

12. **What happens to my account if I lose my job or quit?**
    Unfortunately, participation in your Dependent Care FSA is discontinued as of your last day of employment. Expenses for services rendered after your termination date are not eligible for reimbursement.

Sign up for a Dependent Care FSA and start saving today!

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FloresHR

Commuter Benefits

Do you want to save 30% on commuting costs? Participating in a commuter benefits account can save you up to $1,224 a year.

What are commuter benefits?

Commuter benefits are employer-sponsored tax-advantaged accounts that allow you to set aside money before taxes to spend on parking and public transportation expenses incurred while traveling to and from the office.

How does it work?

Participating in a commuter account is easy:

1. Choose the amount you would like to have deducted from your paycheck each pay period **You can do this during open enrollment or at any time during the year.**
2. Use your FloresHR benefits payment card to pay for eligible commuting costs.

What can it be used for?

Eligible expenses include things like:

Public transportation
Bus, ferry, subway, and train tickets or passes

Parking
Costs to park near your workplace or where you catch public transit

Ridesharing
Vanpool fees when there are six or more adult passengers

Did you know?

Commuter benefits are flexible to meet your needs:

- You can always change your contribution amount if your commuting expenses change
- You can opt out of contributing at any time
- Funds left in your account at the end of the year can usually be rolled over and used the following year

Commuter Benefits Pre-Tax Limits

2025:

- $325 per employee per month ($3,900 per year) for qualified parking expenses
- $325 per employee per month ($3,900 per year) for transit and vanpool expenses

2026:

- $340 per employee per month ($4,080 per year) for qualified parking expenses
- $340 per employee per month ($4,080 per year) for transit and vanpool expenses

Frequently Asked Questions

Commuter Benefits

What is a commuter account?
A commuter account is an employer-sponsored benefit program that lets you set aside money before taxes to spend on parking and public transportation to and from work.

Why should I participate?
The money you put into a commuter parking or transportation account is taken from your paycheck before taxes are deducted. So you can pay for your parking or transportation expenses with money that hasn't been taxed.

You can save an average of 30% on your eligible mass transit and parking expenses.

What is considered a qualified mass transit expense?
Qualified expenses include transit passes, tokens, fare cards, vouchers, or similar items allowing you to ride a mass transit vehicle to or from work. The vehicle may be publicly or privately operated and includes bus, subway, rail, or ferry.

What qualifies as vanpooling?
Vanpooling requires a commuter highway vehicle with a seating capacity of at least 7 adults, including the driver. At least 80 percent of the vehicle mileage must be for transporting employees between their homes and workplace with employees occupying at least one-half of the vehicle's seats (not including the driver's seat).

What is a qualified parking expense?
Get reimbursed for parking expenses incurred at or near your work location or a parking location from which you continue your commute to work by vanpool or mass transit. Out-of-pocket parking fees for parking meters, garages and lots qualify. Parking at or near your home is not an eligible expense.

Can I use my commuter account for commuting expenses like tolls and gas?
No. Commuter account funds may not be used for tolls, gas, or mileage.

Can I use my commuter account to pay for business or personal travel expenses?
No. You can only use commuter account funds to pay for your regular commute between your home and office on mass transit or vanpools.

Whose commuter expenses are covered?
Qualified expenses include those incurred for your transportation between your residence and worksite. Expenses for your spouse or dependents are not eligible.

Is there a limit to how much I can contribute or spend each month?
Yes. Monthly limits are set by the IRS. Any monthly expenses above these limits are not tax-exempt and cannot be applied to future months.

How does it work?
When you enroll in a commuter account, you authorize your employer to set aside an amount before taxes to pay for parking and/or mass transit from each paycheck, You cannot exceed the IRS limits mentioned above. You then pay for the qualified transportation with your FloresHR Benefits Payment Card.

Revised 10/25

Sign up for commuter benefits and start saving today!

DISABILITY & PAID FAMILY LEAVE

About FMLA

The federal Family and Medical Leave Act (FMLA) provides eligible employees with up to 12 weeks of unpaid leave, job protection and health benefits continuation in the event of their own serious health condition or the serious health condition of a qualifying family member.
You are eligible for FMLA at the time of the qualifying event if you have at least 12 months of service and have worked a minimum of 1,250 hours in the previous 12 months with The Fedcap Group.

Short-Term Disability

Disability benefits are provided to you by The Fedcap Group. You have the opportunity to purchase Buy-Up Short-Term Disability through Anthem. Partial disability benefits are available if you return to work part-time to help fill the gap in your income.

If you are absent from work you must notify your manager. If you are absent for more than three consecutive days, on the fourth day you must contact The Standard at 888-868-7046. If your absence is related to a disability, you must contact The Standard at 800-232-0113 to file a claim under the Family Medical Leave Act (FMLA) and/or Disability. In addition, you must also contact your Manager.

State	Statutory Disability Benefit	Core Disability	Eligible Waiting Period	Benefit Duration
New York Employees	50% of salary up to $170 per week	60% of salary up to $400 per week (including Statutory benefits)	7 days of total disability	26 weeks
New Jersey Employees	85% of salary up to $1,199 per week		7 days of total disability	26 weeks
Rhode Island Employees	Up to $1,103 per week		7 days of total disability	30 weeks
Hawaii Employees	58% of salary up to $837 per week		7 days of total disability	26 weeks
California Employees	Up to $1,680.29 per week		7 days of total disability	52 weeks
All Other Employees	n/a	60% of salary up to $400 per week	7 days of total disability	26 weeks
Buy-Up Short-Term Disability	60% of salary up to a weekly maximum benefit of $1,500. Calculate your weekly benefit by subtracting any other income you receive as a result of your disability from the amount shown. The benefit amount is the payment you may receive if you become disabled.			

PAID FAMILY LEAVE

State	Weekly Benefit Amount	Qualifying Event	Maximum Leave / Benefit Period(s)	Contact Information
New York	67% of an employee's average weekly wage. The maximum weekly benefit amount is $1,228.53. Note: New York PFL includes prenatal leave	• Family member's serious health condition • Bond with a new child • Military-related qualifying exigency	12 weeks during any consecutive 52-week period.	https://paidfamilyleave.ny.gov/ 844-337-6303 Monday - Friday 8:30am - 4:30pm
New Jersey	85% of an employee's average weekly wage. The maximum weekly benefit amount is $1,199.	• To care for a family member with a serious health condition or for reasons related to a public health emergency • To bond with a new child • For reasons related to domestic or sexual violence	12 weeks.	https://myleavebenefits.nj.gov/worker/fli/ 609-292-7060 Monday - Friday 8:00am - 4:30pm
Massachusetts	The maximum weekly benefit amount is $1,230.39 (adjusted annually to equal 64% of the state average weekly wage).	• Family leave (bond with a new child, military-related qualifying exigency, care for a family member who is a servicemember, family member's serious health condition) • Medical leave (individual's own serious health condition)	26 weeks in a 52-consecutive-week period (maximum of 20 weeks for medical leave, 26 weeks for family leave to care for a covered servicemember and 12 weeks for family leave. Waiting period is 7 calendar day	https://mass.gov/info-details/paid-family-and-medical-leave-pfml-overview-and-benefits 833-344-7365 Monday - Friday 8am - 4:30pm
Rhode Island	4.62% of the wages paid in the highest quarter of the employee's base period. The maximum weekly benefit amount is $1,103.	• To care for a seriously ill family member • To bond with a new child • To donate bone marrow or body organ	8 weeks - there is no waiting period, but employee must be out of office for 7 days to be eligible for benefits	https://dlt.ri.gov/individuals/temporary-disability-caregiver-insurance 401-462-8420 Monday - Friday 8am - 3:30pm (closed Wednesdays)
District of Columbia	Amount varies depending on whether an employee's average weekly wage equals, exceeds or is less than 150% of the District's minimum wage multiplied by 40. The maximum weekly benefit amount is $1,190.	• Family leave (family member's serious health condition) • Medical leave (employee's own serious health condition) • Parental leave (birth, adoption, foster care placement) • Prenatal leave	12 workweeks in a 52-workweek period, generally (maximum of 12 weeks for family leave, 12 weeks for medical leave, 12 weeks for parental leave and two weeks for prenatal leave).	https://dcpaidfamilyleave.dc.gov/ 202-899-3700
Colorado	The maximum weekly benefit is 90% of the state average weekly wage. However, the maximum weekly benefit is $1,381.45 per week for PFML from July 1, 2025.	• For the employee's own serious health condition • To care for a family member with a serious health condition • To care for a new child during the first year after their birth, adoption or foster care placement • For safe leave	12 weeks in an application year. 4 additional weeks if the employee has a serious health condition related to pregnancy or childbirth complications. Effective January 1, 2026, 12 additional weeks is available if an employee's child is receiving care in a neonatal intensive care unit.)	https://famli.colorado.gov/ 866-263-2654 Monday - Friday 7am - 6pm

PAID FAMILY LEAVE

Accurate as of publication date. Regulations may change before effective date.

State	Weekly Benefit Amount	Qualifying Event	Maximum Leave / Benefit Period(s)	Contact Information
California	70% of the average weekly earnings shown in highest quarter of the employee's base period (90% for low income employees). The maximum weekly benefit amount is $1,681.	• To care for a seriously ill family member; • To bond with a new child; or • For a military-related qualifying exigency	8 weeks	https://edd.ca.gov/en/disability/paid-family-leave/ 800-300-5616 Monday - Friday 8am - 5pm Pacific Time
Delaware Effective January 1, 2026	80% of an employee's average weekly wage during the preceding 12 months. The maximum weekly benefit amount for 2026 and 2027 is $900.	• Parental leave (birth, adoption, foster care placement of a child) • Family caregiving leave (family member's serious health condition or qualifying exigency) • Medical leave (employee's serious health condition)	12 weeks in an application year (up to 12 weeks of parental leave in an application year, and up to six weeks of medical leave and family caregiving leave in any 24-month period)	https://labor.delaware.gov/delaware-paid-leave-is-coming/
Maine Effective May 1, 2026 Payroll Contrbutions start date - January 1, 2025	The weekly benefit amount is the total of: • 90% of the employee's wages that do not exceed 50% of the state's average weekly wage; plus • 66% of the employee's wages that do not exceed 50% of the state's average weekly wage. • The maximum weekly benefit is $1,647.	• Family leave: To care for family with serious health condition • Medical leave: To care for one's own serious medical needs • Safe leave: To stay safe or to help a family member stay safe after abuse or violence • Military leave: For emergencies related to a family member's impending military deployment	12 weeks per benefit year - benefits are not payable during the first calendar days of leave	https://www.maine.gov/paidleave/
Maryland Effective by **January 3, 2028** Payroll Contributions start date - **January 1, 2027**	The amount varies depending on whether a covered individual's average weekly wage equals, exceeds or is less than 65% of the state's average weekly wage. The maximum weekly benefit amount is $1,000 for the 12-month period beginning **January 3, 2028 (tentative).**	•To welcome a child into their home, including through adoption and foster care • To care for themselves, if they have a serious health condition • To care for a family member's serious health condition • To make arrangements for a family member's military deployment	12 weeks per application year. A covered individual may qualify for an additional 12 weeks if leave for their own serious health condition either precedes or follows leave taken to care for a child after birth or placement.	https://paidleave.maryland.gov/Pages/default.aspx

Group Long Term Disability Insurance

AnthemLife

The Fedcap Group, Inc.

See your benefit guide for specific plan details, eligibility definitions, limitations, and exclusions.

Group Long Term Disability Benefit Amount: 60% of monthly earnings up to a maximum monthly benefit of $5,000.

Elimination Period

The number of days you must be unable to work due to an approved qualifying disability before benefits begin: 90 days

Maximum Benefit Period: to normal Social Security retirement age

See your certificate for specific maximum payment durations based on age at the time of disability. Benefits paid at the time of an approved qualifying disability may vary from the benefit duration period shown.

Partial Disability Benefits

If you are able to return to work part-time, you may still receive a portion of your Long Term Disability Benefit to help fill the gap in your income.

Survivor Benefit

If you pass away after receiving Long Term Disability Benefits for at least 180 consecutive days, and are receiving benefits at the time of your death, a lump-sum payment benefit will be paid to your beneficiary. The Survivor Benefit is equal to three times your monthly benefit.

Vocational Rehabilitation

We may provide services, such as vocational testing and training, job modifications and job placement to help you return to active employment if you suffer a disability.

Social Security Assistance

If you are receiving Long Term Disability Benefits, we will help you apply for Social Security and, if necessary, offer guidance through the appeal process.

Resource Advisor

This program provides you and your family access to work/life resources, at no additional cost to you, including: face-to-face visits with a counselor or online visits via LiveHealth Online; identity monitoring and identity theft victim recovery services, legal and financial consultations; toll-free, 24/7 phone counseling from anywhere in the United States; and unlimited access to Resource Advisor online resources at www.resourceadvisor.anthem.com, program name “AnthemResourceAdvisor”. To access Resource Advisor call (888) 209-7840.

Pre-Existing Conditions

A pre-existing condition is an illness or injury for which you received treatment or where symptoms were present within 3 months prior to your effective date of coverage. A disability that begins in the first 12 months after your effective date will not be covered if it results from a pre-existing condition.

This is not a contract. It is a partial listing of benefits and services that is dependent on the Plan Options chosen. This benefit overview is only one piece of your entire enrollment package. All benefits and services are subject to the conditions, limitations, exclusions and provisions listed in the contract documents: the Certificate, Policy, and/or Trust Agreement for this product. In the event of a conflict between the contract documents and this benefits description, the contract documents will prevail. If you have any questions, please contact the Benefit Service Center.

Exclusions and limitations are listed in detail in the certificate, policy or trust agreement that applies to this product.

DISABILITY & PAID FAMILY LEAVE (CONT.)

For an employee over the age of 60 who goes on leave, the below schedule would apply:

Your Age When Disability Begins	Maximum Benefit Period
Less than age 60	To Social Security Normal Retirement Age (SSNRA) *
Age 60	60 months or to SSNRA*, whichever is greater
Age 61	48 months or to SSNRA*, whichever is greater
Age 62	42 months or to SSNRA*, whichever is greater
Age 63	36 months or to SSNRA*, whichever is greater
Age 64	30 months or to SSNRA*, whichever is greater
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

*** - For employees born 1965 or later, the SSNRA is age 67.**

Basic Group Term Life Insurance

AnthemLife

The Fedcap Group, Inc. – Staff

See your benefit guide for specific plan details, eligibility definitions, limitations, and exclusions.

Group Term Life Insurance Benefit: 1 times annual earnings to a maximum of $100,000.

Accidental Death and Dismemberment Insurance Benefit: Equal to Group Term Life Benefit Amount

Designating Beneficiaries

You will need to designate your beneficiaries in Oracle HCM (www.fedcapgroup.org/oracle). In the event of your death, your designated beneficiaries will receive the proceeds of the insurance benefit.

Benefits after age 70

At age 70, your benefits will be reduced as follows:

50% reduction at age 70

All benefits end at retirement.

Living Benefit (accelerated death benefit)

You can request up to 50% of your Group Term Life Benefits to be paid while you are living, if you are terminally ill with less than 12 months to live. If you take a Living Benefit payment, the amount your beneficiary receives after your death will be reduced by the amount you were paid.

Waiver of Premium

Your life insurance coverage may continue until you turn age 65 if you become totally disabled and are unable to work prior to age 60. You will not pay premiums after the first six months after we approve your waiver of premium claim.

Conversion

If you leave your job for any reason, you may be able to convert your group life coverage to an individual policy. You must apply for coverage and pay the first month's premium for the individual policy within 31 days of the last day you were employed.

Resource Advisor

This program provides you and your family access to work/life resources, at no additional cost to you, including: face-to-face visits with a counselor or online visits via LiveHealth Online; identity monitoring and identity theft victim recovery services; legal and financial consultations; toll-free, 24/7 phone counseling from anywhere in the United States; and unlimited access to Resource Advisor online resources at www.resourceadvisor.anthem.com, program name "AnthemResourceAdvisor". To access Resource Advisor call (888) 209-7840.

Travel Assistance

This program provides you access to emergency medical help, travel services and useful tips for your trip if you travel more than 100 miles from home – all at no additional cost to you. You can access Travel Assistance benefits by calling: US and Canada (866) 295-4890, other locations (call collect) (202) 296-7482. **All services must be arranged in advance by Generali Global Assistance, Inc. the Travel Assistance vendor.**

Voluntary Life Insurance

AnthemLife

The Fedcap Group

See your benefit certificate for specific plan details, eligibility definitions, limitations and exclusions.

Voluntary Group Term Life Insurance Benefit

You may purchase coverage in an amount from $10,000 to $1,000,000 or 5x annual earnings, whichever is less in increments of $10,000.

Guaranteed Issue Amount

$200,000 or 3x annual earnings, whichever is less

If your application is submitted to Anthem within 31 days of you becoming eligible, the Guaranteed Issue amount is available without evidence of insurability. You must submit evidence of insurability and Anthem must approve any amounts above the Guaranteed Issue amount in writing.

If your application is submitted to Anthem more than 31 days after you became eligible, the Guaranteed Issue amount does not apply. You must submit evidence of insurability and Anthem must approve all amounts in writing.

Voluntary Accidental Death and Dismemberment Insurance Benefit: Equal to Voluntary Term Life Benefit elected.

Voluntary Life Coverage for your Family

You may also choose additional life and accidental death and dismemberment coverage for your spouse and for your children:

You may purchase coverage for your spouse in $5,000 increments to a maximum of $250,000.
You may purchase coverage for your children in $1,000 increments to a maximum of $20,000.

Spouse Guaranteed Issue Amount: $30,000

If your application for your spouse/child(ren) is submitted to Anthem within 31 days of you becoming eligible, the Spouse Guaranteed Issue amount is available without evidence of insurability. You must submit evidence of insurability for your Spouse and Anthem must approve any amounts above the Spouse Guaranteed Issue amount in writing.

If your Spouse/Child(ren) application is submitted to Anthem more than 31 days after you became eligible, the Spouse Guaranteed Issue amount does not apply. You must submit evidence of insurability for your Spouse and Anthem must approve all amounts in writing.

Dependent coverage may not exceed 100% of the employee's benefit amount. Child coverage begins on the 15th day following birth and terminates at age 29.

Benefits after age 65

After age 65, your benefits will be reduced as follows:

35% reduction at age 65; 50% reduction at age 70

All benefits end at retirement.

Living Benefit (accelerated death benefit)

You can ask for a portion of your group term life benefits to be paid while you are living, if you are terminally ill with less than 12 months to live. If you take a Living Benefit payment, the amount your beneficiary gets after your death will be reduced by the amount you were paid.

Group life and disability value added services

Extra help for employees and their families

Your life and disability plans include services that your employees and their families can use now, even before they have a claim, at no cost to them. Share the fliers linked in this brochure with your employees to let them know how to access services.

Resource Advisor

Resource Advisor is included with group life and disability plans with services they and their families can use at any time – even if they don't have a claim including:

- Unlimited counseling by phone
- Counseling in person or by LiveHealth Online two-way video counseling[1].
- Legal consultations
- Financial counseling
- Website with wellbeing information including no-cost downloads of WillMaker software, Perks at Work discount program, work/life balance information, and more. Visit www.ResourceAdvisor.Anthem.com and log in with the program name "AnthemResourceAdvisor" to access resources.

Share these fliers with your employees to let them know the benefits available now:

- Resource Advisor flier
- Online Will tool flier
- Perks at Work flier

Travel Assistance

Help for travel emergencies when your employees travel more than 100 miles from home. Travel Assistance is included with group life plans. It includes:

- 24/7 help line for problems while traveling
- Emergency medical evacuations
- Return the vehicle in a medical emergency
- Return children, traveling companion, and pets in a medical emergency
- Visit by family member or friend when an employee is hospitalized while traveling
- And much more.[2]

Share Travel Assistance information with your employees:

- Travel Assistance flier
- Travel Assistance detailed brochure

Group Life Beneficiary Support Services

We provide extra help to life insurance beneficiaries when they need it most. These services are included with group life plans:

- Beneficiaries can continue to access Resource Advisor services for six months after the loss.
- Beneficiary Companion™ can help settle the estate[3]. Beneficiary Companion coordinators will make phone calls and take care of important personal and legal matters.
- Beneficiaries can order copies of *The Healing Book: Facing the Death — and Celebrating the Life — of Someone You Love* at no cost to share with children affected by the loss from the Resource Advisor website.

If you would like a copy of *The Healing Book* to have on hand in case of loss, go to www.ResourceAdvisor.Anthem.com and log in with the program name "AnthemResourceAdvisor." Then click *Beneficiary Services*, then click the picture of *The Healing Book* for the order form. Enter "HR Copy" in the "Name of deceased member" field in the order form, then enter your shipping information.

Online resources for your employees

Additional online resources to share with your employees:

- Employees can submit life and disability claims online – the quickest way to get claims started.
- Anthem Life website with links to resources, information about Resource Advisor and Travel Assistance, and more.

[1]Up to three counseling visits per issue
[2]Travel Assistance is administered by Generali Global Assistance and all services must be pre-approved in advance by Generali Global Assistance.
[3]Beneficiary Companion services available only when the beneficiary is also the legal executor of the estate.

Summary of Benefits – The Fedcap Group

Accident 24 Hour Plan

Accident coverage provides a cash benefit in one lump sum if you or a covered family member is injured because of an accident. Use accident coverage to help pay for out-of-pocket medical costs, such as ambulance fees, physical therapy, X-rays or daily expenses like rent, food, transportation. This plan covers accidents that occur both at and outside of the workplace.

Key features:

- Cash benefit is paid directly to you in a lump-sum, tax-free payment.
- No medical questions or exam needed to enroll.
- You can take your coverage with you even if you leave your employer.[1]
- No limitations for pre-existing conditions.[2]

Convenience

We are here to help. To file a claim, start with the claim form available from your employer. Follow the instructions on the form to submit and contact the Anthem Supplemental Contact Center with any questions.

	Benefit	Payment Limitation	Amount
Hospital and emergency	Hospital admission	Once/accident within 90 days	$1,500
	Daily hospital confinement	Up to 365 days/lifetime (total daily and ICU)	$300
	Daily ICU confinement	Up to 30 days/accident (subject to 365 Days/lifetime)	Not covered
	Ambulance – air	Once/accident within 72 Hours	$1,500
	Ambulance – ground	Once/accident within 90 Days	$400
	Blood/plasma/platelets	Once/accident within 90 Days	$400
	Emergency room	Once /accident within 72 Hours	$250
	Diagnostic exam	Once/accident within 90 Days	$200
	Urgent care	Once /accident within 72 Hours	$200
	X-ray	Once/accident within 90 Days	$200
Follow-up care	Accident follow-up	Up to 3 treatments/accident within 90 days	$100
	Acupuncture	Up to 10 visits/accident within 365 days	$25
	Child care	Up to 30 days/accident while insured is confined	$25
	Chiropractic care	Up to 10 visits/accident within 365 days	$25
	Initial doctor office visit	Once/accident within 90 days	$100
	Lodging	Up to 30 nights/lifetime	Not covered
	Medical appliance	Once/accident within 90 days	$200
	Physical therapy	Up to 10 visits /accident within 90 days	$50
	Rehabilitation facility	Up to 15 days/lifetime within 90 days	$200
	Transportation	Up to 3 trips/accident	$400

Summary of Benefits – The Fedcap Group

Specified Disease $20,000 Plan

Specified Disease (specified disease) coverage provides the added layer of security you want and need when illness occurs— a lump-sum cash benefit to help pay for unexpected costs. You decide how to use the benefits to best support recovery for yourself or a family member. Use your Specified Disease coverage to help pay for out-of-pocket medical costs, such as for prescriptions, hospital bills, X-rays or daily expenses like rent, food or transportation.

Key features:

- Cash benefit is paid directly to you in a lump-sum, tax-free payment.
- $50 payment towards health screenings, such as a lipid panel or fasting glucose test. .
- You can take your coverage with you even if you leave your employer.[1]

Convenience

We are here to help. To file a claim, start with the claim form provided by your employer. Follow the instructions on the form to submit and contact the phone number listed on that form with any questions about your benefits or about how to file a claim.

Note: Specified Disease benefits for covered spouse and dependents are 50% of the amount shown below, except for Health Screening which is $50 for any covered member, and Skin Cancer, which is $250 for any covered member.

	Benefit	Amount
Cancer	Invasive cancer	$20,000
	Non-invasive cancer	$5,000
Vascular	Heart attack (myocardial infarction)	$20,000
	Stroke	$20,000
	Coronary artery disease	$5,000
Other	Major organ failure	$20,000
	End-stage renal disease	$20,000
	Skin Cancer benefit, per member, once per lifetime	$250
	Health screening benefit: per member, per calendar year	$50
Other Key Features	Additional occurrence of multiple conditions	Covered with no separation period
	Lifetime benefit maximum — employee	Lesser of $500,000 or 2500%
	Lifetime benefit maximum — spouse & children	Lesser of $500,000 or 2500%

1 Not available in all states. Insured will only be able to continue coverage while the policy is in-force with the policyholder and the insured must pay premium if electing to continue coverage after leaving employer.
2 Covered accidents or illness must occur after the effective date of coverage.

Group Specified Disease benefits provided by policy form SCI B XX18 P or state equivalent.
This is not a contract; it is a partial listing of benefits and services. All covered service are subject to the conditions, limitations, exclusions, terms and provisions of your policy. In the event of a discrepancy between the information in this summary and the policy, your policy will prevail. If you have any questions, please contact your Human Resources/Benefits manager. If you have any questions, please contact your Human Resources/Benefits manager.

Empire BlueCross BlueShield

An Anthem Company

Your $50 health screening benefit is just a phone call away!

As part of your Empire plan, you have a $50 health screening benefit for tests like mammograms, colonoscopies or fasting blood glucose tests.

To take advantage of this benefit:

- Call the Claims line at 1-800-604-5379.
- Be ready to share this information for you or your covered dependent:
  - Social Security number
  - Date of birth
  - Address
  - Provider's name
  - Name of the test
  - Date of the test

We'll confirm your test and then send you a check. It's that simple!

You and your covered dependents (spouse and children) are each allowed one $50 health screening benefit each calendar year.

The eligible tests include:[1]

Abdominal aortic aneurysm ultrasound
Bone density screening
Bone marrow testing
Breast ultrasound
CA 15-3 (blood test for breast cancer)
CA 125 (blood test for ovarian cancer)
Other cancer screening
Carotid ultrasound
CEA (blood test for colon cancer)
Cervical cancer screening
Chest X-ray
Colonoscopy
CT angiography
Double contrast barium enema
ECG/EKG
Fasting blood glucose test
Flexible sigmoidoscopy
Hemoccult stool analysis
Lipid panel
Mammography
PAD ultrasound
Pap test
PSA (blood test for prostate cancer)
SPEP (blood test for myeloma)
Serum cholesterol test
Stress test (bicycle or treadmill)
Thermography
Triglycerides blood test (HDL/LDL)

1 Tests can vary by state and by the type of plan offered. Not available for all plans in all states. Please check your *Certificate of Coverage* for details.

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Summary of Benefits – The Fedcap Group

Hospital Indemnity Plan

With Intensive Care Benefits

Hospital Indemnity provides a lump-sum, tax-free cash benefit to help pay for costs that can come with a hospital stay that your health plan doesn't cover. Use your hospital indemnity coverage to help pay for out-of-pocket medical costs or daily expenses like rent, food or transportation.

Key features:

- Cash benefit is paid directly to you in a lump-sum, tax-free payment.
- Covers hospitalization for maternity from day one with no waiting period.
- You can take your coverage with you even if you leave your employer for up to three years.[1]
- No limitations for pre-existing conditions.[2]

Convenience

We are here to help. To file a claim, start with the claim form provided by your employer. Follow the instructions on the form to submit and contact the phone number listed on that form with any questions about your benefits or about how to file a claim.

Benefit	Amount	Days
Hospital confinement - first-day benefit	$165	5 days
Daily hospital confinement	$165	90 days
Intensive care unit confinement — first day benefit	$165	5 days
Daily intensive care unit confinement	$165	90 days
Pre-existing conditions limitation	None	
Maternity benefit waiting period	None	

1 Not available in all states. Insured will only be able to continue coverage while the policy is in-force with the policyholder and the insured must pay premium if electing to continue coverage after leaving employer.
2 Covered accidents or illness must occur after the effective date of coverage.

Group Hospital Indemnity benefits provided by policy form SHI B XX18 P or state equivalent.
This is not a contract; it is a partial listing of benefits and services. All covered service are subject to the conditions, limitations, exclusions, terms and provisions of your policy. In the event of a discrepancy between the information in this summary and the policy, your policy will prevail. If you have any questions, please contact your Human Resources/Benefits manager.

10/2020

Disability insurance

When the unexpected happens, you want a backup plan

If you get sick or injured and can't work, your paycheck may go away — but your regular expenses won't.

A disability plan can provide peace of mind. Think of it as a backup plan for the worst-case scenario and a way to protect your income.

Did you know that 1 in 4 of today's 20-year-olds will become disabled before they retire?[1] **If you get sick or injured and can't work, our disability coverage pays you part of your salary, up to the limit allowed by your plan**. It can help you cover medical bills and other expenses while you're not getting a paycheck.

Most people think of workplace injuries or accidents when they think of disability. But 90% of disabilities are caused by illness, such as arthritis, back pain or cancer.[1]

Fast and accurate payments

We know that when you need disability benefits, you need them fast. So our claims turnaround time is among the fastest in the industry – usually within two days.[2] And our accuracy rate for claims payments is 99.9%.[2]

How much disability insurance do you need?

Here's a quick checklist to help you estimate how much disability coverage you'll need. Fill in your regular monthly expenses and add them up to get an estimate of your total expenses.

Mortgage or rent	$_____
Transportation (car payments, car repairs, gas)	$_____
Utilities	$_____
Food	$_____
Chid care orelder care	$_____
Medical	$_____
Education	$_____
Loan or credit card payments	$_____
_____	$_____
_____	$_____
Total	$_____

1 Council for Disability Awareness website. *Chances of Disability* (accessed February 6, 2017). www.disabilitycanhappen.org.

2 Internal data, 2016.

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Filing a claim

for your accident, specified disease, or hospital indemnity plan

If you ever need to file a claim for your accident, specified disease, or hospital indemnity plan, you should know that it's different than filing a claim for your medical plan. With your medical coverage, your doctor or other health care provider files claims for you. To use your accident, specified disease, or hospital indemnity benefits, you will need to fill out a claim form and mail it to us. You will also need to provide paperwork from the care you received.

Here's how it works:

1. Gather your paperwork

You will need to provide all the paperwork related to your claim, such as any time you saw a doctor or had a treatment for the accident or specified disease. This may include:

- Doctor notes.
- Emergency room or hospital discharge papers.
- Lab reports.
- Itemized hospital or doctor bills.
- Medical summary of benefits.
- Childcare, transportation, and/or lodging receipts.
- Police reports (if your claim involves a car accident).

You may have to ask your doctors or other health care providers for these records.

2. Fill out the claim form

If you don't already have it, reach out to your human resources department, or you can go to the **Forms Library** at **empireblue.com/forms**. The records you gathered will help you answer the questions. You will need to know things like:

- Whether you're filing an accident, specified disease, or hospital indemnity claim.
- The dates of your injury or illness and when you received treatments.
- The names of your doctors and the places where you received treatment.

3. Sign the form and mail or fax it to us

Mail it to:
Empire Supplemental Insurance Benefit Department
P.O. Box 2076
Grapevine, TX 76099

Or fax it to:
469-417-1977

Do you have questions about the form or how to submit your claim?
We're here to help. You can reach us at 800-604-5379.

403(B) PLAN

403(b) Thrift Plan

Saving for retirement is important. You have the opportunity to set aside money on a pre-tax and/or post-tax basis to help build your retirement nest egg.

Eligibility	Employee Contributions: You are eligible to enroll at any time during your employment. There is no minimum service or age requirement to make salary reduction contributions, including Designated Roth contributions, to this plan.
Plan Entry	You are included as a participant in the plan immediately upon enrollment.
Retirement	Attainment of age 65.
Contributions	Salary Deduction: At participant's discretion Maximum Allowed: **$24,500** (as of 2026) Catch up Contribution Age 50+: **$8,000** (2026) Supercatchup Contribution Age 60-63: **$11,500** (inclusive of the $8,000) Mandatory Roth Catchup Contributions for High Earners (Employees who are 50 years or older and earn more than $145,000) must have Roth contributions (post tax deductions).
Vesting	Salary Deduction: 100% vested immediately
Changes to 403(b)	To change beneficiaries, funding allocation and/or salary deduction, contact Mutual of America at 212-224-2111
Rollovers	You may transfer the taxable portion of a cash distribution from another qualified retirement plan (including an IRA, 403(b), 408(a) or 401(k)).

For assistance, please contact Mutual of America directly at 212-224-2111.

Cover the costs on a wide range of common legal issues with a Legal Plan.

Access experienced attorneys to help with estate planning, home sales, tax audits and more.

Just a few times in life you might need legal help.

Getting married

- Prenuptial agreement
- Name change
- Updating or creating estate planning documents

Buying, renting or selling a home

- Reviewing contracts and lease agreements
- Preparing deeds
- Attending the closing

Dealing with identity theft

- Attorney consultations regarding potential creditor actions
- Assistance with contacting banks and creditors
- Attorney defense for issues related to identity theft

Starting a family

- Creating wills and estate planning documents
- School and administrative hearings
- Adoption

Caring for aging parents

- Attorney consultations on Medicaid/Medicare questions
- Reviewing nursing home agreement
- Reviewing estate planning documents

Sending kids off to college

- Security deposit assistance
- Reviewing leases
- Student loan debt assistance

Legal help made easy.

See how simple it is to use your plan.

1 Easy to find an attorney

Create an account at **legalplans.com** to see your coverages, select an attorney and get a case number for your legal matter. Or, give us a call at **800.821.6400** for assistance.

2 Easy to make an appointment

Call the attorney you select, provide your case number and schedule a time to talk or meet.

3 Easy from start to finish

That's it! There are no copays, deductibles or claim forms when you use a network attorney for a covered matter.

Enroll in MetLife Legal Plans during annual enrollment

Legal Disclosures

Women's Health and Cancer Rights Act of 1998

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

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

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

	PPO		EPO	HRA3000
	INN**	OON**	INN**	INN**
Individual Deductible	$1,250	$3,000	$2,000	$3,000
Family Deductible	$3,125	$7,500	$4,000	$6,000
Coinsurance	20%	40%	30%	10%

**INN=In-Network, OON=Out-of-Network

Newborns' and Mothers' Health Protection Act

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

Special Enrollment Rights Under HIPAA

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in the Fedcap health plan in the future 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, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you lose Medicare or CHIP coverage because you are no longer eligible you must request enrollment within 60 days. If you or your dependents become eligible for premium assistance under a State Medicaid or CHIP program that would pay the employee portion of the health insurance premium you may request enrollment within 60 days. To request special enrollment or obtain more information, contact The Fedcap Benefit Service Center at 1-866-533-3227 or benefitservicecenter@fedcap.org.

Mental Health Parity

The Mental Health Parity and Addiction Equity Act of 2008 requires plans to provide mental health and substance abuse benefits at the same level that benefits for medical and surgical related benefits are offered. Additional information and details can be found by visiting the Department of Labor's Mental Health Parity http://www.dol.gov/general/topic/health-plans/mental

Summary of Benefits and Coverage

As an employee, the health benefits available to you represent a valuable component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.
Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan provides a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. The SBC is available on the company intranet. A paper copy is also available, free of charge, by calling the Fedcap Benefit Service Center at 1-866-533-3227.

Legal Disclosures

Continuing Coverage Through COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows you, your spouse and your covered dependents to temporarily extend medical, dental and vision benefits and Health Care FSA in certain situations where coverage would otherwise end (like at your termination of employment or a reduction in hours). If you elect COBRA coverage, your benefits will continue for a defined period of time. Your spouse and dependent children can also continue coverage under COBRA upon a divorce, loss of dependent status, or if you decease. You will be required to pay the premiums for this continued coverage, which will be the full cost of the plan plus a 2% administrative fee. For more information about continuing coverage through COBRA, please refer to your Plan Documents or call the Fedcap Benefit Service Center at 1-866-533-3227 or benefitservicecenter@fedcap.org.

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 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 review 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 a day until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

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

Contact Information

Questions regarding any of this information can be directed to Donna Quinn, VP of Benefits at 212-727-4267 or dquinn@fedcap.org.

Legal Disclosures

Important Notice from Fedcap 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 The Fedcap Group and about your options under Medicare's prescription drug coverage. This information can help you decide if want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. Anthem BlueCross BlueShield has determined that the prescription drug coverage offered by The Fedcap Group is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from The Fedcap Group. This is also important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from The Fedcap Group. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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 decide to drop your current coverage with The Fedcap Group, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under The Fedcap Group.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under The Fedcap Group is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current The Fedcap Group coverage will not be affected. You may keep this coverage if you elect Part D and this plan will coordinate your Part D coverage.

If you do decide to join a Medicare drug plan and drop your current The Fedcap Group coverage, be aware that you and your dependents will [or will not] be able to get this coverage back.

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 The Fedcap Group 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.

Legal Disclosures

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).

Date:	November 1, 2025
Name of Entity/ Sender:	The Fedcap Group
Contact-Position/ Office:	Fedcap Benefit Service Center
Address:	c/o Benefit Management Solutions P.O. Box 2828 East Setauket, NY 11733

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 (1-877-543-7669) 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 –

Legal Disclosures

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 1-855-692-5447	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://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://mycohibi.com/ HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://health.alaska.gov/dpa/Pages/default.aspx	FLORIDA – Medicaid Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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
CALIFORNIA– Medicaid Website: Health Insurance Premium Payment (HIPP) Program-https://www.dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov	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 ServicesMedicaid 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	MONTANA– Medicaid Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KANSAS– Medicaid Website: http://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	NEBRASKA– Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
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	NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

Legal Disclosures

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	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
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	NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
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)	NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid Enrollment Website: https://www.maine.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: -800-977-6740 TTY: Maine relay 711	NORTH CAROLINA – Medicaid Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP Website: http://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	NORTH DAKOTA – Medicaid Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
MINNESOTA – Medicaid Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	OREGON – Medicaid Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	RHODE ISLAND – Medicaid and CHIP Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	SOUTH DAKOTA - Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059

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PENNSYLVANIA – Medicaid Website: https://www.pa.gov/en/services/dhs/apply-for-medic-aid-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)	UTAH – Medicaid and CHIP Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
SOUTH CAROLINA - Medicaid Website: https://www.scdhhs.gov Phone: 1-888-549-0820	VIRGINIA – Medicaid and CHIP Website: https://coverva.dmas.virginia.gov/learn/premiumassis-tance/famis-select https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
TEXAS– Medicaid Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	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)
VERMONT– Medicaid Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	WYOMING – Medicaid Website: https://health.wyo.gov/healthcarefin/medicaid/pro-grams-and-eligibility/ Phone: 1-800-251-1269
WASHINGTON – Medicaid Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	WISCONSIN – Medicaid and CHIP Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002

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:

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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.

Legal Disclosures

Important Notice from Fedcap about New Health Insurance Marketplace Coverage Options and Your Health Coverage

Part A: General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2025 for coverage starting as early as January 1, 2026.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if you employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit1.

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your plan documents or contact the Fedcap Benefit Service Center at 1-866-533-3227 or benefitservicecenter@fedcap.org.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

Legal Disclosures

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 shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums. This information is numbered to correspond to the Marketplace application.

3. Employer Name The Fedcap Group		4. Employer Identification Number (EIN) 83-0765672
5. Employer address 633 Third Avenue, 6th Floor		6. Employer phone number (212) 727-4200
7. City New York	8. State NY	9. ZIP Code 10017
10. Who can we contact about employee health coverage at this job? Donna Quinn		
11. Phone number (if different from above) (212) 727-4267		12. Email address dquinn@fedcap.org

Here is some basic information about health coverage offered by this employer:
As your employer, we offer a health plan coverage to employees who work 30 hours or more per week .
With respect to dependents, we offer coverage. Eligible dependents are:

- Your legal spouse
- Your dependent children

If checked, this coverage meets the minimum value standard[1], and the cost of this coverage to you is intended to be affordable, based on employee wages.
Note: 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.

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

October 28, 2025