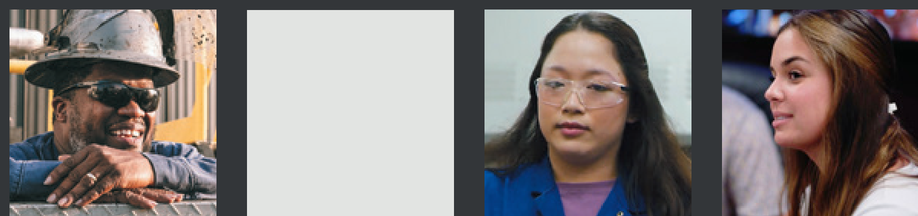
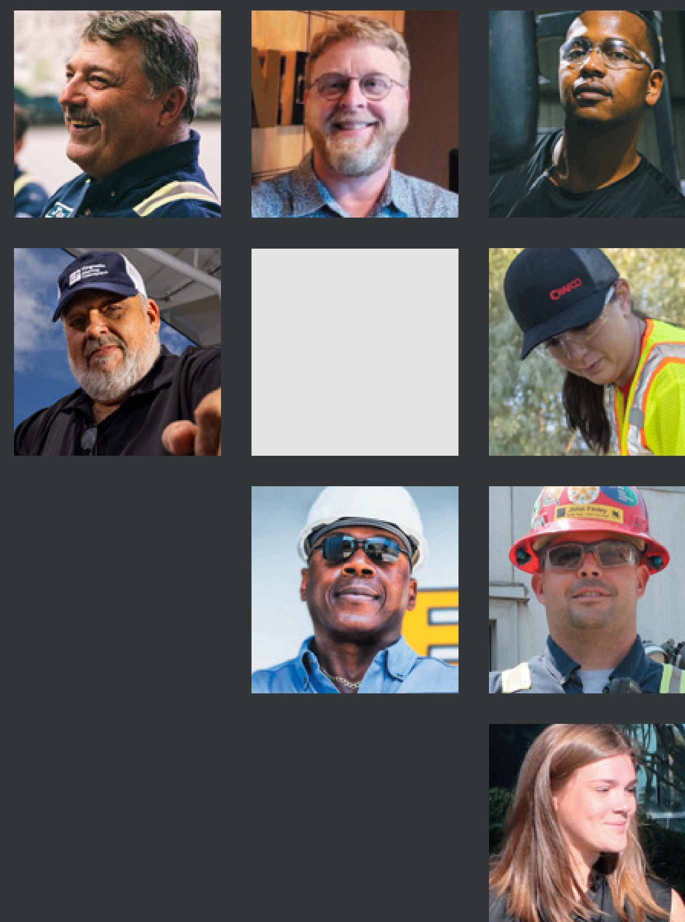




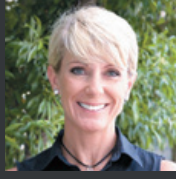
OPEN ENROLLMENT BENEFITS OVERVIEW

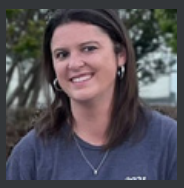
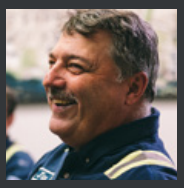
November 6 – December 1, 2023

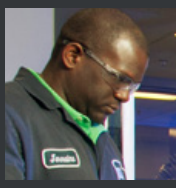
ERGON®

UNITED BY SERVICE. DRIVEN BY SOLUTIONS.







WELCOME TO YOUR BENEFITS.

Aligning with Ergon's mission, we are excited to introduce your enhanced suite of benefits, available January 1, 2024.

In the following pages, you will find information to help you make informed benefit decisions to help protect your health, lifestyle, future and family.

You will also discover new choices that will partner with other plans to give our Ergon family a broad range to select from to better meet individual needs.

Active Enrollment Year

All eligible employees will need to participate in Open Enrollment in November 2023, even those who are waiving coverage.

This Guide Is an Overview

The benefits discussed in this guide will be available to select during Open Enrollment. Coverage is effective January 1, 2024.

bswift

ask EMMA

ERGON

UNITED BY SERVICE. DRIVEN BY SOLUTIONS.

OPEN ENROLLMENT

November 6 – December 1, 2023

CONTENTS

What's New in 2024?

MEDICAL

Network: United Healthcare

Two health plans to choose from:

1. **Preferred Provider Organization (PPO)** – The same familiar Ergon PPO plan structure
2. **High-Deductible Health Plan (HDHP)** with a Health Savings Account (HSA)

FLEXIBLE & HEALTH SAVINGS ACCOUNTS

1. Dependent Care Flex Account (DC-FSA)
2. Medical Flexible Spending Account (FSA)
3. Health Savings Account (HSA)

DENTAL

Two dental plans to choose from:

1. General Plan
2. Enhanced Plan (offers orthodontia benefit)

VISION

General Vision Plan

COMPANY-PROVIDED LIFE & AD&D

- 2x Employee's Annual Salary (based on a 40-hour work week)
- Spouse coverage **increased to $10,000**
- Child coverage **increased to $1,000**

VOLUNTARY SUPPLEMENTAL LIFE & AD&D

- Employee Supplemental Life & AD&D
- Spouse Supplemental Life & AD&D
- Child Supplemental Life & AD&D

VOLUNTARY BENEFITS

- Hospital Indemnity Plan*
- Accident Insurance*
- Critical Illness*

** Regular part-time employees working 20 hours or more per week are eligible for these three plans.*

UMR A UnitedHealthcare Company · GG&A · Ameritas · New York Life · VOYA FINANCIAL

Who is Eligible for Benefit Coverage?

EMPLOYEES

- Full-Time Employees
- Full-Time Equivalent (FTE)—Employees working 30-39 hours per week
- Employees with variable hours and seasonal schedules may be considered eligible for some plans

ELIGIBLE DEPENDENTS

- Legally married spouse or registered domestic partner
- Natural, adopted or stepchildren up to age 26
- Court-ordered dependents or children named in a Qualified Medical Child Support Order (QMCSO)

Note: Human Resources will request documentation such as birth certificate, social security card, marriage certificate, etc. to verify dependents before their enrollment is finalized.

WHEN CAN YOU ENROLL?

You can enroll in benefits when you are **first eligible** as a new hire (within 30 days of employment).

You can enroll during **annual Open Enrollment** or within 30 days of a **qualifying life event**.

If you miss the deadline to enroll, you will need to wait until the next Open Enrollment period begins unless you or a family member experience an eligible life event.

Making Changes to Your Elections

There are specific qualifying life events that open a **30-day window** for employees to make changes to their elections such as adding or dropping dependents, selecting a plan that you may have waived or waiving a plan you previously selected.

ELIGIBLE QUALIFYING LIFE EVENTS

- Change in marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse or dependent child(ren)
- *Special enrollment event* under HIPAA, including a new dependent by marriage, birth or adoption or loss of coverage under another health plan
- Event allowed under the Children's Health Insurance Program (CHIP), which provides a 60-day window to request enrollment due to events allowed under CHIP

Please Note: If you or one of your dependents experiences a life event, it is important to reach out to your benefits team for guidance as soon as possible. **If you miss the 30-day window, you will need to wait until the next open enrollment period to make applicable changes.**

Medical Plan Options

Ergon has partnered with UMR for the new plan year and is introducing a **second medical plan option**. Both medical plans utilize the United Healthcare Choice Plus network which is a true national network. This means you will find in-network coverage no matter where you are in the U.S.

	PPO Plan		High-Deductible (HDHP) with HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network
GENERAL PLAN PROVISIONS				
Annual Deductible	Stacked		Embedded	
Employee Only	$500 per person	$500 per person, separate	$3,200 Individual	$6,400 Individual, separate
Employee + 1 or more	$500 per person	$500 per person, separate	$6,400 family	$12,800 family, separate
Coinsurance %	20%/80% after deductible	40%/60% after deductible	20%/80% after deductible	40%/60% after deductible
Coinsurance out-of-pocket	$2,000 per person	Unlimited	N/A	N/A
Max out-of-pocket	$6,350/$12,700 Family	Unlimited	$6,350/$12,700 Family	Unlimited
Physician's office visit	20% after deductible	40% after deductible	20% after deductible	40%/60% after deductible
Preventive/Wellness	100%	Not covered	100%	Not covered
PRESCRIPTION DRUGS				
Separate Rx Deductible	$100	$100	N/A	N/A
Category 1	$15	$15	Cal. yr. deductible, then $15	Annual deductible, then $15
Category 2	$35	$35	Cal. yr. deductible, then $35	Annual deductible, then $35
Category 3	$75	$75	Cal. yr. deductible, then $75	Annual deductible, then $75
Category 4	$100	$100	Cal. yr. deductible, then $100	Annual deductible, then $100
Specialty	$100	$100	Cal. yr. deductible, then $100	Annual deductible, then $100

Monthly Premium Rate			
PPO Employee	**PPO Dependents**	**HDHP Employee**	**HDHP Dependents**
$100 Employee Non Smoker	$100 Per Covered Dependent	$50 Employee Non Smoker	$50 Per Covered Dependent
$200 Employee Smoker	–	$100 Employee Smoker	–

** Monthly Dependent Premium is capped at 5 children*

Ergon HSA Contribution
Employee Only: $250 annual employer contribution (per employee)
Employee + 1 (or more): $500 annual employer contribution (per family)

PPO

- Higher premium out of your check, balanced with a lower out-of-pocket cost at time of service.
- Leverage tools available to obtain quality service at the lowest cost.
- After you meet your deductible, the plan's coinsurance will kick in and pay 80% of your medical costs. Prescriptions have a separate deductible, and once met, you will pay the applicable co-pay based on the tier of the drug prescribed.
- Partners with the Flexible Spending Account (FSA) help offset out-of-pocket costs for medical, dental and vision expenses.

HIGH-DEDUCTIBLE HEALTH PLAN

- Lower premium out of your check, balanced with a higher out-of-pocket cost at time of service.
- Leverage tools available to obtain quality service at the lowest cost.
- After you meet your deductible, the plan coinsurance will kick in and pay 80% of your medical and prescription drug costs. The out-of-pocket maximum serves as a built-in cap on annual healthcare expenses. Deductible and prescription drug costs count toward the out-of-pocket maximum.
- Health Savings Account with Employer Contribution $250 individual/$500 family.

Key differences between your two medical options:

PPO

Stacked Deductible

Each family member has their own $500 deductible to meet before the coinsurance kicks in. A family of two would have a 2 x $500 = $1000 deductible, while a family of six would have a 6 x 500 = $3,000 deductible.

Coinsurance

Each family member has their own $2,000 coinsurance maximum until they hit the out-of-pocket maximum. At that time, the plan will pick up 100%. The prescription drug deductible amount and co-pay amounts do not apply to the coinsurance maximum.

Partners with the Health Care Flexible Spending Account (FSA)

Prescription Co-pays

After a family member meets the prescription deductible, that individual would pay the applicable co-pay amount based on the category of the drug prescribed.

Prescription Drug	
Separate Rx Deductible	$100
Category 1	$15
Category 2	$35
Category 3	$75
Category 4	$100
Specialty	$100

HIGH-DEDUCTIBLE HEALTH PLAN

Embedded Deductible

When a family member meets their individual deductible of $3,200, coinsurance will apply to that member only. All charges applied toward individual deductibles are also applied toward the family deductible amount of $6,400. Once the family deductible is met, it is met for all members on the plan for the remainder of the plan year. A family of two has a $6,400 family deductible, and a family of six has the same $6,400 family deductible.

Coinsurance

Costs for services and prescriptions will be paid by the employee until the deductible is met. Once an individual meets the deductible, then the plan's coinsurance kicks in at 80%. Prescription charges will be the applicable co-pay based on category until the member hits the out-of-pocket maximum. At that time, the plan will pick up 100% of medical and prescription costs.

Partners with the Health Savings Account (HSA):

To be eligible to participate in an HSA, you must:

- Be enrolled in the High-Deductible Health Plan (HDHP)
- Not be entitled to benefits under Medicare (Part A, Part B, Part C or Part D)
- Not be enrolled in a Health Care FSA
- Not be enrolled at the same time in a PPO, HMO or other non-HDHP health plan

Administered by OPTUM Financial™

Health Savings Account

A Health Savings Account (HSA) is an easy way to pay for health care expenses you have today and to save for expenses you may have in the future. If enrolled in the HDHP, you may choose to contribute pre-tax dollars from your check into your HSA.

There is no "use it or lose it" stipulation. Your balance rolls over year to year and will continue to build over time. **You own the account** and can continue to use it even if you change medical plans or leave the company.

Ergon will help get your account started by making an employer contribution to your HSA:

- **Employee Only:** $250 annual contribution, divided by the number of pay cycles
- **Employee + 1 (or more):** $500 annual contribution, divided by the number of pay cycles

You must be enrolled in the HDHP and have an open HSA to receive the Ergon contribution. Ergon will contribute an annual amount per employee, distributed over each pay cycle.

Additionally, employees can contribute up to the limit set by the IRS (includes the employer contribution as listed below):

- **Individual:** 2023 limit of $3,850 per year
- **Individual + 1/Family:** 2023 limit of $7,750 per year
- **Age 55 and over?** You can contribute an additional $1,000 per year

Are you eligible for Medicare or Social Security Benefits or will become eligible in the near future? Please contact CMS at 1-800-633-4227 or cms.gov for additional information related to HSA eligibility.

Administered by GG&A

Flexible Spending Accounts

Health Care Flexible Spending Account (FSA) – Set aside pre-tax dollars to pay for or to reimburse yourself for medical, dental and/or vision expenses not covered by your insurance benefits. **"Use it or lose it"** plan. If you have funds left over at the end of the year, up to $610 can be carried over into the next plan year. Any remaining funds will be forfeited.

Dependent Care Flexible Spending Account (DC-FSA) – Set aside pre-tax dollars to pay for or to reimburse yourself for day care expenses for children under 13 or dependent adult care expenses. This is a **"use it or lose it"** plan. Unused funds remaining at the end of the year will be forfeited to the plan.

Preventive Care

What is considered Preventive Care?
The Affordable Care Act (ACA) requires health insurers to cover a specific set of services at no cost to you, even if you have not met your yearly deductible. These services vary by age, gender and medical history. **Both medical plans will cover preventive care in full when using an in-network provider.**

Not all exams and tests are considered preventive. Some may be considered diagnostic *based on your current medical condition*. You may be responsible for paying all or a portion of the cost for those services. If you have a question about whether a service will be covered as preventive care, ask your doctor or contact UMR on their website at www.umr.com.

Ergon will provide up to four hours of paid time off for you to attend your wellness exam.

Typical Preventive Care Examples:
- Annual Physical/Wellness Exam
- Diabetes Screening
- Cholesterol Screening
- Blood Pressure Screening

GenerationYou
GenerationYou is a care solution that includes:

- **NurseLine:** support by phone or online chat
- **Ongoing Condition Support:** Get expert resources and personal support for managing the challenges of living with chronic conditions like diabetes (type 1 or 2), kidney disease, cancer, etc.
- **Complete "The Story of You" online within the first 90 days of 2024 and receive a $25 gift card!**

Prescription Drugs

What is a Formulary?
A drug formulary is a list of prescription drugs covered by your medical plan. Medications are separated into categories ranging from least expensive to most expensive for you. "Preferred" drugs or generic drugs will cost less than "non-preferred," brand name or specialty drugs.

Talk with your doctor when a medication is prescribed. There may be alternative medications that will perform the same but will be at a lower cost to you.

GoodRx.com is a great resource for High-Deductible Health Plan members to get an idea of what prescriptions will cost until their deductible is met.

As a reminder, HDHP members will pay the full cost of a medication until they meet the individual deductible. At that time, the coinsurance and prescription co-pays will start. Utilizing manufacturer's coupons and additional resources can reduce out-of-pocket costs. You can also use funds available in your Health Savings Account to pay at the time of purchase or to reimburse yourself later.

THE FORMULARY DRUG CATEGORIES DETERMINE YOUR COST:

$	$$	$$$	$$$$
Category 1	Category 2	Category 3	Category 4/Specialty

Ameritas

Dental Benefits

Ergon has partnered with Ameritas for the new plan year, and we are introducing a second dental plan option with a higher annual benefit amount and an orthodontia benefit. For reference purposes, the in-network benefits are reflected below.

DENTAL PLAN OPTIONS	Basic Dental	Enhanced Dental
	In-Network	In-Network
GENERAL PLAN PROVISIONS		
Provider Network	dentalnetwork.ameritas.com	
Annual Maximum	$1,000 (per covered person)	$2,000 (per covered person)
Calendar Year Deductible	$50 Individual/$150 Family	$50 Individual/$150 Family
COINSURANCE PERCENTAGE		
Class I – Preventive Procedures	100%, Deductible Waived	100%, Deductible Waived
Class II – Basic Procedures	80%	90%
Class III – Major Procedures	50%	60%
Class IV – Orthodontic Procedures	Not Included	50%
Ortho Lifetime Maximum	N/A	$1,500 (Adult and Child)
PROCEDURES		
Sealants (Child through age 15)	Class I	Class I
Oral Surgery	Class III	Class III
Endodontic Procedures	Class III	Class III
Non-Surgical Periodontal Procedures	Class III	Class III
Prosthodontic Procedures	Class III	Class III
Implants	Class III	Class III
PREMIUM COMPARISON		
Employee Only	$21.02	$26.46
Employee + 1 Dependent (Two Party)	$39.88	$50.88
Employee + 2 or More (Family)	$64.82	$82.58

Dental Benefits

Basic dental insurance covers three main types of treatments:

- **Preventive care** which includes routine cleanings, exams and X-rays
- **Basic care** which focuses on repairing or restoring teeth with fillings, caps, etc.
- **Major care** which is more advanced treatments like crowns, dentures or bridges
- **Orthodontia**, which focuses on the proper alignment of teeth within the mouth, is available in the enhanced plan for both adults and children

Vision Benefits

Ergon has partnered with Ameritas for the new plan year, and we are introducing a voluntary Vision Plan using the VSP network. Vision Plan enrollment is **not** contingent upon employees enrolling in a Dental Plan.

VISION PLAN OPTIONS	In-Network	Out-of-Network
GENERAL PLAN PROVISIONS		
Provider Network	vsp.com	
Eye Exam	**1 Exam Every 12 Months**	**1 Exam Every 12 Months**
Co-payment Required	$10 Co-pay	–
Maximum Reimbursed	100% After Co-pay	Up to $45
Materials Co-payment	$25 Co-pay	–
Frequency	**1 Set of Lenses Every 12 Months**	**1 Set of Lenses Every 12 Months**
LENSES AND FRAMES		
Single Vision Lenses	100% After Co-pay	Up to $30/pair
Bifocal Lenses – Lined Bifocals	100% After Co-pay	Up to $50/pair
Trifocal Lenses – Lined Trifocals	100% After Co-pay	Up to $65/pair
Lenticular Lenses	100% After Co-pay	Up to $100/pair
Medically Necessary Contact Lenses	100% After Co-pay	Up to $210
Elective Contact Lenses	Up to $130	Up to $105
Frames	**1 Set of Frames Every 12 Months**	**1 Set of Frames Every 12 Months**
Maximum Reimbursed	Up to $130/pair + 20% off balance	Up to $57
PREMIUM COMPARISON		
Employee Only	$6.04	
Employee + 1 Dependent (Two Party)	$10.96	
Employee + 2 or More (Family)	$15.78	

Life & Disability

Is your family protected?
You work hard to care for and protect your family. Ergon does the same for its family of employees by providing Life and Accidental Death & Dismemberment (AD&D) coverage for you, your spouse and child(ren).

In 2024, employees will have the additional option to select voluntary employee, spouse and/or child Supplemental Life and AD&D coverage.

This added benefit will help ensure that things like medical bills, funeral expenses, unsettled debts, rent or mortgage can be managed in a family tragedy.

Beneficiary
If the worst happens, the person (or people) on record as your beneficiary will receive the benefit. Make sure you elect at least one beneficiary for your life insurance benefit and change your beneficiary as soon as possible if your situation changes.

COMPANY-PAID LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT
Administered by Life Insurance Company of North America.

- **100% of premiums paid by Ergon**
- **Employee Life Coverage:** 2x the employee's annual salary* based on a 40-hour week (up to a maximum death benefit of $1,000,000)
- **Spouse/Registered Domestic Partner Life Coverage:** $10,000
- **Dependent Child Coverage:** $1,000
- **AD&D:** Pays 2x the employee's annual salary in addition to the life insurance benefit, based on a 40-hour week (up to a maximum benefit of $1,000,000)

* *Note: Benefits are reduced after age 70 (65% of benefit) and age 75 (50% of benefit).*

Voluntary Supplemental Life and Accidental Death & Dismemberment

Employees can choose additional coverage for their spouse and/or child(ren) if they purchase supplemental employee coverage for themselves.

EMPLOYEE SUPPLEMENTAL LIFE AND AD&D

Administered by Life Insurance Company of North America.

- **Increments of $10,000**
- **Minimum Benefit:** $10,000
- **Maximum Benefit:** Lesser of 7x annual salary or $1,000,000
- **Guarantee Issue Amount:** $200,000
- **Age Reduction:** Age 70 – 65% of full benefit amount; Age 75 – 50% of full benefit amount

SPOUSE SUPPLEMENTAL LIFE AND AD&D

Administered by Life Insurance Company of North America.

- **Requires Employee Supplemental Life enrollment**
- **Minimum Benefit:** $5,000
- **Maximum Benefit:** Lesser of 100% of Employee Supplemental amount or $250,000
- **Guarantee Issue Amount:** $50,000
- **No coverage over age 70**

CHILD(REN) SUPPLEMENTAL LIFE AND AD&D

Administered by Life Insurance Company of North America.

- **Requires Employee Supplemental Life enrollment**
- **Minimum Benefit:** $10,000
- **Maximum Benefit:** $20,000
- **Guarantee Issue Amount:** $10,000 or $20,000

To Calculate Your Bi-Weekly Cost:

$_____/$1,000 = $_____ x $_____ = $_____ x 12 = $_____ / 26 = $_____

Elected Coverage | Monthly Rate | Monthly Cost | Annual Cost | Bi-Weekly Cost

EXAMPLE:

$50,000/$1,000 = $50 x 0.13 = $6.50 x 12 = $78 / 26 = $3

Coverage | Monthly Rate | Monthly Cost | Annual Cost | Bi-Weekly Cost

MONTHLY RATES		
Employee Age	**Spouse Age**	**$ Per 1K of Coverage**
Under 25	**Under 25**	$0.06
25-29	**25-29**	$0.08
30-34	**30-34**	$0.08
35-39	**35-39**	$0.09
40-44	**40-44**	$0.13
45-49	**45-49**	$0.20
50-54	**50-54**	$0.31
55-59	**55-59**	$0.50
60-64	**60-64**	$0.76
65-69	**65-69**	$1.29
70-74	**N/A**	$2.45
75-79	**N/A**	$4.63
80-84	**N/A**	$8.63
85-89	**N/A**	$15.00
90-94	**N/A**	$24.00
95+	**N/A**	$37.00

Long-Term Disability (LTD)

Long-Term Disability (LTD) insurance provides income replacement if you are unable to work due to an extended illness or injury.

LTD INSURANCE PLAN DETAILS:
Administered by Life Insurance Company of North America.

- **Eligibility Waiting Period:** One year of employment
- **Cost to Employee:** .44% of monthly salary (premiums shared 50/50 by employee and Ergon)
- **Disability Benefit:** Pays 60% of monthly salary; payments not to exceed $9,000 per month
- **Qualifying Disability Period:** 90 days
- **Benefit Duration:** Disability benefits paid up to age 65 or until employee can return to work; benefit period is limited beginning at age 65

LTD COST CALCULATION
Rate: 0.87 per $100 of Covered Monthly Pay

$1,600 / 100 = 160 x 0.87 = $13.92

Monthly Salary Rate Monthly Premium

50% Paid by Employee	**$6.96**
50% Paid by Ergon	**$6.96**
	$13.92 (per month)

VOYA FINANCIAL

Additional Voluntary Benefits

Accident, Hospital Indemnity and Critical Illness coverage options are available for both full-time and part-time employees working 20 hours or more per week.

Below is a summary of conditions these plans would cover and the associated benefit amount.

The benefit is paid to the covered member and can be used for any purpose or to offset out-of-pocket medical costs or deductible amounts. These plans do not replace Medical Insurance but can be partnered with the High-Deductible Health Plan to help offset out-of-pocket costs should something serious occur.

Accident Insurance	Benefit Amount
GENERAL PLAN PROVISIONS	
Initial Treatment – ER Visit	$250
Initial Treatment – Office, Urgent Care	$100
Initial Hospitalization – 24+ Hours Inpatient Stay	$1,750
Daily Confinement	$275/day, 365 days max
Lacerations – Based on Length	Up to $750
Fractures (Closed)	Up to $5,000
Appliances	Up to $275
Ground Ambulance	$400
Major Diagnostic Exam – CT/MRI	$300
Follow-Up	$100
Physical Therapy	$60 per visit, 10 visit max
Wellness Benefit	**$50 per year**
MONTHLY RATES	
Employee Only	$8.53
Employee + Spouse	$17.06
Employee + Child(ren)	$18.15
Family	$26.68

Hospital Indemnity Plan	Benefit Amount
GENERAL PLAN PROVISIONS	
Pre-Existing Conditions	None
Waiting Period	None
Hospital Admission Benefit	$1,500
Daily Confinement	$100, Max 31 Days Per Confinement
ICU Confinement	$200, Max 15 Days Per Person
MONTHLY RATES	
Employee Only	$14.95
Employee + Spouse	$34.94
Employee + Child(ren)	$26.12
Family	$46.11

Critical Illness Insurance

Who can I cover?
Choose coverage for yourself, your spouse and/or your dependent child(ren). To cover a spouse or child, employees must select coverage for themselves.

Critical Illness Benefit Options

- **Employee:** Employee benefit amount in $10,000 increments ($10,000, $20,000 or $30,000)
- **Spouse:** 50% of employee amount elected ($5,000, $10,000 or $15,000)
- **Child:** 25% of employee amount elected ($2,500, $5,000 or $7,500)

Critical Illness Insurance	Benefit Amount
GENERAL PLAN PROVISIONS	
Pre-Existing Condition	$250
Waiting Period	$100
Guarantee-Issue Amount	$1,750
Covered Conditions	$275/day, 365 days max
Initial Benefit	Up to $750
Spouse/Dependents	Up to $5,000
Additional Occurrence	Up to $275
Additional Occurrence Waiting Period	$400
Reoccurrance	$300
Reoccurrance Waiting Period	$100
Wellness Benefit	**$50 per year**
MONTHLY RATES (RATE PER $1,000 OF COVERAGE)	
EMPLOYEE AGE	
Under 25	$0.38
25-29	$0.41
30-34	$0.52
35-39	$0.65
40-44	$0.97
45-49	$1.26
50-54	$1.70
55-59	$2.28
60-64	$3.23
65-69	$3.33
70+	$4.70

HOW TO CALCULATE RATES :

40-YEAR-OLD EMPLOYEE ELECTS FAMILY COVERAGE

Coverage		Calculation Example
$10,000	Employee	10,000/1,000 x 0.97 = Monthly Premium of $9.70
$5,000	Spouse	5,000/1,000 x 0.97 = Monthly Premium of $4.85
$2,500	Child	2,500 Child Coverage at No Additional Cost
		Monthly Premium for Family Coverage: $14.55

36-YEAR-OLD EMPLOYEE ELECTS EMPLOYEE + CHILD COVERAGE

Coverage		Calculation Example
$20,000	Employee	20,000/1,000 x 0.65 = Monthly Premium of $13
$5,000	Child	5,000 Child Coverage at No Additional Cost
		Monthly Premium for Employee + Child(ren) Coverage: $13

50-YEAR-OLD EMPLOYEE ELECTS EMPLOYEE + SPOUSE COVERAGE

Coverage		Calculation Example
$20,000	Employee	20,000/1,000 x 1.70 = Monthly Premium of $34
$10,000	Spouse	10,000/1,000 x 1.70 = Monthly Premium of $17
		Monthly Premium for Employee + Spouse Coverage: $51

These notices are being provided to make certain that you understand your right to apply for group health coverage. You should read the notices even if you plan to waive health coverage at this time.

Loss of Other Coverage

If you are declining coverage 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 the other coverage (or if the employer stops contributing toward 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).

Example: You waived coverage under this plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a 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, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

HIPAA 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 toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Employer Representative.

Summary of Benefits and Coverage

Health plans are required to provide members with a Summary of Benefits and Coverage (SBC). The SBC is different from the standard summary, in that it provides members with improved standardized information designed to help better understand your coverage and compare the options available to you.

Patient Protection

If the Group Health Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the carrier 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 the 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, or for information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or refer to the carrier website. It is your responsibility to ensure that the information provided on your application for coverage is accurate and complete. Any omissions or incorrect statements made by you on your application may invalidate your coverage. The carrier has the right to rescind coverage based on fraud or misrepresentation.

Women's Health and Cancer Rights Act of 1998

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; 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 medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

Michelle's Law

Michelle's Law was enacted in 2008 to ensure that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law is named after a New Hampshire college student, Michelle Morse, who continued her studies while battling colon cancer in order to maintain health insurance coverage under her parents' plan. Michelle died of colon cancer in November 2005 at the age of 22. The Affordable Care Act (ACA) further expanded coverage requirements for dependents, effective for plan years beginning on or after September 23, 2010. Under the ACA, group health plans or insurers that provide coverage for dependent children must continue to make coverage available until a child attains age 26, regardless of student status.

Coverage Requirements - Michelle's Law allows seriously ill or injured college students, who are covered dependents under group health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status. Under Michelle's Law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

Notice Requirements - If a group health plan requires a certification of student status for coverage under the plan, it must send a Michelle's Law notice along with any notice regarding the certification requirement. The Michelle's Law notice must be written in language understandable to a typical plan participant and must describe the terms of the continuation

coverage available under Michelle's Law during medically necessary leaves of absence.

Impact of the ACA - The ACA's adult child coverage mandate diminished the impact of Michelle's Law on many health plans. Under the ACA, if a group health plan or insurer provides dependent coverage for children, the plan or insurer must continue to make the coverage available until the child attains age 26, regardless of student status. The impact of Michelle's Law on group health plans will generally be limited to health plans providing coverage to dependent students age 26 or over.

The Newborns' and Mothers' Health Protection Act (NMHPA)

This was enacted in 1996 to provide protections to mothers and their newborn children with respect to the length of hospital stays after childbirth. Under the NMHPA, group health plans may not restrict mothers' and newborns' benefits for hospital stays after childbirth to less than:

48 hours following a vaginal delivery; and
96 hours following a delivery by cesarean section.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay relating to 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice of Medicare Part D Creditable Coverage

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

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

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like 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.
- The Group Health Plan has determined that the prescription drug coverage offered by your Medical 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 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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).
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 you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

COBRA Continuation of Coverage

The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage general notice that plans may use to provide the general notice. To use this model general notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers use of the model general notice, to be good faith compliance with the general notice content requirements of COBRA. The use of the model notices isn't required. The model notices are provided to help facilitate compliance with the applicable notice requirements.

Introduction

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 must pay 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;
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 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, Medicaid, 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**.

If you have 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.

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, 2023. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY:711 Email: masspremassistance@accenture.com
INDIANA – Medicaid	**MINNESOTA – 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	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
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki HawkiPhone:1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: http://www.dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-657-3739 Email:HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – 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)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – 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	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	**SOUTH DAKOTA - Medicaid**
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	Website: http://dss.sd.gov Phone: 1-888-828-0059

NEW YORK – Medicaid	TEXAS – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.dmas.virginia.gov/learn/premium-assistance/famis-select CHIP Website: https://www.coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premiums-payment-hipp-programs Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Phone: 1-800-986-KIDS (5437) CHIPP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN–Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W.,

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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 your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace is where you can get coverage through the Marketplace for 2023 if you qualify or for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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 8.39% 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 Human Resources.

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.

[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.

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 Ergon, Inc.		4. Employer Identification Number (EIN)	
5. Employer address 2829 Lakeland Drive		6. Employer phone number 601-933-3000	
7. City Flowood	8. State MS		9. ZIP code 39232
10. Who can we contact about employee health coverage at this job? Human Resources Department			
11. Phone number (if different from above)		12. Email address	

(expires 6-30-2024)

Here is some basic information about health coverage offered by this employer:
As your employer, we offer a health plan to:

☒ All employees. Eligible employees are: Full-time working 30+ hours per week

☐ Some employees. Eligible employees are: All Full-time Eligible Employees

With respect to dependents

☒ We do offer coverage. Eligible dependents are:
Spouse and Dependents of employees up to age 26;

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee, or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary 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 Benefits Summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996.

If you have any questions about this summary, contact Human Resources.[i]

[i] **Note:** While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996.