



2027 Retiree Medical Enrollment

Annual Enrollment: October 28 – November 11, 2026

2027 Retiree Medical Enrollment

October 2027



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Non-Medicare-eligible retirees who have questions can contact benefitsoffice@fnal.gov or (630) 840-5055. Retirees with Medicare who have questions about their coverage should contact **Via Benefits at 1-855-241-5721**

Annual Enrollment - October 28 to November 11

Annual Enrollment is your opportunity to make changes to your retiree medical coverage for the upcoming year. Fermilab provides retirees with a comprehensive, competitive healthcare benefit program.

This Enrollment Guide focuses on the medical plans offered to Fermilab retirees and their dependents who are **not Medicare-eligible**. These retirees and their dependents receive medical and prescription drug coverage in the PPO or HMO plans provided by Blue Cross Blue Shield of Illinois. Note that prescription drug coverage in the PPO plan is with Express Scripts.

During this time, you may switch between the HMO and PPO plans or drop a dependent, but you may not add new dependents without a qualifying life event.

To make a change, complete the enclosed Annual Enrollment form on page 12 and send it to the Fermilab Benefits Office. If you do nothing, your coverage will stay the same in 2026. If you or your dependent becomes Medicare-eligible in 2027, please refer to page 9 of the guide for more information about transitioning to Via Benefits.

Medicare-eligible retirees will continue to partner with **Via Benefits** for supplemental medical and prescription drug coverage. **Via Benefits** will mail materials separately to Medicare-eligible retirees and their dependents explaining their 2027 options. If you have questions about this, call **Via Benefits** directly at **1.855.241.5721**.

What's happening in 2027?

1. **Medical plan rates are increasing.** Rate increases are dictated by several factors, including claims experience, projected experience, population demographics, and health care inflation. The 2027 retiree medical plan rates are on page 7.
2. **PPO Plan only –** Retirees enrolled in the PPO plan must purchase maintenance medications in a 90-day supply through Express Scripts Mail Order service or at a Walgreens retail location. PPO retirees can also download an Express Scripts mobile app for easy access. See page 6 for details.
3. **PPO Plan only – Teladoc – Diabetes supplies at no cost.** See page 8 for details.

How Your Benefits Work When You Retire

Benefit coverage is at the top of many retirees' lists, especially if retirement happens before reaching Medicare eligibility. That's why Fermilab offers a reduced-rate medical package to retirees and their families. Dental and Vision coverage can continue under COBRA for up to 18 months.

Eligibility

Employees who meet the eligibility requirements for retirement but are not yet Medicare-eligible are offered the option to continue their current coverage with the lab for themselves and their families at a reduced COBRA rate until they become Medicare-eligible. To take advantage, retirees must sign up at the time of retirement. This option is not available later.

Qualified Dependents

Dependents who are eligible for coverage when the employee retires are eligible to continue the coverage until eligibility expires. This includes legal spouses, children, and step-children. Eligibility ends when either the dependent becomes Medicare-eligible or turns 26.

COBRA Continuation Coverage

Dependents who turn 26 while covered under the Fermilab reduced retiree rates will be offered continued COBRA coverage. If elected, coverage lasts for up to 18 months.

Making Changes During the Year

Generally, you can only change your benefit elections during the annual enrollment period, unless you experience a Qualifying Life Event (QLE) such as marriage or divorce. Changes must be made within 31 days of the QLE. Complete the form on page 14 and return to the Benefits Department



Medicare

When you or your dependent becomes Medicare-eligible, sign up with an effective date on the first day of the month of your 65th birthday. Fermi coverage will continue for one additional month before you transfer to Via Benefits for your supplemental coverage. As that time approaches, Fermi will notify you and provide the information you need to contact Via Benefits. The Fermi Benefits Team will make any necessary changes to your payments. See [page 9](#) for further details.

To sign up for Medicare, visit www.ssa.gov and click on Medicare near the top of the. Information you will need includes:

Basic information about yourself

Social Security number

Where you were born (city, state, country)

Health insurance information

Start and end dates for any current group health plans

Start and end dates for any group health plans after age 65

For Part B only

Valid email address

Your existing Medicare number

Retiree Medical Plan Options

Fermilab offers its retirees two medical plan options: a **PPO (Preferred Provider Organization)** and an **HMO (Health Maintenance Organization)**. Each plan provides comprehensive medical coverage, but they differ in how care is accessed, how costs are shared, and the level of flexibility you have when choosing providers. Understanding these differences helps you select the plan that best fits your health needs, budget, and preferences.

Blue Cross/Blue Shield PPO

A PPO plan offers the greatest flexibility in choosing doctors, specialists, and hospitals, allowing you to see providers both inside and outside the plan's network without needing referrals.

In-network care typically has lower deductibles and coinsurance, while out-of-network care is covered but at a higher cost. This is best for maximum flexibility for those who travel frequently or have established relationships with providers.

Blue Advantage HMO

An HMO plan focuses on coordinated care within a defined network of doctors and hospitals. Members choose a primary care physician (PCP) who manages most care and provides referrals to specialists. Care must be received from in-network providers, except in emergencies, and specialists are seen only by referral.

Generally, the HMO has lower premiums and predictable copays, but there is no out-of-network coverage except in an emergency. This option is best if you prefer lower costs, don't mind staying within a network, and value coordinated care through a single PCP. When switching to the HMO, you must call BCBS to name your PCP.



Go Mobile with Blue

- Download the BCBSIL Mobile App for secure access to your important healthcare updates on the go.
- Find in-network doctors and care facilities from your mobile device.
- Access and download your digital ID card and review your claims and coverage information.
- Create an account today. Text **BCBSILAPP to 33633 to sign up.**

Receive Important BCBSIL Text Messages

- Be sure to opt in to text messages so you don't miss important health care updates.

Medical Plan Comparison

MEDICAL PLAN HIGHLIGHTS	Blue Cross Blue Shield IL PPO		Blue Advantage HMO
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
CALENDAR YEAR PLAN DEDUCTIBLE (paid once in a calendar year)			
Individual	\$600	\$1,000	N/A
Family (maximum)	\$1,650	\$2,500	N/A
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes deductible, medical and prescription drug co-pays)			
Individual	\$3,500	\$5,520	\$1,500
Family (maximum)	\$7,200	\$10,800	\$3,000
PHYSICIAN CHARGES (co-pays apply to the out-of-pocket maximum)			
Primary Care	\$30 Co-pay	80% after deductible	\$20 Co-pay
Telehealth via MDLIVE	\$15 Copay		N/A
Specialist	\$40 Co-pay		\$30 Co-pay
DIAGNOSTIC X-RAY AND LAB TESTS			
Billed as place of service office	\$30 Co-pay	80% after deductible	100%
Billed as place of service hospital	80% after deductible		
HOSPITAL			
Inpatient	80% after deductible		\$250 Co-pay
Emergency Room			\$150 Co-pay
Urgent Care			\$20 Co-pay (In Medical Group)
SURGERY			
Inpatient	80% after deductible		100%
Outpatient			\$50 Co-pay
PREVENTIVE SERVICES			
Annual Physical Exam	100%	Not Covered	100%
Immunizations and Inoculations			
Routine Eye Exams	Blue 365 discount program		100% every 12 months EyeMed Select
Discounts on Glasses			Frame Allowance every 24 months
MENTAL HEALTH/SUBSTANCE USE			
Office Visits	\$30 Co-pay, 100%	80% after deductible	\$20 Co-pay, 100%
Telehealth via MDLIVE	\$15 Co-pay, 100%	N/A	N/A
Hospital Inpatient	80% after deductible	80% after deductible	\$250 Co-pay, 100%
PREScription DRUGS	IN-NETWORK (Express Scripts)	OUT-OF-NETWORK	IN-NETWORK (Prime Therapeutics)
Generic In-Network	\$20 co-pay retail (34-day supply) \$40 co-pay mail order (90 days)	80% after \$50 deductible	\$20 co-pay retail (34-day supply) \$40 co-pay mail order (90 days)
Preferred Brand	\$40 co-pay retail (34-day supply) \$80 co-pay mail order (90 days)		\$40 co-pay retail (34-day supply) \$80 co-pay mail order (90 days)
Non-Preferred Brand	\$80 co-pay retail (34-day supply) \$160 co-pay mail order (90 days)		\$70 co-pay retail (34-day supply) \$140 co-pay mail order (90 days)
Specialty Drugs	\$150 co-pay (30-day supply)	Not Covered	\$70 co-pay

Prescription Drug Coverage with the PPO and Express Scripts

- Blue Cross Blue Shield of Illinois (BCBSIL) PPO plan participants **must purchase maintenance medications in a 90-day supply at Walgreens or via mail order with Express Scripts.**
- Filling a 3-month supply of your long-term medication can help you save time, money and trips to the pharmacy.
- Mail-order service through Express Scripts remains an option at the same benefit coverage level.
- Impacted plan participants will be notified by Express Scripts via letter to the address on file.
- Plan participants will receive two courtesy fills for the incorrect supply amount (34 days instead of 90) or pharmacy (CVS instead of Walgreens).
- Plan participants will receive a letter after each courtesy fill with instructions on the next steps.
- Express Scripts and Walgreens will assist plan participants with converting to a 90-day supply or the transfer of a prescription to Walgreens.
- Express Scripts will assist plan participants in switching to the mail order service if there is no Walgreens close to them.

Create your Express Scripts digital account today to get all of your pharmacy information in one place. Start by scanning this QR code.



Prescription Drug Coverage with the HMO

- Blue Cross Blue Shield of Illinois (BCBSIL) HMO plan participants may purchase prescriptions through a participating pharmacy.
- To find a participating pharmacy, log into your BCBSIL account at www.bcbsil.com

PPO Plan participants will receive diabetes supplies through Teladoc at no cost to the participant.

- Blue Cross Blue Shield of Illinois (BCBSIL) PPO plan participants may purchase diabetes supplies through Teladoc at no cost to the plan participant.
- Participants will receive:
 - An advanced blood glucose meter
 - Unlimited strips and lancets
 - Real-time tips and support from certified diabetes educators.
- The program is accessible at www.teladochealth.com or (800) 835-2362, client registration code FERMILAB.
- This program assists those impacted by diabetes with the cost of the meter and supplies and provides additional support and tools.

2027 Retiree Medical Plan Monthly Rates

Grandfathered Rates (Retired before 1/1/2020)

Coverage Tier	Blue Advantage HMO	Blue Cross PPO
Single	\$362.88	\$498.28
Retiree & Spouse	\$698.25	\$1,007.05
Retiree & Child(ren)	\$669.30	\$910.19
Family	\$1,038.33	\$1,437.93

Non-Grandfathered Rates (Retired on or after 1/1/2020)

Coverage Tier	Blue Advantage HMO	Blue Cross PPO
Single	\$637.49	\$875.36
Retiree & Spouse	\$1,226.65	\$1,769.15
Retiree & Child(ren)	\$1,175.80	\$1,598.98
Family	\$1,824.09	\$2,526.10

Your Coverage Tier

Tier	Description	Effect of Medicare
Single	One person is covered: 1. Retiree only, or 2. Spouse only, or 3. Child only	No other family members are covered on our plan, or all others have Medicare
Retiree & Spouse	Retiree and spouse	Neither has Medicare
Retiree & Child(ren)	Two or more people – at least one is a child under age 26, such as: 1. Retiree + child(ren) 2. Spouse + child(ren) 3. Two or more children	1. Spouse may have Medicare 2. Retiree may have Medicare 3. Both parents may have Medicare
Family	Retiree, spouse, and one or more children	No one has Medicare

Frequently Asked Questions:

Q: What are my options during Annual Enrollment?

A: This is your annual opportunity to:

- Change between the HMO and PPO plans.
- Drop a dependent.
- Review and update contact information. (This can be completed anytime throughout the year by sending an email to: benefitsoffice@fnal.gov.)

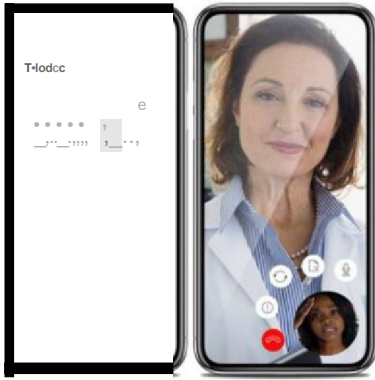
Q: Can I add a dependent during Annual Enrollment?

A: No, the plan does not allow retirees to add dependents to the plan after retirement unless it's a newly acquired dependent. For example, the retiree gets married. The new spouse must be added to the plan within 31 days of the event (marriage).

Do you have questions regarding 2027 Enrollment?

Contact the Benefits team at: benefitsoffice@fnal.gov or (630) 840-5055 (regular business hours)

NOTE: Medicare-eligible retirees and dependents should direct questions to Via Benefits at 1-855-241-5721



What is Teladoc Health?

Teladoc Health is a global, virtual, whole person care company offering complete care to help you get well and live well. With thousands of U.S. board-certified providers, chronic condition coaches, dermatologists, therapists, licensed nurses, nutritionists, and specialists, they can provide support, diagnose, recommend treatment, and prescribe medication, if necessary.

Empowering all people everywhere to live their healthiest lives through:

- Preventative and ongoing needs met by virtual Primary Care
- Connected health-monitoring devices and certified health coaches to help manage conditions like diabetes, hypertension, and weight challenges
- 24/7 care for non-emergency conditions like allergies, flu, cough and infections
- Eczema, psoriasis, rashes, acne, and other skin conditions
- Depression, anxiety, relationship issues
- Nutrition, wellness consults and more



Member registration

Registration and member experience



Multiple ways to join

- Register online: **TeladocHealth.com/ Register /FERMILAB**
- Call member support: 1-800-835-2362
- Registration code: **FERMILAB**



Information gathered

- Personal Information: Name, address, email, password
- Insurance information: Member/health plan ID to validate eligibility
- Health profile: Creates a tailored experience from the start of the program



Teladoc
HEALTH

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When You Become Medicare Eligible

Fermilab partners with Via Benefits to help Medicare-eligible retirees compare and enroll in individual Medicare plans. Each eligible retiree and dependent receives a Health Reimbursement Account (HRA) funded at \$175 per month to help cover their healthcare costs.

Your Timeline

Apply before you turn 65

Apply for Medicare several months before your 65th birthday, so Parts A & B are active on the first day of the month you turn 65. This avoids any gaps in coverage and ensures any claims are processed correctly.

6 months before turning 65, you will receive:

- A letter from Via Benefits encouraging you to schedule a call with a benefit advisor.

3 months before turning 65, you will receive:

- A Via Benefits Enrollment Guide
- A cover letter explaining your next steps



Medicare Enrollment

Medicare becomes effective on the first day of the month you turn 65.

Why timely enrollment matters:

- Medicare becomes primary, and Blue Cross Blue Shield becomes secondary.
- If you are not enrolled when Medicare becomes primary, you must pay the portion Medicare would have covered.
- Enrollment in Medicare Parts A and B is required to enroll through Via Benefits.

Your HRA (Health Reimbursement Account)

Fermilab provides \$175/month per Medicare-eligible person once enrolled through Via Benefits.

Your HRA can be used for:

- Medical, dental, and vision plan premiums
- Medicare Part B premiums
- Prescription drug (Part D) premiums
- Medicare Advantage or supplemental plan premiums
- Eligible out-of-pocket healthcare expenses (copays, deductibles, coinsurance)

Rollover: Unused HRA funds carry over year to year, allowing your balance to grow.

Via Benefits Eligibility

You become eligible for the Via Benefits program on the first day of the month **following** your 65th birthday. This gives you time to meet with Via Benefits and select your new plan before Fermi coverage ends.

Example:

- John Smith retired and enrolled in Fermilab's PPO plan. He turns 65 on February 14, 2027.
- John's timeline:
 - ✓ February 1, 2027, Medicare coverage begins. Apply as early as November 2026 to avoid coverage gaps.
 - ✓ March 31, 2027, Fermilab PPO coverage ends
 - ✓ April 1, 2027, Via Benefits eligibility begins

2027 Automatic Account Debit Schedule

Below are the dates your benefit premium will be deducted from the checking account on file. If sufficient funds are not available on the listed date, you will be charged an NFS fee, and coverage may be canceled. To notify Fermilab of a bank account change, please complete and return the form on page 12 by the 15th of the month before the effective date to avoid an NFS fee.

Coverage Month	ACH Debit Date	Deadline to Report Changes	Coverage Month	ACH Debit Date	Deadline to Report Changes
January	1/11/2027	12/31/2027	July	7/12/2027	6/30/2027
February	2/10/2027	1/31/2027	August	8/10/2027	7/31/2027
March	3/10/2027	2/28/2027	September	9/10/2027	8/31/2027
April	4/12/2027	3/31/2027	October	10/12/2027	9/30/2027
May	5/10/2027	4/30/2027	November	11/10/2027	10/31/2027
June	6/10/2027	5/31/2027	December	12/10/2027	11/30/2027

Medical Plan Rates Update

- In August 2019, active Fermilab employees were notified of a change to the retiree healthcare insurance contribution percentage.
- This change impacts employees who retire after January 1, 2020.
- **If you retired before 12/31/2019, neither you nor your dependent is impacted.** Non-Medicare-eligible retirees and covered dependents as of 12/31/2019 were grandfathered at the cost-sharing percentage rate in effect in 2019, which averages about 37% of the total premium.
- For those who retired after 1/1/2020, Fermilab changed the percentage that the non-Medicare-eligible retiree pays for retiree medical coverage as outlined in the schedule below. **Please note that the 65% cost share, effective 1/1/2022, remains unchanged in 2027, with no further increases planned at this time.**

Retirement Date	Effective	Retiree Pays	Grandfathering
On or before December 31, 2019	upon retirement	37% of premium – cost share	Yes, until Medicare-eligible
On or after January 1, 2020	1/1/2020 – 12/31/2021	50% of premium – cost share	No
	1/1/2022 - present	65% of premium – cost share	No

1095 Mailings

While a 1095 is no longer required for tax filing, it will be provided by Fermi or BCBS, depending on the plan you are enrolled in, by the IRS deadline, March 2, 2027

Visit the retiree benefits website!

For the most up-to-date retiree benefits information, visit <https://retirees.fnal.gov>. The latest information on 2027 annual enrollment is available on the website. No user ID or password required.

Benefit Plan Contacts

Product/Plan	Contact	Location	Phone Number	Email/Web Address
Retiree Billing	Chrys Lewis	FNAL Accounting	630-840-4369	clewis@fnal.gov
BlueCross/BlueShield of IL PPO (P56727) Vision Discount – Blue 365* Telehealth via MDLIVE Prescriptions (BCBS IL PPO) Retail & Mail Order	Blue Cross/Blue Shield	Customer Service	800-548-1686	www.bcbsil.com
	EyeMed	Customer Service	800-548-1686	www.bcbsil.com
	MDLIVE	Customer Service	888-676-4204	www.MDLIVE.com/bcbsil.com
	Express Scripts	Customer Service	866-814-7105	www.express-scripts.com/fermilab www.express-scripts.com
Blue Advantage HMO (B51346) Prescriptions (BA HMO) Retail Mail Order Vision Care (HMO Only)	Blue Cross/Blue Shield	Customer Service	800-892-2803	www.bcbsil.com
	Prime Therapeutics Prime Mail or Walgreens	Customer Service	800-423-1973 877-357-7463 800-275-7204	www.myprime.com
	EyeMed	Customer Service	800-892-2803	www.bcbsil.com
	Fidelity: 401(a) (88977) 403(b) (501801)	Service Center	800-343-0860	www.netbenefits.com/fermilab
Legacy Retirement Savings Plan Providers	BNY Mellon (formerly Dreyfus) (B556572238)	Customer Service	800-358-0910	www.dreyfus.com
	TIAA-CREF: 401(a) (101300) 403(b) (101301)	Customer Service	800-842-2273	www.tiaa.org
Retiree Medical Medicare eligible retirees Retiree Medical Questions	Via Benefits	Service Center	855-241-5721	https://my.viabenefits.com
	Fermilab	Fermilab Benefits	(630) 840-5055	benefitsoffice@fnal.gov

Do you have questions regarding 2027 Enrollment?

Contact the Benefits team at:

benefitsoffice@fnal.gov

or

(630) 840-5055

(regular business hours)

Note: Medicare-eligible retirees and dependents should direct questions to Via Benefits at 1-855-241-5721

Fermi National Accelerator Laboratory
Medical Plan for Non-Medicare Eligible Retirees and Dependents
Annual Enrollment Form

Fermi ID	Retiree Last Name	Retiree First Name	Middle Initial	Home email address
Street Address		City	State, Zip	Home Phone

Retiree Medical Coverage

☐ Plan Change ☐ Blue Cross Blue Shield PPO ☐ Blue Cross Blue Shield Blue Advantage HMO	☐ Coverage Change ☐ Single ☐ Retiree + Child(ren)	☐ Retiree + Spouse ☐ Family	☐ No Change
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BENEFITS OFFICE USE ONLY

Benefit Program <u>RET</u>	Billing Effective Date _____	Payment Method <u>ACH</u>
BPPORU (BCBS PPO No MCR)	0200 (BCBS PPO No MCR)	1 (Single) 2 (Retiree + Spouse)
BLADRU (BCBS HMO no MCR)	0200 (BCBS HMO No MCR)	3 (Retiree + Child(ren)) 4 (Family)

Please provide information below for yourself and your eligible dependents to be covered under the Fermilab Retiree Medical Plan

Name, Last/First/Middle Initial	Gender	Birth Date (mm/dd/yyyy)	Last 4 digits of Social Security Number (SSN is not required)	Blue Cross - HMO PCP Name	Blue Cross HMO – Medical Group Number (3 digits)
<i>Self</i>			not required		
<i>Spouse*</i>			not required		
<i>Child *</i>			not required		

☐ **I decline coverage**, and I understand that I cannot elect coverage at a later date.

Retiree Acknowledgements:

I understand that premiums for my retiree medical coverage will be automatically deducted from my bank account. Completion of an authorization agreement is required. I understand that my coverage will be terminated for non-payment of my premiums.

I understand that my coverage once terminated cannot be reinstated.

I understand that subject to the provisions of the Medicare Secondary Payer Act [42 U.S.C. §1395y (b) (2) (A) (ii) and the terms of the Fermilab Medical Plan for Employees and Retirees, upon my retirement from Fermilab, Medicare becomes the primary payer for all medical claims for me and my covered dependents who are eligible for Medicare. This includes retirees and dependents whose Medicare eligibility is due to age, disability or any other reason. I understand that if I or my covered dependent is eligible for Medicare, it is my responsibility to enroll in Medicare Parts A and B prior to my retirement, and to pay any required premiums. I further understand that the FFDG medical plan has no responsibility to pay any medical expenses incurred by me or by my covered dependents for services for which Medicare would have paid except for my failure to timely enroll.

I have been provided a copy of the FFDG Summary Plan Description for Active and Retired Employees in electronic format, and understand that if I wish to receive a hard copy, that one will be provided to me.

I understand that FFDG reserves the right to amend, modify or terminate the plan at any time.

Signature _____ Date _____

Benefits Office Signature _____ Date _____

Fermi Forward Discovery Group, LLC
Benefits Office
Retiree Medical Plan Enrollment Change Form
Please Print

Fermi ID or Social Security Number	Retiree Last Name	Retiree First Name	Middle Initial
Street Address	City	State, Zip	Home/Cell Phone/Email

Medical Coverage Change

Effective Date of Change (mm/dd/yyyy):

☐ I wish to

☐ I want to change my coverage tier to*

☐ Change to the Blue Cross Blue Shield PPO

☐ Retiree and Spouse*

☐ Change to the Blue Cross Blue Shield Blue Advantage HMO

☐ Retiree and Child*

☐ Cancel Coverage. I understand that I cannot elect coverage at a later date.

☐ Retiree Only*

Benefit Program **RET** Billing Effective Date _____ Payment Method ACH

Please provide the information below for yourself and your eligible dependents to be covered under the Fermilab Retiree Medical Plan

Name, Last/First/Middle Initial	Gender	Birth Date (mm/dd/yyyy)	Social Security Number Not Needed	Blue Cross - HMO Medical Group Number (3 digits)
<i>Self</i>			Not Needed	
<i>Spouse*</i>			Not Needed	
<i>Child *</i>			Not Needed	

***Note: You can only enroll new dependents within 31 days of retirement, marriage, or birth/adoption of a child. Retirees can cancel dependents, but the dependents may not re-enroll in the plan later.**

I understand that premiums for my medical/dental coverage will be automatically deducted from my bank account. Completion of a bank authorization agreement is required. I understand that my coverage will be terminated for nonpayment of my premiums and that it cannot be reinstated. FFDG reserves the right to amend, modify, or terminate the plan at any time.

Signature _____ Date _____

Benefits Office Signature _____ Date _____

Return this form to: Fermilab Benefits at benefitsoffice@fnal.gov
or mail to **HR Benefits Office PO Box 500, MS 126 Kirk Road & Pine St., Batavia, IL 60510**

Retirement Plan Resources

Now that you are no longer an active Fermilab employee, you have access to your Fermi-provided 401(a) retirement plan.

TIAA – This is the company that held Fermilab plans until 2015. If you worked at Fermilab before 2015, you may have a TIAA account. To find out, visit www.tiaa.com, log in, and choose “Get online access” to find your account using your SSN and date of birth. You may also want to update your beneficiary designation.



Fidelity NetBenefits®

Fidelity – This is the current company of Fermilab retirement plans. If you still have money with Fidelity, you can now access your Fermi-provided funds. Contact Fidelity at www.netbenefits.com/fermilab to begin a rollover, request a transfer or change your beneficiary.

To register, click on Log in or register > Register as a new user > Yes > and enter your information to locate your account.



Legally Required Notices

Notice of Creditable Coverage for Retirees and Surviving Spouses of Fermilab and the Superconducting Super Collider

Dear Medical Plan Participant,

This is an important notice about your prescription drug coverage provided by Fermi Forward Discovery Group, LLC ("FFDG") to eligible retirees of Fermi National Accelerator Laboratory ("Fermilab") and the Superconducting Super Collider ("SSC"). This notice explains your options under Medicare Part D. FFDG is required to provide this notice to retirees and active employees who may be Medicare eligible or who have Medicare eligible dependents. Please read this notice carefully and keep it where you can find it.

For the 2027 plan year, FFDG will continue to provide you with prescription drug coverage through either the PPO or HMO plans through the Blue Cross/Blue Shield of Illinois.

FFDG has determined that the prescription drug coverage it provides through these plans is creditable. This means that the amount the plan expects to pay on average for prescription drugs for covered individuals in 2027 is the same or more than what standard Medicare Part D prescription drug coverage would be expected to pay on average. Our decision to continue to provide you with prescription drug coverage means that you do not need to sign up for a Medicare Part D plan, although the final choice is yours. If you do elect Medicare Part D in the future, you will not be subject to the Medicare Part D increased premium.

What Are Your Choices?

1. Keep your FFDG coverage with the prescription drug benefits you have today.
2. Cancel your FFDG coverage and enroll in a Medicare prescription drug plan.
3. Keep your FFDG coverage and enroll in a Medicare prescription drug plan.

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

If you cancel your FFDG coverage, you will lose both medical and prescription drug coverage because these benefits are integrated. If you cancel your coverage under the FFDG plan, you will never be able to get FFDG's coverage back. In addition, if you enroll in Medicare Part D, FFDG will not pay the insurance premium for Medicare Part D.

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. This means that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage.

However, if you lose creditable prescription drug coverage, through no fault of your own or if you decide to drop FFDG-sponsored coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP). 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. Further information about the coverage provided by the FFDG plan can be found in the summary plan description.

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

If you drop or cancel your FFDG coverage and you don't enroll in a Medicare prescription drug plan after your current coverage ends, you may have to pay more to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you do not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Coverage:

Contact our office at the address or phone number listed on the next page. Note: you may receive this notice at other times in the future: before the next period you can enroll in Medicare prescription drug coverage, or if this coverage changes. You also may request a copy of this notice.

For More Information about Your Options under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. If you are enrolled in Medicare, you'll get a copy of the handbook in the mail every year. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- For individuals with limited income and resources, extra help paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration (SSA) online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

If you elect Medicare Part D, you must notify the Fermilab Benefits Office directly in writing immediately.

Fermi Forward Discovery Group, LLC/Fermi National Accelerator Laboratory
Benefits Office
P.O Box 500, MS 126
Batavia, IL 60510 - 5011
(630) 840-6463

Legally Required Notices

Women's Health and Cancer Rights Act (WHCRA)

The Women's Health and Cancer Rights Act (WHCRA), signed into law on October 21, 1998, contains protections for patients who elect breast reconstruction in connection with a mastectomy. For plan participants and beneficiaries receiving benefits in connection with a mastectomy, plans offering coverage for a mastectomy must also cover reconstructive surgery and other benefits related to a mastectomy. When a covered person receives benefits for a mastectomy and decides to have breast reconstruction, based on consultation between the attending physician and the patient, the medical plan must cover reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce symmetrical appearance; prostheses and physical complications in all stages of mastectomy, including lymphedemas. Coverage of these services is subject to the terms and conditions of your health plan, including your plan's normal co-payment, annual deductibles and coinsurance provisions.

Qualified Changes in Status / Changing Your Pre-Tax Contribution Amount Mid-Year

We sponsor a program that allows you to pay for certain benefits using pre-tax dollars. With this program, contributions are deducted from your paycheck before federal, state, and Social Security taxes are withheld. As a result, you reduce your taxable income and take home more money. How much you save in taxes will vary depending on where you live and on your own personal tax situation. These programs are regulated by the Internal Revenue Service (IRS). The IRS requires you to make your pre-tax elections before the start of the election-period year. The IRS permits you to change your pre-tax contribution amount mid-year only if you have a change in status, which includes the following:

- Birth, placement for adoption, or adoption of a child, or being subject to a Qualified Medical Child Support Order which orders you to provide medical coverage for a child.
- Marriage, legal separation, annulment, or divorce.
- Death of a dependent.
- A change in employment status that affects eligibility under the plan.
- A change in election that is on account of, and corresponds with, a change made under another employer plan.
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan.

The change you make must be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. If your spouse's employment terminates and he/she loses employer-sponsored coverage, you may elect coverage for yourself and your spouse under our program. However, the change must be requested within 31 days of the change in status. If you do not notify the Benefits Office within 31 days, you must wait until the next annual enrollment period to make a change. These rules relate to the program allowing you to pay for certain benefits using pre-tax dollars. Please review the medical booklet and other vendor documents for information about when those programs allow you to add or drop coverage, add or drop dependents, and make other changes to your benefit coverage, as the rules for those programs may differ from the pre-tax program.

Grandfathered Health Plan

Effective January 1, 2014, none of the plans at Fermilab are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act).

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Primary Care Provider

Blue Cross Blue Shield Blue Advantage HMO Medical Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Blue Cross may designate a primary care provider automatically, until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Blue Cross at 1-800-892-2803 or www.bcbsil.com.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Blue Cross or from your primary care provider in order to obtain access to obstetrical or gynecological care from a health care professional in the medical plan 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 Blue Cross at 1-800-892-2803 or www.bcbsil.com.

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Benefits Office.

The Children's Health Insurance Program Reauthorization Act of 2009 added the following two special enrollment opportunities:

- The employee or dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility; or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

It is your responsibility to notify the Benefits Office within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. More information on CHIP is provided below.

Protecting Your Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employer health plans to maintain the privacy of your health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information. If you would like a copy of the Plan's Notice of Privacy Practices,

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums. A list of states that offer these programs and information about how to contact them is available on the Benefits page at: <https://hr.fnal.gov/benefits/legal-notices/>.

Notes



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