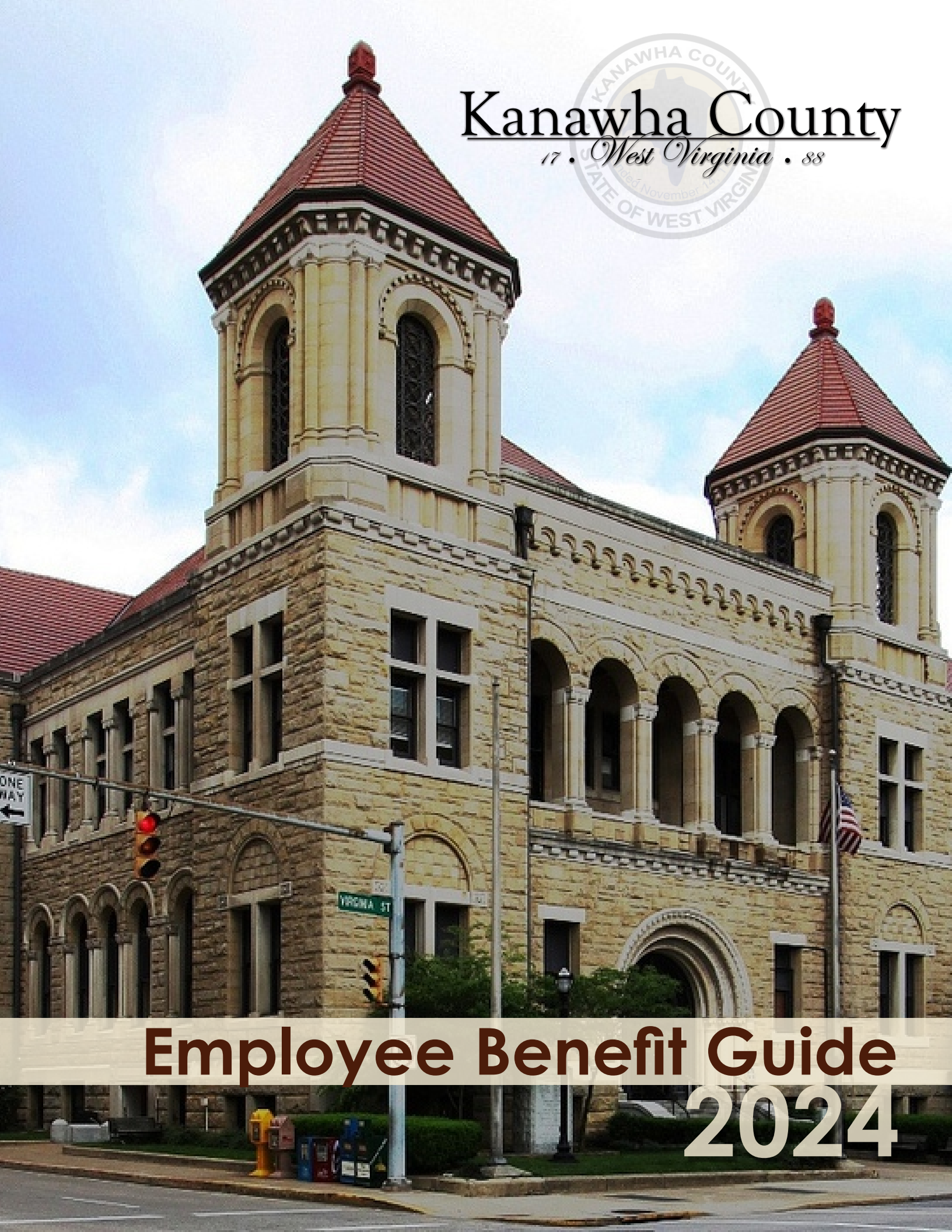

Kanawha County
17 . West Virginia . 88
Employee Benefit Guide
2024

Kanawha County
17 • West Virginia • 88

Welcome to your 2024 Employee Benefits!

Kanawha County Commission recognizes the important role employee benefits play as a critical component of your overall compensation. We strive to maintain a benefits program that is competitive within our industry and designed to protect your health, your family, and your way of life.

This guide was created to answer some of the questions you may have and provide the tools and resources you will need to take full advantage of the programs and plans being offered. Please read it carefully along with any supplemental materials you receive.

For any questions about the benefits outlined in the guide, please contact your Human Resources Department.

What's Inside

PLEASE NOTE: This booklet provides a summary of the benefits available but is not your Summary Plan Description (SPD). Your company reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

Carrier Contacts

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. Follow these steps if you require assistance:

- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.

- For claims assistance, please contact the insurance carrier. You will need your ID number or Social Security number along with date of service and provider name.

Carriers	Website	Phone
Medical UMR	www.umr.com	1.888.440.7342
Health & Wellness Center KCEAA	http://www.kceaa.org/clinic.html	304.346.8877
Dental Guardian	www.guardiananytime.com	1.800.600.1600
Vision Guardian	www.guardiananytime.com	1.800.600.1600
Health Reimbursement Account The Health Plan	Cds.healthplan.org	1.866.347.3640
Flexible Spending Account The Health Plan	Cds.healthplan.org	1.866.347.3640
Basic / Voluntary Life and AD&D Guardian	www.guardiananytime.com	1.800.600.1600
Employee Assistance Program Guardian	www.Guidanceresources.com	1.855.239.0743
Voluntary Worksite Benefits Aflac	www.aflac.com	1.800.433.3036
Retirement Benefits Nationwide	www.frsforu.com	1.888.402.5272

Eligibility

Kanawha County Commission shares in the cost by paying for a portion of the employee and dependent health insurance costs. Dependents are eligible to participate in the health & welfare plan. Your completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

Any elections made will remain in effect and cannot be changed or revoked until the next annual Open Enrollment period, unless the change is due to and consistent with a family/life status change.

Who is eligible for Benefits?

- For new employees working 35-40 hours per week, benefits begin the 1st of the following month
- All current employees working 30 hours per week

Eligible Dependents

- A spouse to whom you are legally married
- A dependent child under the age of 26. Coverage terminates at the end of the month of the dependent's 26th birthday.

You will need to supply a copy of your marriage certificate and your children's birth certificates at initial enrollment.

Coverage for eligible dependents generally begins on the same day your coverage is effective.

**Additional carrier conditions may apply.*

Please Note: If you cover an individual on your benefit plan who is not an eligible dependent, this is considered fraud and theft. Claims may be reprocessed and become your responsibility. Providing false statements regarding Tobacco usage is against company policy. Anyone found providing false statements will be subject to discipline up to and including termination of employment.

Benefit Change in Status

Kanawha County Commission sponsors a cafeteria plan which allows eligible employees to choose from a menu of different benefits to suit their needs and to pay for some or all of those benefits with pre-tax dollars.

Participant elections made under a cafeteria plan are generally irrevocable and run from the beginning of the Plan Year (or date of initial eligibility) through the end of the Plan Year. You will not be able to change or revoke your elections during the Plan Year unless you experience an IRS permitted qualifying event. Any change you make must be consistent with the qualifying event. Examples of qualifying events that may entitle you to make a mid-year change in your election during a Plan Year, include:

- Birth / Adoption
- Divorce
- Death
- FMLA Related Leave
- Open enrollment under spouse's employer's benefit plan
- Dependent Child Age Limit
- Marriage
- Loss of Coverage
- Eligible for Medicare
- Beginning or end of spouse's coverage

Employers do not have to permit any exceptions to the election irrevocability rule for cafeteria plans. Please consult your Plan Administrator for the specific qualifying events permitted by your plan.

IMPORTANT: You must notify your Plan Administrator within 30 days from the Status Change in order to make a change in your benefit selections.

Medical Insurance

UMR medical plans offer freedom of choice with access to a large national network of physicians, hospitals and health care professionals (clinics, labs, care centers, etc.). To find a network provider, visit www.umr.com or call 1.800.440.7342.

	PEIA Plan A		PEIA Plan C	
	In Network	Out of Network	In Network	Out of Network
Deductible *(Individual / Family)*	$450 / $900	$900 / $1,800	$1,600 / $3,200	$1,600 / $3,200
Out of Pocket Maximum *(Individual / Family)*	$2,500 / $5,000	$5,000 / $10,000	$2,500 / $5,000	No coverage
Physician Office Visits *Primary Care / Specialist*	**In WV** : $20 PCP / $40 Specialist **OOSWA:** $20 PCP / $40 Specialist **OOSNA**: $20 PCP / $40 Specialist	NOT COVERED Except in an emergency or if approved in advance by UMR	**PCP & Specialist:** Deductible + 20%	NOT COVERED Except in an emergency or if approved in advance by UMR
Preventive Care	Covered in Full	NOT COVERED	Covered In Full	NOT COVERED
Emergency Room	**In WV**: Deductible + 20% **OOS**: Deductible + 30%	NOT COVERED Except in an emergency or if approved in advance by UMR	Deductible + 20%	NOT COVERED Except in an emergency or if approved in advance by UMR
Emergency Room *(non-emergency)*	$100 copay then deductible + 20%	NA	Deductible + 20%	NA
Urgent Care	**In WV:** $50 **OOSWA:** $50 **OOSNA:** 2x deductible + 40%	NOT COVERED Except in an emergency or if approved in advance by UMR	Deductible + 20%	NOT COVERED Except in an emergency or if approved in advance by UMR
Inpatient Services	**In WV:** $100 copay + deductible + 20% **OOSWA:** $100 copay + deductible + 30% **OOSWA**::$600 copay 2 x deductible + 40%	NOT COVERED Except in an emergency or if approved in advance by UMR	Deductible + 20%	NOT COVERED Except in an emergency or if approved in advance by UMR
Outpatient Surgery Hospital / Alternative Care Facility	**In WV:** $100 copay + deductible + 20% **OOSWA:** $100 copay + deductible + 30% **OOSWA:** $600 copay 2 x deductible + 40%	NOT COVERED Except in an emergency or if approved in advance by UMR	Deductible + 20%	NOT COVERED Except in an emergency or if approved in advance by UMR

Prescription Drugs *(Retail 31-day supply)*	PEIA Plan A	
	In Network	Out of Network
Deductible (Ind/family)	$75 / $150	$10 after deductible PEIA will reimburse ESI's allowed amount, less any member responsibility
Out of Pocket	$1,750 / $3,500	$25 after deductible PEIA will reimburse ESI's allowed amount, less any member responsibility
Tier 1 / 2 / 3	$10 / $25 / 75%	75% coinsurance, PEIA will reimburse ESI's allowed amount, less any member responsibility

Prescription Drugs *(Retail 31-day supply)*	PEIA Plan C
	Out of Network
Deductible (Ind/family)	$1,600 / $3,200	$10 after deductible PEIA will reimburse ESI's allowed amount, less any member responsibility
Out of Pocket	$2,500 / $5,000	$25 after deductible PEIA will reimburse ESI's allowed amount, less any member responsibility
Tier 1 / 2 / 3	$10 after deductible / $25 after deductible / 75% after deductible	75% coinsurance, PEIA will reimburse ESI's allowed amount, less any member responsibility

Rates Per Pay	Plan A		Plan C	
	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
Employee Only	$68.10	$80.60	$41.20	$53.70
Employee + Children	$125.30	$150.30	$63.40	$88.40
Family	$149.40	$174.40	$89.00	$114.00

Which Health Plan may be financially better for me and my family?

LOW UTILIZER OF HEALTH BENEFITS

(I/we only take a few medications and go to the doctor once or twice a year)

My annual payroll deduction + Projected Medical/Rx Out of pocket Expenses

Plan A Projected Expenses		
Employee Only	**Employee/Child(ren)**	**Family**
$1,794.40	**$3,407.20**	**$4,225.60**

Plan C Projected Expenses		
Employee Only	**Employee/Child(ren)**	**Family**
-$211.20	**-$1,078.40**	**$136.00**

Why does Plan C cost so much less? KCC will put $1,600 (employee only) and $3,200 (Employee +1 or more) into an HSA (Health Savings Account) account you can use for your medical expenses. HSA dollars can only be used for eligible expenses. Un-used monies will rollover to the next year for use on future eligible expenses.

How do you calculate the above numbers?
Your payroll deductions:
Plan A on an annual basis will be Employee: $1634.40, Employee/Child(ren) $3,007.20, Family $3,585.60
Plan C on an annual basis will be Employee: $988.80, Employee/Child(ren) $1,521.60, Family $2,136.00
Projected medical expense based on the above example:
Plan A: Employee: $160 ($10x12 months + $20 x2 doctor visit), Employee/Child(ren) $400, Family $640
Plan C (actual cost of the services): Employee: $400, Employee/Child(ren) $600, Family $1,200

MEDIUM UTILIZER OF HEALTH BENEFITS

(I/we take 4 - 6 medications per month and go to my primary 4-6 times a year and a specalist 2-3 times per year.)

My annual payroll deduction + Projected Medical/Rx Out of pocket Expenses

Plan A Projected Expenses		
Employee Only	**Employee/Child(ren)**	**Family**
$2,484.40	**$4,282.20**	**$6,135.60**

Plan C Projected Expenses		
Employee Only	**Employee/Child(ren)**	**Family**
$1,393.80	**$1,329.10**	**$4,951.00**

Why does Plan C cost so much less? KCC will put $1,600 (employee only) and $3,200 (Employee +1 or more) into an HSA (Health Savings Account) account you can use for your medical expenses. HSA dollars can only be used for eligible expenses. Un-used monies will rollover to the next year for use on future eligible expenses.

Your payroll deductions are the same as listed above in the low utilizer area footnote.
Projected medical expense based on the above example:
Plan A: Employee: $850 (Rx $40x12 months + $20 x4 PCP + $40 x 2 Specialist), Employee/Child(ren) $1,275, Family $2,550
Plan C (actual cost of the services): Employee: $2,005, Employee/Child(ren) $3,007, Family $5,000

HIGH UTILIZER OF HEALTH BENEFITS

(I take 8 generic medications per month, 1 Specialty medication per month and go to my primary 6 times a year and a specalist 4 times per year. Either me or a family member reach the maximum out of pocket each year.)

My annual payroll deduction + Projected Medical/Rx Out of pocket Expenses

Plan A Projected Expenses		
Employee Only	**Employee/Child(ren)**	**Family**
$10,234.40	**$12,267.20**	**$13,385.60**

Plan C Projected Expenses		
Employee Only	**Employee/Child(ren)**	**Family**
$1,888.80	**$3,321.60**	**$3,936.00**

Why does Plan C cost so much less? KCC will put $1,600 (employee only) and $3,200 (Employee +1 or more) into an HSA (Health Savings Account) account you can use for your medical expenses. HSA dollars can only be used for eligible expenses. Un-used monies will rollover to the next year for use on future eligible expenses.

Your payroll deductions are the same as listed above in the low utilizer area footnote.

Projected medical expense based on the above example:
Plan A: Employee: $8,600 (Rx $80x12 months+$100x12 Spec. Rx, $20 x6 PCP+$40x4 Specialist, max-out of pocket $8,600), Employee/Child(ren) $9,260, Family $9,800
Plan C (actual cost of the services): Employee: $2,500, Employee/Child(ren) $5,000, Family $5,000

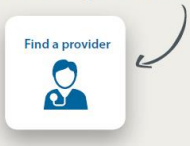
Plan A Highlights - Medical Deductible: $600/$1,200 Medical Max Out of Pocket: $6,850/$13,700
Rx Dedcutible: $75/$150 Rx Max Out of Pocket: $1,750/$3,500

Plan C Highlights
Medical/Rx Deductible: $1,600/$3,200 Medical Max Out of Pocket: $2,500/$5,000

Find a provider

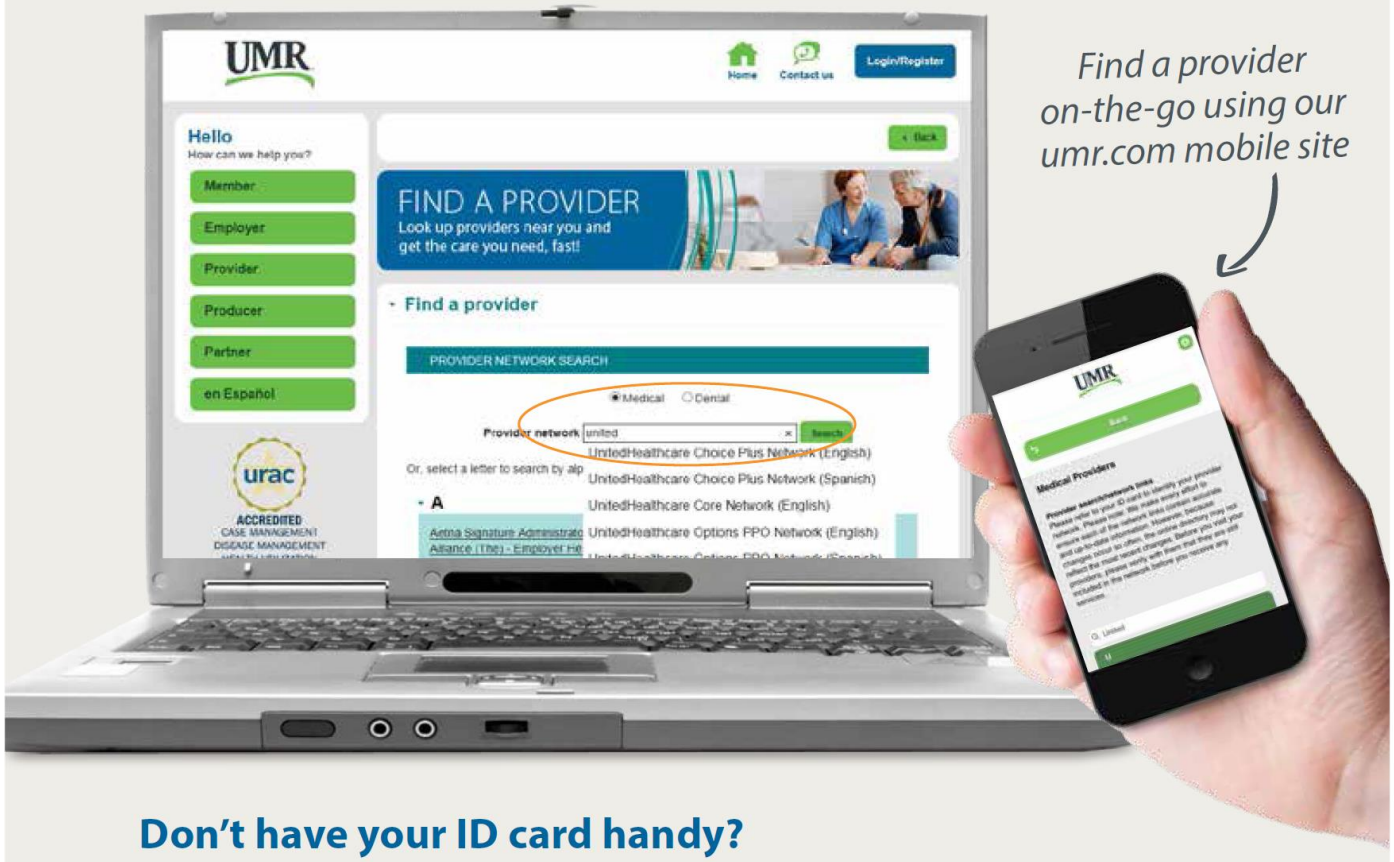
Finding a network provider on umr.com has never been easier

1 Go to **umr.com** and select **"Find a provider"**



2 Look for the name of your provider network on your **ID card**

3 Begin a search for your provider network using our alphabet navigation, or type the name into the **search box**



Find a provider on-the-go using our umr.com mobile site

Don't have your ID card handy?

That's OK. If you log in to your umr.com account and click "Find a provider" from the MyMenu, you will be directed to your in-network provider listing.

UMR℠

A UnitedHealthcare Company

Get all your answers ***quick*** and ***easy*** @ **umr.com**

UMR
A UnitedHealthcare Company

Make umr.com your first stop

You want managing your health care to be fast and easy, right? You got it. At umr.com, you'll find everything you want to know – and need to do – as soon as you log in.

No hassles. No waiting. Just the answers you're looking for anytime, night or day!

Log in now to:

View **My taskbar,** your personalized benefits to-do list

Check your benefits and see what's covered

Look up what you owe and how much you've paid

Find a doctor in your network

Learn about medical conditions and treatment options

Access tools and trusted resources to help you live a healthier life

Getting started

If you already have an account, go to **umr.com** and click the **Login/Register** button in the upper-right corner. If it's your first time visiting us, click the **Login/Register** button in the upper-right corner to open an account. Make sure you have your ID card handy and follow the steps to get started.

WANT A QUICK TOUR?
Use the QR code reader on your smart phone to watch a short video.

Note: *The images shown reflect available features within our desktop site. These features may or may not be available to all users, depending on your individual and/or company benefits.*

You don't need a Ph.D. to understand your benefits

We've made it easy to find the top things people want to know. Choose **Benefits & coverage** from myMenu to find out:

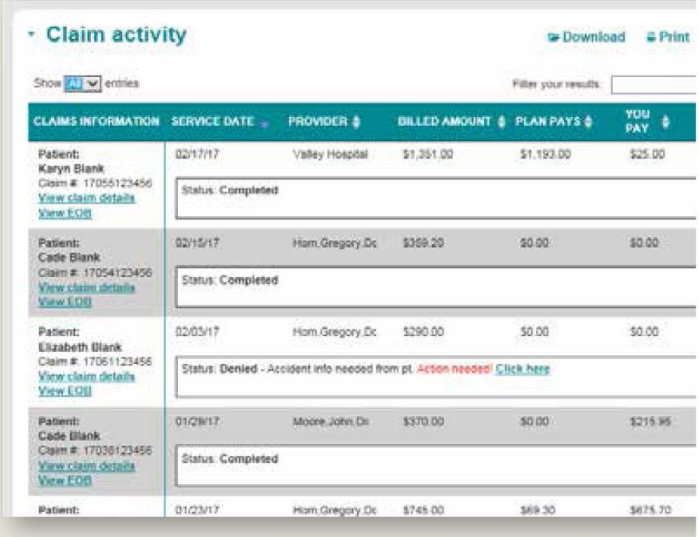
- What health care services are covered?
- What's the cost difference between an in-network and out-of-network service?
- What's your deductible, and are you close to reaching it?
- Is there a copayment for your office visit? If so, how much?

Did your dog eat your ID card?

No worries. It's easy to get a replacement online.

Just click **ID card** from myMenu to see a copy of your card. With a couple more clicks you can have a new card mailed to your home.

Can't wait for the mailman? Print a temporary copy from our desktop site. Or, use your smart phone to view your ID card or fax a copy to your doctor's office.



Fictionalized data

Buried in paperwork? A single click lets you track all your claims

Check in at your convenience to see if a claim has been processed and what you might owe. To get more details on a specific claim, click view claim details or view EOB. This will tell you the type of services provided, the amount billed and the amount paid, if any, and whether there's any action that needs to be taken before the claim can be processed.

You can choose to receive a secure e-mail any time you have a new EOB. If you're not ready to give up paper completely, you can print out copies from our claims center.

Don't be surprised by unexpected costs

- Know the price you'll pay ahead of time. Search treatments or procedures in the **Health cost estimator.**
- Get your in-network discount. Use **Find a provider** to look up doctors and facilities near you.

Helpful apps, calculators, videos and health information all in one place

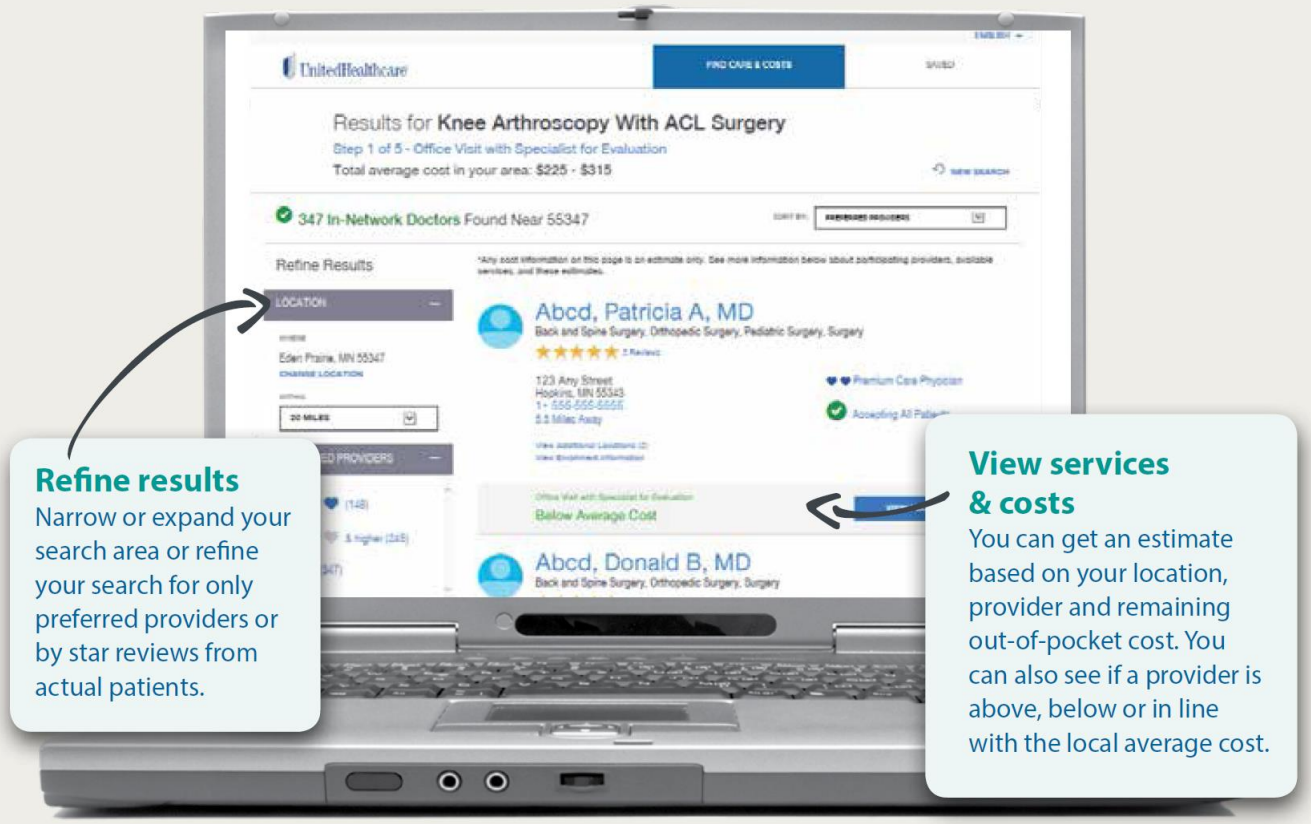
Choose **Health center** from the myMenu and select the tile shortcuts that interest you.

- Online health information: up-to-date and ad-free
- Our top picks for healthy eating and exercise
- Free tools, apps and calculators

Know what you'll pay before getting care

A UnitedHealthcare Company

The health cost estimator allows you to research treatment options and learn about the recommended care and estimated costs associated with your selected treatment option. You can even access quality and efficiency measurements for participating providers.



Refine results
Narrow or expand your search area or refine your search for only preferred providers or by star reviews from actual patients.

View services & costs
You can get an estimate based on your location, provider and remaining out-of-pocket cost. You can also see if a provider is above, below or in line with the local average cost.

Health cost estimator

It's easy to get started. Just look for the ***Health cost estimator*** tile on your personal home page.

Health & Wellness Center

The free clinic for all county employees and their families**.

No Co-Pay. Ever.

If you are covered by PEIA or another carrier, we bill them for services provided.
But you will never be charged a co-pay, just have your insurance card with you when you visit.

Free Medical Services

- Primary Care for ages 16 and up
- Sports physicals
- Medical counseling
- Acute Care for ages 2 and up
- School physicals
- Standard lab tests for free

Skip the pharmacy!

If we are your primary care provider, we provide standard maintenance medications for conditions such as cholesterol, diabetes and high blood pressure, free of charge.

We have acute care medications on hand, such as antibiotics and muscle relaxers, available at a low cost at the time of your visit.

OFFICE HOURS:
Mon: 8 a.m. to 4 p.m.
Tues: 8 a.m. to 4 p.m.
Wed: 8 a.m. to 12 noon
Thurs: 8 a.m. to 4 p.m.
Fri: 8 a.m. to 4 p.m.

Call us for an appointment
304.346.8877
We can usually get you in the same day!

***** Call us with any questions about services and eligibility of family members***

Health Savings Account (HSA)

What is a Health Savings Account (HSA)?

A Health Savings Account is a tax-advantaged trust account that allows you to take charge of your health, your savings and your future.

It allows you to put away tax-free dollars to help pay for your eligible healthcare expenses including medical, prescription drugs, dental, vision, certain premium expenses like COBRA and Medicare premiums, etc., both today and in the future.

The 2024 maximum annual contribution to an HSA is $4,150 for single coverage and $8,300 for family coverage (combined between yourself and "the company"). The IRS determines the contribution maximums annually. If you are 55 or older anytime in 2024, you may contribute an additional $1,000 in a catch-up contribution.

Who is eligible for an HSA?

- You must be enrolled in a qualified High Deductible Health Plan (HDHP).
- You cannot be covered by any other plan that is not a qualified HDHP, with certain exceptions.
- You cannot be enrolled in Medicare or receiving Social Security.
- You cannot be claimed on another person's tax return.
- You have not received VA medical benefits at any time over the past three months.

What is a High Deductible Health Plan

A HDHP is a plan with a certain annual deductible amount and a maximum out-of-pocket limit.

Sometimes referred to as consumer-driven health plan, a HDHP still covers you for catastrophic illness and injury—what health insurance was originally intended to do.

How does the HDHP Deductible Work?

Under the HDHP, your annual deductible and out-of-pocket maximum includes both medical and pharmacy expenses. All expenses are your responsibility until the deductible is reached (except qualified preventive care). All individual deductible amounts will count towards meeting the family deductible.

When do I use my HSA?

After visiting a physician, facility, or pharmacy, swipe your HSA debit card for payment. Your HSA dollars can be used to pay your out-of-pocket expenses (deductibles and coinsurance) billed by the physician, facility, or pharmacy, or you can choose to save your HSA dollars for a future medical expense. In addition, HSA dollars are available to pay for dental, vision and other expenses as well.

Advantages of an HSA

- Money you put into your account is deducted pretax therefore reducing your taxable income.
- Money that stays in your account earns tax-free interest.
- Money you pay from your account to pay for your qualified healthcare expenses is not taxed.
- Money rolls over from year-to-year – no "use it or lose it" restriction.

Who Administers my HSA

The Health Plan
cds.healthplan.org
866.347.3640
customersolutions@healthplan.org

Sample Eligible Expenses 213 (d)

All submitted expenses are reviewed according to the regulations of Internal Revenue Code Section 213 (d). For the complete list of IRS Section 213(d) expenses, please visit Publication 502 (available at www.irs.gov) or you can access approved items through the Health Shopper link on the portal and mobile applications. Some expenses may require documentation from your physician.

Drugs

Eligible:

- Prescription drugs that treat a medical condition
- Birth control drugs
- OTC pain relief, allergy
- Insulin
- Vitamins (if prescribed)

Ineligible:

- Dietary supplements, including vitamins and herbs
- Drugs for cosmetic purposes

Vision Care

Eligible:

- Optometrist or ophthalmologist fees
- Eyeglasses
- Contact lenses and cleaning solutions
- Prescription sunglasses
- Corrective eye surgery (such as radial keratotomy)

Ineligible:

- Lens replacement insurance
- Warranties
- Protection plans
- Coating/tints that do not treat a medical condition

Dental/Orthodontic Care

Eligible:

- Dental care
- Artificial teeth/dentures
- Cost of fluoridation of home water supply advised by dentist
- Braces, orthodontic services (only those incurred within the active plan year)

Ineligible:

- Teeth bleaching
- Tooth bonding that is not medically necessary

Treatments/Therapies

Eligible:

- Weight loss programs prescribed to treat a medical condition
- X-ray treatments
- Smoking cessation programs
- Treatment for alcoholism or drug dependency
- Acupuncture
- Vaccinations
- Physical therapy (as a medical treatment)
- Speech therapy
- Occupational therapy
- Infertility treatment

Ineligible:

- Physical treatments unrelated to specific health problem (e.g., massage for general well-being)
- Any illegal treatment

Insurance

Eligible:

- Deductibles and co-payments for health care
- Insurance premiums (medical, dental, vision)
- Coinsurance (the percentage of charges not paid by your health care plan)
- Amounts over usual and customary limits
- Qualified long term care premiums

Ineligible:

- Employer sponsored Health Insurance
- Premiums/contributions for insurance coverage (including loss of income and loss of life)
- Premiums paid by you for life insurance policies and for loss of life, limb, sight, etc. policies
- Expenses paid by your health care plan

Fees/Services

Eligible:

- Physician's fees
- Routine/preventive physicals
- Obstetrical expenses
- Hospital services
- Nursing services for care of a specific medical ailment
- Cost of a nurse's room and board when nurse services qualify
- The Social Security tax paid with respect to wages of a nurse when nurse's services qualify
- Surgical or diagnostic services
- Legal sterilization
- Cosmetic surgery/procedures that treat deformity caused by an accident or trauma, disease, or an abnormality at birth
- Services of chiropractors and osteopaths
- Anesthesiologist fees
- Dermatologist fees
- Gynecologist fees

Ineligible:

- Cosmetic surgery/procedures that improve patient's appearance but do not meaningfully promote the proper function of the body or prevent/treat an illness/disease
- Payments to domestic help, companion, babysitter, chauffeur, etc. who primarily render services of a nonmedical nature
- Nursemaids or practical nurses who render general care for healthy infants

Sample Eligible Expenses 213 (d) (continued)

Fees/Services

Eligible:

- Physician's fees
- Routine/preventive physicals
- Obstetrical expenses
- Hospital services
- Nursing services for care of a specific medical ailment
- Cost of a nurse's room and board when nurse services qualify
- The Social Security tax paid with respect to wages of a nurse when nurse's services qualify
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- Nursemaids or practical nurses who render general care for healthy infants

Medical Equipment Eligible:

Eligible:

- Wheelchair or autoette (cost of operating/maintaining)
- Crutches (purchased or rented)
- Oxygen equipment and oxygen used to relieve breathing problems that results from a medical condition
- Artificial limbs
- Support hose (if medically necessary)
- Wigs (where necessary for mental health of individual who loses hair because of disease)

Ineligible:

- Wigs, when not medically necessary for mental health

Psychiatric Care

Eligible:

- Services of psychotherapists, psychiatrists, and psychologists
- Legal fees directly related to commitment of a mentally ill person

Ineligible:

- Psychoanalysis undertaken to satisfy curriculum requirements of a student
- Marriage counseling

Assistance for the Disabled

Eligible:

- Cost of guide for a blind person
- Cost of note-taker for a deaf child in school
- Cost of Braille books and magazines in excess of cost of regular editions
- Seeing eye dog (cost of buying, training, and maintaining)
- Hearing-trained cat or other animal to assist deaf person (cost of buying, training, and maintaining)
- Household visual alert system for deaf person
- Excess costs of specifically equipping automobile for a disabled person over the cost of ordinary automobile; device for lifting a disabled person into automobile

Miscellaneous Charges

Eligible:

- Sales tax associated with an eligible expense
- Hearing aids, batteries for operation of hearing aids, and hearing aid repairs
- Expenses connected with donating an organ
- Cost of computer storage of medical records
- Transportation expenses primarily for, and essential to, medical care including car mileage, bus, taxi, train, plane fares, ambulance services, parking fees and tolls
- Lodging expenses (not provided in a hospital or similar institution) not to exceed $50 per night per individual while away from home if the lodging is primarily for, and essential to, medical care provided by a doctor.

Ineligible:

- Expenses of divorce when doctor or psychiatrist recommends divorce
- Cost of toiletries, cosmetics, and sundry items (e.g., soap, toothbrushes)
- Maternity clothes
- Diaper service
- Distilled water purchased to avoid drinking fluoridated city water supply
- Installation of power steering in an automobile
- Pajamas purchased to wear in hospital
- Mobile telephone used for personal phone calls, as well as, calls to a physician

Why will I save money? Money that is redirected to your HRA account is exempt from federal income taxes, Social Security taxes, and, in most cases, state income taxes.

NOTE: Effective January 1, 2020, you can use your HRA 213(d) account funds to purchase OTC drugs and medicines (e.g. Advil, ibuprofen, cough syrup).

Dental Insurance

Guardian

Your smile does more than just brighten up a room – it's an indicator of your overall physical health. Many diseases such as diabetes, leukemia, oral cancer, pancreatic cancer, heart disease, kidney disease, and osteoporosis first present signs and symptoms in the mouth. Regular dental checkups allow for early detection of these underlying medical issues. Furthermore, certain dental disorders can cause other problems within the body if left untreated. In essence, good dental health promotes good overall health.

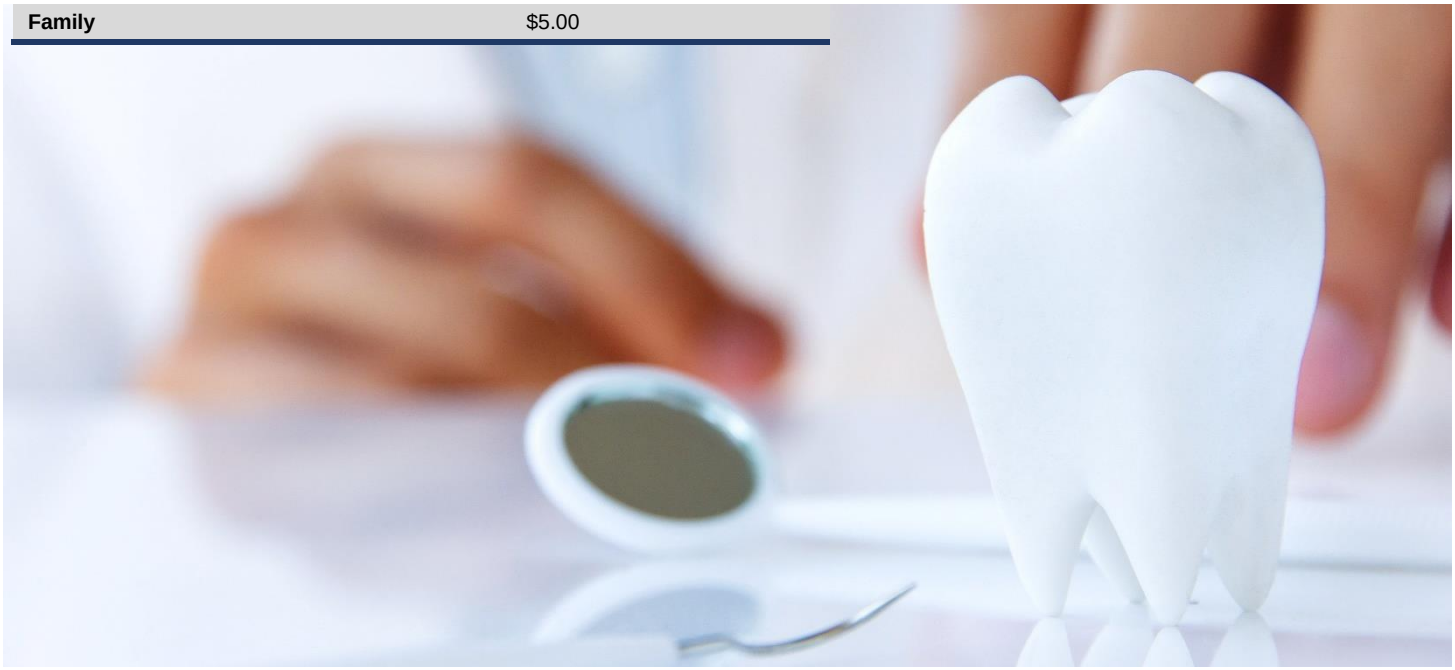
	In-Network	Out-of-Network
Calendar Year Deductible* *(Single / Family)*	$25 / $50	$25 / $50
Annual Benefit Maximum	$1,800 per member	$1,800 per member
Diagnostic & Preventative* *Oral Exams, Routine Cleanings, X-Rays*	Plan Pays 100%	Plan Pays 100%
Basic Services *Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery*	Plan Pays 80%	Plan Pays 80%
Major Services *Crowns, Inlays, Onlays, Cast Restorations, Root Canal, Extractions, Implants*	Plan Pays 50%	Plan Pays 50%
Orthodontia Dependent child(ren) only ***($2,000 Lifetime Maximum per Member)***	Plan Pays 50%	Plan Pays 50%

**Deductible does not apply to Preventive care*

****Non-Guardian Dentists** *(out-of-network)*

Visit a dentist in the PPO network to maximize your savings. These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill. Find a dentist at www.guardiananytime.com.

Rates Per Pay	
Employee Only	$3.00
Employee + Children	$4.00
Family	$5.00



Vision Insurance

Guardian

Guardian provides vision coverage for routine eye exams, lenses and frames. In-network physician services provide a higher benefit plan coverage and lower out of pocket expenses. Choose from a large network of ophthalmologists, optometrists and opticians from private practices to retailers like Costco Optical and Vision Works. To find a Network provider in the VSP network, visit www.VSP.com.

	Network	Out-of-Network
Routine eye exam *(every calendar year)*	$10 copay	Up to $39
Materials Copay *(waived for elective contact lenses)*	$25	NA
Eyeglass frames *(every two calendar years)*	80% of amount over $250	Up to $46
Costco, Walmart and Sam's Club Frame allowance	Amount over $135	
Standard Lenses *(every calendar year)*		
Single Vision	$0	Up to $23
Lined Bifocal	$0	Up to $37
Lined Trifocal	$0	Up to $49
Lenticular	$0	Up to $64
Contact Lenses *(every 12 months)* *instead of eye glasses*		
Contact lens exam *Standard contact lens fit and evaluation*	15% off UCR	No discounts
Elective Conventional	Up to $250	Up to $100
Medically Necessary	$0	Up to $210
In-Network Value added Features		
Cosmetic Extras	Avg. 20-25% off retail price	No discounts
Glasses *(Additional pair of frames and lenses)*	20% off retail price	No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price	No discounts

Rates Per Pay	
Employee Only	$1.00
Employee + Children	$1.50
Family	$1.50

Basic Life and AD&D Insurance

Kanawha County Commission provides Basic Term Life and Accidental Death & Dismemberment (AD&D) in the amount of $50,000.

In addition to the amount above, PEIA gives $10,000 in basic life to employees. You do not need to enroll in the health insurance to receive this.

Accidental Death and Dismemberment coverage is equal to the Basic Term Life amount.

Benefits reduce 35% at age 65, 45% at age 70.

Voluntary Term Life and AD&D Insurance

In addition to the provided life insurance, you may also purchase additional life insurance coverage through Guardian for yourself, your spouse, and your dependent children. Please see your benefits administrator or HR department for rates.

Accidental Death and Dismemberment coverage is equal to the Voluntary Term Life amount.

Voluntary Life and AD&D	
Employee Benefit	$25,000 increments to a maximum of $100,000. Guarantee Issue: $100,000
Spouse Benefit	$25,000 increments to a maximum of $50,000, not to exceed 100% of employee amount. Guarantee Issue: $50,000 *Spouse coverage terminates at age 70.*
Child Benefit	14 days to 23 years (25 if full time student): $2,500 increments to a maximum of $10,000

Coverage will be reduced 35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80

Guarantee Issue is only available during your initial enrollment and for new hires only. Please note, if you do NOT enroll when first eligible for life coverage, you will be required to submit Evidence of Insurability Health/Medical Information which could result in denial of coverage.

Coverage amounts over the Guarantee Issue Amount will require a health application/evidence of insurability. For Late Entrants, all coverage amounts will require a health application/evidence of insurability. Certain pre-existing conditions may disqualify you from receiving additional life amounts after the initial enrollment period.

Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style.

Semi-monthly premiums displayed. Cost of AD&D is included.

Policy Election Amount	Policy Election Cost Per Age Bracket								
Employee	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$25,000	$1.26	$1.44	$1.66	$2.59	$3.31	$5.00	$8.11	$11.44	$11.68
$50,000	$2.53	$2.88	$3.33	$5.18	$6.63	$10.00	$16.23	$22.88	$23.35
$75,000	$3.79	$4.31	$4.99	$7.76	$9.94	$15.00	$24.34	$34.31	$35.03
$100,000	$5.05	$5.75	$6.65	$10.35	$13.25	$20.00	$32.45	$45.75	$46.70
Policy Election Amount									
Spouse									
$25,000	$1.26	$1.44	$1.66	$2.59	$3.31	$5.00	$8.11	$11.44	$11.68
$50,000	$2.53	$2.88	$3.33	$5.18	$6.63	$10.00	$16.23	$22.88	$23.35
Policy Election Amount									
Child(ren)									
$2,500	$0.21	$0.21	$0.21	$0.21	$0.21	$0.21	$0.21	$0.21	$0.21
$5,000	$0.41	$0.41	$0.41	$0.41	$0.41	$0.41	$0.41	$0.41	$0.41
$7,500	$0.62	$0.62	$0.62	$0.62	$0.62	$0.62	$0.62	$0.62	$0.62
$10,000	$0.82	$0.82	$0.82	$0.82	$0.82	$0.82	$0.82	$0.82	$0.82

Employee Assistance Program

Guardian

GuidanceResources® - Employee Assistance Program

Sometimes life can feel overwhelming. It doesn't have to.

Guardian's Employee Assistance Program provides confidential counseling, expert guidance, and valuable resources to help you handle any of life's challenges, big or small.

How it can help

Confidential emotional support

- Anxiety, depression, stress

Work and lifestyle support

- Child, elder and pet care

Financial resources and legal guidance

- Retirement planning, taxes
- Wills, trusts and estate planning

How to access
24/7 live assistance

Call
1 855 239 0743
TRS: Dial 711

Visit
guidanceresources.com

App: GuidanceNow℠
Organization web ID: Guardian
Note: First-time users will need to register first with the organization web ID: Guardian.

This service is only available if you purchase qualifying lines of coverage. See your plan administrator for more details.

Legal/financial assistance and resources services are not available in the state of New York.

The Employee Assistance Program is a suite of services solely created and offered by ComPsych. Guardian is not responsible or liable for care or advice given by any provider or any service offering within the Employee Assistance Program. This information is for informational purposes only. It is not a contract. Only the plan service agreement can provide the actual terms, services, limitations and exclusions. Guardian and ComPsych reserve the right to discontinue the Employee Assistance Program at any time without notice. Legal services provided through the Employee Assistance Program will not be provided in connection with or any action against Guardian, ComPsych, or your employer. The Employee Assistance Program, or any individual service offering within the Program, is not an insurance benefit and may not be available in all states.

Long-Term Deferred Compensation

Nationwide is on your side

Discover the long-term benefits of deferred compensation

Whether you're just starting your career, winding it down or anywhere in-between, you have your Nationwide Deferred Compensation Retirement Specialists to help you prepare for and live in retirement.

Three Easy ways to get the most out of your Plan

1. ENROLL in just minutes. Our online process is simple and intuitive.

2. WATCH videos that can help you understand why you should consider saving, investing and preparing for retirement through your 457(b) plan.

3. MANAGE if you are already enrolled in the plan.
» Set up an online account
» Increase contributions
» Consolidate retirement assets*

We're here to help, for personal assistance with any step of Plan participation, **SCHEDULE AN APPOINTMENT** with a Retirement Specialist.

Book an Appointment

Lynn Robinette, MBS, CRC
Retirement Specialist
Proud Nationwide Member
Nationwide Financial
C: 434.534.5673
lynn.robinette@nationwide.com
Backup Team
Retirement Resource Group
1-888-401-5272
nrsforu.com

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*Qualified retirement plans, deferred compensation plans and individual retirement accounts are all different, including fees and when you can access funds. Assets rolled over from your account(s) may be subject to surrender charges, other fees and/or a 10% tax penalty if withdrawn before age 59 1/2.
Investing involves market risk, including possible loss of principal. No investment strategy can guarantee a profit or avoid loss. Actual results will vary depending on your investment and market experience.

NRM-15229M1 (04/21)

Nationwide® is on your side

Nationwide Indexed Principal Protection℠ at a glance

Background

Nationwide Indexed Principal Protection℠ (NW-IPP), our group fixed indexed annuity, provides principal protection with the opportunity for growth. The investment option may appeal to participants nearing or in retirement who seek to help preserve their retirement plan savings by having some upside exposure to the market with downside protection.

How it works	
Contributions	Every pay cycle, money is deducted from the participant's paycheck and deposited into their retirement plan as normal. Money can also be reallocated from other investment options to NW-IPP via an exchange.
Allocation	Money is allocated according to the participant's investment selections. This could be a mix of investment options, including equity mutual funds and fixed income mutual funds as well as NW-IPP. Up to 100% of the participant's portfolio can be allocated to NW-IPP.
Interest account	At the time of each payroll deduction or lump-sum exchange, money allocated to NW-IPP goes into an interest account, which earns a nominal interest rate. At the beginning of each calendar quarter, all the money in the interest account is automatically swept into a new index account.
Index account	It's possible to have up to four (4) index accounts at any given time. Each index account has its own cap rate and has a maturity of one year. Interest earnings credited are dependent on the index cap rate and the annual performance of the market index.

Product basics	
Product type	Group flexible purchase payment deferred fixed indexed annuity
Plan types	457(b)/401(k)/401(a)
Minimum initial purchase amount	N/A — any amount can be contributed via payroll deduction or exchange
Index term	One year
Accounts	• **Interest account:** The annual interest rate is credited daily and will have a guaranteed minimum interest rate of 0.5% • **Index accounts:** Interest earnings are credited annually based on the performance of the market index without capital gains or dividends, up to the index cap rate and floored at 0%; funds must remain in the index account for the entire one-year index term to receive interest earnings; a new one-year index account begins each calendar quarter (it's possible to have up to four index accounts at any time) Purchase payments are initially allocated to, and accumulated in, the interest account. On the first day of each calendar quarter, funds accumulated in the interest account and all interest earned are automatically swept into an index account.

Continued on back

Voluntary Worksite Benefits

Open enrollment will begin Mid-October and run through Mid-November – watch for more details.

Accident Insurance

Peace of mind doesn't happen by accident. It occurs when you have a plan that helps protect you in the event of the unexpected. The accident policy includes payouts for emergency treatment, broken bones, burns, lacerations, concussions, back or knee injuries and other out-of-pocket expenses that may or may not be covered by your medical insurance.

Aflac Accident Insurance pays cash benefits directly to you that can be used for any expense, from groceries to bills.

You have the choice between a High Level or Mid-Level Accident plan. Each plan pays a different amount per incident.

Critical Illness

Aflac's Critical Illness plan helps provide financial peace of mind if you experience a serious health event, such as a heart attack or stroke. More importantly, the plan helps you focus on recuperation instead of the distraction of out-of-pocket costs. With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned)—giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses such as car payments, mortgage or rent payments, or utility bills. This plan also includes benefits for cancer and health screening. Each dependent child is covered at 50% of the primary insured's benefit amount at no additional charge.

Aflac Critical Illness plan allows you to help protect the things you love the most from the things you expect the least.

Hospital Indemnity

When the unexpected happens, a trip to the hospital may be a possibility. Hospital indemnity insurance can help ease your stress about hospital bills so you can focus more on getting better.

Essentially, hospital indemnity insurance can help provide protection or assistance with expensive bills that can add up after a visit to the hospital. Hospital indemnity insurance can also be referred to as hospital insurance.

Your primary medical insurance provider may cover a lot of the costs after copays are made and deductibles are met. However, there can still be substantial out-of-pocket expenses. Hospital indemnity insurance plans pay you directly, unless otherwise assigned, to help with hospital costs.

The Hospital Indemnity plan benefits include:

- Hospital Confinement Benefit
- Hospital Admission Benefit
- Hospital Intensive Care Benefit
- Intermediate Intensive Care Step-Down Unit
- Successor Insured Benefit

Short-Term Disability

Illnesses or injuries that keep you from working not only hurts productivity, they also can make it difficult for you to pay your bills.

Aflac Short-Term Disability helps protect your income in the event of a covered injury or illness. It provides coverage options that allow you to choose the plans that are right for you, based on your individual financial needs and income.

For more detailed information on these benefits including rates, please contact your HR Department or the Aflac representative.

Voluntary Worksite Benefits

Open enrollment will begin Mid-October and run through Mid-November – watch for more details.

Short-Term Disability

Illnesses or injuries that keep you from working not only hurts productivity, they also can make it difficult for you to pay your bills.

6 month 14/14 policy

Based on Semimonthly Rates

Employees are eligible to cover up to 60% of their income for off-the job injury, illness, surgery, maternity, or mental health.

If you make:	You are eligible for:
$20,000/annually	$1,000/month
$30,000/annually	$1,500/month
$40,000/annually	$2,000/month
$50,000/annually	$2,500/month

*All rates below include a $5.46/semimonthly rider that pays $1000 after five years if the policyholder does not have any claims.

Semimonthly rates for a 6 month policy that kicks in after 14 days:

Age	18-49	50-64	65-74
$1000/month	$15.86	$20.40	$23.65
$1500/month	$21.05	$27.88	$32.75
$2000/month	$26.26	$35.35	$41.85
$2500/month	$31.46	$42.84	$50.96

3 month 14/14 policy

Based on Semimonthly Rates

Employees are eligible to cover up to 60% of their income for off-the job injury, illness, surgery, maternity, or mental health.

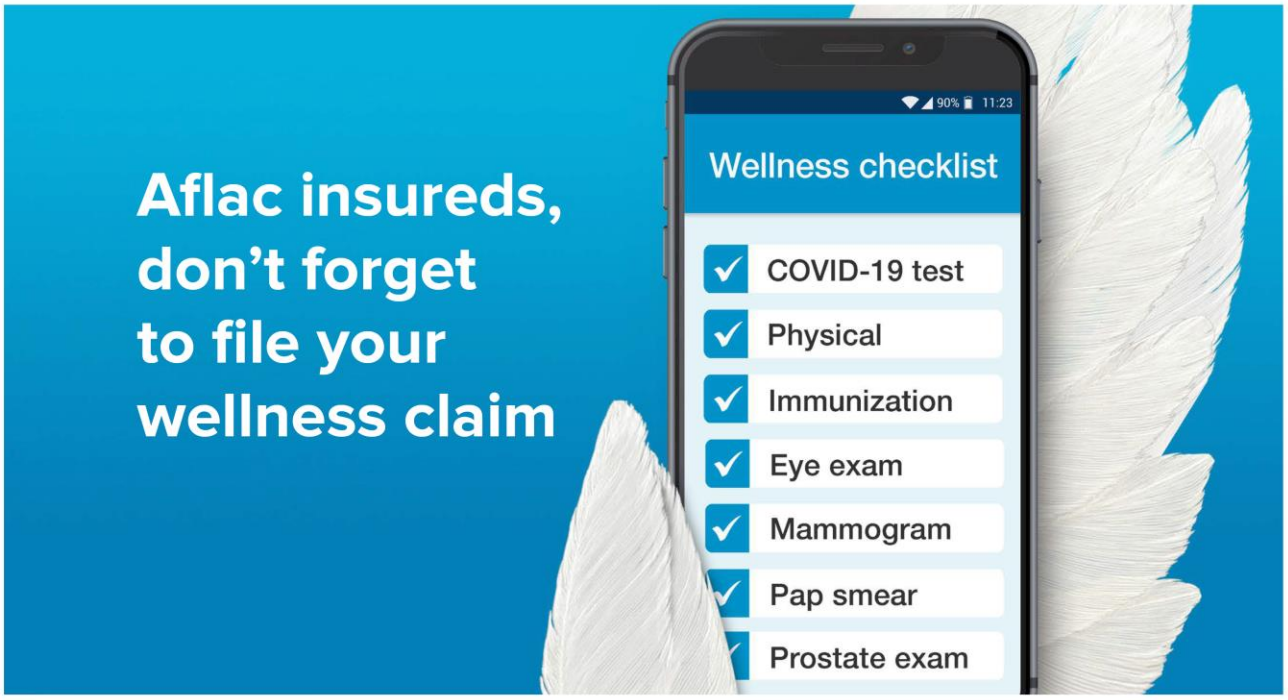
If you make:	You are eligible for:
$20,000/annually	$1,000/month
$30,000/annually	$1,500/month
$40,000/annually	$2,000/month
$50,000/annually	$2,500/month

*All rates below include a $5.46/semimonthly rider that pays $1000 after five years if the policyholder does not have any claims.

Semimonthly rates for a 3 month policy that kicks in after 14 days:

Age	18-49	50-64	65-74
$1000/month	$13.91	$15.86	$17.81
$1500/month	$18.14	$21.06	$23.99
$2000/month	$22.36	$26.22	$30.16
$2500/month	$26.59	$31.46	$36.34

Please call, text, or email Zack Dunham, your local agent, at 740-416-6595 or zachary_dunham@us.aflac.com.



There could be cash waiting for you

As part of your benefits package, you had the chance to sign up for an Aflac plan. Your plan helps with expenses health insurance doesn't cover, and benefits can be used in any way you want – whether that's to pay unexpected medical bills or everyday living expenses.

Aflac wants to put money into your pocket by encouraging you to file a wellness/health screening claim. After all, your plan provides a once-yearly benefit for proactively managing your health with a COVID-19 or antibody test, physical, immunization, eye exam, mammogram, pap smear, prostate screening **or** another covered exam.

If you've previously filed an Aflac claim, simply follow the process you've used in the past to receive your benefits. Or, you can visit **www.aflacgroupinsurance.com** to submit your claim online.

Aflac®

This is a brief product overview only. The plan has limitations and exclusions that affect benefits payable. Refer to your plan for complete details.

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups situsted in California, group coverage is underwritten by Continental American Life Insurance Company. For groups situsted in New York, coverage is underwritten by Aflac of New York.

Continental American Insurance Company | Columbia, SC

Managing your coverage has never been easier

To access and manage your coverage online, visit aflac.com/myaflac to register your account.

Once registered, you can take advantage of these features, available 24/7:

Submit a claim and track the status:

Simply select **new claim**, answer a few questions about what happened and upload your supporting documents.

To prevent delays in processing your claim, be sure to:

- Enroll in direct deposit for faster claims payment.
- If applicable, upload your completed Physician's Statement.
- Sign your claim digitally in the indicated areas and upload all billing and supporting documentation.

Once submitted, you can track your claim status as it is processing.

Have questions? Connect whenever you need us 24/7 by scanning the QR code on the left, logging in to your account or chatting with us at aflacgroupinsurance.com.

Aflac®

To submit your claim by mail, send your completed forms and supporting documents to P.O. Box 84075 Columbus, GA 31993, Attn: Claims Department.

*Registration of a new MyAflac account can take up to 24 hours to take effect.
Aflac herein means Aflac and/or Aflac of New York and/or Continental American Insurance Company and/or Continental American Life Insurance Company.

Compliance 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 or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. 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 (855-692-7447)

CALIFORNIA – Medicaid
Website:Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp
Phone: 1-916-445-8322
Email: hipp@dhcs.ca.gov

COLORADO –Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Ctr: 1-800-221-3943/ State Relay 711 CHP+
https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI)
https://www.colorado.gov/pacific/hcpf/health-insurancebuy-program
HIBI Customer Service: 1-855-692-6422

FLORIDA – Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://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
HIPP Website:
https://dhs.iowa.gov/ime/members/Medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
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: KIHIPP_PROGRAM@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
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

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

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext 5218

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

NEW YORK – Medicaid
Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website:
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website:
http://www.dhs.pa.gov/providers/pages/medical/hipp-program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

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: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA– Medicaid and CHIP
Website: http://www.coverva.org/hipp
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
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 January 31, 2024 or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid
www.cms.hhs.gov
1.877.267.2323, Menu Option 4, Ext.61565

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in the Company-sponsored health and welfare benefit plan are reminded that the Company's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

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

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

- You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic 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, the Company asks Employees not to provide any genetic information when providing or responding to a 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.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits hall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits

Women's Preventive Health Benefits

- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment, and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules. If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives conflict, the Plan document will control.

Health Insurance Marketplace

The Patient Protection Affordability Care Act ("PPACA") was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit dol.gov/ebsa/healthreform.

Currently, as a result of the 2017 Tax Cuts and Jobs Act, as of 2019, the Federal Penalty for individuals that do not have (or maintain) health insurance coverage for themselves, their spouse and children was reduce to $0. However, several states have implemented an ACA-like-individual mandate penalty. If you are considering not having health coverage, please contact your tax advisor about any potential penalties/fines in your state.

PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace ("Marketplace"), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying as low income); subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in the Company's medical plan, then PPACA may have little effect on you. The Company's medical plan meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plan, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by the Company, your payments for coverage will be made on an after-tax basis. (See https://www.healthcare.gov/have-job-based-coverage/)

If you are not eligible to enroll in the Company's medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered though the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: healthcare.gov).

How Can I Get More Information?
For more information about purchasing medical coverage through the Marketplace please visit healthcare.gov or call 800-318- 2596.