MACF
Missouri Alliance for Children & Families

2024 - 2025



Benefits Brochure

WELCOME

Welcome To Your 2024-2025 Benefits Guide!

At Missouri Alliance for Children and Families, our employees are our most valuable asset. We are committed to providing a comprehensive employee benefits program to help everyone stay healthy, feel secure, and maintain a quality work-life balance.

This guide is intended to provide a high-level summary of your benefits. To see plan documents and view your benefits online, please visit macf.millercares.com.

Who is Eligible?

All full-time employees are eligible for benefits on the first of the month following their date of hire. Part-time employees may be eligible for certain benefits. Open enrollment for benefits is in September of each year.

Once Open Enrollment has ended, employees will only be able to make benefit changes if they experience a qualifying life event, such as marriage, annulment or divorce, the birth or adoption of a child, a change in a dependent's status, etc. Notify Human Resources within 30 days of the qualifying life event to make applicable benefit changes.

MACF
Missouri Alliance for Children & Families

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MEDICAL

Auxiant
Independent Solutions › Real Results

Medical Plan One - Base Plan

Your employer offers medical insurance to all full-time employees working 30 or more hours per week (or 130 or more per month). It covers medical expenses such as visits to the doctor's office, emergency care, and prescription drugs. It's important to have a medical plan that meets your needs and the needs of your family.

Keep in mind that your out-of-pocket costs will be lower if you receive care from an in-network doctor and facility. To find an in-network doctor, please visit auxiant.com. For more information or to see plan documents, visit **macf.millercares.com**.

	In-Network	Out-of-Network
Deductible (Indiv./Family)	$2,000/$4,000	$6,000/$12,000
Member Coinsurance	20%	50%
Out-of-Pocket Max (Indiv./Family)	$6,250/$12,500	$12,500/$25,000
Preventive Care	Covered at 100%	50% Coinsurance
Primary Care Visit	$35 Copay	50% Coinsurance
Specialist Visit	$40 Copay	50% Coinsurance
Physician's Office (Outpatient Mental Health/Outpatient Substance Use Disorder)	Covered at 100%	50% Coinsurance
Urgent Care	$100 Copay	50% Coinsurance
Emergency Room	$300 Copay	
Retail Prescriptions (30 Days)		
Tier 1	$15 Copay	Not Covered
Tier 2	$40 Copay	Not Covered
Tier 3	$75 Copay	Not Covered
Mail Order Prescriptions (90 Days)		
Tier 1	$38 Copay	Not Covered
Tier 2	$100 Copay	Not Covered
Tier 3	$188 Copay	Not Covered

Per Pay Period Cost	
Employee	$0.00
Employee + Spouse	$197.00
Employee + Child(ren)	$151.00
Employee + Family	$332.00

*Information provided for illustrative purposes. For more detailed information, please refer to your summary plan description found at **macf.millercares.com**. In the case of a discrepancy, the actual plan documents will prevail.*

MEDICAL

Auxiant
Independent Solutions › Real Results

Medical Plan Two - Buy-Up Plan

Your employer offers medical insurance to all full-time employees working 30 or more hours per week (or 130 or more per month). It covers medical expenses such as visits to the doctor's office, emergency care, and prescription drugs. It's important to have a medical plan that meets your needs and the needs of your family.

Keep in mind that your out-of-pocket costs will be lower if you receive care from an in-network doctor and facility. To find an in-network doctor, please visit auxiant.com. For more information or to see plan documents, visit **macf.millercares.com**.

	In-Network	Out-of-Network
Deductible (Indiv./Family)	$2,000/$4,000	$6,000/$12,000
Member Coinsurance	0%	30%
Out-of-Pocket Max (Indiv./Family)	$4,000/$8,000	$8,000/$16,000
Preventive Care	Covered at 100%	30% Coinsurance
Primary Care Visit	$25 Copay	30% Coinsurance
Specialist Visit	$30 Copay	30% Coinsurance
Physician's Office (Outpatient Mental Health/Outpatient Substance Use Disorder)	Covered at 100%	50% Coinsurance
Urgent Care	$100 Copay	30% Coinsurance
Emergency Room	$300 Copay	
Retail Prescriptions (30 Days)		
Tier 1	$15 Copay	Not Covered
Tier 2	$40 Copay	Not Covered
Tier 3	$75 Copay	Not Covered
Mail Order Prescriptions (90 Days)		
Tier 1	$38 Copay	Not Covered
Tier 2	$100 Copay	Not Covered
Tier 3	$188 Copay	Not Covered

Per Pay Period Cost	
Employee	$12.50
Employee + Spouse	$222.50
Employee + Child(ren)	$175.00
Employee + Family	$386.50

Missouri Alliance for Children and Families Health Plan

How can I verify my eligibility and benefits, and follow-up on claims?

Auxiant can be reached by phone at **800-279-6772**, or by going online at **www.auxiant.com**. You have access to your claims and benefit information via the Auxiant website, as well as a link to live chat with customer service. Providers can also utilize Auxiant's customer service line to verify eligibility and benefits, as well as follow up on claims processing and precertification requests.

Auxiant Customer Service: 800-279-6772 (front of ID card)

Auxiant Website: www.auxiant.com (front of ID card)

Precertification: 866-726-6584 (back of ID card)

Where can I access assistance with locating a network provider?

Members receiving care in greater parts of Missouri, Illinois, and Arkansas utilize the **HealthLink Open Access III** network for in-network benefits. They can be reached by phone at **800-624-2356** for assistance with verifying in-network providers. You can also search for in-network providers using their website at **www.healthlink.com**.

Members receiving care in northwest Missouri and Kansas utilize **Freedom Network Select** for in-network benefits. They can be reached by phone at **800-544-3014**, and have an online provider directory at **www.phpkc.com**.

If you or your dependent/s need access to in-network providers outside of the HealthLink Open Access III or Freedom Network Select coverage areas, **First Health** should be referred to for wrap coverage by all members. They can be reached at **800-226-5116**, and have an online provider directory at **www.myfirsthealth.com**.

HealthLink Open Access III: 800-624-2356, www.healthlink.com (front of ID card)

Freedom Network Select: 800-544-3014, www.phpkc.com

First Health: 800-226-5116, www.myfirsthealth.com (back of ID card)

How can I contact the prescription benefits network?

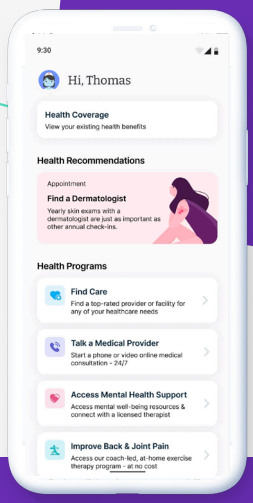
Liviniti can be reached by phone at **800-710-9341** for assistance with prescription benefits and claims. You can also utilize their online member portal at **www.liviniti.com**.

Liviniti: 800-710-9341, www.liviniti.com (front of ID card)

HealthJoy

HealthJoy Helps You and Your Family

HealthJoy connects you with the right care and support throughout the year, making it easier to be healthy and well.





Meet Emily, a busy customer service representative who's expecting her first baby this year.

Cost Estimation

Before she gives birth, Emily asks a healthcare concierge to estimate out-of-pocket costs.

Rx Savings Review

Her husband requests a review and finds a lower-cost prescription for his allergies.

Medical Plan Details

Emily uses her benefits wallet to track out-of-pocket and deductible spending.

Provider Search

Emily uses the provider search feature to find a pediatrician for her new baby.

Accounts for Spouses and Dependents

Family members enrolled in Emily's plan can download HealthJoy from their phone to have access to the same information..

How will HealthJoy help YOU this year?

Click the Download and Activate link in your email or visit go.healthjoy.com/activate to get started



How to Download and Activate HealthJoy

HealthJoy is the first stop for all your healthcare and employee benefits needs. We've created an easy and seamless process to get started today! Below are some of the many methods you can use to activate your HealthJoy account:

APP STORE | EMAIL | SMS | FLYER | POSTCARD | WEBINAR

1 **Download the App**

Use one of the above methods to download the HealthJoy app, such as scanning the QR code on this flyer. The app is available for Android, iPhone, and iPad.

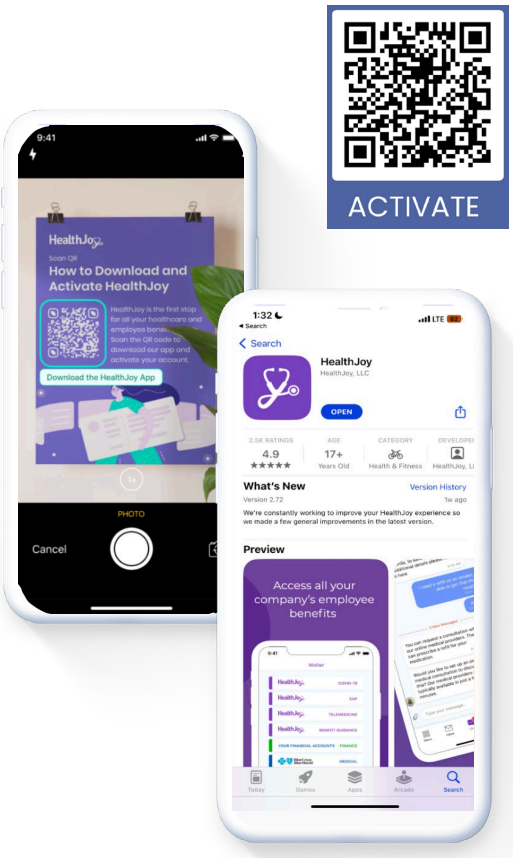
2 **Sign Up**

Open the HealthJoy app, click "Sign Up," and enter the email address tied to your employee benefits. If you use a different email, you'll need to answer additional security questions, including date of birth and the last four digits of your SSN, to verify your identity.

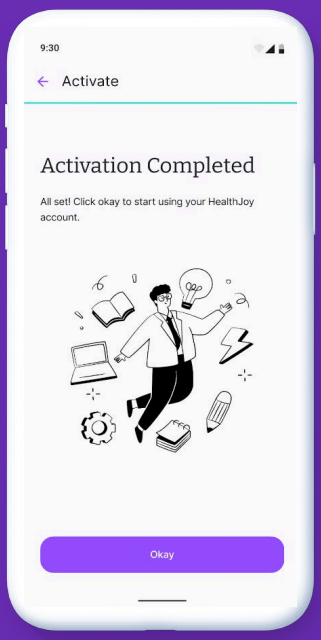
NOTE: An email address is required to create your HealthJoy account.

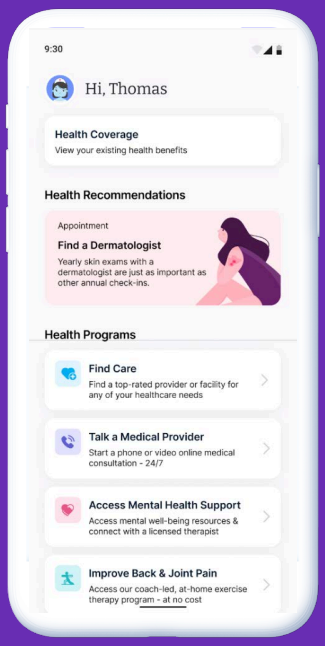
3 **Activate**

You'll receive an activation link via email and/or SMS after verifying your identity and plan benefits. Lastly, you'll be prompted to create a password of at least eight characters to secure your account. The entire process will take less than three minutes to complete.



Success! You now have full access to your HealthJoy account. JOY, your virtual healthcare assistant, will welcome you and provide tips on how to use the app.





Did you forget your password?

You can still log in! Enter your email address on the login screen. You can choose to update your password, or we can send a "magic link" to your phone or email so you can log in.

ACTIVATE

Or, visit: www.healthjoy.com/download

If you have any other issues with activation or logging into our system, please call or email us at:

(877) 500-3212
support@healthjoy.com

DENTAL

Dental Plan

Dental insurance offers coverage for preventive care like routine exams, cleanings, and X-rays, as well as basic and major services like fillings, extractions, root canals, and crowns. MACF pays 90% of the employee premium.

Keep in mind that your costs will generally be lower if you choose an in-network dentist. To find an in-network dentist, please visit lfg.go2dental.com. For more information or to see plan documents, visit **macf.millercares.com**.

	In-Network
Deductible (Indiv./Family)	$50/$150
Annual Maximum Per Person	$1,000 (Applies to Preventive & Diagnostic Care)
Preventive and Diagnostic Services	100%, No Deductible
Basic Services	90%, After Deductible
Major Services	60%, After Deductible

Per Pay Period Cost	
Employee Only	$1.00
Employee + Spouse	$11.26
Employee + Child(ren)	$16.75
Family	$30.10



VISION

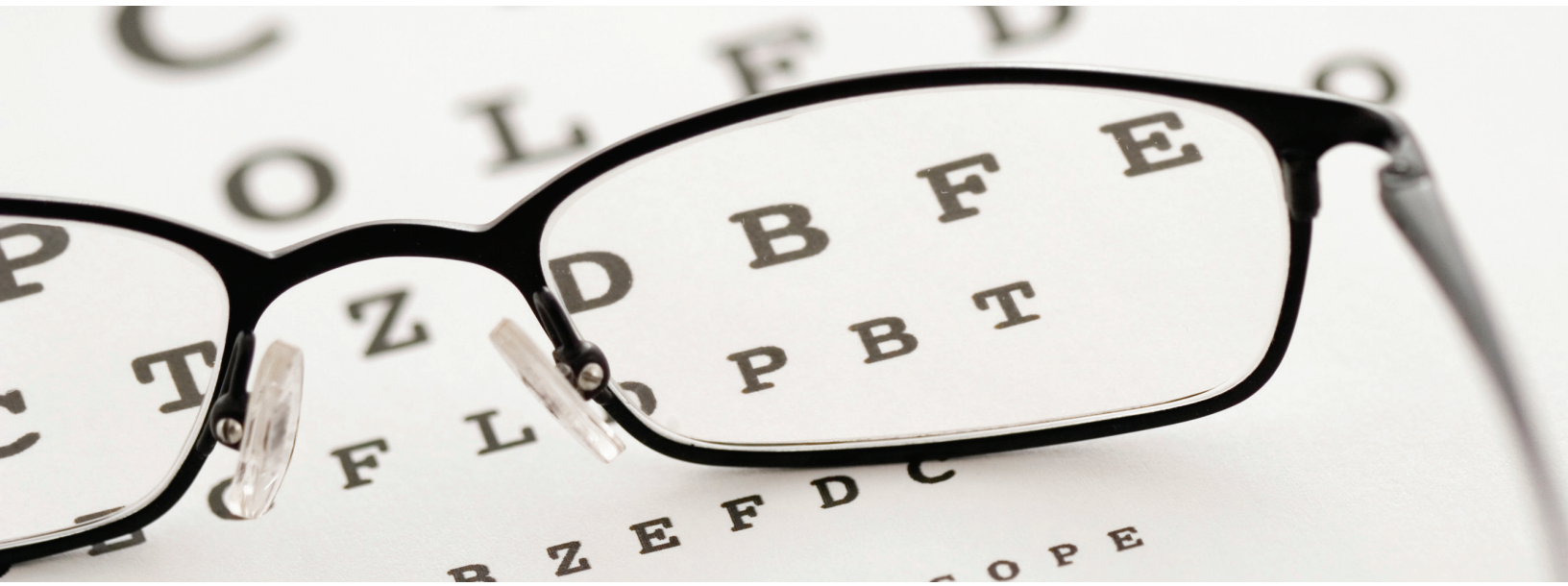
Voluntary Vision Plan

Vision insurance offers coverage for the routine care of your eyes and may provide coverage for eyeglasses and contact lenses. You plan will pay for these services based upon the schedule below. Be sure to check your plan certificate for details.

Keep in mind that your costs will generally be lower if you choose an in-network eye-doctor. To find an in-network eye-doctor, please visit lvc.lfg.com. For more information or to see plan documents, visit **macf.millercares.com**.

	In-Network	Frequency
Routine Eye Exam	$10 Copay	Every 12 Months
Materials Copay	$25 Copay	Every 12 Months
Frames	Up to $130 Allowance	Every 12 Months
Standard Lenses	Covered 100% After Copay	Every 12 Months
Contact Lenses - Elective	Up to $125 Allowance	Every 12 Months
Contact Lenses - Therapeutic	Covered at 100%	Every 12 Months

Per Pay Period Cost	
Employee Only	$2.84
Employee + Spouse	$5.38
Employee + Child(ren)	$6.30
Family	$8.86



Basic Life and AD&D

Basic Group Life and Accidental Death and Dismemberment (AD&D) coverage is a **100% employer-paid** benefit, provided at no cost to you. The basic life benefit will be paid to your beneficiaries in the event of your death. The AD&D benefit will be paid to you in the event of an injury resulting from a covered accident. For more information or to see plan documents, visit macf.millercares.com.

Benefits	
Eligibility	All active, full-time employees working a minimum of 30 hours per week.
Eligibility Waiting Period	No waiting period.
Benefit Amount	$50,000
Benefit Maximum	$50,000
Benefit Reduction Schedule	Benefits will reduce to 65% at age 65 and to 50% at age 70.

Voluntary Life and AD&D

When your needs call for more than Basic Life and AD&D coverage, additional Voluntary Life and AD&D coverage is available for purchase for you, your spouse and your dependent children. Coverage purchased through this plan is offered at a group discounted rate with guaranteed issue amounts. Employees must elect coverage in order to purchase spouse or child coverage. For more information or to see plan documents, visit macf.millercares.com.

Benefits	
Employee	
Benefit Maximum	$10,000 increments up to $500,000 not to exceed 2x employee's annual salary
Guaranteed Issue	$100,000
Benefit Reductions	Benefits will reduce to 65% at age 65, and to 50% at age 70.
Spouse	
Benefit Maximum	$5,000 increments up to $250,000 not to exceed 50% of the employee's benefit amount
Guaranteed Issue	$10,000
Benefit Reductions	Benefits will reduce to 65% at age 65, and to 50% at age 70
Child(ren)	
Benefit Maximum	$10,000 for children 14-days old to 26 years old (if unmarried & a full-time student)
Guaranteed Issue	For children day 1 to age 14 days a flat benefit of $500 is available
AD&D	
AD&D Benefit	Equal to Voluntary Life Benefit for Employee and Spouse coverage

DISABILITY

Voluntary Short-Term Disability

Short-Term Disability insurance is “paycheck” protection that pays a percentage of your salary if you become temporarily disabled for a period of weeks. Common short-term disability claims include injury, pregnancy and minor surgeries.

Benefits	
Benefit Amount *(after your claim is approved)*	Not to exceed 60% of total weekly earnings
Maximum Benefit Amount	$600 per week
Minimum Benefit Amount	$25 per week
Benefits Begin	As soon as 15 days from the date you are unable to work due to illness or injury
Benefit Duration	Up to 13-weeks
Additional Plan Information	This plan provides a benefit for covered disabilities resulting from illness or injury that are not work-related



FSA FLEXIBLE SPENDING ACCOUNT

A Flexible Spending Account (FSA) is an employer owned account that lets you set aside pre-tax dollars (which lowers your taxable income) to pay for eligible out-of-pocket expenses. Open enrollment for this benefit is in November. Your employer offers two types of FSAs:

1. **Healthcare FSA –** Can be used to pay eligible medical, dental, orthodontia, and vision expenses
2. **Dependent Care –** Can be used to pay eligible expenses for childcare, eldercare, or care for a disabled dependent

2025 MACF MAXIMUM CONTRIBUTION



HEALTHCARE FSA
$2,500



DEPENDENT CARE FSA
$5,000

HRA HEALTH REIMBURSEMENT ACCOUNT

Employees enrolled in the MACF medical plan are eligible for reimbursement of a $1,500 deductible per person with a maximum of $4,000 for family. The employee must pay $500 per person ($1,000 for family) to the group health plan before the HRA begins to pay. The HRA is administered by Surrency. MACF will honor the above reimbursement allocation for both in-network and out-of-network services.

SUPPLEMENTAL BENEFITS

Both full-time and part-time employees are eligible to purchase supplemental insurance plans through Aflac. Open enrollment for these benefits takes place in December. Available benefits may include:

- Accident
- Cancer
- Dental
- Life
- Hospital Indemnity
- Critical Illness

Lincoln Financial Group®

Employee Assistance Program

The resources you need to meet life's challenges



EmployeeConnect℠ offers professional, confidential services to help you and your loved ones improve your quality of life.

In-person guidance

Some matters are best resolved by meeting with a professional in person. With *EmployeeConnect*℠, you and your family get:

- In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year)
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and **25% off** subsequent meetings

Unlimited 24/7 assistance

You and your family can access the following services anytime — online, on the mobile app or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning and more
- Legal information and referrals for family law, estate planning, consumer and civil law
- Financial guidance on household budgeting and short- and long-term planning

Online resources

EmployeeConnect℠ offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit GuidanceResources.com or download the GuidanceNow℠ mobile app. You'll find:

- Articles and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets and more

We partner with your employer to offer this service at no additional cost to you!

EmployeeConnect℠ counselors are experienced and credentialed.

When you call the toll-free line, you'll talk to an experienced professional who will provide counseling, work-life advice and referrals. All counselors hold master's degrees, with broad-based clinical skills and at least three years of experience in counseling on a variety of issues. For face-to-face sessions, you'll meet with a credentialed, state-licensed counselor.

You'll receive customized information for each work-life service you use.

Take advantage of *EmployeeConnect*℠

For more information about the program, visit GuidanceResources.com, download the GuidanceNow℠ mobile app or call 888-628-4824.

GuidanceResources.com login credentials:

Username: LFGSupport Password: LFGSupport1

RETIREMENT

Insurance, Retirement, Investments and Advice.

401(k) Retirement Plan

This is a pre-tax contribution plan that allows you to set aside money for retirement purposes. Both full-time and part-time employees are eligible to participate in the 401(k) retirement plan. Employees become eligible upon their first day of employment.

MACF offers a discretionary contribution of up to 5%. You must complete at least one year of service to receive employer-matching contributions.

Under a 401(k) retirement plan, “vesting” refers to ownership. Each employee vests, or owns, a certain percentage of their account. At MACF, employee contributions are always fully and immediately vested. This means employees own 100% of the amount they contribute on their own.

The percentage of employer contributions that employees vest depends on years of service at MACF. See the below chart for exact percentages.

Years of Service	Percentage Vested
Less than 2 years	0%
2 years	20%
3 years	40%
4 years	60%
5 years	80%
6 years	100%



COMPUTER PURCHASE PROGRAM

After 30 days of employment, both regular full-time and regular part-time employees may be eligible to participate in the MACF Computer Employee purchase plan if he/she is in good standing.

Purchase Limits
The cost of new Dell Personal Computer equipment, peripherals, designated software, and taxes up to $1,500.

Payback Duration
Not to exceed 12 months

Hardware
Computer hardware and peripherals must be new, not reconditioned or factory refurbished.

Software/Peripherals
All software and peripherals offered by Dell at the time of purchase are permissible; however, such items must be ordered with a computer.

Method of Payment
Payroll deduction (copy of agreement shall be authorization to make the deduction). Balance is due upon termination from employment with MACF and any amount owed may be withheld from the employee's final paycheck. If the balance is not paid in full or the amount exceeds the employee's final paycheck, the equipment must be turned in to MACF.

EQUIPMENT PURCHASE PROGRAM

After 30 days of employment, both regular full-time and regular part-time employees may be eligible to participate in the MACF Employee Work-Related Equipment purchase plan.

Purchase Limits
The cost of new GPS systems, printers, or network equipment purchased through the Dell Employee Purchase Program is limited to $500. Limit can be exceeded if the employee pays an amount exceeding $500 to Dell at the time of purchase.

Payback Duration
Not to exceed 6 months

Hardware
Work-related equipment such as GPS systems, printers, and network equipment must be new, not reconditioned or factory refurbished.

Software/Peripherals
All software and peripherals offered by Dell at the time of purchase are permissible; however, such items must be ordered with a computer.

Method of Payment
Payroll deduction (copy of agreement shall be authorization to make the deduction). Balance is due upon termination from employment with MACF and any amount owed may be withheld from the employee's final paycheck. If the balance is not paid in full or the amount exceeds the employee's final paycheck, the equipment must be turned in to MACF.

OTHER BENEFITS

Reimbursable Expenses

MACF offers mileage reimbursement at $0.55 per mile.

Education Compensation

The Tuition Reimbursement Program is available to employees seeking a degree relevant to present or future MACF job development. Employees will be admitted to the program following supervisory approval and will be reimbursed for 50% of the cost of each course they successfully complete, not to exceed $143.45 per credit hour.

Professional Development

MACF may accept internal and external requests for internships that go toward the completion of graduate and upper graduate degrees within the human services field. Internal accommodations may include a change or modification of duties that suit a flexible schedule.



TIME OFF

Paid Time Off (PTO)

As outlined in the Employee Manual, employees may accrue 16 hours of PTO per month, up to a maximum of 240 hours, that can be used for vacation, personal days, or sick leave. After five years of employment, employees may accrue 20 hours per month up to a maximum of 240 hours.

Upon employment separation, employees will accrue PTO that is prorated based on the number of days actually worked during the month of employment separation. The employee may be "paid out" on their remaining PTO balance based on the employee's base annual salary (converted to a base hourly rate) if:

1. The employee provided a 14-day written notice of resignation and
2. The employee has satisfactorily completed all required work prior to or on the last date of employment.

PTO may be used for any MACF Paid or Unpaid Leave policies, including FMLA.

Paid Holidays

Memorial Day
Juneteenth
Independence Day
Labor Day
Thanksgiving Day
Day after Thanksgiving Day
Christmas Day
New Years Day
Martin Luther King, Jr. Day

Employees may take other holidays by utilizing earned PTO hours. These are subject to supervisory approval.

Extended Sick Leave (ESL)

Should employees reach the PTO maximum of 240 hours, additional PTO hours will be transferred to ESL. This shall be used by employees for themselves or for a dependent in the case of illness or medical necessity. The employee may accrue up to a maximum of 480 hours (12 weeks). ESL may be used for any MACF Paid or Unpaid Leave policies, including FMLA.

Election Day

We encourage you to exercise your voting privileges in local, state, and national elections. However, since the polls are open for long periods, you are encouraged to vote before or after regular working hours. If necessary, you may take up to three hours of leave from work to vote in a governmental election or referendum. You will be expected to notify your supervisor at least one day in advance.

School Leave

Parents, foster parents, or legal guardians are allowed to take up to four hours of paid time off per school year per child to visit the child's school. This applies to children in pre-school through college (age 23 maximum).

TIME OFF

Funeral (Bereavement) Leave

Upon request, up to five working days of leave with pay (not charged to other leave time) shall be granted to regular full-time employees to make arrangements for and attend funeral services of their spouse, child, parent, parent-in-law, grandparent, grandparent-in-law, granddaughter, grandson, daughter-in-law, son-in-law, step-parent, domestic partner, brother, sister, brother-in-law, sister-in-law, daughter or son of their spouse or domestic partner, and any relative living in their own or their domestic partner's household.

Jury Duty

It is your civic duty as a citizen to report for jury duty whenever called. If you are called for jury duty, you must notify your HR Department within 48 hours of receipt of the jury summons.

MACF will permit you to take the necessary time off and we wish to help you avoid any financial loss because of such service. MACF will reimburse you for the difference between your jury pay and your regular pay, not to exceed eight hours per day, for a maximum of ten business days.

Share Leave

Employees who have been employed for a minimum of six months and are considered to be in "good standing" (must have had no Corrective Action plan within one year of Share Leave request) and who have exhausted all PTO and ESL may be eligible for an additional 120 hours
(3 weeks) of Share Leave per calendar year as described in the MACF Share Leave Policy.



NOTICES

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 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Notice of Patient Protections

Your plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you can designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Human Resources Department.

You do not need prior authorization from your plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our 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 the Human Resources Department.

Women's Health and Cancer Rights Act

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

Newborns' and Mothers' Health Protection Act

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

HIPAA Privacy

Your employer is required by law to take reasonable steps to ensure the privacy and inform you about the uses of your protected health information (PHI). The use and disclosure of PHI is regulated by the federal law known as HIPAA (the Health Insurance Portability and Accountability Act). A more complete description of your privacy rights and protections is available to you on request. Contact the Human Resources Department with any questions or to request a copy of the full HIPAA privacy notice.

NOTICES

Important Notice about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. We have determined that the prescription drug coverage offered by the health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from **October 15 to December 7.** However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current coverage (you cannot drop your prescription drug coverage **without** dropping your medical coverage), be aware that you and your dependents may enroll back into the benefit plan during an open enrollment period under the benefit plan.

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).

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

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

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

For More Information about this Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your current health plan changes. You also may request a copy of this notice at any time.

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

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

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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://health.alaska.gov/dpa/Pages/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: 916-445-8322
Fax: 916-440-5676
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 Center: 1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

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

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

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: https://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
HIPP Phone: 1-800-967-4660

KENTUCKY - Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

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: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS - Medicaid AND CHIP
Website: https://www.mass.gov//masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

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

NOTICES

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
Email: HHSHIPPProgram@mt.gov

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

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: https://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: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

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

OREGON - Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND - Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA - Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS - Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

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

VERMONT - Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA - Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

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

WEST VIRGINIA - Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
HIPP: http://mywvhipp.com/
Medcaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

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

To see if any other states have added a premium assistance program since 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 & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.
The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

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

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

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

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

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

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

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

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Human Resources/Plan Administrator within 60 days after the qualifying event occurs.

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

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

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

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

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

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Health Insurance Marketplace Coverage Options & Your Health Coverage

General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards. The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than **9.12%** of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed **9.12%** of the employee's household income

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

Health Insurance Marketplace Coverage Options & Your Health Coverage Cont.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit **HealthCare.gov** or call the Marketplace Call Center at **1-800-318-2596**. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit **https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/** for more details.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resources Department.

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

NOTICES

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the entity responsible for enforcing the federal and/or state balance or surprise billing protection laws. Visit https://www.commonwealthfund.org/publications/maps-and-interactives/2022/feb/map-no-surprises-act for information and to view the No Surprises Act Map.

For more information about the impact of the No Surprises Act on consumers, including how to file complaints, please refer to the Centers for Medicaid and Medicaid Services' No Surprises Act Consumer Medical Bill Rights page.

Visit https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets for more information about your rights under federal law.

Visit https://www.ncsl.org/health/surprise-and-balance-billing-state-policy-options for more information about your rights under state law.

To contact state regulators regarding the No Surprises Act, please click here for agency websites.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

CONTACTS

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1.800.279.6772
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1.800.423.2765
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Vision
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1.800.440.8453
lvc.lfg.com

HealthJoy
1.877.500.3212
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healthjoy.com/download

Life and AD&D
Lincoln Financial
1.800.487.1485
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Disability
Lincoln Financial
1.800.423.2765
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FSA-Flexible Spending Account
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To see plan documents and view your benefits online, please visit macf.millercares.com.