INSERT LOGO

benefits 2023

FOR BENEFITS EFFECTIVE **JANUARY 1 – DECEMBER 31, 2023**

welcome!

We are pleased to present our benefit offerings for the 2023 plan year. Our employees are our most valuable asset and the health and well-being of you and your dependents is very important to us.

We want to ensure that we illustrate our commitment to you by providing you with valuable benefit options and the tools and resources you need to stay committed to your health.

[[Client Name]] offers a comprehensive benefits package including Medical, Dental, Vision, Disability, and Life Insurance options as
well as pre-tax spending accounts for regular employees that work an average of 20 hours per week.

If you have any questions about the benefits outlined in this guide, please see **page 28** for a list of resources available to help you.

INSIDE THIS GUIDE

03 WHAT'S NEW FOR 2023

04 HOW TO ENROLL & MAKING PLAN CHANGES

05 MEDICAL & RX PLANS

07 MAXIMIZE YOUR MEDICAL & RX BENEFITS

08 CLAIM EXAMPLES—PPO VS. HSA

10 TELEMEDICINE

11 WELLNESS PROGRAM

12 MEDICAL & RX CONTRIBUTIONS

13 PRE-TAX SAVINGS ACCOUNTS

16 COMMUTER BENEFITS

17 DENTAL PLANS

21 VISION PLAN

23 LIFE, AD&D & DISABILITY PLANS

26 VOLUNTARY BENEFITS

27 ADDITIONAL BENEFITS

28 BENEFIT RESOURCES

29 GLOSSARY OF TERMS

30 CARRIER CONTACTS

31 LEGAL NOTICES

WHAT'S NEW FOR 2020

2023 PLAN HIGHLIGHTS

- We will be staying with CIGNA for Medical and Dental, and there will be no plan design changes.
- Our Vision plan will remain with VSP, and there will be no plan design changes.
- Life and Disability will also continue to be offered by Cigna.

WHAT'S NEW IN 2023?

- [[Client Name]] will now be offering new Voluntary Hospital Indemnity and Voluntary Accident
  plans through Cigna. If you are interested in signing up for either of these benefits please see **page 26** for additional details.
- Our Wellness partner will transition to US Wellness. More details about the Wellness program are included on **page 11**.
- We will have one change to our Wellness program in 2023. All employees with spouses enrolled on the medical plan must now accumulate 130 points to receive the incentive for the 2023 plan year.
- For the Short Term disability plan there will be a decrease for the waiting period. The benefits will change from a 14-day waiting period to a 7-day waiting period.
- In 2023 we will also be offering an Identity Theft Protection and Credit Monitoring Insurance with Countrywide Prepaid Legal

HOW TO ENROLL & MAKING PLAN CHANGES

ENROLLING ONLINE WITH ULTIPRO

Benefit elections can only be made through UltiPro. Emails and voicemails with election information will not be accepted or processed. Review your plan options and costs and make your benefit plan elections by logging into UltiPro. Follow the instructions below:

1. Visit UltiPro by clicking the link on the [[Client Name]] website.

2. The UltiPro user name is your [[Client Name]] email address. Passwords can be reset by contacting your Human Resources Business Partner.
   The default password will be the employee's date of birth in the MMDDYYYY format.

3. Select the “Menu” tab in the top left of the UltiPro home page to display all of the UltiPro modules.

4. Click on “Life Event”, select “I am a New Hire”. Each benefit will have an individual tab. Once the election is made, an employee can advance by clicking on the "Right Arrow - Next" icon.

5. Once all elections are made, click on the Submit icon.

MAKING PLAN CHANGES

Please remember, you can only make changes to your benefits during Open Enrollment, unless you experience a Qualified Life Event.

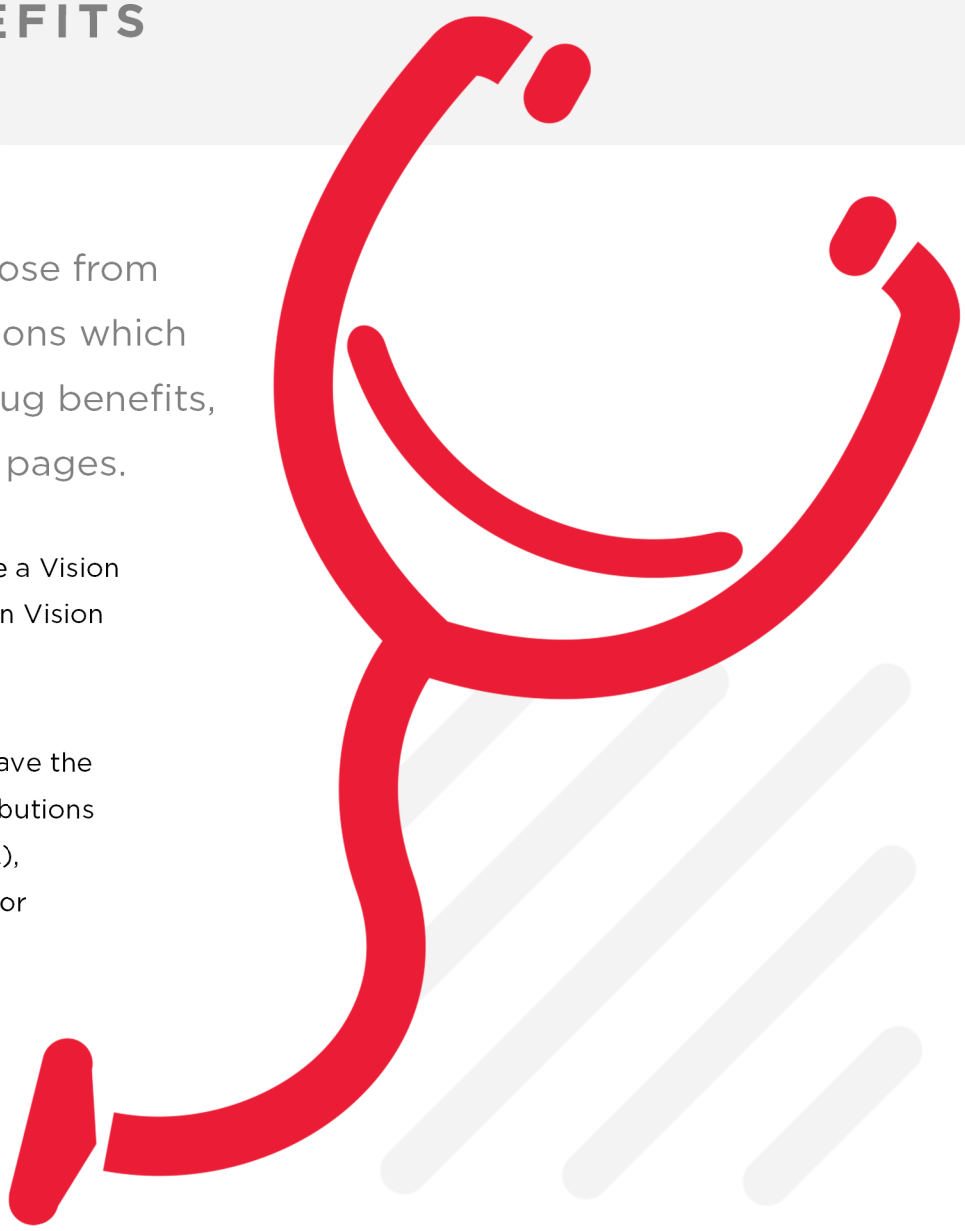
Qualified Life Events include marriage, civil union/domestic partnership status change, divorce, birth or adoption of a child, change in child's dependent status, death of a spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse/civil union/domestic partner, commencement or termination of adoption proceedings, or change in spouse's/civil union/domestic partner's benefits or employment status.

PLEASE NOTE: You must notify Human Resources within 30 days of experiencing a qualified status change.

ADMINISTERED BY CIGNA

MEDICAL & PRESCRIPTION PLANS

YOUR 2023 BENEFITS



Eligible employees may choose from **two** Cigna medical plan options which each include prescription drug benefits, as outlined on the following pages.

NOTE: Cigna medical plans do not have a Vision reimbursement benefit. To participate in Vision benefits, please see page 21.

If YOU ELECT THE HDHP PLAN: You have the option of making pre-tax payroll contributions toward a Health Savings Account (HSA), administered by PayFlex. See page 14 for more details.

MEDICAL & PRESCRIPTION BENEFITS: CIGNA

	CIGNA HDHP WITH HSA	CIGNA PPO
IN-NETWORK BENEFITS		
Calendar Year Deductible Individual/Family	$1,500 / $3,000	$500 / $1,000
Out-of-Pocket Maximum Individual/Family	$6,450 / $6,450	$6,600 / $13,200
Employer Funded HSA* Individual/Family	$750 / $1,500	Not included
Preventive Care Services	Plan pays 100% - no deductible	Plan pays 100%
PCP Office Visits	Plan pays 90% after deductible	$20 copay
Specialist Office Visit	Plan pays 90% after deductible	$40 copay
Inpatient Hospital	Plan pays 90% after deductible	Plan pays 90% after deductible
Outpatient Surgery	Plan pays 90% after deductible	Plan pays 90% after deductible
Outpatient Lab & X-Ray	Plan pays 90% after deductible	Plan pays 90% after deductible
Emergency Room	Plan pays 90% after deductible	Plan pays 90% after deductible
OUT-OF-NETWORK BENEFITS		
Calendar Year Deductible Individual/Family	$5,000 / $10,000	$1,000 / $2,000
Out-of-Pocket Maximum Individual/Family	$10,000 / $20,000	$10,000 / $20,000
Coinsurance (% Plan Pays)	Plan pays 50% after deductible	70% after deductible
PRESCRIPTION DRUG BENEFITS		
Retail Pharmacy** Generic Formulary Brand Non-Formulary Brand	 $20 copay after deductible $40 copay after deductible $70 copay after deductible	 $10 copay $20 copay $35 copay
Mail Order** Generic Formulary Brand Non-Formulary Brand	 $60 copay after deductible $120 copay after deductible $210 copay after deductible	 $30 copay $60 copay $105 copay

* Retail: Up to a 30-day supply /Mail Order: Up to a 90-day supply.

Cigna medical plans do not have a Vision reimbursement benefit. To participate in Vision benefits, please see page 21.

MAXIMIZE YOUR MEDICAL & PHARMACY BENEFITS

SAVE WITH GENERIC DRUGS

A generic drug is a version of a brand drug. Generic drugs are reviewed and approved by the U.S. Food and Drug Administration (FDA), just as brand drugs are. According to the FDA, compared to its brand counterpart, a generic drug:

- is chemically the same
- is as safe and effective
- meets the same standards set by the FDA

The major difference is that the generic drug often costs much less.

GOODRX

Compare Prescription Prices and Save!

GoodRx is a valuable resource that allows you to compare prescription drug prices at local and mail-order pharmacies and discover free coupons and savings tips. This is a great resource for members enrolled in the HDHP plan!

Learn more about Good Rx and start saving today by visiting **connerstrong.goodrx.com**.

DID YOU KNOW?

You don't need to use your prescription benefits through Express Scripts to take advantage of the savings available through GoodRx. Some of the discounts found on GoodRx can be less expensive than your costs using the Express Scripts plan.

Learn more about Good Rx and start saving today by visiting **connerstrong.goodrx.com**.

USING IN-NETWORK PROVIDERS

Consider In-Network Options First

You will typically pay less for covered services when you visit providers that are part of your medical plan's network. In-network providers agree to discounted fees.

You are responsible only for any co-pay or deductible that is included in your plan design.

URGENT CARE CENTERS

Urgent Care Centers are a convenient, cost-effective medical care alternative when your primary care physician is unavailable. Typically, no appointments are necessary at most Urgent Care Centers and hours extend beyond regular doctor's office hours making them available earlier and later than your primary care physician.

Most are open 7 days a week! With over an estimated 3,000 centers nationwide, finding a local urgent care center is easy!

RETAIL CLINICS

Quality Medical Care on Your Schedule UMR cardholders can go to any participating MinuteClinic, RediClinic, The Little Clinic or Walgreens Healthcare Clinic for basic medical needs as an alternative to a traditional doctor's office visit.

CLAIM EXAMPLES – PPO VS. HSA

EXAMPLE *01*

Employee with **Single coverage and few healthcare services**, completes wellness requirements.

		PPO		HDHP WITH HSA	
	BILLED AMOUNT	YOUR COST	NOTES	YOUR COST	NOTES
Preventive Care Visit	$150	**$0**	Covered 100%	**$0**	Covered 100%
Visit to Primary Care Provider	$130	**$20**	PCP Copay	**$130**	Applies to Deductible
Visit to Specialist	$160	**$40**	Specialist Copay	**$160**	Applies to Deductible
Out-of-Pocket Cost Before FSA/HSA		**$60**		**$290**	
FSA/HSA Funding		**N/A**	Employer FSA Wellness Contribution: $500	**N/A**	Employer HSA Wellness Contribution: $750
Out-of-Pocket Cost After FSA/HSA		**$0**		**$0**	
Annual Payroll Deductions		**$990**		**$346**	
Total Annual Cost to Employee		**$990**		**$346**	

EXAMPLE *02*

Employee with **Single coverage and moderate healthcare services**, completes wellness requirements.

		PPO		HDHP WITH HSA	
	BILLED AMOUNT	YOUR COST	NOTES	YOUR COST	NOTES
Preventive Care Visit	$150	**$0**	Covered 100%	**$0**	Covered 100%
Visit to Primary Care Provider	$130	**$20**	PCP Copay	**$130**	Applies to Deductible
Visit to Specialist	$160	**$40**	Specialist Copay	**$160**	Applies to Deductible
Emergency Room Visit	$2,000	**$650**	90% After Deductible	**$1,289**	90% After Deductible
Outpatient Surgery	$1,200	**$120**	90% After Deductible	**$120**	90% After Deductible
Out-of-Pocket Cost Before FSA/HSA		**$830**		**$1,699**	
FSA/HSA Funding		**N/A**	Employer FSA Wellness Contribution: $500	**N/A**	Employer HSA Wellness Contribution: $750
Out-of-Pocket Cost After FSA/HSA		**$330**		**$949**	
Annual Payroll Deductions		**$990**		**$346**	
Total Annual Cost to Employee		**$1,320**		**$1,295**	

CLAIM EXAMPLES – PPO VS. HSA

EXAMPLE 03

Employee with **Family coverage and moderate healthcare services**, completes wellness requirements.

		PPO		HDHP WITH HSA	
	BILLED AMOUNT	YOUR COST	NOTES	YOUR COST	NOTES
Preventive Care Visit	$150	**$0**	Covered 100%	**$0**	Covered 100%
Visit to Primary Care Provider	$130	**$20**	PCP Copay	**$130**	Applies to Deductible
Visit to Specialist	$160	**$40**	Specialist Copay	**$160**	Applies to Deductible
Emergency Room Visit	$2,000	**$650**	90% After Deductible	**$2,000**	90% After Deductible
Outpatient Surgery	$5,000	**$500**	90% After Deductible	**$1,139**	90% After Deductible
Out-of-Pocket Cost Before FSA/HSA		**$830**		**$1,699**	
FSA/HSA Funding		**N/A**	FSA Wellness Contribution: $500	**N/A**	HSA Wellness Contribution: $1,500
Out-of-Pocket Cost After FSA/HSA		**$710**		**$1,929**	
Annual Payroll Deductions		**$6,003**		$4,052	
Total Annual Cost to Employee		**$6,713**		**$5,981**	

* Assumes care is for one family member.

EXAMPLE 04

Employee with **Single coverage and few healthcare services**, completes wellness requirements.

		PPO		HDHP WITH HSA	
	BILLED AMOUNT	YOUR COST	NOTES	YOUR COST	NOTES
Preventive Care Visit	$150	**$0**	Covered 100%	**$0**	Covered 100%
Inpatient Hospitalization	$50,000	**$5,450**	90% After Deductible	**$6,450**	90% After Deductible, $6,450 out-of-pocket maximum
Out-of-Pocket Cost Before FSA/HSA		**$5,450**		**$6,450**	
FSA/HSA Funding		**N/A**	FSA Wellness Contribution: $500	**N/A**	HSA Wellness Contribution: $1,500
Out-of-Pocket Cost After FSA/HSA		**$4,950**		**$4,950**	
Annual Payroll Deductions		**$6,003**		**$4,052**	
Total Annual Cost to Employee		**$10,953**		**$9,002**	

* Assumes care is for one family member.

TELEMEDICINE: TELADOC

Whether you're on PTO or it's the middle of the night, the care you need is just a call or click away.

All benefit eligible employees, regardless of medical enrolled status, have access to the Teladoc benefit. In addition, if you are enrolled in a medical plan at [[Client Name]], you may also access the Teladoc benefit for the dependents you cover under the medical plan. Teladoc is offered outside of the medical plan and has no impact on your medical deductibles, copays, coinsurance or out-of-pocket maximum.

Teladoc gives you access **24 hours, 7 days a week** to a U.S. board-certified doctor through the convenience of phone, video, or mobile app visits. It's an affordable option for quality medical care.

Teladoc benefits include:

- Talk to a doctor anytime, anywhere you happen to be
- Receive quality care via phone, video or mobile app
- Prompt treatment, median call back in 10 minutes
- A network of doctors that can treat every member of the family
- Prescriptions sent to pharmacy of choice if medically necessary
- Teladoc is less expensive than the ER or urgent care

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink eye
- Respiratory infection
- Sinus problems
- Skin problems
- And more

WELLNESS PROGRAM: US WELLNESS

We are very excited to partner with **US Wellness** to administer the [[Client Name]] Wellness Program for the 2020 – 2021 plan year.

2023 WELLNESS INCENTIVE

Through your participation in various events throughout the plan year (1/1/2023 through 12/31/22), you will earn points which will correlate to the **Wellness Plan Incentive**, specifically Health Savings Account funding (HDHP plan participants) or Flexible Spending Account and paycheck contributions (PPO plan participants) for the 2023 benefit plan year.

Funding for each plan is as follows (if employees earn the required points):

- **HDHP Enrollees:** $750 Single/$1,500 Family HSA Contribution
- **PPO Enrollees:** $750 Single/$1,500 Family FSA Contribution & Medical Premium Reduction

ELIGIBILITY

Participation in the Wellness Program is voluntary, however, employees must complete certain program requirements to receive the HSA/FSA incentives in the 2023 plan year. **To be eligible for the Wellness Plan incentive, the following must be completed:**

- Employees **must** complete a biometric screening and an annual wellness visit with a primary care physician.
- Spouses covered under the [[Client Name]] medical plan will need to complete a biometric screening and an annual wellness visit with a primary care physician.
- Employees may earn points by completing individual wellness workshops, completing additional preventive wellness visits, participating in wellness challenges, and/or completing qualifying independent wellness activities. Employees can earn double points when spouses/domestic partners complete preventive wellness visits.
    - Employees with single coverage on the [[Client Name]] plan will need to earn **100 points**, while employees with spouses/domestic partners on the [[Client Name]] plan will need to earn **130 points**.

MEDICAL & PRESCRIPTION CONTRIBUTIONS

Average monthly cost is based on the per pay amount (26 pays divided by 12 months).

CIGNA HDHP WITH HSA

	PER PAY	AVERAGE MONTHLY
Employee Only	$13.97	$30.26
Employee & Spouse	$128.21	$277.79
Employee & Child(ren)	$89.30	$193.48
Family	$163.63	$354.53

ARE YOU ELECTING THE PPO PLAN?

During the 2023 benefit year, [[Client Name]] will fund the FSA for employee only coverage for employees enrolled in the PPO plan that have completed the Wellness Program requirements. In addition, employees with employee and spouse, employee and children, and employee and family coverage will receive $500 into the FSA and the remaining funds will be deducted from the medical paycheck premiums. See **page 11** for more details on the Wellness Program.

	CIGNA PPO PLAN WITHOUT WELLNESS CREDIT		CIGNA PPO PLAN WITH WELLNESS CREDIT	
	PER PAY	AVG MONTHLY	PER PAY	AVG MONTHLY
Employee Only	$50.41	$109.23	$39.99	$86.65
Employee & Spouse	$222.66	$482.42	$180.98	$392.12
Employee & Child(ren)	$172.24	$373.19	$130.56	$282.88
Family	$284.10	$615.54	$241.96	$525.24

ADMINISTERED BY PAYFLEX

PRE-TAX SAVINGS ACCOUNTS

YOUR 2023 BENEFITS

If you participate in the HDHP, eligible employees can elect to participate in the **Health Savings Account (HSA)**. The HSA is a tax-exempt savings account that can be used for eligible healthcare expenses.

If you are not eligible for the HSA, a Healthcare **Flexible Spending Account (FSA)** is another type of tax-exempt account that allows you to set aside funds that can be used for eligible healthcare expenses.

HEALTH SAVINGS ACCOUNT (HSA)

ARE YOU ELECTING THE HDHP PLAN?

If you elect the HDHP with HSA, you have the option of making pre-tax payroll contributions toward a Health Savings Account (HSA), administered by PayFlex, An HSA allows you to save money for qualified healthcare expenses that you're expecting, such as contact lenses or prescriptions, as well as the unexpected ones.

HSA ADVANTAGES

- **Employer Contribution:** For employees that meet the Wellness Program requirements, [[Client Name]] will make an annual contribution to your HSA up to $750* for individual coverage and $1,500* for family coverage—that covers the first half of the plan's deductible!
- The money you deposit and withdraw is **tax-free**.
- An HSA is portable, meaning that if you leave [[Client Name]] or retire, you can take your HSA funds with you.

CONTRIBUTION LIMITS

HSA contribution limits are set by the Internal Revenue Service (IRS) and adjusted annually. The limits for the 2023 plan year are:

- **$3,650** for individual coverage in 2023
- **$7,300** for family coverage in 2023
- **$1,000 extra** if you're 55 or older, also known as catch-up contributions

QUALIFIED MEDICAL EXPENSES

You can use the funds in your HSA to pay for qualified healthcare expenses such as:

- Doctor visits
- Dental care, including extractions and braces
- Vision care, including contact lenses, prescription sunglasses and LASIK surgery
- Prescription medications
- Chiropractic services
- Acupuncture
- Hearing aids and batteries

FLEXIBLE SPENDING ACCOUNTS

The **Flexible Spending Accounts (FSA),** administered by PayFlex, provide an opportunity for you to better control the cost of health care and dependent care expenses. By setting aside pre-tax dollars from your paycheck, you have an account that's dedicated for the reimbursement of qualified healthcare expenses.

HEALTHCARE FSA

A **Healthcare Flexible Spending Account** is used to reimburse out-of-pocket medical expenses incurred by you and your dependents. The maximum you can contribute to the Healthcare FSA is **$2,850**. This benefit is only available to the members participating in the medical PPO plan.

IMPORTANT: *If you are enrolling in HDHP with HSA plan, you may not participate in a Healthcare FSA. However, you may contribute toward a Limited Purpose FSA, up to a maximum of $2,750, which can be used for eligible vision and dental expenses only.*

DEPENDENT CARE FSA

A **Dependent Care Flexible Spending Account** is used to reimburse expenses related to the care of eligible dependents. The maximum that you can contribute to the Dependent Care FSA is **$5,000** if you are a single employee or married filing jointly, or **$2,500** if you are married and filing separately. Please keep in mind this is a use-it-or-lose-it fund.

ELIGIBLE EXPENSES

For a full list of eligible FSA expenses, please visit **www.irs.gov** and reference Publication 502.

"USE-IT-OR-LOSE-IT" RULE

You should contribute the amount of money you expect to pay out-of-pocket for eligible expenses for the plan period. You may rollover a maximum of $500 of unused Healthcare FSA funds to the next plan year. Any unused Dependent Care FSA funds are forfeited at the end of the plan year.

COMMUTER BENEFITS

[[Client Name]] is pleased to provide our employees with the opportunity to enroll in a spending account specific to work-related transit expenses, administered by Payflex.

Transit pre-tax reimbursement accounts allow you to pay for eligible work-related transit commuter expenses through pre-tax payroll deductions from your paycheck.

You are able to make a monthly pre-tax election **up to $270**. You are able to make changes to your pre-tax election amount on a month to month basis.

NOTE: Once you make your election, you will receive a debit card that can be used to pay for work-related transit expenses. Your debit card is loaded with your pre-tax deductions each time a deduction is taken from your paycheck. Each time you use your debit card to pay for transit purchases, the funds are automatically debited from your transit account.

CARRYOVER FUNDS

Any unused funds from your transit account may be carried over to subsequent years. There is no annual "use it or lose it" rule.

While unused amounts cannot be cashed out, they do not need to be forfeited, and can be carried over to provide transit benefits in subsequent years.

ELIGIBLE EXPENSES

Eligible work-related transit expenses include vouchers & passes, tokens for buses, trains/rail/subway, ferries, and vanpooling costs.

QUESTIONS?

Call PayFlex at **555.555.5555**
or visit **www.payflex.com**

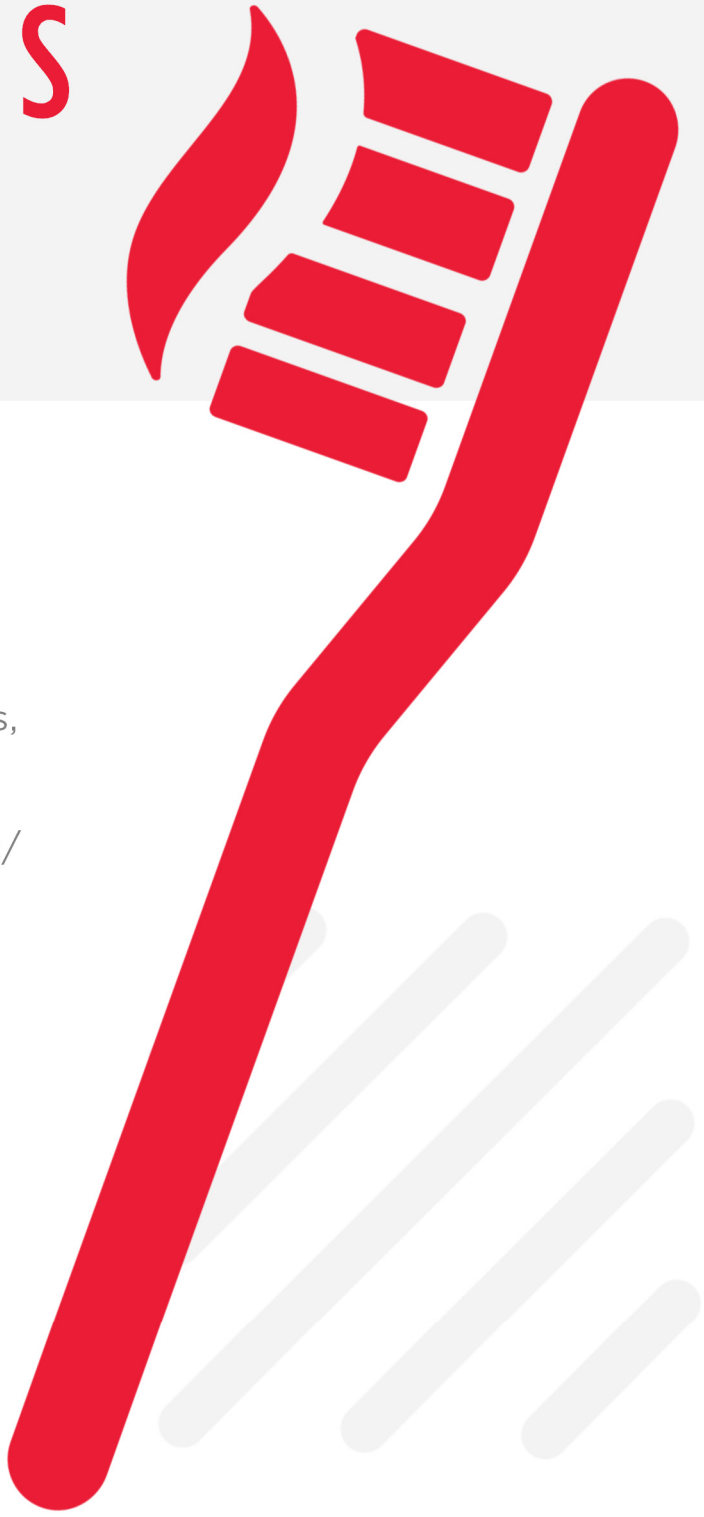
ONLINE ORDERING

The PayFlex Commuter benefit lets members enjoy "website to home site" service. This means you can order public transportation passes online. Members can elect, order and receive passes and vouchers each month with the click of a button. Through the website, **www.payflex.com**, members can:

- Research transit and parking options
- Place, view and track orders
- Set orders to recur monthly
- Learn more through online Q&As

DENTAL PLANS

YOUR 2023 BENEFITS



Good dental health is important to your overall well-being. At the same time, we all need different types of dental treatment. The Cigna Dental plans, offered by [[Client Name]], provide varying levels of coverage for Diagnostic/ Preventive Services, Basic Services, Major Services, and Orthodontia.

Depending on where you live, you may select between either the DHMO or DPPO Advantage dental plans offered through Cigna. You may **not** switch between the two plans during the calendar year.

DENTAL BENEFITS: CIGNA

FINDING A DENTIST

Locating Participating DPPO Advantage or DHMO Dental Providers

Each time you need dental care, you have the freedom to visit any dentist of your choice. However, where you receive care directly impacts the amount the plan pays and your out-of-pocket costs.

1. Log on to **www.cigna.com**
2. Click on “Find a Doctor, Dentist, or Facility”
3. Click “Employer or School” on the How You are Covered page
4. Enter location zip code, then select “Doctor by Type”
5. Choose “Dentist” or “Child's Dentist” from the drop-down list
6. Confirm location and then select “Continue” to move to plan selection
7. Select your plan: **Total Cigna DPPO (Cigna DPPO Advantage and Cigna DPPO)** or Cigna Dental Care Access **(Formerly Cigna Dental Care HMO Plan)**
8. Participating providers will be reflected on the next page

For the most accurate provider results, please log in/register at **www.mycigna.com**

DENTAL CONTRIBUTIONS

[[Client Name]] is committed to maintaining comprehensive, competitive benefits that meet the needs of our employees and their families. All bi-weekly payroll deductions are taken on a pre-tax basis.

DPPO ADVANTAGE PLAN

	BI-WEEKLY CONTRIBUTIONS
Employee Only	$7.63
Employee & Spouse	$14.34
Employee & Child(ren)	$17.43
Family	$24.13

DHMO PLAN

	BI-WEEKLY CONTRIBUTIONS
Employee Only	$0.00
Employee & Spouse	$5.56
Employee & Child(ren)	$6.07
Family	$12.00

DENTAL BENEFITS: CIGNA DPPO ADVANTAGE

CIGNA DPPO ADVANTAGE

Dental Option 1

Each time you need dental care, you have the freedom to visit any dentist of your choice. However, where you receive care directly impacts the amount the plan pays and your out-of-pocket costs.

Our dental PPO program offers you the opportunity to increase the annual maximum benefit beyond the $1,500 calendar-year limit.

If you visit your dentist for any preventive service (cleaning/x-ray), the annual maximum benefit for the following year will be increased by $100 resulting in a $1,600 calendar year maximum benefit. This process continues in future years until your annual maximum reaches $1,800. For additional information, log onto and register at **www.mycigna.com**.

	DPPO PLAN		
	DPPO ADVANTAGE	DPPO	OUT-OF-NETWORK
Deductible Individual/Family	$25 / $75	$50 / $150	$50 / $150
Calendar Year Maximum (per patient)	$1,500	$1,500	$1,500
Orthodontia Benefits (child to age 26)	Plan Pays 50% No Deductible	Plan Pays 50% No Deductible	Plan Pays 50% No Deductible
Orthodontia Lifetime Maximum (per patient)	$1,000	$1,000	$1,000
Class I: Preventive & Diagnostic Exams, Cleanings, Routine X-rays, Fluoride Application, Sealants	Plan Pays 100% No Deductible	Plan Pays 90% No Deductible	Plan Pays 90% No Deductible
Class II: Basic Restorative Fillings, Simple Extractions Endodontics (root canal) Periodontics, Oral Surgery Bridges, Crowns and Inlay Repairs	Plan Pays 80%*	Plan Pays 70%*	Plan Pays 70%*
Class III: Major Restorative **Crowns, Inlays, Onlays** Bridges, Dentures, Implants	Plan Pays 50%*	Plan Pays 50%*	Plan Pays 50%*

DENTAL BENEFITS: CIGNA DHMO PLAN

CIGNA DHMO PLAN

Dental Option 2

The DHMO offers you a very high level of benefits with no annual maximum and less out of pocket expense. Under the DHMO dental plan, you must select a Primary Care Dentist who participates in the CIGNA DHMO network and you must always work within that network. The DHMO dentist would refer you to another participating dentist if you were to require specialty service.

	DHMO PLAN		
	IN-NETWORK	SAMPLE K1-09 FEE CODES	K1-09 E MPLOYEE COST
Calendar Year Deductible (Does not apply to Preventive & Diagnostic Services) Individual/Family	N/A	N/A	N/A
Calendar Year Maximum (per patient)	Unlimited	Unlimited	Unlimited
Orthodontia Benefits (Children & Adults)	K1-09 Schedule	D8670 (Periodic Ortho Treatment - Child up to age 26; 24 month treatment)	$2,040
Orthodontia Lifetime Maximum (per patient)	N/A	N/A	N/A
Preventive & Diagnostic Services Prophylaxis Cleanings,Oral Examinations, Topical Fluoride,X-ray, Sealants, Bitewing X-ray	Plan pays 100%	D1110 (Adult Cleaning) D0120 (est. patient exam) D0210 (x-rays-intraoral) D0274 (Bitewwings-4)	$0 $0 $0 $0
Basic Services Fillings, Extractions, Oral Surgery, Endodontics, Periodontics, Anesthesia, Periodontal surgery	K1-09 Schedule	D2150 (Amalgam 2 surface) D3330 (root canal-molar; Excluding final restoration) D4260 (osseous surgery 4 or more teeth per quadrant	$0 $335 $400
Major Services Repair of Bridges and Dentures, Full and Partial Dentures Crowns, Inlays, Onlays	K1-09 Schedule	D5510 (repair broken Complete denture base) D6634 (onlay-titanium)	$88 $450

ADMINISTERED BY EYEMED

VISION PLAN

YOUR 2023 BENEFITS

[[Client Name]] offers a voluntary vision plan through VSP. This benefit offers coverage for vision exams and hardware, as outlined on the following page, once every 12 months.

Vision reimbursement plan is not available through the Cigna medical plan. Employees interested in comprehensive vision insurance can elect vision coverage through VSP.

VISION BENEFITS: VSP

Our voluntary vision plan is administered by VSP and provides coverage for a range of vision care including exams, frames, lenses and contact lenses. Take care of your vision and overall health while saving on your eye care and eyewear needs.

VSP VISION PLAN

	IN-NETWORK	OUT-OF-NETWORK
Eye Examination	$10 copay	Up to $40 reimbursement
Lenses Single Vision Bifocal Trifocal Lenticular	$25 copay	Reimbursements: Up to $40 Up to $60 Up to $80 Up to $80
Frames	$130 allowance (20% off balance)	Up to $50 reimbursement
Contact Lenses (in lieu of eyeglasses)	$130 allowance	Up to $105 reimbursement
Frequency *Examination* *Frames* *Lenses* *Contact Lenses*	Once every 12 months Once every 12 months Once every 12 months Once every 12 months	

VISION CONTRIBUTIONS

[[Client Name]] is committed to maintaining comprehensive, competitive benefits that meet the needs of our employees and their families.

All bi-weekly payroll deductions are taken on a pre-tax basis.

Average monthly cost is based on the per pay amount (26 pays

VSP PLAN

	PER PAY	AVERAGE MONTHLY
Employee Only	$2.58	$5.58
Employee & Spouse	$5.19	$11.24
Employee & Child(ren)	$5.59	$12.12
Family	$7.19	$15.58

ADMINISTERED BY CIGNA

LIFE, AD&D & DISABILITY PLANS

YOUR 2023 BENEFITS

Life and Accidental Death & Dismemberment (AD&D) insurance provides protection to those who depend on you financially, in the event of your death or an accident that results in death or serious injury.

Short-Term and Long-Term Disability also help to protect your income in the event that you become disabled and are unable to work.

LIFE & AD&D INSURANCE: CIGNA

BASIC LIFE AND AD&D

[[Client Name]] offers company-paid group life and AD&D insurance in the amount of 1x Annual Salary rounded to the nearest $1,000 up to a maximum of $50,000.

SUPPLEMENTAL LIFE AND AD&D

In addition to your Basic Life and AD&D, you have the option of electing supplemental Life and AD&D insurance.

Coverage is available for you, your spouse and eligible dependent children. The rates for this coverage are age-based and will increase each time you enter into a new age bracket.

Employee Coverage

You have the option of purchasing additional coverage for yourself in $10,000 increments up to the lesser of 5x annual salary or $500,000. Coverage is guaranteed up to $100,000 for new hires with further Evidence of Insurability required for any additional amount. Please note if you did not enroll in this coverage when it was first offered to you, then you will be considered a late enrollee, and be required to submit evidence of insurability, for any amount.

Spouse Voluntary Life Insurance

You may purchase coverage for your spouse in $5,000 increments up to $100,000 (cannot exceed 50% of the employee's voluntary life election).

Child Voluntary Life Insurance

Voluntary Life Insurance for dependent children may be purchased up to $10,000 (cannot exceed the employee's supplemental life election). Coverage is available for children to age 19 or up to age 25 if a full-time student. If child passes away from age 14 days to six months, the beneficiary will receive a maximum of $1,000.

Please note:
You must purchase Voluntary Life Insurance for yourself in order to elect Dependent Life Insurance (Spouse and/or Child). Life Insurance elections may require (EOI). EOI is an application process in which you provide medical information regarding the condition of your health to the insurance carrier for review.

DISABILITY INSURANCE

[[Client Name]] pays entirely for Short Term and Long Term Disability with no cost to members for these coverages.

SHORT-TERM DISABILITY

Short Term Disability is available to all employees working average of 20 hours per week or more. Short Term Disability, provided by Cigna, replaces a portion of your income in the event you are unable to work due to an injury or illness that occurs outside of the workplace.

- **Benefit:** 66.7% of pre-disability earnings up to a maximum benefit of $2,000 per week for up to 11 weeks.
- **Waiting Period:** Accident & Illness: Benefits begin after 7 days.

LONG-TERM DISABILITY

Long Term Disability works the same as Short Term Disability in that it will replace a portion of your income, but for longer term injuries/illness that prohibit active employment. The Long Term Disability coverage was designed to “dovetail” with Short Term Disability so that no gap in coverage exists.

- **Benefit:** 60% of pre-disability earnings up to a maximum benefit of $5,000 per month until you are able to return to work or up until you reach age 65.
- **Coverage Period:** After 90 day elimination period, coverage lasts until employee is able to return to work at their job, or any other job they are qualified, otherwise the benefit lasts until Social Security Retirement Age.

VOLUNTARY BENEFITS

HOSPITAL INDEMNITY INSURANCE

Cigna

A hospital stay can happen at any time, and it can be costly. Hospital Indemnity insurance helps you and your loved ones have additional financial protection.

With hospital indemnity insurance, you get a benefit paid directly to the covered person, unless otherwise assigned, after a covered hospitalization resulting from a covered injury or illness.

It can be used for expenses, such as:

- Copays, deductibles, and coinsurance
- You can use it towards unexpected costs such as; child care, help around the house, follow up services

ACCIDENT INSURANCE

Cigna

Accidents happen and they can affect your financial health. With Accident Insurance, you get a benefit to help pay for costs associated with a covered accident or injury. You can use the money however you'd like.

Accident Insurance covers:

- Initial & emergency care
- Hospitalization
- Fractures & Dislocation
- Follow-up care

ID THEFT PLAN

Countrywide

The Diamond ID Theft Plan administered by Countrywide provides identity theft insurance as well as credit monitoring, credit scores and credit reports.

In addition to coverage for the employee, you can choose to cover your spouse and dependents under age 24. Enhancements to this plan include: bureau credit reports/ scores from 3 bureaus every 30 days, ID Theft insurance up to $1,000,000, Opt Out Option (Junk Mail/Do Not Call List), Checking Account Report (to show history of consumers checking account transactions), Credit Score Tracker and Information & Resource Center.

The cost for each coverage can be viewed through Ultipro when making your benefit elections.

ADDITIONAL BENEFITS

401(K) PLAN

Employees may elect to set aside pre-tax or post-tax dollars in the Burns 401(k) Plan. BPAS, Burns' 401(k) vendor, provides a traditional 401(k) plan, Roth 401(k) plan, and comprehensive fund options in which employees may invest funds.

Burns provides a discretionary match to employees who work a minimum of 1,000 hours during a given plan year and were actively employed on the last day of the plan year. The annual discretionary match is equal to 50% of the employee's contribution deferral percentage, up to a maximum of 6% of the employee's eligible compensation. Burns funds its discretionary match in a one-time deposit made during the quarter immediately following the plan year.

The vesting schedule of the employer's discretionary match is based on an employee's tenure. For employees who meet eligibility requirements, 20% of the employer match will vest after an employee has completed two years of eligible employment. Thereafter, vesting will increase by 20% annually for each year in which eligibility requirements are met. An employee will be fully vested after completing six years of eligible employment.

TIME OFF BENEFIT

Eligible employees will receive seven company-paid holidays. In addition, employees may be eligible to receive up to two floating holidays, along with compensated sick and vacation time. Please refer to the employee handbook for eligibility requirements and related information.

PROFESSIONAL DEVELOPMENT

Upon completing one year of full time employment, employees are eligible to participate in the Burns Tuition Assistance Program. Tuition reimbursement for 50% of the cost of approved courses or programs, up to annual maximum of $5,250, is available.

Employee are also able to take continuing education courses through the Burns Learning Management System to maintain certifications and licenses. Burns also hosts professional organization meetings and seminars onsite.

Burns will also pay for eligible professional training courses, association members, and professional registration fees. Employees are eligible to receive a bonus for receiving the Certification of Engineer in Training (EIT) or passing the Professional Engineering License. For additional information, please refer to the employee handbook.

BENEFIT RESOURCES

BENEPORTAL

Online Benefits Resource

BenePortal, is [[Client Name]]'s virtual employee benefits portal, providing access to company benefits programs, health and wellness information, recommended links, pertinent forms and guides, and a wealth of additional tools and resources.

BenePortal is available 24/7 to [[Client Name]]'s employees and their eligible dependents to access benefit plan information, insurance company contacts, forms, guides, links and other applicable benefit materials.

Simply go to **www.samplebenefitsportal.com** to access your benefits information today!

BenePortal features include:

- Secure online access - with NO login required!
- Mobile optimized site
- Direct links to specific enrollment sites
- Plan summaries
- Wellness resources
- Carrier contacts
- Downloadable forms
- GoodRx
- Benefit Perks Discount Program
- And more!

MEMBER ADVOCACY TEAM

Conner Strong & Buckelew

Employee benefits can be complex, making it difficult to fully understand your coverage and use it properly. Member Advocacy allows you to speak to a specially trained Member Advocate, who can answer your questions and help you get the most out of your benefits.

Member Advocates are available Monday through Friday, 8:30 am to 5 pm (Eastern Time). After hours, you will be able to leave a message with a live representative and receive a response by phone or email during business hours within 24 to 48 hours of your inquiry.

To contact Member Advocacy, call **800.563.9929**, Monday through Friday, 8:30 am to 5 pm (EST) or submit a request online at **www.connerstrong.com/memberadvocacy**

GLOSSARY OF TERMS

Allowed Amount

The amount agreed upon between the provider and the insurance company for the service provided. It is almost always less than the billed amount, which is why enrollees see different amounts on their explanations of benefits (EOBs). For example, a provider may charge $120 per hour of psychotherapy, but the insurance company pays them $95 — the allowed amount for that service.

Balance Billing

This type of billing is typically done with out-of-network providers. It means that the enrollee is charged the difference between the provider-billed amount and the insurance-allowed amount. For example, if a primary care physician bills an insurance company $150, but the allowed amount is only $90 (60 percent), the physician would charge the patient $60 (40 percent) under a balance billing situation.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage of the covered expense for the service. You pay coinsurance plus any deductibles you owe.

Copayment (copay)

A fixed amount you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The cost a participant will pay to satisfy the deductible before the coinsurance fee structure is effective.

- The PPO family deductible must be met by two or more members ($500 per member).
- The HDHP family deductible can be met by one member.

Out-of-Network Providers

A provider who does not have a contract with your plan to provide services to you. The EPO Plan does not cover out-of-network providers. You will be responsible for all charges (except out-of-network emergency room) for services received by an out-of-network provider.

Out-of-Pocket Maximum

The most you will pay during a Plan Year before your plan begins to pay 100% of the covered expenses.

- The PPO family Out-of-Pocket Maximum may be met by one member.
- The HDHP family Out-of-Pocket Maximum may be met by one member.

Preferred Provider

A provider who has a contract with your plan to provide services to you at a discount.

GLOSSARY OF TERMS

Generic Prescription Drug

A drug either chemically equivalent or therapeutically equivalent to brand-name drugs, meaning they have the same ingredients or the same clinical results; they are usually cheaper than brand-name drugs.

Brand-Name Prescription Drug

A drug that has a trade name and is protected by a patent; they are usually more e pensive than generic drugs due to expensive advertising.

CARRIER CONTACTS

BENEFIT	CARRIER	PHONE	WEBSITE
Member Advocacy	Conner Strong & Buckelew	800-563-9929	www.connerstrong.com/memberadvocacy
Medical & Dental	Cigna	800-244-6224	www.mycigna.com
Vision	VSP	800-877-7195	www.vsp.com
Life, Disability, Accident, & Hospital Indemnity	Cigna	888-842-4462	www.cigna.com
HSA, FSA & Commuter Benefits	PayFlex	844-729-3539	www.payflex.com
EAP	Health Advocate	866-695-8622	www.healthadvocate.com
Pet Insurance	Nationwide	877-738-7874	www.petinsurance.com

LEGAL NOTICES

Special Enrollment Notice

Loss of other Coverage (excluding Medicaid or a State Children's Health Insurance Program).
If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage (including COBRA coverage) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within [30 days or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage. Coverage will be effective the first of the month following your request for enrollment.

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

New dependent by marriage, birth, adoption, or placement for adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within [30 days or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption.

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

To request special enrollment or obtain more information, contact Human Resources.

Newborns' and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act

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

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other benefits. If you have any questions, please speak with Human Resources.

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 July 31, 2019. 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)

LEGAL NOTICES

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+ Website: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991 / State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
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.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
Website: http://dhs.iowa.gov/Hawki
Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: https://chfs.ky.gov
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
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: 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://dma.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/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347 or 401-462-0311

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

LEGAL NOTICES

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

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

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/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2019, 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

Notice Regarding Wellness Program

The [[Client Name]] Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. You will be asked to complete a biometric screening, which will include a blood test. In addition you can earn points by completing individual wellness workshops, completing additional preventive wellness visits, participating in wellness challenges, and/or completing qualifying independent wellness activities. You are not required to complete any of the activities to earn points, participate in the blood test, or any other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of a $750 contribution to their health savings account if you participate in the HDHP, or a $500 FSA contribution and $250 annual payroll deduction discount. Although you are not required to complete any wellness activities, only employees who do so will receive the incentive.
If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources.

The information from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information
We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and [[Client Name]] may use aggregate information it collects to design a program based on identified health risks in the workplace, the [[Client Name]] Wellness Program will never disclose any of your personal information either lpublicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are a health coach, or registered nurse in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources.

INSURANCE MARKETPLACE NOTICE

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets our needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the insurance carrier's customer service number located on your ID card. 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.
To get information about the Marketplace coverage, you can call the government's 24/7 Help-Line at 1-800-318-2596 or go to https://www.healthcare.gov/marketplace/individual/.

PART B: Information about Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name [[Client Name]]		4. Employer Identification Number (EIN) 00-0000000
5. Employer Address 123 Somewhere Street		6. Employer phone number 555-555-5555
7. City Somewhere	8. State New Jersey	9. Zip Code 12345

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

[[Client Name]] reserves the right to modify, amend, suspend or terminate any plan, in whole or in part, at any time. The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. If you have any questions about your Guide, contact Human Resources.