



2021 EMPLOYEE BENEFITS GUIDE



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* F&M is not the plan sponsor or the plan fiduciary of the Aflac and United Pet Care voluntary employee-paid programs. As a result, these programs are not covered by the Employee Retirement Income Security Act of 1974, as amended (ERISA). Administration is performed by the respective vendor.

This guide provides a brief summary of the employee benefit plans in effect on April 1, 2021 (revised for changes effective January 1, 2022) for regular full-time benefits-eligible employees of Farmers & Merchants Bank of Long Beach and participating companies. It is not a Summary Plan Description (SPD). However, this guide serves as the "Summary of Material Modification" to our benefit plans in accordance with the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA). If there is a discrepancy between this guide and the applicable insurance contract, agreement, SPD, plan document or employee manual, the applicable insurance contract, agreement, SPD, plan document or employee manual will prevail.

Every effort is made to ensure this guide contains the most current information available. Please refer to the date of publication on the back cover and keep in mind a more current version may be available on the F&M Benefits Website.

This guide is not intended to be interpreted as a legal promise of benefits or guarantee of future or continued employment, or as stating provisions and terms of employment. Farmers & Merchants Bank, the participating companies and their respective employees recognize their mutual right to end their employment relationship at any time and acknowledge that such relationship is one of at-will employment.

Farmers & Merchants Bank, at its sole discretion, reserves the right to change (including, but not limited to, the right to amend, suspend or terminate) or make exceptions to its personnel policies, procedures and employee benefit plans, or to change employee contributions at its discretion at any time and without prior notice. The policies and employee benefit plans described in this document may vary from location to location to conform to applicable law or business unit needs.

Introduction

Introduction

At Farmers & Merchants Bank (also referred to as "F&M" or "the Bank" in this guide), employee benefits are an important component of your "total compensation" package. Our program provides employees with excellent plan design and flexibility when enrolling for coverage.

F&M recognizes that one size does not fit all, and that after your initial benefits enrollment period, you may need to make changes to your elections from time to time. That's why F&M provides you with a once-a-year opportunity (usually scheduled in February or March) to make changes to your benefits for the plan year that begins on the following April 1.

This guide briefly describes the F&M employee benefits program effective April 1, 2021 for regular full-time benefits-eligible employees. Please read this guide carefully so that you may make informed enrollment decisions. This guide should be kept with your other important F&M documents.

For the most up-to-date benefit plan information (including certificates of coverage and summary plan descriptions), visit the F&M Benefits Website or contact the F&M Benefits Hotline or Human Resources.



F&M Benefits Website

<https://fmb.mybenefits.teamcreativa.com>

or click the "F&M Benefits" tab from F&M's internal Human Resources website



F&M Benefits Hotline

(866) 318-1235

fmbenefits@teamcreativa.com



Human Resources

(562) 499-4809

As an employee of F&M, you are eligible for an array of health and welfare benefits, including:

- Medical/Prescription Drug Insurance
- Dental Insurance
- Vision Insurance
- Disability Insurance
- Life and Accident Insurance
- An Employee Assistance Program
- Several Voluntary Plans

Some benefits are paid entirely by the Bank and other benefits require that you share in the cost for your coverage. Refer to *Employee Contributions* for more information on the cost of coverage. In addition to your health and welfare benefits, the Bank also provides you with a gym membership program, a profit sharing and 401(k) plan, paid holidays and vacation and employee banking discounts.

Refer to the applicable sections of this guide for more details about each plan. If you have questions or require additional information, you may reach out to the appropriate contacts listed on the *Important Contact Information* page.

Eligibility and Enrollment

Benefit Plan Eligibility

You are eligible to participate in the F&M employee benefit plans if you are classified as a full-time employee regularly scheduled to work 36 or more hours per week.

You are not eligible for the F&M employee benefit plans if you are:

- An employee who is not classified as a regular full-time employee
- An individual who has signed an agreement, or has otherwise agreed, to provide services to the Bank as an independent contractor, regardless of the tax or other legal consequences of such an arrangement
- A leased employee compensated through a leasing entity, whether or not you fall within the definition of a leased employee as defined in Section 414(n) of the Internal Revenue Code

Certain plans also permit you to cover your eligible dependents, which include your:

- Legal spouse (unless legally separated) or a same/opposite-sex registered domestic partner* (also referred to as "DP" in this guide)
- Your child, including:
 - Biological child
 - Stepchild
 - Legally adopted child
 - A child who has been placed with you in anticipation of adoption

Children listed above must be under 26 years of age, regardless of whether that child qualifies as your dependent for federal income tax purposes.

Your dependent children who are age 26 or over and physically or mentally incapable of self-support may continue coverage beyond age 26 if they remain totally incapacitated and dependent on you for support.

If your spouse/registered domestic partner works for F&M, either you or your spouse/registered domestic partner can elect to cover your dependent children, but not both of you.

If your dependents (spouse, registered domestic partner and/or children) are active full-time employees of F&M or if they are on active duty in the military service of any country, they must obtain their own medical insurance (i.e., they cannot be enrolled as a dependent under your F&M medical plan).

Certain plans may have coverage and age restrictions due to insurance, state and/or federal regulations. Refer to the applicable section of this guide to ensure you understand the eligibility requirements for each of the plans.



In addition, you can also cover the following dependents if they are claimed as your dependent for federal income tax purposes:

- Your registered domestic partner's child*, and
- A child for whom you are the legal guardian/legal custodian

* In order to cover a domestic partner under the F&M benefit plans, you and your domestic partner must file a Declaration (or Confidential Declaration) of Domestic Partnership with the State of California. Visit www.sos.ca.gov/dpregistry for detailed state requirements. In addition, enrolling a domestic partner or child of a domestic partner will require you to complete a Tax Status Declaration Form.

Contact the F&M Benefits Hotline or Human Resources for additional information regarding benefit plan eligibility.

Initial Eligibility Period

You have a certain time frame to enroll yourself and your eligible dependents for coverage. This initial eligibility period begins on your first day of full-time employment, and ends 30 days after that date.*

If you do not enroll on or before the end of your initial eligibility period:

- You will have to wait until the next open enrollment to change your benefit elections (except as described in *Making Changes During the Year*)
- You will be automatically enrolled in the core benefit plans that are paid in full by the Bank (basic life, basic accidental death and dismemberment, and the employee assistance program)

Special enrollment rules apply if you terminate employment and are then rehired. Contact Human Resources for additional information.

* If you complete your enrollment after your effective date of coverage, retroactive payroll deductions will be calculated and may be withheld from your first paycheck after elections are made. You should enroll early to avoid retroactive payroll deductions.

Eligibility and Enrollment

How to Enroll

Enrolling for benefit coverage is easy! During the new hire onboarding process, you'll receive instructions on how to go online and complete your benefit plan elections. If you enroll any dependents, you'll need their name(s), Social Security number(s) and date(s) of birth.

After making your benefit elections, be sure to view and print a benefits confirmation statement. **You will not receive a confirmation statement from Human Resources.** If you need assistance enrolling for benefits, or if you have questions regarding your initial eligibility period and effective date, contact the F&M Benefits Hotline.

When Coverage Begins

The following table shows the dates your coverage will be effective under the various benefit plans for:

- Newly hired employees
- Employees who experience a qualifying event
- Changes made during open enrollment

The effective dates shown in this table assume enrollment has been properly completed and submitted timely.

For more details on when coverage begins for a specific employee benefit plan, refer to the applicable section of this guide.

Effective Date of Coverage for Selected Events			
Plans	New Hire Enrollment	Qualifying Event (Reported Within 31 Days)	Open Enrollment (OE)
Medical, Dental, Vision	On your first day of active full-time employment	Date of qualifying event	April 1 following OE period
Long Term Disability*		Not applicable	April 1 following OE period
Basic Life, Basic Accidental Death and Dismemberment (AD&D)		Not applicable	Not applicable
Optional Life*		Date of qualifying event	April 1 following OE period
Dependent Life*		Date of qualifying event	April 1 following OE period
Employee Assistance Program		Not applicable	Not applicable
Aflac Voluntary Plans	Varies based on date of enrollment (contact Aflac for more information)		April 1 following OE period
United Pet Care (UPC)	Varies based on date of enrollment (contact UPC for more information)		April 1 following OE period
Profit Sharing and 401(k)	On your first day of active full-time employment	Not applicable	Not applicable

* Your election may require you to submit evidence of insurability satisfactory to the insurance company before coverage is approved. The effective date of coverage will be the date the insurance company approves insurability. Evidence of insurability is not required for dependent children.

HIPAA Special Enrollment Rights

You have special enrollment rights if you acquire a new dependent, or if you decline coverage under the F&M health plans for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. Refer to the Legal Notices section titled *HIPAA Special Enrollment Rights* for more information or contact the F&M Benefits Hotline or Human Resources.



Eligibility and Enrollment

Making Changes During the Year

Generally, after you have made your benefit plan elections, you may only change those elections during the next annual open enrollment period. However, if you experience a qualifying event during the year and you want to make changes to your coverage, **you must notify Human Resources or the F&M Benefits Hotline within 31 days of the qualifying event date and provide the required supporting documentation** (e.g., marriage license, birth certificate, proof that you lost other coverage, etc.).

Your new election must be on account of the qualifying event, your supporting documentation must correspond with that change of coverage and the documentation must provide the specific date in which your coverage change took place.

Example: If you lost coverage under your spouse's medical plan effective July 1 and want to enroll in the F&M medical plan with no lapse in coverage, you must provide supporting documentation that proves you lost coverage on July 1 – this document must be submitted to Human Resources or the F&M Benefits Hotline no later than July 31 (i.e., within 31 days of your loss of coverage) in order for your mid-year change to be considered for approval.

A qualifying event is defined as an event that results in the gain or loss of eligibility by you or your dependents.

For example:

- A change in legal marital status
- A change in number of dependents
- A change in employment status
- Your dependent satisfies or ceases to satisfy the requirements for dependents, including a registered domestic partner or a registered domestic partner's child
- A change in residence or worksite by you or your dependent that causes a loss or gain of coverage

The rules regarding changes after your new hire enrollment and the open enrollment period are very specific; therefore, you should contact the F&M Benefits Hotline or Human Resources if you have any questions.

When Coverage Ends

The following table shows the dates your coverage ends under the various employee benefit plans.

Coverage for a dependent will end on the date your dependent no longer meets the definition of an eligible dependent or when your coverage ends (whichever occurs first).

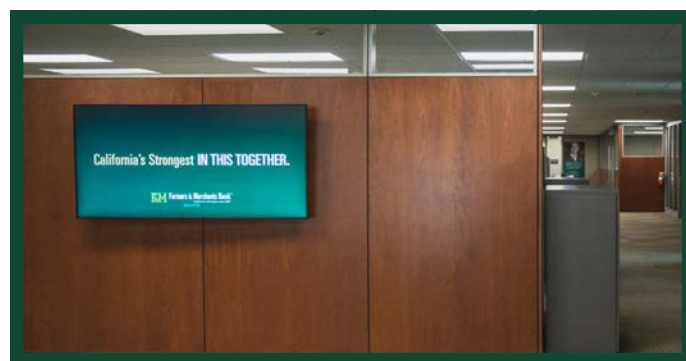
Benefit Plans	Last Day of Coverage
Medical ¹ Dental ¹ Vision ¹ Employee Assistance Program ¹ Aflac Voluntary Plans ² United Pet Care ²	The last day of the month in which your employment or benefits eligibility ends
Long Term Disability ³ Life and Accident ⁴ Profit Sharing and 401(k) ²	The last day in which your employment or benefits eligibility ends

¹ Eligible for COBRA continuation as long as you enroll and pay the premiums by the date designated on your COBRA notice. Within 14 days of your benefits termination date, you'll receive a packet in the mail from F&M's COBRA administrator outlining your continuation options, costs and enrollment deadlines. If you haven't received your COBRA packet and know you want to continue your medical, dental, vision and/or employee assistance program, contact the F&M Benefits Hotline or Human Resources.

² Contact the vendor directly within 31 days of your benefits termination date for options on how to continue your plan(s) on an individual basis.

³ If a qualified disability commences before your coverage terminates, you'll be eligible to receive LTD benefits. In addition, the LTD policy contains a conversion provision – you must apply within 60 days of your benefits termination date. Visit www.prudential.com/links/forms/group-insurance-employees for a link to the Group Long Term Disability Insurance Conversion Plan Kit.

⁴ The life insurance policy contains both conversion and portability provisions – you must apply within 31 days of your benefits termination date. Visit www.prudential.com/giconversions for more information or call (877) 889-2070 to schedule a complimentary consultation with a local licensed and registered financial professional who can help you understand your life insurance continuation options.



To make changes to your benefits mid-year, contact Human Resources or the F&M Benefits Hotline within 31 days of your qualifying event. You'll be provided with information on how to make changes to your coverage based on your (or your dependent's) qualifying event.

Medical

Medical

The medical plans offered by F&M are designed to help protect you and your covered dependents against financial loss by paying for a substantial portion of eligible expenses incurred for medically necessary care and treatment.

F&M offers five medical plans:

- Cigna CDHP Gold
 - Cigna CDHP Silver
 - Cigna CDHP Bronze HSA
 - Cigna Network HMO
 - MemorialCare Partnership 
- If you enroll for coverage within your initial eligibility period, your coverage will be effective on your first day of active full-time employment.
 - If you do not enroll for coverage within your initial eligibility period, you may enroll for coverage during the next open enrollment period or in accordance with *Making Changes During the Year*.

Your Cost

F&M pays most of the cost of providing you and your eligible dependents with medical coverage. Refer to *Employee Contributions* for the applicable cost.

Additional Health Coverage through Aflac

Did you know that in addition to the medical plan offerings, Aflac also offers coverage for specified health events, cancer protection, accidents and hospital benefits? Refer to *Aflac Voluntary Products* for more information.

Summary of Benefits and Coverage (SBC)

The Affordable Care Act requires that you have access to an SBC to help you understand and evaluate your health plan choices. To get a copy of the SBC for the F&M sponsored medical plans, contact the F&M Benefits Hotline at (866) 318-1235 or fmbenefits@teamcreativa.com.



Talking to Your Doctor and Preparing for an Appointment



Play an active role in your health care by talking to your doctor. Honest and clear communication between you and your physician can help you both make informed choices about your health. It's important to be truthful and upfront about your symptoms even if you feel embarrassed or shy and ask questions to make sure you understand your diagnosis, treatment, and recovery.

Here are a few tips that can help you talk to your doctor and make the most of your appointment:

- Write down a list of questions and concerns before your appointment
- Consider bringing a close friend or family member with you
- Take notes about what the doctor says, or ask a friend or family member to take notes for you
- Learn how to access your medical records, so you can keep track of test results, diagnoses, treatments plans, and medications and prepare for your next appointment
- Ask for the doctor's contact information and their preferred method of communication
- Remember that nurses and pharmacists are also good sources of information

Medical

Summary of Medical Plan Provisions

The following table summarizes the key features of the medical plans available to you and your eligible dependents. To receive the highest level of benefits, utilize in-network providers and fully understand what is expected of you. **Keep in mind that your provider's participation in your plan's network may change at any time, so it is important to verify that your provider is contracted with your plan's network prior to receiving services.** The CDHPs use the Open Access Plus network and the Network HMO plan uses the medical HMO network. The MemorialCare Partnership plan uses the MemorialCare Direct Network, which includes MemorialCare and UCLA Health providers.

F&M Medical Plans		
Plan Provisions	Cigna CDHP Gold ¹	
	In-Network	Out-of-Network
Calendar Year Deductible (ded.)	You Pay	
■ Individual		\$1,000
■ Family (employee + 1 or more dependents) ⁴		\$2,000
Calendar Year Out-of-Pocket Maximum		
■ Individual	\$3,000	\$6,000
■ Family (employee + 1 or more dependents) ⁵	\$6,000	\$12,000
Preventive Care Services	No copay ⁶	Not covered
Physician Services		
■ Office visits		
■ Specialist visits	10% after ded.	30% after ded.
■ Surgery in a physician's office		
Hospital Services		
■ Room and board, delivery		
■ Surgeon, assistant surgeon, anesthesiologist	10% after ded.	30% after ded.
■ Outpatient		
Emergency/Urgent Services		
■ Ambulance		
■ Emergency room		10% after ded.
■ Urgent care		
Other Services		
■ Lab, x-ray, diagnostic tests (other than preventive)		
■ Short-term physical and occupational therapy, speech therapy	10% after ded.	30% after ded.
■ Durable medical equipment		
Prescription Drugs (Retail – Up to 30 Day Supply)		
■ Tier 1 (Generic)	\$15 copay ⁸	
■ Tier 2 (Preferred Brand)	\$40 copay ⁸	Not covered
■ Tier 3 (Non-Preferred Brand)	\$60 copay ⁸	

¹ This plan uses the Cigna Open Access Plus Provider Network. Use Cigna's Find Docs & Services tool on your member website to help you search for providers and compare out-of-pocket estimates so that you can budget and plan for future health care expenses.

² This plan uses the Cigna Network HMO Provider Network. If you receive services outside of California, you may be billed different copays for Mental Health or Substance Use Disorder, depending on the facility you receive services.

³ This plan uses the MemorialCare Direct Network, which includes MemorialCare and UCLA Health providers. PCP referral is required on most services.

⁴ All plans have embedded deductibles. This means that the deductible will be met for an individual who meets the individual deductible prior to the family meeting the family deductible.

This summary is provided for general information only. In addition to deductible, copay and coinsurance amounts, you are responsible for out-of-network provider charges that are higher than the plan's allowable fee. Since exclusions, dollar/frequency limitations and prior authorization may apply in certain cases, you should talk to your doctor, contact Cigna or Centivo Concierge, and reach out to the F&M Benefits Hotline if you need further clarification.

Medical



F&M Medical Plans					
Cigna CDHP Silver ¹		Cigna CDHP Bronze ¹		Cigna Network HMO ²	MemorialCare Partnership ³ NEW
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network Only
You Pay		You Pay		You Pay	You Pay
\$2,000		\$3,500		None	None
\$4,000		\$7,000		None	None
\$8,550	\$17,100	\$7,000	\$14,000	\$2,000	\$2,000
\$17,100	\$34,200	\$14,000	\$28,000	\$5,000	\$5,000
No copay ⁶	Not covered	No copay ⁶	Not covered	No copay ⁶	No copay ⁷
20% after ded.	40% after ded.	10% after ded.	30% after ded.	\$20 copay \$40 copay \$20 copay (\$40 specialist)	\$10 copay \$40 copay \$10 copay (\$40 specialist)
20% after ded.	40% after ded.	10% after ded.	30% after ded.	\$300 copay per admission No copay \$150 copay	\$300 copay per admission No copay \$150 copay
20% after ded.		10% after ded.		No copay \$200 copay \$50 copay	No copay \$200 copay \$50 copay
20% after ded.	40% after ded.	10% after ded.	30% after ded.	No copay \$50 copay No copay	No copay \$50 copay No copay
\$15 copay ⁸ \$40 copay ⁸ \$60 copay ⁸	Not covered	\$15 copay after ded. ⁸ \$40 copay after ded. ⁸ \$60 copay after ded. ⁸	Not covered	\$15 copay ⁸ \$40 copay ⁸ \$60 copay ⁸	\$15 copay ⁹ \$40 copay ⁹ \$60 copay ⁹

⁵ Copays, deductibles and coinsurance apply toward the calendar year out-of-pocket maximum. All plans have embedded out-of-pocket maximums. This means that the out-of-pocket maximum will be met for an individual who meets the individual maximum prior to the family meeting the family maximum.

⁶ Visit www.cigna.com/individuals-families/understanding-insurance/preventive-care or contact Cigna member services for more information.

⁷ Contact Centivo Concierge for more information.

⁸ These plans use the Cigna Standard 3 Tier prescription drug list (available at www.cigna.com/drug-list). Use the Prescription Drug Price Quote tool on www.mycigna.com to price a medication and see the lower cost options available to you at your selected retail pharmacy and Cigna Home Delivery Pharmacy. In-network retail drugs (up to a 90-day supply) are available at three times the retail 30-day supply copay for the CDHPs and the Non-CA HMO plan only. In-network home delivery (mail order) drugs (up to a 90-day supply) are available at two times the retail 30-day supply copay for all plans. Specialty drugs are limited to a 30-day supply for all these plans.

⁹ This plan uses the drug list available at www.withmehealth.com/assets/documents/WMH-Premier-Plus-Formulary-Abridged_Jan-2021.pdf.

Medical – Cigna

Cigna Consumer Driven Health Plans (CDHPs)

F&M offers three CDHPs: Gold, Silver and Bronze. You should carefully understand the provisions of each plan before you make your medical election. The CDHPs are all about choice – choice of coverage level and choice of how you spend your health care dollars. You're in the driver's seat when it comes to your health care decisions. Regardless of the option you choose, all CDHPs offer comprehensive medical and prescription drug coverage, no-cost in-network preventive care and coinsurance after meeting your calendar year deductible. Deductibles and out-of-pocket maximums vary per plan/coverage option. In addition, the CDHPs have out-of-pocket maximum provisions (also known as a safety net) to protect you in the event of catastrophic medical expenses.

The CDHPs allow you the freedom to choose the doctors, other health professionals and facilities that work best for you. If you choose to receive services from medical providers and facilities contracted with Cigna's Open Access Plus network, you will pay lower costs and eliminate the need for paperwork. If you need to see a specialist, you do not need a referral to see a doctor who is contracted with Cigna's Open Access Plus network – just schedule the appointment and go. Pre-authorization may be necessary for hospitalizations and some types of outpatient care, but there's no paperwork for you.

You also have the freedom to visit doctors or use facilities that are not part of Cigna's Open Access Plus network, but your costs will be higher and you may need to file a claim.

Cigna Network HMO Plan

Cigna's Network HMO plan is designed to help you stay healthy. The HMO plan includes comprehensive medical and prescription drug coverage, no-cost in-network preventive care, no deductibles, and out-of-pocket maximum provisions (also known as a safety net) to protect you in the event of catastrophic medical expenses. The majority of eligible in-network services (except for preventive care) require you to pay a fixed dollar amount (i.e., a copay) to receive eligible medical services and prescription drugs. Copays count toward your out-of-pocket maximum.

Upon enrolling in the Cigna Network HMO plan, you choose a primary care physician (PCP) who is part of the Cigna network to serve as your personal doctor.



Out-of-network coverage is NOT covered, except in the case of an emergency.

Your PCP can treat you for a wide variety of conditions, provide preventive care, refer you to specialists and coordinate hospital care when needed. If you need to see a specialist, you will need to obtain a referral from your PCP. The only exception is OB/GYN services, for which you do not need a referral to receive care. Pre-authorization may be necessary for hospitalizations and some types of outpatient care, but there's no paperwork for you.

Your choice of a PCP may affect the facilities and specialists from which you may receive services – talk to your doctor or medical group for details. For instructions on how to choose a PCP, refer to *How to Search for a Cigna Primary Care Physician (PCP)*.

Cigna CDHP Comparison – Gold, Silver and Bronze

Here is a comparison of some key features of the Cigna Gold, Silver and Bronze CDHPs. A more detailed table is on pages 8 – 9.

Feature	CDHP Gold	CDHP Silver	CDHP Bronze
Deductible – The amount you pay upfront each calendar year before the plan starts to pay for your eligible medical expenses. You do not need to pay a deductible for in-network preventive care services.	\$1,000 (Individual) \$2,000 (Family)	\$2,000 (Individual) \$4,000 (Family)	\$3,500 (Individual) \$7,000 (Family)
Plans with higher deductibles and lower employee contributions provide the flexibility of paying more later (if necessary) in higher deductible costs.		X	X
Plans with lower deductibles and higher employee contributions provide the benefit of paying less later (if necessary) in lower deductible costs.	X		
Coinsurance – The percentage of the total eligible medical expenses you must pay once you satisfy your deductible (in-network percentages shown). Coinsurance payments count toward the out-of-pocket maximum.	10%	20%	10%
Out-of-pocket maximum – A safety net that limits how much you pay out of pocket in copays, deductibles and coinsurance for eligible medical and prescription drug expenses each calendar year (in-network maximums shown).	\$3,000 (Individual) \$6,000 (Family)	\$8,550 (Individual) \$17,100 (Family)	\$7,000 (Individual) \$14,000 (Family)
Health savings account (HSA)* – An interest-generating account you fund with after-tax contributions to help pay medical, prescription drug, dental and vision expenses. Your HSA rolls over year to year and is yours to keep, even if you change coverage, change employers or retire.	Not eligible	Not eligible	Maximum 2021 calendar year contribution**: \$3,600 (Individual) \$7,200 (Family)

* The state of California taxes the money you put in your HSA. Check with your tax advisor to see how your account is affected. HSA Bank partners with Cigna to administer your HSA. Visit www.hsabank.com/hsabank/learning-center/compare-your-health-plans for access to an HSA decision-support tool. For answers to frequently asked questions, visit www.hsabank.com/hsabank/learning-center/learning-center-frequently-asked-questions.

** If you are age 55 or above, the IRS allows you to contribute an additional \$1,000 per calendar year to your HSA. The IRS may change maximum contribution amounts in later calendar years.

Medical – Cigna

How to Search for a Cigna Primary Care Physician (PCP)

Your choice of a PCP may affect the specialists from which you may receive services. Before you finalize your PCP selection, you should check to see if the PCP is associated with the specialist you prefer to use. If the referral to the specialist is not possible, you should ask the specialist about which PCPs can make referrals to them, and then verify the information with the PCP before making your selection.

This also applies to facilities. Your choice of hospital, sub-acute or transitional care facilities, outpatient surgical facilities, or skilled nursing facilities is limited to those facilities that participate in your PCP's medical group or network. The selection of facilities for inpatient care, outpatient surgery or hospitalization may be further limited to facilities affiliated with your PCP's medical group or network. To receive a list of facilities that are contracted for sub-acute or transitional care, or for skilled nursing facilities, please contact Cigna at (800) 244-6224.

Locate a PCP online

1. Go to **www.cigna.com**
2. Select **Find a Doctor, Dentist or Facility** on the home page
3. Click **Employer or School**
4. Enter your location (**Address, City, or Zip**)
5. Choose **Doctor by Type** and select **Primary Care: All Specialties**
6. You must **Select a Plan** to ensure you're searching for PCPs contracted with the F&M Cigna plan
 - CDHP (Gold, Silver and Bronze) enrollees should select the medical plan option: **Open Access Plus, Open Access Plus Tiered** (do not choose the CareLink option)
 - HMO enrollees should select the medical plan option: **Southern California** (do not choose the Select or Value options)
7. You can **Sort, Filter by** or search using **More Options**
8. When you locate the PCP of your choice, click their name to view their information and PCP ID number; if you're not an existing patient, you'll want to make sure the provider is accepting new patients



Cigna Website

www.mycigna.com

First time visitors: Establish a user ID and password. Then, information is available 24/7.

Designate Your PCP

If you are enrolling in the medical plan for the first time, you can assign a PCP to yourself and your enrolled dependents during your initial enrollment period through the benefits enrollment website.

If you do not enter a valid PCP ID number for your Cigna HMO plan during your initial eligibility period, Cigna will automatically assign you and your dependents to a PCP based on your home zip code. You are not required to select a PCP if you are enrolled in a CDHP, but you are encouraged to select a PCP to help coordinate care and act as your personal health advocate.

You may voluntarily change your PCP, but not more than once per month, by contacting Cigna member services.

- If you select a new PCP before the fifteenth day of the month, the designation will be effective on the first day of the month following your selection
- If you select a new PCP on or after the fifteenth day of the month, the designation will be effective on the first day of the month following the next full month

For example, if you notify Cigna on June 10, the change will be effective on July 1. If you notify Cigna on June 15, the change will be effective on August 1.

Cigna Medical ID Cards

www.mycigna.com

To request a replacement medical ID card, submit the request on the myCigna website before going to your next doctor's appointment. If you need services before your card arrives, ask the health care provider to call Cigna Customer Service at (800) 244-6224 to verify your coverage information.

You can also always access an electronic version of your ID card in the myCigna mobile app.



Medical – Cigna



Cigna Lifestyle Management Programs

Manage your health with Cigna's no cost programs that are accessible both over the phone and online:

- Weight management
- Tobacco cessation
- Stress management

For more information and to start taking action now, go to www.mycigna.com or call (800) 244-6224.

Ask Your Cigna Doctor About After Hours Care

Contact your doctor during their regular business hours for instructions on how to receive medical care or prescription refills when their office is closed (such as weeknights, weekends and holidays). If you're part of the Network HMO plan, your PCP or medical group may have specific procedures you must follow when seeking care after hours.

You can also contact Cigna's 24/7 Health Information Line or initiate a video visit with a regular doctor through Cigna Telehealth Connection from any smart device with high-speed internet access and a camera with audio capability. For covered services related to mental health and substance abuse, you have access to the Cigna Behavioral Health network of providers.

If you have an urgent medical need that's not life-threatening when your doctor's office is closed, consider visiting an in-network urgent care facility which usually has shorter wait times and costs less than an emergency room.

Cigna Telehealth Connection (Virtual Doctor Visits)

Cigna provides access to telehealth services as part of your medical plan through MDLIVE. Cigna Telehealth Connection lets you get the care you need – including most prescriptions – for a wide range of minor conditions. You can connect with a board-certified doctor via video chat or phone, without leaving your home or office. Televisits with MDLIVE can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost much less than going to the emergency room. **The cost of a virtual doctor or phone visit is the same or less than with your primary care provider.** Remember, your telehealth services are only available for minor, non-life threatening conditions. In an emergency, dial 911 or go to the nearest hospital.

Choose when: Day or night, weekdays, weekends and holidays

Choose where: Home, work or on the go

Choose how: Phone or video chat

Choose who: MDLIVE doctors

Whether it's the middle of the night and your child is sick or you're at work and not feeling well, you can speak to a doctor and even get a prescription (if medically necessary) for the following conditions: sore throat, headache, stomachache, fever, cold and flu, allergies, rash, acne, UTIs, and more.

To begin your access to video chat and phone visits with doctors, register with MDLIVE today!

www.MDLIVEforCigna.com
(888) 726-3171

Signing up is easy!

1. Set up and create an account with MDLIVE
2. Complete a medical history using their "virtual clipboard"
3. Download vendor apps to your smartphone/mobile device



MDLIVE is only available for medical visits. For covered services related to mental health and substance abuse, you have access to the Cigna Behavioral Health network of providers. Go to <https://apps.cignabehavioral.com/web/consumer.do#/findAtherapist> to search for a video telehealth specialist. Once you select a behavioral health provider, call the number provided on the website to make an appointment. **Telehealth visits with Cigna Behavioral Health network providers cost the same as an in-office visit.**



Cigna customer service representatives are available 24/7 to take your calls at (800) 24-CIGNA (800-244-6224). You can also call the Cigna HealthCare 24-Hour Health Information LineSM at (800) 564-9286 to speak with a health care professional.

Medical – Cigna

Cigna Home Delivery (Mail Order) Pharmacy

Cigna's Home Delivery Pharmacy is designed especially for individuals who take prescriptions on an ongoing basis. When you choose Cigna Home Delivery Pharmacy to fill your ongoing medications, you can take advantage of the following:

- Licensed pharmacists available 24/7
- Up to a 90-day supply in one fill
- Standard delivery to your home or other preferred location at no additional cost
- Savings (obtain up to three months for the price of two months)
- Refill reminders (sign up to get reminders by email or text to help make sure you don't miss a dose)

Manage your medications 24 hours a day, 7 days a week:

- Visit www.mycigna.com or download the myCigna app on your mobile device – You can compare prices, track order and ship dates, see the number of refills you have left, and more
- Call (800) 835-3784 – Listen to the prompts and select the appropriate option to: receive a price quote, place your first order, enroll in the program, or place orders for refills

You can place your order through the mail or by phone:

Mail:

1. Request a prescription from your doctor for a 90-day supply with refills
2. Download an order form from www.mycigna.com
3. Mail the completed order form, the original prescription(s) and your payment to the address provided on the form

Phone:

1. Have the following information handy when you call:
 - Name and Cigna ID number
 - Prescription medication names and dosage (for you or a covered family member)
 - Doctor's information (name and phone number)
 - Payment information (American Express, Discover, MasterCard or VISA)
2. Call (800) 835-3784, listen to the prompts and select the appropriate option to enroll in mail order pharmacy
3. After your information is confirmed, Cigna will request a prescription from your doctor and mail it to your home or other location of your choice

To receive a price quote, log in to www.mycigna.com and visit the Prescription Drug Price Quote tool on the pharmacy home page or call (800) 835-3784, listen to the prompts and select the appropriate option to receive a price quote.

Amplifon Hearing Discounts*

The Cigna medical plans give you access to many Amplifon hearing benefits, such as:

- **Discounted prices** on hundreds of brand-name hearing aids
- **Low price guarantee** – if you find the same product at a lower price, Amplifon will beat it by 5%
- **Risk-free 60-day trial** – 100% money-back guarantee if you're not satisfied with the hearing aids
- **3-year warranty** – one of the longest in the industry
- **Free batteries** mailed directly to your home (max 160 cells per hearing aid, about a \$150 value)
- **Expert care** by a licensed and credentialed Amplifon hearing specialist, from the initial hearing test and hearing aid fitting through ongoing aftercare

Here's how easy it is to access your hearing benefits:

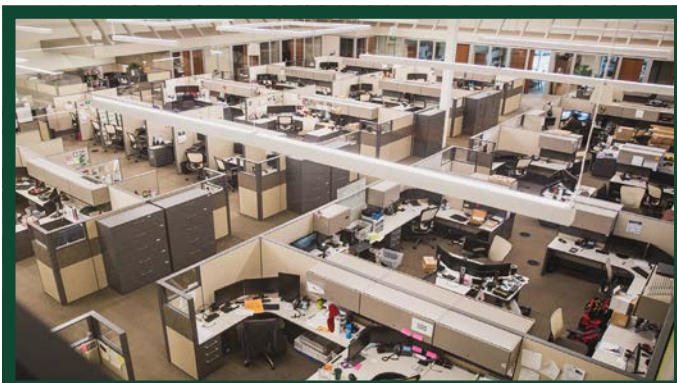
1. Call Amplifon at (888) 207-2798 to select your nearest hearing specialist
2. A Patient Care Advocate will explain the process and assist in making an appointment
3. Amplifon will send information to you and the hearing specialist prior to the appointment to ensure your Cigna benefit is activated

* This is not insurance. Cigna contracts with Amplifon to provide only discounts for its members.

Cigna Health and Well-Being Library

www.cigna.com/healthwellness

This online library is designed to give you information to stay educated about your health and health-related expenses. Whether you're looking for articles, tools, podcasts or simple health care term definitions, the library is your source for accurate information you can trust.





Medical – MemorialCare Partnership

NEW

MemorialCare Partnership Plan

The MemorialCare Partnership plan offers you comprehensive medical and prescription drug coverage, no-cost in-network preventive care, no deductibles, and out-of-pocket maximum provisions (also known as a safety net) to protect you in the event of catastrophic medical expenses. The majority of eligible in-network services (except for preventive care) require you to pay a fixed dollar amount (i.e., a copay) to receive eligible medical services and prescription drugs. Copays count toward your out-of-pocket maximum.

The plan is built around a partnership between you and your personally selected primary care physician (PCP) – your first stop for all your health care needs – with referrals to specialists as necessary. While referrals are not required for emergency care, OB/GYN or behavioral health, health care services provided by those other than your PCP team, must be preauthorized.



Out-of-network coverage is NOT covered, except in the case of an emergency.

The plan uses the MemorialCare Direct Network that focuses on high-quality care and a great patient experience. The health care provider network includes MemorialCare and UCLA Health providers giving you access to extensive on-site and virtual care options. WithMe Health is the prescription drug administrator.

- For more information about the MemorialCare Direct Network, visit www.memorialcare.org/FMB
- For more information about WithMe Health, download the WithMe Health app

Centivo is the claims administrator and has an easy-to-use app, member portal and a Concierge team for your support.



Centivo Concierge (833) 615-0793

Call the Centivo Concierge Monday through Friday from 5 am to 8 pm PT for assistance with:

- Benefits questions
- PCP activation
- Claims
- Prescription coordination
- Cost estimations

MemorialCare Navigation Center

The MemorialCare Navigation Center offers centralized appointment scheduling, helps with prescriptions, and can connect you with a nurseline 24/7. Their Patient Navigators can help you:

- Make or change appointments
- Find a primary care or specialist provider
- Obtain information about your prescriptions
- Get 24/7 access to a Telephone Advice Nurse

You can reach the MemorialCare Navigation Center at (877) 696-3622.

How to Search for a MemorialCare Direct Network Primary Care Physician (PCP)

You will not be restricted on where you can get specialist care based on who you choose as a PCP. While providers are likely to refer you to a specialist within their health system, your provider is able to refer you to specialists across health systems.

Locate a PCP online

1. Go to <https://fmb.centivo.com>
2. Select a **Specialty** from the dropdown list
3. Optionally, you can enter a **practitioner's name**
4. Enter your **Zip Code**
5. Click **Search**

All of the providers that are displayed are included in the MemorialCare Direct Network.

Designate Your PCP

After you've enrolled in the plan, you'll receive your member ID number from Centivo. You'll also be given instructions on how to activate your online account and choose an in-network doctor to lead your Primary Care Team to help you navigate the healthcare system and coordinate your care. You can change your designated PCP at any time, effective immediately.

Activation is quick and simple to complete online through the Centivo app, the member portal or by calling the Centivo Concierge Team.



MemorialCare Partnership Plan ID Cards

You can always access an electronic version of your ID card in the Centivo app or member portal at <https://my.centivo.com>. To request a new ID card, contact the Centivo Concierge Team at (833) 615-0793.

Medical – MemorialCare Partnership

Care Management Programs

Manage your health together with your provider through the following programs, available at no extra cost.

- **Maternity/Newborn Program:** Tech-integrated OB care with a dedicated app – BabyScripts.
- **Diabetes Program:** Interdisciplinary Care team approach including the PCP, Pharmacist, Registered Dietician, Case Manager (Social Worker), and medical assistant that provides one-on-one extended visits to help members get their diabetes under control.
- **Oncology Program:** Dedicated cancer institutes offering the full spectrum of cancer care and support services such as nurse navigation, screening programs, psychosocial and palliative care.
- **Disease Management Programs:** Patient support and management of specific conditions, such as asthma and congestive heart failure, including care plan development and medication review.

Your provider will notify you if you are eligible for a care management program.

Virtual Care

You can get virtual care from the providers you are already working with through a secure telehealth system. Utilizing a HIPAA-compliant and secure video platform, your provider can address concerns that may not require a detailed physical exam. The steps for setting up a virtual care visit are simple, but will differ based on whether you are using a MemorialCare or UCLA Health provider. Your provider will be able to help you if you have any trouble in scheduling or preparing for a virtual visit. You may use your smartphone or a computer with webcam capabilities. During a virtual visit, you can:

- Meet face-to-face with your provider or specialist
- Discuss an individualized care plan
- Ask medication questions and discuss test results
- Access and review your medical records
- Make follow-up appointments

To schedule an appointment with a MemorialCare provider, call the MemorialCare Navigation Center at (877) 696-3622. For those who sign up for the myChart app, a virtual visit may also be scheduled online. Additionally, MemorialCare offers virtual visits for non-emergency urgent care. You can view wait times and enter the virtual waiting room by visiting www.memorialcare.org/urgentcare.

To schedule a virtual care visit with a UCLA Health provider, call your doctor's office directly.

WithMe Health Prescription Drug Mobile App

www.go.withmehealth.com

WithMe Health manages the pharmacy benefits for the MemorialCare Partnership plan. Download the app to:

- Access your digital ID card and benefit information
- Manage your medications
- Find nearby network pharmacies
- Keep track of your drug costs and copays
- Get real time answers to any questions about your medications and pharmacy benefits

WithMe Health Member Support: (866) 840-1877

Mail Order Pharmacy

Mail order pharmacy is a great way to save money on your maintenance medications. WithMe Health, the prescription drug manager, is contracted with Costco Mail Order Pharmacy to provide an efficient mail order pharmacy for your ongoing maintenance medications. You do not need to be a Costco Member to use the Costco Mail Order Pharmacy.

To get started using the mail order pharmacy, you must register your information with Costco Mail Order Pharmacy using either of the following easy registration options:

- **Online** (recommended method): Visit www.costco.com/home-delivery and select **Get Started**. On the sign in page, select **New to Costco > Create an Account**. Your account will start within 24 hours. By registering online, you can also track the progress of your orders.
- **Mail:** Complete the Prescription Request Form, which you can request from the Centivo Concierge Team and submit it by mail to:

Costco Mail Order Pharmacy
215 Deining Circle
Corona, CA 92880-9911

Once your prescription is established, you can request prescription drug refills be mailed to your home. For assistance, call Costco Mail Order Pharmacy at (800) 607-6861.



MemorialCare Partnership Plan Member Portal

<https://my.centivo.com>

First time visitors: You will need your member ID number in order to create an account, which you will receive with your ID card. Then, information is available 24/7.

Dental

Dental

The dental plans offered by F&M are designed to assist you and your covered dependents by paying a portion of eligible expenses incurred for a wide range of dental services. The dental plans are insured by Cigna.

- If you enroll for coverage within your initial eligibility period, your coverage will be effective on your first day of active full-time employment.
- If you do not enroll for coverage within your initial eligibility period, you may enroll for coverage during the next open enrollment period or in accordance with *Making Changes During the Year*.

Your Cost

You pay the full cost of dental coverage. Refer to *Employee Contributions* for the applicable cost.



Cigna Website
www.mycigna.com

First time visitors: Establish a user ID and password. Then, information is available 24/7.

Cigna Dental Health Resources

www.cigna.com/healthwellness/dental-health-resources
Learn about changes you can make to benefit your teeth and your overall well-being by visiting this online library. It's designed to give you information to stay educated about your dental health.



Why is Dental Insurance Important?

Oral health is important, not only for looks, but for your general health as well. The American Dental Association recommends regular dental checkups because they can improve your health by helping you:

- **Prevent oral cancer:** An oral cancer screening is a routine part of a dental exam. Regular checkups, including an examination of the entire mouth, are essential in the early detection of cancerous and pre-cancerous conditions.
- **Prevent gum disease:** If diagnosed early, gum disease can be treated and reversed. Regular dental cleanings and checkups, flossing daily, brushing twice a day, and eating a balanced diet are key factors in preventing gum disease.
- **Help maintain good physical health:** Recent studies indicate there may be an association between oral health and serious health conditions such as cardiovascular disease and diabetes, underscoring the importance of good oral hygiene habits. Visiting your dentist regularly can help keep you and your smile healthy.
- **Prevent the need for advanced treatment:** Your dentist and hygienist will be able to detect any early signs of problems with your teeth or gums that can be easily treatable. If these problems go untreated, root canals, gum surgery and removal of teeth could become the only treatment options available.
- **Protect your children's health:** Regular checkups can help prevent tooth decay in your children, which if untreated, can cause decay so severe that the teeth cannot be repaired. Children need strong, healthy teeth to talk and to chew their food. Schedule your child's first dental visit when their first tooth appears. Treat your first dental visit as you would a well-baby checkup with your child's physician.

Dental

Cigna Dental PPO Plan

Cigna's dental PPO plan allows you to choose the dentists, specialists and other dental professionals and facilities that work best for you. You are not required to select a primary care dentist and you do not need a referral to receive care from a specialist. Whether you choose a dentist contracted in the Cigna dental PPO Advantage network or outside the network, your coverage will include a wide range of eligible services. Cigna's negotiated rates are available to you when you use in-network participating dentists or specialists.

By selecting a dentist or specialist contracted in Cigna's Advantage network (i.e., an in-network dentist), you will pay less for covered services. Dentists in the Advantage network will submit claims on your behalf. If you select a dentist who is not contracted in Cigna's Advantage network (i.e., an out-of-network dentist), your out-of-pocket expenses will generally be higher and you may be required to file your own claims.

Most diagnostic and preventive care procedures are covered at no cost or low cost to you when you visit a participating in-network dentist. For other services, you will pay a percentage of the cost (coinsurance amount) to the dentist at the time of service. Depending on the type of service, you may also be required to pay your calendar year deductible.

Cigna Dental HMO Plan

Cigna's dental HMO plan provides you with access to a network of dentists and other dental providers who have agreed to offer their services at predetermined rates. You may select a primary care dentist at the time of enrollment and you must receive services from this dentist when you need dental care. You and each covered member of your family may select a different primary care dentist. If you do not select a primary care dentist, one will be selected for you based on your home zip code.

Your primary care dentist will provide all of your services, including referrals as needed to specialists such as endodontists or periodontists. In addition, dentists in the HMO network will submit claims on your behalf.

Most diagnostic and preventive care procedures are covered at no cost or low cost to you when you visit an HMO dentist. For other services, you will pay a designated copay each time you receive care. There are no deductibles or calendar year maximums. Treatment rendered by out-of-network dentists is not eligible, except in emergency situations as determined by Cigna.

Your provider's participation in the Cigna network may change at any time, so it's important to verify that your provider is contracted with the Cigna network (dental PPO Advantage or dental HMO) before receiving services. For instructions on how to find a dental provider, refer to *How to Search for a Cigna Dentist*.

How to Maintain a Healthy Smile with your Dentist's Help

Here are some tips from the American Dental Association to help you take care of your smile:

- **Build a relationship.** Continuity of care is an important part of any health plan and dental health is no exception. When your dentist sees you regularly, they're in a good position to catch oral problems early. For instance, catching gum disease when it's still reversible, or cavities when they're small and are more easily treated.
- **Maintain.** Keeping your mouth healthy is essential to your overall well-being. It's important to keep your dentist informed of any changes in your health as well.
- **Talk about it!** Only your dentist can determine what the best treatment plan is for you. Have questions about your oral health or certain dental procedures? Start a conversation. Ask your dentist to explain step-by-step. Dentists love having satisfied, healthy patients.

Additional Dental Coverage through Aflac

Did you know that in addition to the Cigna dental plan offering, Aflac also offers dental coverage? Refer to *Aflac Voluntary Products* for more information.



Dental

Summary of Dental Plan Provisions

The following table summarizes the key features of the dental plans available to you and your eligible dependents. To receive the highest level of benefits, utilize in-network providers and fully understand what is expected of you.

F&M Dental Plans			
Provision	Cigna Dental PPO (Advantage Network) ¹		Cigna Dental HMO ²
	In-Network	Out-of-Network ³	In-Network Only
Calendar Year Maximum Benefits (per person)	\$1,000 - \$1,450 ⁴		None
Lifetime Orthodontia Maximum	\$1,000		None
	You Pay	You Pay	You Pay
Calendar Year Deductible (ded.)			
▪ Individual	\$50	\$100	None
▪ Family	\$150	\$300	None
Diagnostic and Preventive Services			
▪ Oral exams, routine cleanings, x-rays, fluoride application, sealants	0%	0%	No copay for most services
Basic Restorative Services			
▪ Fillings, simple extractions, anesthetics, major periodontics, minor periodontics, repairs (bridges, crowns, inlays and dentures)	20% after ded.	50% after ded.	Copays ranging from \$0 to \$90
Major Services			
▪ Oral surgery, root canal therapy, endodontics, crowns, inlays, onlays, dentures, bridges	50% after ded.	75% after ded.	Copays ranging from \$0 to \$425
Orthodontia Services (adults and dependent children)	50%	50%	Copays ranging from \$40 to \$1,800

¹ The Cigna dental PPO plan has a late entrant limitation. A late entrant is a person who: (a) becomes covered in the Cigna dental PPO plan more than 31 days after he or she is eligible; or (b) becomes covered again, after his or her coverage lapsed because he or she did not make required payments. During the first 24 months that a late entrant is covered by this plan, Cigna will provide only 50% coverage on major services and orthodontia (unless you or a family member is in the middle of active orthodontic treatment when you enroll in the Cigna dental PPO plan).

² The Cigna dental HMO plan uses a patient charge schedule to determine covered procedures and patient charges. Not all network dentists perform all listed services and it is suggested to check with your network dentist in advance of receiving services. Contact Cigna member services for the most recent copy of the patient charge schedule.

³ For services provided by a Cigna PPO Advantage Network dentist, Cigna will reimburse the dentist according to a contracted fee schedule. Cigna PPO Advantage Network dentists are not allowed to balance bill you for charges that exceed the contracted fee. For services provided by an out-of-network dentist, Cigna will reimburse based on the maximum reimbursable charge fee schedule. Using out-of-network providers may result in you being balance-billed by the provider.

⁴ Your plan encourages yearly visits to your dentist for preventive care. If you were enrolled in this dental PPO plan in the 2017, 2018, 2019 and 2020 plan years and received a preventive service during each of those years and you enroll for the 2021 plan year, your calendar year maximum benefits will be \$1,450. If you were enrolled in this dental PPO plan for the 2020 plan year and did not receive a diagnostic/preventive service, or if you are enrolling in this dental PPO plan for the first time, your calendar year maximum benefits will be \$1,000.

This summary is provided for general information only. Since exclusions, dollar/frequency limitations and prior authorization may apply in certain cases, you should refer to the specific plan documents available on the F&M Benefits Website for detailed information.

Dental Provider Definitions

Endodontist: Treats diseases of the tooth root, dental pulp and surrounding tissue

Oral Surgeon: Specializes in the surgical treatment of the jaw, face and teeth

Orthodontist: Prevents and corrects irregularities of the teeth using braces

Pedodontist (or Pediatric Dentist): Treats children

Periodontist: Studies and treats gum disease

Prosthodontist: Treats and corrects missing teeth using dental implants, dentures, crowns and some cosmetic procedures

How Do I Know Which Types of Dentistry I Need?

Your general dentist or physician will refer you for any types of dentistry they're not qualified to provide.

It's important to see your general dentist at least once a year – not just for teeth cleaning, but for an examination that ensures your oral health. Receiving a professional opinion will help you manage any potential problems before they become significant. See your general dentist immediately if you're experiencing any pain in your mouth.

Dental

How to Search for a Cigna Dentist

1. Go to **www.cigna.com**
2. Select **Find a Doctor, Dentist or Facility** on the home page
3. Click **Employer or School**
4. Enter your location (**Address, City, or Zip**)
5. Choose **Doctor by Type** and select **General Dentist**
6. You must **Select a Plan** to ensure you're searching for dentists contracted with the F&M Cigna plan
 - PPO enrollees should select the dental plan option: **Cigna DPPO Advantage** (look for dentists who are "Cigna DPPO Advantage" on the search results page because they may provide a better benefit level with greater savings)
 - HMO enrollees should select the dental plan option: **Cigna Dental Care Access (formerly Cigna Dental Care HMO)**
7. You can **Sort, Filter by** or search using **More Options**
8. When you locate the dentist of your choice, click their name to view their information (if searching for an HMO dentist, you can see the dentist's "DHMO Office Number" for assigning your primary care dentist); if you're not an existing patient, you'll want to make sure the provider is accepting new patients

If you are enrolling in the Cigna dental HMO plan for the first time, you can assign a dentist to yourself and your enrolled dependents during your initial enrollment period through the benefits enrollment website.



If you do not enter a valid DHMO office number for your Cigna dental HMO plan during your initial eligibility period, Cigna will automatically assign you and your dependents to a dentist based on your home zip code. You are not required to select a primary care dentist for your Cigna dental PPO plan.

You may voluntarily change your primary care dentist, but not more than once per month, by contacting Cigna member services.

- If you select a new primary care dentist before the fifteenth day of the month, the designation will be effective on the first day of the month following your selection
- If you select a new primary care dentist on or after the fifteenth day of the month, the designation will be effective on the first day of the month following the next full month

For example, if you notify Cigna on June 10, the change will be effective on July 1. If you notify Cigna on June 15, the change will be effective on August 1.

Cigna Dental PPO Online Dental Tools

www.mycigna.com and the myCigna mobile app

- **Brighter ScoreSM**. Compare dentists based on scores for affordability, patient experience and professional history.
- **Dental office reviews and comparisons.*** Find detailed information to compare dental offices. View dentist profiles with pictures and video content. Read verified patient reviews.
- **Online appointment scheduling.*** Book an appointment online with participating dentists.
- **Enhanced search and transparent pricing.** Search for a dentist by a procedure or group of procedures. Information is personalized for your specific plan, showing your out-of-pocket costs, including coinsurance and deductibles.
- **Easy 24/7 access.** These features are available anytime, anywhere on mobile phones or tablets.

* Online appointment scheduling and profile features may vary by dentist.



Vision

Vision

F&M understands the importance of taking care of your eyesight. The vision plans offered by the Bank promote preventive care through regular eye exams and early corrective treatment. The vision plans are insured by Vision Service Plan (VSP).

- If you enroll for coverage within your initial eligibility period, your coverage will be effective on your first day of active full-time employment.
- If you do not enroll for coverage within your initial eligibility period, you may enroll for coverage during the next open enrollment period or in accordance with *Making Changes During the Year*.

Your Cost

You pay the full cost of vision coverage. Refer to *Employee Contributions* for the applicable cost.

Why is Vision Insurance Important?

According to the National Eye Institute, more than 11 million Americans have an uncorrected visual impairment that can impact their quality of life. Getting an annual eye exam can help prevent vision problems before they start. Who should get an eye exam, when and why?

- **Babies:** About 80% of what babies learn is through their eyes (schedule an eye exam at six months, between two and three years old and before kindergarten)
- **Children:** One in four children have vision problems that can interfere with learning and behavior (schedule an eye exam once a year, preferably around the beginning of the school year to give your child a healthy start)
- **Adults:** Even if you had laser vision surgery or have naturally good vision, you can still encounter vision problems (schedule an eye exam once a year)
- **Seniors:** As we age, we're more susceptible to cataracts, glaucoma and macular degeneration (schedule an eye exam once a year)
- **People with diabetes:** Diabetes is the third leading cause of blindness in the United States (most diabetes-related blindness can be prevented by an annual eye exam)
- **Contact lens wearers:** Contact lenses are medical devices, so regular exams with your eye doctor and review of your prescription are important (schedule a contact lens evaluation and fitting once a year)



VSP Exclusive Member Extras and Discounts

Save 30-60% on hearing aids with VSP and TruHearing:

TruHearing offers significantly reduced out-of-pocket costs on hearing aids for all VSP members and their families (including parents). You can combine these discounts with your medical plan insurance to further minimize your out-of-pocket expenses. For more information, visit www.truhearing.com/vsp or call (877) 396-7194.

For information on additional savings, visit

www.vsp.com/specialoffers: Discover great deals on glasses, sunglasses, contact lenses, LASIK, diabetic care supplies with home delivery, theme parks, movie tickets, travel offers and much more.



How to Search for a VSP Doctor

To find a VSP doctor, go to www.vsp.com and use the **Find a Doctor** tool from the home page. After you select **Choice** from the "Doctor Network" section, you can search by location, office name, or doctor name.

EnVision E-Newsletter

www.vspenvisionnewsletter.com

Read up on the latest in eye health, trends and technology from leading vision experts.



VSP Website

www.vsp.com

First time visitors: Establish a user name and password. Then, information is available 24/7.

Vision

Summary of Vision Plan Provisions

The following table summarizes the key features of the vision plans available to you and your eligible dependents. To receive the highest level of benefits, utilize in-network (VSP Choice) providers and fully understand what is expected of you.

F&M Vision Plans				
Provision	Full Feature		Exam Plus Allowance	
	VSP Choice Network	Out-of-Network	VSP Choice Network	Out-of-Network
Annual Copay - Exam - Prescription glasses - Contact lens evaluation and fitting	You Pay		You Pay	
	\$10 copay \$25 copay Up to a \$60 copay		No copay No copay No copay	
	Plan Pays		Plan Pays	
Vision Exam (once every 12 months)	100%	Up to \$45	100%	Up to \$43
Lenses (complete set, not per lens; once every 12 months) - Single vision - Bifocal - Trifocal - Lenticular	100%	Up to \$30	Up to \$40 allowance	
	100%	Up to \$50		
	100%	Up to \$65		
	100%	Up to \$100		
Frame (once every 24 months)	Up to \$180	Up to \$70	Up to \$60 allowance	
Contacts (once every 12 months in lieu of lenses and frames) - Visually necessary (prior authorization required) - Elective	100%	Up to \$210	Up to \$150 allowance	
	Up to \$150	Up to \$105		
Low Vision Care As necessary for severe visual problems not corrected with regular lenses (limited to a maximum benefit of \$1,000 every two calendar years) - Supplemental testing - Supplemental aids	100%	Up to \$125	Not covered Not covered	
	75%	75%		

This summary is provided for general information only. Since exclusions, dollar/frequency limitations and prior authorization may apply in certain cases, you should refer to the specific plan documents available on the F&M Benefits Website for detailed information.

Using an In-Network Versus an Out-of-Network Provider			
The plan gives you options when it comes to receiving eye care. You may receive services from either VSP Choice providers or out-of-network providers. Although you are not required to use VSP Choice providers, your out-of-pocket costs will be lower when in-network providers are used. This table compares some of the key differences between receiving care from an in-network versus an out-of-network provider.	In-Network		Out-of-Network
	Provider	Must use a VSP in-network (Choice) provider	Use any licensed eye care provider outside the VSP network
	Benefit Authorization	Your in-network provider obtains authorization from VSP when you make your appointment and identify yourself as a VSP member	See out-of-network provider and submit for reimbursement
	Benefits	The plan pays a higher benefit level, which means less out-of-pocket cost for you	The plan pays a lower benefit level, which means more out-of-pocket cost for you
	Claims	Your provider files claims on your behalf	You must file your own claims with VSP
	Additional Discounts and Savings	Available, which means your share of the cost for additional purchases will be less (e.g., LASIK surgery, etc.)	Not available

Whether you use an in-network or out-of-network provider, benefit authorization is required before you receive services.

VSP Doesn't Mail ID Cards

ID cards are not required for services. The provider locates you in VSP's system with the primary subscriber's SSN. If you'd like a printout, log in to www.vsp.com, select **Member Details** > **My Member ID Card** and **Print**.

Disability

Disability Program

The F&M disability program is designed to replace a portion of your income if you are unable to work due to an accident or sickness. It covers you continuously for both short term and long term benefits for qualifying disabilities.

The program is comprised of three plans that help protect you and your family. These coverages also provide the vital support, services and assistance you need to get back to work and to an independent lifestyle.

The following table provides highlights of the plans.

Disability Program			
Plan	Benefit Percentage	Maximum Benefit	Benefit Begins
Sick Pay	100%	100% of base pay	Refer to policy
CA SDI	Up to 70%	\$1,540/week	8th day
LTD	60%	\$10,000/month	181st day

This summary is provided for general information only. Refer to the specific plan documents available on the F&M Benefits Website for detailed information on complete plan provisions, exclusions and limitations.

Sick Leave Policy

The Bank recognizes that a short term illness may cause you to be absent from work from time to time. The Sick Leave Policy is designed to provide pay continuation for those absences. You are automatically enrolled for coverage on your first day of active full-time employment. You will accrue sick leave in accordance with a schedule that's based on your Position Title/Classification. You are eligible to use accrued sick leave time after you have completed ninety (90) days of continuous service.

Upon written or oral request, you may use sick leave for the following purposes:

- Diagnosis, care, or treatment of an existing health condition, or preventive care for you or a family member; or
- If you are a victim of domestic violence, sexual assault, or stalking.

"Family member" means any of the following: (1) a child, which means a biological, adopted, or foster child, stepchild, legal ward, or a child to whom you stand in loco parentis, regardless of age or dependency status; (2) a biological, adoptive, or foster parent, stepparent, or legal guardian of you or your spouse or registered domestic partner, or a person who stood in loco parentis when you were a minor child; (3) a spouse; (4) a registered domestic partner; (5) a grandparent; (6) a grandchild; and (7) a sibling.

Accrual of Sick Leave*

Sick leave benefits are provided to eligible employees using the lump sum method, annually. The allocation of sick leave is based on position title/classification in the following table. This allocation is available for use annually beginning January 1st.

Position Title/Classification	Annual Sick Leave
Vice Presidents and Above	15 days
Full-Time – Non-Titled Employees and Titled Officers below Vice President	9 days
Part-Time Employees	7 days
Seasonal Employees	3 days

* Annual sick leave accrual is prorated for new employees who have completed less than a full year of service as of December 31.

Sick Pay Carried Over From Year to Year

Unused sick leave will be carried over from year to year up to a maximum of 45 days. You will not receive further sick leave beyond the maximum.

Requesting the Use of Sick Leave

When foreseeable, you must notify your supervisor in advance of your scheduled work time. If the need for paid sick leave is unforeseeable, you shall provide notice of the need for the leave as soon as practicable. You are required to notify your supervisor on the first day of your sick leave absence and every subsequent day unless on an extended leave as detailed in a physician's note provided to the Bank.

If you are returning from an absence due to illness or injury of three (3) or more consecutive workdays, you may be required to provide a health care provider's release to return to work.

You may use sick leave in the smallest increment used by the Bank to track employee working time.

For non-exempt employees, sick leave will be calculated based on the regular rate of pay for the work week in which you use sick leave. For exempt employees, sick leave will be paid at the rate being earned at the time the sick leave is taken.

Sick leave benefits are not integrated with benefits provided under State Disability Insurance. In no event shall the combination of disability benefits, plus sick leave benefits, exceed regular earnings.

Suspected abuse of sick leave may result in disciplinary action up to and including termination of employment.

Cashing Out Unused Sick Leave

You are not paid for unused sick leave upon separation of employment. If you are reemployed with the Bank within one year of separation, you will have your unused accumulated sick leave reinstated and it will be available to utilize effective your first day of rehire.

Disability

California State Disability Insurance (SDI)

As an F&M employee working in California, you are automatically enrolled and covered under SDI.

If you are unable to work as a result of a sickness or injury, SDI provides up to 70% of your earnings for up to one year. The maximum weekly benefit is \$1,540 in 2022.

Refer to www.edd.ca.gov/disability/Disability_Insurance.htm for additional information regarding California SDI.

Short Term Disability (STD) Plan

Turn to page 31 to learn about Aflac's STD offering.

Long Term Disability (LTD) Plan

The LTD plan, insured by Prudential, helps to protect you in the event of an illness or injury that continues for a period beyond the time covered by sick pay or California SDI.

- If you enroll for coverage during your initial eligibility period, your coverage will be effective on your first day of active full-time employment.
- If you do not enroll for coverage within your initial eligibility period, you may only enroll for coverage during the next open enrollment period.

You should keep in mind that if you enroll after your initial enrollment period, you will be required to provide evidence of insurability satisfactory to the insurance company before the coverage will become effective.

LTD benefits begin after you have been disabled for 180 days, as determined by the insurance company. LTD benefits pay up to 60% of your pay to a maximum of \$10,000 per month.

Generally, LTD benefits continue as long as you remain totally disabled, up to your normal retirement age* if your disability begins before you attain age 61 (after age 61, benefits continue according to a schedule).

* Your normal retirement age is your retirement age under the Social Security Act, where retirement age depends on your year of birth.

LTD benefits will be reduced by any other benefits you may be eligible to receive such as state disability benefits, workers' compensation or Social Security disability benefits.

Keep in mind that you will be eligible to receive LTD benefits if a qualified disability commences before your coverage terminates. In addition, the LTD policy contains a conversion provision – you must apply within 60 days of your benefits termination date. Visit www.prudential.com/links/forms/group-insurance-employees for a link to the Group Long Term Disability Insurance Conversion Plan Kit. If you need additional assistance, contact the F&M Benefits Hotline or Human Resources.

Your Cost

F&M pays the entire cost of the sick leave policy. You pay the full cost of California SDI and the STD and LTD plans. Refer to *Employee Contributions* for the applicable cost.



Life and Accident

Life and Accident Insurance

The life and accident insurance plans provide you with basic life and accident insurance paid for by the Bank.

In addition, you may purchase optional life insurance for you or you and your dependents at group rates. The life and accident plans are insured by Prudential.

The following table summarizes the coverage that is available.



F&M Life and Accident Insurance Plans					
Plan	Coverage Available			Enrollment Required to Participate	Paid By
	Employee	Spouse/DP ¹	Children		
Basic Life	Two times base pay; maximum \$80,000	–	–	No	F&M
Basic AD&D	Two times base pay; maximum \$80,000	–	–	No	F&M
Optional Life²	\$25,000 – \$500,000 (in increments of \$25,000)	–	–	Yes	Employee
Dependent Life	–	\$10,000 – \$250,000 (in increments of \$10,000)	\$2,500 – \$10,000 (in increments of \$2,500)	Yes	Employee

¹ If you're a first-time eligible employee and enroll your spouse/DP for an amount of coverage that exceeds \$30,000, your spouse/DP will be required to provide evidence of insurability satisfactory to the insurance company before coverage in excess of \$30,000 will become effective. Refer to *Dependent Life – Spouse/DP* for additional plan rules.

² If you're a first-time eligible employee and enroll for an amount of coverage that exceeds \$200,000, you'll be required to provide evidence of insurability satisfactory to the insurance company before coverage in excess of \$200,000 will become effective. Refer to *Optional Life* for additional plan rules.

This summary is provided for general information only. Certain maximums apply to each level of coverage and the evidence of insurability and confinement for care provisions may limit coverage. In addition, life and AD&D coverage is reduced according to an age reduction schedule beginning at age 70. Refer to the specific plan documents available on the F&M Benefits Website for detailed information on complete plan provisions, exclusions and limitations.

Beneficiary Designations: Review and Update Year-Round

When you enroll, you must provide your beneficiary designations. You should also keep in mind that changes in your family status (such as marriage, divorce or new children) do not automatically alter or revoke your previous designations. Therefore, it's important that you review your beneficiary designations from time to time. You can designate a beneficiary or change your previously designated beneficiary on the benefits enrollment website or by contacting the F&M Benefits Hotline.



Life and Accident



Basic Life

You are automatically enrolled for basic life insurance on your first day of active full-time employment.

Basic life insurance is equal to two times your annual base pay rounded to the next higher multiple of \$1,000, if the coverage amount is not a multiple of \$1,000. The maximum amount of basic life insurance is \$80,000.

If your pay changes, your basic life and AD&D insurance amounts will automatically change on the first of the month immediately following the date of the change in your pay.

Based on current tax laws and the amount of your basic life insurance coverage, you may have imputed income that represents the value (as prescribed by the IRS) of your Company-paid life insurance coverage in excess of \$50,000. Any imputed income applicable to you will be shown on your paycheck stub and on your W-2.

Base Pay Definition

For life and accident insurance purposes, your base rate of pay excludes overtime and any other forms of extra compensation.

For example:

- An hourly employee's annual base pay is calculated by multiplying the hourly base rate times 2,080 hours worked in a year, even though you may work more hours in a year
- A salaried employee's annual base pay is calculated by multiplying the pay period base rate times 26, or the monthly rate times 12

Basic AD&D

You are automatically enrolled for basic accidental death and dismemberment (AD&D) insurance on your first day of active full-time employment.

The principal amount of your basic AD&D insurance is equal to two times your annual base pay, rounded to the next higher multiple of \$1,000, if the amount is not a multiple of \$1,000. The maximum amount of basic AD&D insurance is \$80,000.

If your pay changes, your basic AD&D insurance amounts will automatically change on the first of the month immediately following the date of the change in your pay.

Your basic life and AD&D coverage reduces automatically on the first of the month following attainment of the specific age in the following table:

Age	Percent of Available Amount
70	65%
75	50%

Coverage reductions due to age are not subject to rounding.

Life and Accident

Basic AD&D Benefit Schedule

The following table shows losses that are covered under the accident plan and the corresponding benefit amounts shown as a percentage of the covered person's principal amount. These benefit amounts will be paid only if:

- Your death occurs within 365 days from the date of the accident; or
- Your injury results in one or more covered losses listed below within 365 days from the date of the accident

Injury means bodily impairment resulting directly from an accident and independently of all other causes.

Covered Loss	Percentage of Principal Amount
Life	
Both hands, both feet, sight of both eyes or combination of any two	100%
Speech and hearing	
Quadriplegia (total paralysis of upper and lower limbs)	
Paraplegia (total paralysis of both lower limbs)	75%
Hemiplegia (total paralysis of upper and lower limbs on one side of the body)	50%
Hand, foot or sight in one eye	
Speech or hearing	
Thumb and index finger of same hand	25%

If a person suffers more than one covered loss as a result of the same accident, only the largest benefit amount will be paid.



Basic AD&D Special Benefits

There are several additional special benefit payments provided under the accident plan, which may be payable in the event of a covered loss. A covered loss must be incurred before any of the special benefits become eligible for payment.

Special Benefit Provisions

Air Bag – The least of: (1) 10% of your insurance amount or (2) \$10,000

Child Care (payable annually for up to four consecutive years) – The least of: (1) the annual cost charged by the day care center, (2) 1% of your insurance amount, or (3) \$2,000

Child Education – The least of: (1) the actual tuition (exclusive of room and board charged by the school), (2) 1% of your amount of insurance, or (3) \$2,500

Coma – 1% of the principal sum per month for up to 11 months

Disappearance – Up to the full amount

Exposure – Up to the full amount

Felonious Assault – 5% of the principal sum

Return of Remains – The least of: (1) the amount of covered expenses or (2) \$2,500

Seat Belt – The least of: (1) 10% of your insurance amount or (2) \$10,000

Spouse Tuition – The least of: (1) the tuition charged for the program, (2) 1% of your insurance amount, or (3) \$2,500



Life and Accident

Life Insurance for the Various Stages of Life

People give birth and death a lot of attention. But when you think about it, the stuff in the middle is what life is all about: education, work, marriage, children, home ownership, and retirement. Review the events below to determine why Prudential life insurance is so important at each stage of your life.



Marriage

Marriage is often the first time people start thinking about life insurance. You'll want to make sure your partner has the cash available to help pay funeral expenses, keep up with bills, and eliminate debt.



Buying Property

A home purchase may be the single largest investment you make. If you die with an outstanding mortgage, will your dependents be able to cover that monthly responsibility? Money from a life insurance policy may help your family stay in their home.



Having Children

There's nothing like holding your newborn and putting life's priorities into perspective, including the thought of life insurance. From baby formula to college degrees, it's likely you'll be paying for it all. So what will happen to your kids if you die and your income's gone? Will your family be able to stay in their home? Will college still be an option? Life insurance can help replace your income for your growing family and may keep their dreams alive.



Working Years

It's likely you'll spend most of your adult years building your career. As your skills enhance and income increases, you may take on new expenses – a growing family, a bigger home, college tuition. Life insurance can provide money to help protect all that you've achieved in life.

Things to Consider About Life Insurance

Most people don't like to think about needing life insurance. But when an unexpected death happens to a wage earner, we realize how important life insurance can be. You can minimize the impact of an unexpected death by selecting the right amount of life insurance.



Starting Over

Getting divorced, losing a spouse, remarrying, and starting a new family are all reasons to reevaluate your finances. Your life insurance coverage and beneficiaries should be reviewed, too. Consider if your coverage amount needs to be updated to accommodate a new budget, such as additional coverage for yourself or any new dependents.



Pre-Retirement

Who among us isn't looking forward to retirement? Maybe you want to travel, buy a new home, or simply relax in your own backyard. You can do whatever you want, as long as you plan for it. Life insurance can provide a death benefit to your spouse, children, other beneficiaries and/or favorite charity when you die.



Leaving a Legacy

You've spent a lifetime accumulating wealth and you want to pass it on to your loved ones. However, you'll need to consider the fact that passing on assets to family also means you're passing on a potential tax bill. The funds received from life insurance can help them pay the tax bill. It may even enable you to leave them more than you originally anticipated.



Life Insurance Needs Estimator

How much life insurance is enough? Get a quick estimate at www.prudential.com/financial-education/life-insurance-calculator.

Life and Accident

Optional Life

Optional life insurance is available in amounts of \$25,000 – \$500,000 in increments of \$25,000.

- If you enroll for an amount of coverage of \$200,000 or less during your initial eligibility period, coverage will be effective on your first day of active full-time employment.
- If you enroll for an amount of coverage that exceeds \$200,000, you will be required to provide evidence of insurability satisfactory to the insurance company before coverage in excess of \$200,000 will become effective.

If you want to enroll or increase coverage during the next open enrollment period or in accordance with *Making Changes During the Year*, you will be limited to two benefit level increases (up to \$50,000, without evidence of insurability). However, if you enroll for an amount of coverage that exceeds \$50,000, or for a total amount of coverage above \$200,000, you will be required to provide evidence of insurability satisfactory to the insurance company before your new coverage amount will become effective.

Your optional life coverage reduces automatically on the first of the month following attainment of the specific age in the following table:

Age	Percent of Available Amount
70	65%
75	50%

Coverage reductions due to age are not subject to rounding.



When You Need to Submit EOI for Optional Life

You will be required to provide evidence of insurability (EOI) satisfactory to the insurance company before coverage can become effective if:

- You want to enroll for an amount of coverage that exceeds \$200,000;
- You want to enroll for or increase coverage more than two benefit levels (i.e., above \$50,000) during open enrollment;
- You want to enroll for or increase coverage more than two benefit levels (i.e., above \$50,000) following a qualifying event; or
- You have previously been denied coverage.

For example:

- You currently have \$200,000 of coverage. Next open enrollment, you want to increase your coverage \$50,000 (for a total of \$250,000 of coverage). You will be required to submit EOI before the coverage is approved.
- You are a new hire who elects \$25,000 of coverage. Next open enrollment, you can increase your coverage \$50,000 (for a total of \$75,000 of coverage) without submitting EOI.
- You waived coverage as a new hire. You get married, so you want to enroll for optional life coverage as a result of your marriage (a qualifying event). You can automatically be approved for \$50,000 of coverage. Any amount over \$50,000 will require EOI.
- You have previously submitted EOI and Prudential denied your request for coverage. You will be required to submit EOI before any amount of coverage is approved (even for \$50,000 of coverage).

Contact the F&M Benefits Hotline if you are unsure whether or not you need to submit EOI.

Life and Accident

Dependent Life – Spouse/DP

Dependent life insurance for your spouse/DP is available in amounts of \$10,000 – \$250,000 in increments of \$10,000.

The maximum amount of dependent life insurance **is the lesser of:**

- Your combined basic and optional life amount; or
 - \$250,000
- If you enroll your spouse/DP for an amount of coverage of \$30,000 or less during your spouse/DP's initial eligibility period, coverage will be effective on the first day your dependent is eligible.
 - If you enroll your spouse/DP for an amount of coverage that exceeds \$30,000, your spouse/DP will be required to provide evidence of insurability satisfactory to the insurance company before coverage in excess of \$30,000 will become effective.

If you do not enroll for dependent life insurance for your spouse/DP during your initial eligibility period, you may enroll for coverage during the next open enrollment period or in accordance with *Making Changes During the Year*. However, you should keep in mind that if you enroll or increase coverage after your initial eligibility period, your spouse/DP will be required to submit evidence of insurability satisfactory to the insurance company before the new or increased coverage is approved. The effective date of coverage will be the date the insurance company approves insurability.

If your spouse/DP has previously been denied coverage, waived coverage, or wants to increase coverage, your spouse/DP will be required to provide evidence of insurability satisfactory to the insurance company before any coverage can become effective.

Your spouse/DP's dependent life coverage reduces automatically on the first of the month following your attainment of the specific age in the following table:

Age	Percent of Available Amount
70	65%
75	50%

Coverage reductions due to age are not subject to rounding.



Dependent Life – Children

Dependent life insurance for your children is available in amounts of \$2,500 – \$10,000 in increments of \$2,500.

- If you enroll within your dependent child's initial eligibility period, coverage will be effective on the first day your child is eligible.
- If you do not enroll for dependent life insurance for your children during your initial eligibility period, you may enroll for coverage during the next open enrollment period or in accordance with *Making Changes During the Year*.

Evidence of insurability is not required for dependent children.

Your Cost

F&M pays the full cost of basic life and basic AD&D insurance. You pay the full cost of any optional life and dependent life insurance. Refer to *Employee Contributions* for the applicable cost.

Employee Assistance Program

Employee Assistance Program

From time to time, everyone needs help in dealing with stress, family concerns, money worries or other problems. Sometimes discussing problems with a friend or coworker isn't enough. That is when the F&M Employee Assistance Program (EAP) can help. You are automatically enrolled in the EAP on your first day of active full-time employment.

Through ComPsych GuidanceResources, confidential professional counseling, support and information services are available to you and your household members (such as your spouse/DP, child, niece/nephew, boyfriend/girlfriend, etc.) 24 hours a day, 7 days a week. Your use of the program is on a confidential basis.

You and your household members have up to three free sessions per person, per issue, per year. These sessions will be face-to-face with licensed counselors close to your work or home.

In addition, you have unlimited, telephonic access to information from ComPsych's legal and financial professionals. If you require legal representation, a referral to a qualified attorney in your area will be provided, along with a 25% reduction in legal fees.

Your Cost

F&M pays the full cost of the EAP.



**ComPsych GuidanceResources
Employee Assistance Program Website**
www.guidanceresources.com

Create your own confidential user name and password by clicking on "first-time user" and entering "GEN311" as the Organization Web ID.

EAP benefits are available to your ENTIRE household, including roommates!

EAP (ComPsych)	FinancialConnect	LegalConnect	GuidanceResources
Professional counseling services to address: ■ Depression ■ Job pressures ■ Alcohol or drug abuse ■ Marital and family conflicts ■ Stress and anxiety ■ Grief and loss	Financial specialists assist and provide you with resources for: ■ College savings ■ Retirement planning ■ Estate planning ■ Getting out of debt ■ Credit cards or loans ■ Tax questions	Access to attorneys providing information, assistance and referrals: ■ Divorce and family law ■ Debt obligations ■ Landlord and tenant issues ■ Real estate transactions ■ Bankruptcy ■ Criminal actions ■ Civil lawsuits ■ Contracts	Provides helpful information and resources on a variety of matters such as: ■ Personal or relationship issues ■ Legal and financial concerns

To access the EAP, call (800) 311-4327 or visit www.guidanceresources.com and create your own confidential user name and password by clicking on "first-time user" and entering "GEN311" as the Organization Web ID.

On-Demand Training and Multimedia Resources

Log in to your online account to access short (5-10 minute) training modules which include fun, interactive features, and help you build practical skills to deal with real-life challenges such as:

- Balancing work and life
- Connecting mind and body for healthy living
- Coping with a crisis or traumatic event
- Eating healthy on a budget
- Exercise at your desk
- From smoker to smoke free
- Helping a loved one through difficult times
- Keeping your senior loved one independent and safe
- Managing emotions in the workplace
- Managing personal finances
- The impact of attitude on work and life
- Time management tools and principles
- Using kindness to achieve personal success and happiness
- Using reason to resolve conflict

Also be sure to take advantage of the podcasts, resource guides, slideshows, videos, mobile apps and e-books.

Voluntary Plans

Aflac Voluntary Products

Aflac voluntary plans are employee-paid individual policies designed to supplement the F&M benefits plans. Administration and claims services are provided by Aflac. Aflac's One Day PaySM option provides the majority of policyholders a simple way to get claims processed and approved the same day they are submitted. Your effective date of coverage varies based on date of enrollment.

For more details or to set up a one-on-one appointment, contact F&M's dedicated Aflac representative – Seth Jaffe at (714) 658-0489 or seth_jaffe@us.aflac.com.

Short-Term Disability (STD) Insurance

Subject to your benefit period and elimination period, as well as your financial needs and income, Aflac will pay you a cash benefit for each day you are disabled. This policy is guaranteed issue, meaning no medical questionnaire is required. Aflac does not coordinate benefits, so regardless of any other disability insurance benefits you may have, including Social Security, Aflac will pay you directly. Aflac provides benefits for both total and partial disability. Even if you're able to work, partial disability benefits may be available to help compensate for lost income. In addition, premiums may be waived when you have a prolonged disability.

Specified Health Event Protection

A serious medical condition (such as heart attack or stroke) is not only a life-altering physical event, but a devastating financial one as well. Specified health event protection insurance may make all the difference by providing cash benefits as you concentrate on your recovery. This policy pays a first-occurrence benefit, as well as hospital confinement and continuing care benefits. Primary specified health events covered include: coma, paralysis, end-stage renal failure, persistent vegetative state and more.

Personal Cancer Indemnity Plan

Aflac's personal cancer indemnity plan helps you focus on getting well instead of being distracted by the stress and costs of medical and personal bills. With Aflac, you receive cash benefits directly, unless you choose otherwise. Benefits include: experimental treatment, nursing services, skin cancer surgery, anesthesia, outpatient hospital surgery, hospice, home health care, stem cell transplantation and more.

Accident Indemnity Advantage Plans

Aflac offers two accident indemnity advantage plans designed to provide you with cash benefits throughout the different stages of care, regardless of the severity of the injury. Benefits include: initial accident hospitalization, accident emergency treatment, intensive care unit confinement, physical therapy and more.

Dental Insurance

Aflac dental pays benefits for seven categories of dental treatments (including preventive, fillings and basic services, pain management, oral surgery, gum treatments, prosthetic repair, crowns, and major services) and many procedures. Since Aflac doesn't use a network of dentists, you can go to any dentist you choose. This benefit does not have precertification requirements. If the treatment is covered by your policy, you don't need Aflac's permission to receive it. The first year annual maximum is \$1,200. After each 12 consecutive months your policy is in force, Aflac's dental annual maximum building benefit provides an additional \$100 per year (for up to \$500 per covered person). Also, Aflac pays you \$25 (up to two times per year) just for getting your preventive oral exam!

Hospital Advantage/Hospital Confinement Indemnity Insurance

Hospital Advantage/Hospital Confinement Indemnity Insurance pays cash benefits for hospital confinement, rehabilitation facilities, hospital emergency rooms, hospital short-stay, physician visits, ambulance services, invasive diagnostic exams, hospital intensive care unit confinement, and more. Cash benefits range from \$25 – \$1,000 for common hospital stays with an unlimited benefit on continued hospitalization and most benefits have no lifetime maximum. Also, waiver of premium and continuation of coverage benefits provide additional protection.

Your Cost

Your cost will vary based on coverage elected and type of policy purchased. All policies (except STD insurance) permit pretax deductions. Contact Seth Jaffe by phone at (714) 658-0489 or by email at seth_jaffe@us.aflac.com for the applicable cost.

Free 24/7 Fraud Protection Services

Aflac Fraud Protection, powered by EZShield, is available to you at no cost. This program lets you enjoy peace of mind by alleviating the burden of fraud and identity theft with an all-encompassing "Secure, Monitor, Restore" approach to protecting personal information and finances. After you sign up, you will receive an online identity vault, a secure mobile app, and clear communications and alerts.

To learn more about this program and sign up, contact our dedicated Aflac representative.

F&M is not the plan sponsor or the plan fiduciary of the Aflac plans and these plans are not covered by the Employee Retirement Income Security Act of 1974, as amended (ERISA). Administration is performed by Aflac.



Voluntary Plans

United Pet Care

Our pets are much loved members of our families. But, with the rising cost of veterinary care, it's not always easy to get them the medical attention they deserve. That's why United Pet Care's pet health care program may be just the program you need. Your effective date of coverage varies based on date of enrollment.

United Pet Care is not pet insurance. As a member of this program, you save 20% to 50% on every veterinary visit. There are no claim forms, no exclusions due to genetic or preexisting conditions, no exclusions due to age, no deductibles, no limit to the number of office visits and no referrals necessary to participating specialists. Three different savings programs are available, all starting at \$12.50, or less, per month per pet.

United Pet Care offers an excellent selection of veterinary facilities. Simply select the one most convenient for you, show them your membership card and receive your discount at the time of service.

Your Cost

Your cost will vary based on the program you select. If you have any questions or need to enroll, make changes, or cancel, contact United Pet Care at (949) 916-7374 or visit their website.



United Pet Care Website
www.unitedpetcare.com/fmb



F&M is not the plan sponsor or the plan fiduciary of the United Pet Care plans and these plans are not covered by the Employee Retirement Income Security Act of 1974, as amended (ERISA). Administration is performed by United Pet Care.



AZ: 602-266-5303 CA: 949-916-7374



Ensure a long and healthy life for your pet.
You'll save 20-50% instantly on unlimited office visits, procedures and medications.



United Pet Care (UPC) welcomes the employees of Farmers and Merchants Bank to our pet healthcare savings program. You may enroll by the 20th of any month and your membership will be effective the 1st the following month. Please use our easy on-line enrollment below. Should you have any questions, or prefer to enroll over the phone, you may **contact us at 949-916-7374 or toll free at 1-877-872-8800.**

Enrollment Is As Easy As 1-2-3!

United Pet Care is a membership savings program. Simply present your card when you visit your veterinarian for instant savings! To enroll, select your state, choose your program and then your veterinarian.

Programs vary by state and each program features different savings on office visits, procedures, and medications. Veterinarians vary by program. You can start saving right away by enrolling today.

- Email Us >
- FAQs >
- Replace My Card >
- Change My Information >
- Refer a Veterinarian >
- Board Certified Vets >
- Area of Special Care Vets >
- Member Discount Club >
- Emergency Facilities >



Save on boarding, grooming, training, and many other special services.

Gym Membership Program

Gold's Gym Membership*

F&M and Gold's Gym have partnered to offer memberships through convenient F&M paycheck deductions.

For one free trial pass, enrollments, changes, or cancellations, contact Human Resources at (562) 499-4809.

The membership will include:

- One free personal training assessment
- One free 12 week transformation plan
- Free weights
- Kid's club
- Cycling
- Certified personal trainers
- State-of-the-art cardio equipment
- Yoga
- Zumba®

Note: Amenities vary by location.

To find out more about the services and products offered, contact Gold's Gym Long Beach at (562) 436-4653.

* With select new Gold's Gym corporate memberships. Must be at least 18 and a local resident with valid ID. Guest must accompany primary member and be at least 18 years old and a local resident with a valid ID. All guests must sign a waiver of liability. Personal training assessment is for (1) one hour session with a Gold's Gym certified personal trainer for new members only. Not redeemable for cash. Participating Gold's Gyms only. Other restrictions may apply.



YMCA of Greater Long Beach

F&M and the YMCA of Greater Long Beach have partnered to offer memberships through convenient F&M paycheck deductions.

For enrollments, changes, or cancellations, contact Human Resources at (562) 499-4809. If you have a direct bill membership at any of the following YMCA branches, contact Human Resources to change your payment method to F&M paycheck deductions:

- Fairfield Family YMCA
- Los Altos Family YMCA
- Lakewood Family YMCA

Your membership will include access to:

- Group exercise
- Child care
- After school programs
- Social/global programs
- Sports and recreation

Note: Amenities vary by location.

To learn about the services and products offered at each eligible location, visit <http://lbymca.org>.

YMCA Mission Statement

To welcome all people in a united effort to put Judeo-Christian values into practice through programs that develop healthy spirit, mind and body.

YMCA Values Statement

The character development values that we aim to teach – honesty, respect, responsibility, and caring – are the values that guide the behavior of our YMCA. We will be a membership organization that involves all members of the family in a long-term relationship – as participants, volunteers, leaders, and benefactors. Our YMCA will be a model of the kind of world it aims to create: positive, just, inclusive, charitable and loving.

Your Cost

You pay the full cost of the Gold's Gym and YMCA memberships. Your cost will vary based on the location and membership category you select. Please contact Human Resources for membership information and rates.

Profit Sharing and 401(k) Plan

Profit Sharing and 401(k) Plan

The Profit Sharing and 401(k) plan provides a means to build savings for the future by giving you the opportunity to:

- Reduce your taxable income
- Contribute through payroll deductions
- Choose from a range of investment options
- Build a tax-deferred accumulation of dividends, interest and other earnings

You are eligible to participate in the plan on your first day of active full-time employment.

Pretax contributions to the F&M health plans through payroll deductions (i.e., medical, dental, vision, and certain Aflac plans) will lower your wage base for taxes, Social Security and the Profit Sharing and 401(k) plan.

In addition to your contributions, F&M will make:

- An annual safe harbor contribution that is equal to 3% of your calculated compensation to your account. This safe harbor contribution will be immediately 100% vested.
- A profit sharing contribution of 12% of your calculated compensation. This profit sharing contribution will be subject to a six-year vesting schedule (refer to *Vesting*).

The annual safe harbor and profit sharing contributions are normally deposited into your account in January for plan members who have met the eligibility requirements, as of the preceding December 31.

Both employee and Company contributions will be allocated in accordance with your chosen investment election. If you have not made an investment election by the time the contribution is made, the contribution will be invested in the Target Date Fund. You can contact T. Rowe Price, the plan administrator, at any time to change your elections.



Vesting

Your vested balance is the portion of your account that you may take with you when you leave F&M or borrow from when you need a loan. You are always 100% vested in the part of your account balance that comes from any rollovers you may have made to your account. Your employer contribution account will become vested over time according to the following schedule.

Years of Vesting Service*	Percent Vested
<1	0%
1	10%
2	20%
3	40%
4	60%
5	80%
6+	100%

* For vesting purposes, a year of service is working 1,000 or more hours of service (i.e., each hour for which you are paid for the performance of duties and are entitled to receive compensation, as well as each hour – but not more than 501 hours – in which you are paid by F&M for non-performance of duties, including vacations, temporary layoff, approved leave of absence, sickness, disability, jury duty or military duty) during a plan year.

Flexible Investment Options*

You can choose one or more of the investment options available through the plan. If you do not make an investment choice, your contributions will be automatically invested in the Target Date Fund.

You can choose among three investment approaches:

1. A pre-assembled option using Diversified Portfolios** created by the Benefit Funding Services Group.
2. Create your own diversified mix using the do-it-yourself investment options.
3. Target Date Funds: Automatically adjusted over time, the Retirement Funds' allocations are actively managed for 30 years after their target retirement dates. Retirement Funds geared toward a longer time horizon, such as 30 years or more, start out with a more aggressive risk/return potential (the potential to earn or lose money), which gradually becomes more conservative (less risky) over time.

* Consider the investment objectives, risks, and charges and expenses carefully before investing.

** The Diversified Portfolios were developed at the request of the plan sponsor by the Benefit Funding Services Group. They are not mutual funds, but they are diversified portfolios composed of mutual funds and/or common trust funds. The Diversified Portfolios are not sponsored by, or affiliated with, T. Rowe Price.

Profit Sharing and 401(k) Plan

In-Plan Roth Rollovers

An in-plan Roth rollover lets you convert non-Roth amounts (i.e., elective salary deferrals or matching contributions) to a Roth account inside your plan and apply Roth tax advantages to more of your plan savings.

Be aware of short-term tax costs compared with the potential long-term advantages. You may want to consult your tax advisor to compare. In-plan Roth rollovers cannot be reversed after the transfer is made.

Plan Loans

You can take a loan from your vested account balance. The minimum loan amount you can borrow is \$1,000. The maximum you may borrow is the lesser of 50% of your vested account balance or \$50,000 minus your highest outstanding loan balance (a total of all your plan loans) from the preceding 12 months. Your loan plus interest must be paid within five years. If you leave F&M, you must repay your loan in full; otherwise, the outstanding balance will be considered a distribution (refer to *Tax Matters*).

Withdrawals

If you leave F&M for any reason – including retirement after age 62 – you may withdraw your vested account balance. While you are employed, you can make limited withdrawals from your account if you have vested balances held in trust for at least two years. In the event of your death, your beneficiary may withdraw your vested balance.

Online Beneficiary Service

You must name your beneficiary for your plan account. To name your beneficiary, log in to your account on the T. Rowe Price website or call (800) 922-9945.

Rollover Contributions

You may consolidate your retirement savings by “rolling over” vested balances from other employers’ eligible plans, including 401(k), 403(b) or governmental 457 plans. These amounts will be credited to your rollover contribution source within your plan account.

Convenient Account Transactions

At any time, you can change your contribution amount, change current balances (move all or part of an existing account balance from one investment to another, subject to excessive trading guidelines), or change your investment election (how future contributions will be invested). To make a transaction, log in to your T. Rowe Price account or call (800) 922-9945.

Guidance Tools

Your plan offers tools and services to help you choose an investing strategy using your age, salary, desired retirement date and other data. To access your guidance tools, log in to your T. Rowe Price account or call (800) 922-9945.

Excessive Trading Information

Excessive or short-term trading occurs when a participant places frequent trades into and out of an investment, often holding shares for a very short period of time. This practice can drive up the investment’s administrative costs and negatively impact the fund manager’s strategy. As a result, many funds responded with additional monitoring and the implementation of short-term trading fees.

A potential consequence of excessive trading may be the suspension of your trading privileges. Contact T. Rowe Price for additional details.

Redemption Fees

A redemption fee is a charge to an investor who sells shares of a mutual fund on or before a designated holding period specified by the fund. Redemption fees are designed to deter short-term trading and protect the fund and its long-term investors. Funds that are subject to redemption fees are noted in this list. Contact T. Rowe Price for additional details.

Tax Matters

All contributions plus any earnings in the plan are sheltered from federal income taxes while they remain in the plan. Generally, when you take money from the plan, it is taxable (and may be subject to a 10% early withdrawal penalty tax if you are under age 59½) unless you roll it over into a Traditional IRA or another eligible employer plan.

If you meet the applicable compensation limitation, you may directly roll over a distribution from the plan into a Roth IRA. The amount rolled into the Roth IRA is taxable income to you in the year of the rollover. Consult your tax advisor for details.

Before taking money out of your account (a distribution), please read the Special Tax Notice available on the T. Rowe Price website or request a copy by calling (800) 922-9945.

Contact Information

If you need assistance with your Profit Sharing and 401(k) plan, call T. Rowe Price at (800) 922-9945. Representatives are available Monday through Friday between 4 a.m. and 7 p.m. Pacific Time. You can also contact Human Resources for more information.



T. Rowe Price Website
<http://rps.troweprice.com>

First time visitors: Establish a user ID and password. Then, information is available 24/7.

Paid Time Off and Employee Account Benefits

Holiday Policy

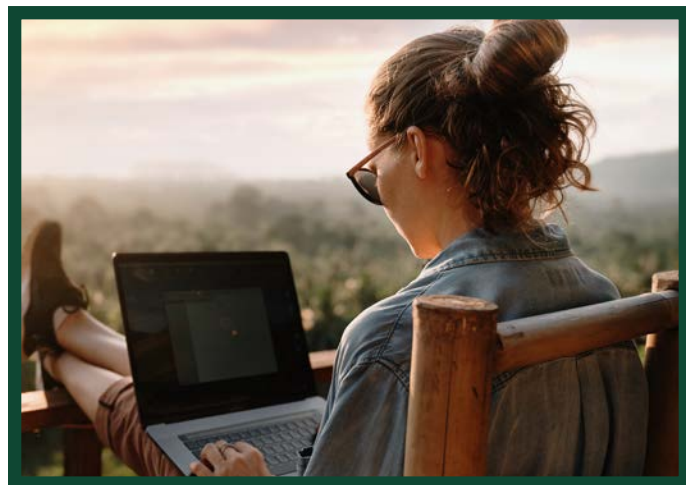
Holidays will be observed on the calendar day designated by the Bank.

You must be classified as a full-time employee regularly scheduled to work 36 or more hours per week to be eligible for holiday pay. In addition, you are eligible for holiday pay on the first day you are actively at work.

Holiday pay is calculated at your base pay rate. Normally, you must work the regularly scheduled workday immediately before and after the holiday in order to be paid for the holiday. For pay purposes, if a holiday occurs during any paid time off (e.g., sick pay, vacation, etc.) it will be treated as a holiday and not as a vacation day.

The following holidays are recognized by F&M during the 2021 calendar year.

Holiday	Date of Observance
New Year's Day	Friday, January 1
Martin Luther King, Jr. Day	Monday, January 18
Presidents' Day	Monday, February 15
Memorial Day	Monday, May 31
Independence Day	Monday, July 5
Labor Day	Monday, September 6
Columbus Day	Monday, October 11
Veterans' Day	Thursday, November 11
Thanksgiving Day	Thursday, November 25
Christmas Day	Saturday, December 25



Vacation Policy

F&M understands employees need time off for necessary rest and relaxation. You are encouraged to use your earned vacation time each year. Vacation time is accrued biweekly on Mondays at the beginning of the pay period, according to the following schedule:

Completed Years of Service	Hours Accrued Biweekly	
	Vice Presidents and Above	All Other Employees
1 – 5	4.615 (240 maximum accrual)	3.077 (160 maximum accrual)
5+	6.154 (320 maximum accrual)	4.615 (240 maximum accrual)

Once the vacation bank limit has been reached, additional vacation will not accrue until some vacation time is used, unless otherwise specified by state law. You should plan your vacation accordingly.

All vacation time must be requested via ADP Self Serve, and approved in advance with your manager. Every effort will be made to schedule time off in accordance with your wishes. However, department priorities may take precedence, and the time off needs of your coworkers will also be considered.

Employee Account Benefits

Checking, Savings and Safe Deposit Account Discounts

See your nearest Banking Relationship Specialist for details.

Residential Mortgage Loans

See your nearest Loan Consultant for details.

Legal Notices



HIPAA Privacy Notice

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to protect the confidentiality of your private health information. More detailed information is provided in the health plans' notice of HIPAA privacy. You may obtain a copy of the notice from Human Resources.

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
- Treatment of physical complications of the mastectomy, including lymphedema

The plan will determine the manner of coverage in consultation with you and your attending doctor. Coverage for breast reconstruction and related services will be subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plans. If you would like more information on WHCRA benefits, call the medical plan's member services department.

HIPAA Special Enrollment Rights

You have special enrollment rights if you acquire a new dependent, or if you decline coverage under the F&M benefit plans for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

To ensure your mid-year benefits and any applicable paycheck deduction changes are processed timely, please contact Human Resources or the F&M Benefits Hotline within 31 days of your qualifying event. You'll be provided with information on how to make changes to your coverage based on your (or your dependent's) qualifying event. For more details, refer to *Making Changes During the Year*.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse/DP) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents if you or your dependents lose eligibility for that 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).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse/DP) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse/DP) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

Legal Notices

Important Notice About 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 available under the medical plans offered by F&M and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- 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 a PPO or HMO) 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.
- F&M has determined that the prescription drug coverage offered under the F&M medical plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.



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

If you decide to join a Medicare drug plan, your current medical coverage will not be affected. When your current medical plan coordinates benefits with Medicare, the combined benefits from Medicare and your current medical coverage will equal, but not exceed, what your current plan would have paid if you were not eligible to receive Medicare.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will not be able to get this coverage back until April 1 following the next open enrollment period.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with F&M and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Legal Notices

For more information about this notice or your current prescription drug coverage, contact the person listed below.

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 F&M changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call (800) MEDICARE (800-633-4227); TTY users should call (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 (800) 772-1213 (TTY (800) 325-0778).

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

Date:	April 1, 2021
Name of Entity/Sender:	Farmers & Merchants Bank of Long Beach
Contact-Position/Office:	Valentina M. H. Fiorentino Senior Vice President Human Resources Director
Address:	302 Pine Avenue Long Beach, CA 90802
Phone Number:	(562) 499-4809

Patient Protection Disclosure

The Cigna Network Health Maintenance Organization (HMO) and MemorialCare Partnership medical plans generally require the designation of a primary care physician (PCP). You have the right to designate any PCP who participates in the network and who is available to accept you or your family members.

If You Are Enrolled in the Cigna Network HMO Plan

Until you make this designation, Cigna designates a PCP for you. For information on how to select a PCP, and for a list of the participating PCPs for the Cigna Network HMO medical plan, contact Cigna at (800) 24-CIGNA (800-244-6224) or visit www.mycigna.com. For children, you may designate a pediatrician as the PCP.

You do not need prior authorization from the Cigna Network HMO medical plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in Cigna's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Cigna at (800) 24-CIGNA (800-244-6224) or visit www.mycigna.com.

If You Are Enrolled in the MemorialCare Partnership Plan

Centivo will not designate a PCP for you. For information on how to select a PCP, and for a list of the participating PCPs for the MemorialCare Partnership medical plan, contact Centivo Concierge at (833) 615-0793 or visit <https://FMB.centivo.com>. For children, you may designate a pediatrician as the PCP.

You do not need a referral from the MemorialCare Partnership medical plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the MemorialCare Direct Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Centivo Concierge at (833) 615-0793 or visit <https://FMB.centivo.com>.



Legal Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage

You can buy health insurance through the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the 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 tax credit that lowers your monthly premium right away.

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

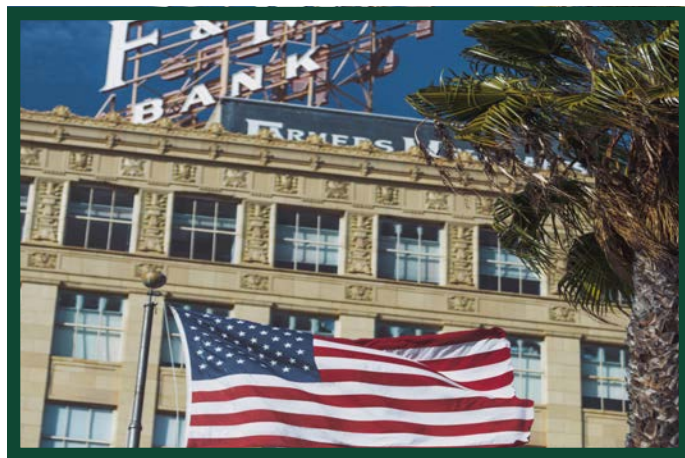
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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 your employer does not offer coverage to you at all, or does not offer coverage that meets certain standards. Your employer's health plan does meet the standards established under the law with regard both to the plan's minimum value and its affordability.

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 to the employer-offered coverage. Also, this employer contribution – as well as any 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.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its costs. Please visit www.healthcare.gov for more information, including an online application for health insurance coverage.



Summary Annual Report (SAR)

The F&M SAR is available online and includes an explanation of plan expenses, employee and employer contribution information, and details on how you can obtain additional information about the plan. Since you are enrolled in, or eligible for, one or more of F&M's benefits plans, it is your legal right as a participant to know this information about your benefits.

Each December 31st, you may view a copy of the prior plan year's SAR on <https://fmb.mybenefits.teamcreativa.com> – select the Forms & Documents link from the left menu. If you require a paper copy of the SAR, you can order it from the F&M Benefits Hotline. Simply email fmbenefits@teamcreativa.com or call (866) 318-1235.

Genetic Information Nondiscrimination Act

Congress passed the Genetic Information Nondiscrimination Act (GINA) establishing a national and uniform standard to protect workers from genetic discrimination. In addition to prohibitions on discrimination in employment practices, GINA prohibits group health insurers and group health plans from adjusting premiums or contributions based on genetic information. Also, GINA amended the HIPAA privacy rules to include genetic information in the definition of protected health information.

Legal Notices

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office, dial (877) KIDS-NOW (543-7669) or visit 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 (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, 2020. Contact your state for more information on eligibility.

Alabama – Medicaid

Website: <http://myalhipp.com>
Phone: 1-855-692-5447

Alaska – Medicaid

The AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
<http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

Arkansas – Medicaid

Website: <http://myarhipp.com>
Phone: 1-855-MyARHIPP (1-855-692-7447)

California – Medicaid

Website: www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-916-440-5676

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

Health First Colorado Website: www.healthfirstcolorado.com
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: www.colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI):
www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

Florida – Medicaid

Website: www.flmedicaidtplecovery.com/flmedicaidtplecovery.com/hipp/index.html
Phone: 1-877-357-3268

Georgia – Medicaid

Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 1-678-564-1162 ext. 2131

Indiana – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: www.in.gov/fssa/hip
Phone: 1-877-438-4479
All other Medicaid
Website: www.in.gov/medicaid
Phone: 1-800-457-4584

Iowa – Medicaid and CHIP (Hawki)

Medicaid Website: <https://dhs.iowa.gov/ime/members>
Medicaid Phone: 1-800-338-8366
Hawki Website: <http://dhs.iowa.gov/Hawki>
Hawki Phone: 1-800-257-8563

Kansas – Medicaid

Website: www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

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: KIHIPPPROGRAM@ky.gov
KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>
Phone: 1-877-524-4718
Kentucky Medicaid Website: <https://chfs.ky.gov>

Louisiana – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Medicaid Hotline: 1-888-342-6207
LaHIPP Phone: 1-855-618-5488

Maine – Medicaid

Enrollment Website: www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine Relay 711
Private Health Insurance Premium Webpage:
www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine Relay 711

Massachusetts – Medicaid and CHIP

Website: www.mass.gov/eohhs/gov/departments/masshealth
Phone: 1-800-862-4840



Legal Notices

Minnesota – Medicaid

Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care-programs/programs-and-services/other-insurance.jsp>
Phone: 1-800-657-3739

Missouri – Medicaid

Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

Montana – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084

Nebraska – Medicaid

Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178

Nevada – Medicaid

Website: <http://dhcfp.nv.gov>
Phone: 1-800-992-0900

New Hampshire – Medicaid

Website: www.dhhs.nh.gov/oii/hipp.htm
Phone: 1-603-271-5218
HIPP program: 1-800-852-3345 ext. 5218

New Jersey – Medicaid and CHIP

Medicaid Website:
www.state.nj.us/humanservices/dmahs/clients/medicaid
Medicaid Phone: 1-609-631-2392
CHIP Website: www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

New York – Medicaid

Website: www.health.ny.gov/health_care/medicaid
Phone: 1-800-541-2831

North Carolina – Medicaid

Website: <https://medicaid.ncdhhs.gov>
Phone: 1-919-855-4100

North Dakota – Medicaid

Website: www.nd.gov/dhs/services/medicalserv/medicaid
Phone: 1-844-854-4825

Oklahoma – Medicaid and CHIP

Website: www.insureoklahoma.org
Phone: 1-888-365-3742

Oregon – Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

Pennsylvania – Medicaid

Website: www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

Rhode Island – Medicaid and CHIP

Website: www.eohhs.ri.gov
Phone: 1-855-697-4347
Direct Rlte Share Line: 1-401-462-0311

South Carolina – Medicaid

Website: www.scdhhs.gov
Phone: 1-888-549-0820

South Dakota – Medicaid

Website: <http://dss.sd.gov>
Phone: 1-888-828-0059

Texas – Medicaid

Website: <http://gethipptexas.com>
Phone: 1-800-440-0493

Utah – Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov>
CHIP Website: <http://health.utah.gov/chip>
Phone: 1-877-543-7669

Vermont – Medicaid

Website: www.greenmountaincare.org
Phone: 1-800-250-8427

Virginia – Medicaid and CHIP

Website: www.coverva.org/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

Washington – Medicaid

Website: www.hca.wa.gov
Phone: 1-800-562-3022

West Virginia – Medicaid

Website: <http://mywvhipp.com>
Phone: 1-855-MyWVHIP (699-8447)

Wisconsin – Medicaid and CHIP

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

Wyoming – Medicaid

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

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

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

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

Employee Contributions (Effective April 1, 2021)

Employee Contributions

Your cost for coverage depends on how many eligible dependents you enroll and what benefit choices you make.

- **Pretax deductions:** Medical, dental, vision, Aflac plans (except STD insurance), and 401(k) contributions
- **After-tax deductions:** Health savings account, optional employee and dependent life, Aflac STD insurance, United Pet Care (UPC), gym memberships, and Roth contributions

Company-Paid Plans

F&M pays the entire cost of the sick leave policy, basic life insurance, basic accidental death and dismemberment insurance, and the employee assistance program.

Enrollments for Registered Domestic Partners and Their Children

Unless claimed as your federal tax dependent under Internal Revenue Code Section 152, the cost to cover a registered domestic partner will be deducted from your pay on an after-tax basis.

In addition, you will be subject to domestic partner imputed income on your federal taxes if you enroll a registered domestic partner in your medical plan (refer to the medical table below).

Children of a registered domestic partner are eligible for coverage only if they are claimed as your federal tax dependent. Contact the F&M Benefits Hotline or Human Resources for more information.

Medical (Biweekly Employee Contributions)				
Plan	Employee Only	Employee and 1 Dependent	Employee and 2 or More Dependents	Domestic Partner Imputed Income
Cigna CDHP Gold	\$131.26	\$262.51	\$393.77	\$350.42
Cigna CDHP Silver	\$112.93	\$225.86	\$338.80	\$301.50
Cigna CDHP Bronze	\$105.33	\$210.67	\$316.01	\$281.22
Cigna Network HMO	\$51.25	\$102.51	\$153.76	\$278.14
MemorialCare Partnership 	\$51.25	\$102.51	\$153.76	\$278.14

Dental (Biweekly Employee Contributions)			
Plan	Employee Only	Employee and 1 Dependent	Employee and 2 or More Dependents
Cigna Dental PPO	\$17.02	\$33.28	\$51.74
Cigna Dental HMO	\$7.50	\$13.62	\$19.86

Vision (Biweekly Employee Contributions)			
Plan	Employee Only	Employee and 1 Dependent	Employee and 2 or More Dependents
VSP Full Feature	\$5.10	\$7.93	\$12.59
VSP Exam Plus Allowance	\$4.51	\$6.98	\$11.09

Long Term Disability (Employee Monthly Cost Per \$100 of Covered Pay)	
Plan	Employee
Prudential LTD	\$0.19

Refer to *Important Contact Information* to request your contributions for the Aflac, UPC, Gym Membership, Profit Sharing and 401(k) plans.

Optional Life (Employee Monthly Cost Per \$1,000 of Coverage)			
Age*	Employee	Spouse/DP*	Children
< 30	\$0.050	\$0.050	\$0.170 Regardless of the number of children covered
30 – 34	\$0.060	\$0.060	
35 – 39	\$0.088	\$0.088	
40 – 44	\$0.138	\$0.138	
45 – 49	\$0.221	\$0.221	
50 – 54	\$0.340	\$0.340	
55 – 59	\$0.587	\$0.587	
60 – 64	\$0.970	\$0.970	
65 – 69	\$1.510	\$1.510	
70 – 74	\$2.990	\$2.990	
75+	\$4.770	\$4.770	

* The cost for spouse/domestic partner dependent life coverage is based on the employee's age.

Put important contact information in the palm of your hand

From your mobile device:

- Go to <https://fmb.mybenefits.teamcreativa.com/contacts>
- Then follow the on-screen instructions to add the app to your home screen



Benefit Resources	Group #	Contact Information
Cigna CDHP Medical Cigna Network HMO Medical	3333211	(800) 244-6224 www.mycigna.com
Cigna 24/7 Health Information Line	3333211	(800) 564-9286
Cigna Telehealth Connection – MDLIVE		(888) 726-3171 www.MDLIVEforCigna.com
Cigna Home Delivery Pharmacy	3333211	(800) 835-3784
HSA Bank (CDHP Bronze members)		(800) 357-6246 www.hsabank.com
MemorialCare Partnership Medical Centivo Concierge	FMB01	(833) 615-0793 https://my.centivo.com www.memorialcare.org/FMB
Cigna Dental PPO Cigna Dental HMO	3333211	(800) 244-6224 www.mycigna.com
VSP Vision	30019544	(800) 877-7195 www.vsp.com
Disability (Sick Pay, CA SDI, LTD)	LTD: 06525	Contact Human Resources
Prudential Life and Accident	06525	Contact Human Resources
ComPsych GuidanceResources Employee Assistance Program		(800) 311-4327 www.guidanceresources.com Organization Web ID: GEN311
Gym Membership Program		Contact Human Resources
T. Rowe Price Profit Sharing and 401(k)		(800) 922-9945 http://rps.troweprice.com
Aflac – Agent Seth Jaffe	BKY43	(714) 658-0489 seth_jaffe@us.aflac.com
United Pet Care	1105	(949) 916-7374 www.unitedpetcare.com/fmb
F&M Human Resources		(562) 499-4809
F&M Benefits Website		https://fmb.mybenefits.teamcreativa.com
Benefits Enrollment/Changes		Contact the F&M Benefits Hotline or visit https://workforcenow.adp.com
Payroll		Contact Human Resources or visit https://workforcenow.adp.com
F&M Benefits Hotline		(866) 318-1235 fmbenefits@teamcreativa.com
HealthEquity/WageWorks COBRA Administration		(888) 678-4881 https://mybenefits.wageworks.com

Important Information About Medicare Prescription Drug Coverage

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please refer to pages 38 – 39 for more details.