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CHILLICOTHE
CITY SCHOOL DISTRICT

OAPSE/AFSCME

Employee
Benefits Guide

PLAN YEAR

July 1, 2021 - June 30, 2022

www.schwendeman.com | Ph: 800-837-6793 | Fax: 740-376-2979

Disclaimer

IMPORTANT PLEASE READ!

This employee benefits guide presents an overview of your current benefits, but is not a contract. This guide does not include all plan rules and details and is not considered a summary plan description or a certificate of coverage. The terms of your benefits are governed by legal plan documents including insurance contracts. If there are any differences between the benefits described in this guide and the legal plan documents and insurance contracts, the legal plan documents and insurance contracts are the final authority.

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Employee Benefits Guide Introduction

Welcome to your Employee Benefits Guide!

Employee Benefits Guide Overview

This guide provides a general overview of your benefit choices to help you select the right coverage for your needs.

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Quality Service

Advocacy Team

Chillicothe City School District employees have access to the Schwendeman Agency, Inc. Advocacy Team to provide help with questions involving claims, coverage, enrollment and all other concerns regarding their employee benefits. Our advocacy team is made up of trained professionals who understand your benefits plan and are highly dedicated to providing solutions to your problems.

Simple, reliable, and free:

800-837-6793 (toll-free) Monday - Friday 8:00am - 5:00pm EST

Contact Information

help@schwendeman.com

Client Advocate: Heather Delaney - h.delaney@schwendeman.com

Benefits	Provider	Website	Customer Service
Medical	United Healthcare	www.uhc.com	(877) 844-4999
Dental	Trustmark	www.trustmarkbenefits.com	(800) 918-8877
Vision	VSP	www.vsp.com	(800) 877-7195
Life/Vol. Life	AUL/OneAmerica	www.oneamerica.com	(800) 553-5318
Health Savings Account	Vinton County Bank	www.vncbfamily.com	(740) 774-4444

Eligibility

Determine your eligibility

To determine the benefits for which you may be eligible, please refer to the chart below. You are eligible to participate in these plans upon meeting each plan's eligibility requirements. You also have the option to enroll your eligible dependents in some of these plans. Eligible Dependents may include:

Medical

- For calendar year 2021, if the spouse of a member has insurance available through the spouse's employer, and the spouse withdraws from coverage under the Districts insurance plan, the member shall have a monthly stipend in the amount of seventy five dollars ($75.00) which will be deposited into the member's health savings account. If the spouse does not withdraw from the District's plan, the member will pay a surcharge on the monthly premiums in the amount of one hundred and fifteen dollars ($115.00) per month. For calendar year 2022, the monthly stipend amount is fifty dollars ($50.00) and the surcharge is one hundred and twenty dollars ($120.00) per month.
- Your legal spouse
- Your children. For a child to be eligible, they must be:
    - Less than 26 years of age
    - The natural child, stepchild or adopted child of the subscriber.

Dental

- Your legal spouse
- Your children. For a child to be eligible, they must be:
    - Less than 25 years of age (ends on the day the dependent turns 25)
    - The natural child, stepchild or adopted child of the subscriber.

Vision

- Your legal spouse
- Your children. For a child to be eligible, they must be:
    - Dependent children are covered up until the end of the month the dependent turns 26
    - The natural child, stepchild or adopted child of the subscriber.

Benefit Plan	Eligibility	New Hire Waiting Period
Medical / Rx	Employees on a contract of at least .50 or more	Date of Hire
Dental	Employees on a contract of at least .50 or more	Date of Hire
Vision	Employees on a contract of at least .50 or more	Date of Hire
Basic Life	Employees on a contract of at least .50 or more	Date of Hire
Voluntary Life	Employees on a contract of at least .50 or more	First of the month following date of hire

Enrollment Dates and Making Changes

Enrollment Details

Open Enrollment: We provide open enrollment to our employees from October 1 - October 31 each year.

Making Changes to your Benefits

The Section 125 Plan year is from January 1 - December 31 each year. Your election to participate in Medical, Dental, and/or Vision, will constitute your election to participate under the Premium Only plan on a pre-tax basis. A Section 125 Premium Expense plan allows you to pay for your portion of the health insurance premium on a pre-tax basis.

Important Note:

Deductible year is from January 1 - December 31

What is a Qualifying Event?

The following events qualify for a mid-year change in coverage:

- Marriage
- Divorce or legal separation
- Birth
- Adoption or Placement for Adoption
- Death of a dependent
- Ineligibility of a dependent
- Loss of coverage
- Change in your employment status or that of your spouse
- A qualified domestic relations order or similar court order
- Entitlement to Medicare or Medicaid

Medical Benefit Summary

Administered by: United Healthcare

Medical Benefits	In-Network	Out-of-Network
Deductible		
Single	$2,800	$4,500
Family	$5,600	$9,000
Coinsurance	0%	20%
Out-of-Pocket Maximum		
Single	$2,800	$5,500
Family	$5,600	$11,000
Physician Office Visit		
Primary Care	No charge after deductible (No charge if pregnant)	Deductible & Coinsurance
Specialist	No charge after deductible	Deductible & Coinsurance
Preventative	No charge	Deductible & Coinsurance
Laboratory & X-Ray	No charge after deductible	Deductible & Coinsurance
Hospital Services		
Facility Fee (hospital room)	No charge after deductible	Deductible & Coinsurance
Physician/Surgeon Fees	No charge after deductible	Deductible & Coinsurance
Emergency Services		
Urgent Care	No charge after deductible	Deductible & Coinsurance
Emergency Room	No charge after deductible	No charge after deductible*
Emergency Ambulance Services	No charge after deductible	No charge after deductible*
Mental Health		
Outpatient Mental Health	No charge after deductible	Deductible & Coinsurance
Inpatient Mental Health	No charge after deductible	Deductible & Coinsurance
Other Services		
Durable Medical Equipment (DME)	No charge after deductible	Deductible & Coinsurance
Outpatient Therapy: Physical	No charge after deductible	Deductible & Coinsurance
Outpatient Therapy: Occupational	No charge after deductible	Deductible & Coinsurance
Outpatient Therapy: Speech	No charge after deductible	Deductible & Coinsurance
Home Health Care	No charge after deductible	Deductible & Coinsurance
Skilled Nursing Care	No charge after deductible	Deductible & Coinsurance
Hospice Services	No charge after deductible	Deductible & Coinsurance
*0% coinsurance after network deductible.		

Medical Benefit Summary

Medical Benefits	In-Network	Out-of-Network
Prescription Drug		
Tier 1	No charge after deductible	20% coinsurance after deductible
Tier 2	No charge after deductible	20% coinsurance after deductible
Tier 3	No charge after deductible	20% coinsurance after deductible

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Health Insurance Opt-Out Incentive

Health Insurance Opt-Out Incentive Plan

Any employee who declines to take the Board offered health insurance plan will be compensated $2,400.00 for employees who are eligible for a family plan and $1,200.00 for employees only eligible for a single plan. If a husband and wife are both district employees and one selects family coverage the other employee shall be considered as having opted out on single plan coverage and shall receive $1,200.00 compensation. Likewise, members who would be otherwise eligible for family coverage and only elect a single plan, the employee shall be considered as having opted out on family plan coverage and shall receive the $1,200.00 compensation. Part-time employee opt-out payments will be prorated as follows:

5-hour cook @71 %= $852.00 for single and $1,704.00 for family
3.5-hour cook @50%= $600.00 for single and $1,200.00 for family
4-hour custodian @50%= $600.00 for single an $1,200.00 for family

The following attributes are included in this program:

A. In order to qualify for this compensation, the employee must make a request in writing to the Treasurer and state that they have health insurance coverage through their spouse or elsewhere. Eligible employees must complete twelve (12) continuous months of noncoverage (September 1 through August 31) before they become eligible for the full opt-out payment. Payment for the opt-out incentive will be included in the affected employee's regular August 20th pay.

B. The Board agrees to pick up employees on Board provided coverage within thirty (30) days of written request by the employee indicating a voluntary or involuntary loss of coverage elsewhere. Coverage under the Chillicothe plan shall be retroactive to the date of loss of prior coverage elsewhere provided that the employee makes the election for coverage under the school district's plan within thirty (30) days from the date of the event.

C. If an employee chooses option (b) anytime within the employed year, then all alternative compensation provided by this article will be denied.

D. New employees hired after August 1 who choose the opt-out shall be granted the incentive on a prorated basis.

E. Any bargaining unit member who's alternative insurance is Medicare is not eligible for the opt out. Medicaid or the ACA Exchange alternative insurance is eligible for the opt out. Additionally, any employee under the age of 26 covered under his/her parent's insurance and who's parent(s) are employed by the District is not eligible for the opt out.

HSA Plan Overview

Eligibility

To be eligible for a Health Savings Account (HSA), you must be covered under an HSA-qualified plan on the first day of the month. Also, you must not be:

- Covered by any other health plan, including a spouse's health insurance
- Covered by your own or a spouse's medical flexible spending account (FSA) or health reimbursement account (HRA)
- Enrolled in any part of Medicare, Medicaid or Tricare
- Claimed as a dependent on another person's tax return

Benefit Overview

Chillicothe City School District provides all employees who meet the eligibility requirements and are enrolled in an HSA medical plan the option to open a Health Savings Account.

A health savings account (HSA) is a savings and investment account that can be used to reimburse eligible medical expenses such as: doctor's office visits, prescriptions, vision and dental expenses.

Unlike a generic savings account, the money is deposited tax free or is tax deductible if contributed after tax. Those funds remain tax free when used to pay or reimburse for eligible healthcare expenses.

Health Savings Accounts are employee owned and more importantly, unused funds carry over each year and continue to earn interest tax-free.

Contributions

For calendar year 2021, employees enrolled in the medical plan with single coverage will receive an annual employer contribution of $1,344 and those enrolled in family coverage will receive an annual employer contribution of $2,688. For calendar year 2022, employees enrolled in the medical plan with single coverage will receive an annual employer contribution of $1,260 and those enrolled in family coverage will receive an annual employer contribution of $2,520.

The maximum amount (including employer contributions) you can deposit into your account for 2021 is $3,600 if you have single coverage and $7,200 for family coverage, even if your policy's deductible is less than that. If you are age 55 or older, you can also make additional 'catch-up' contributions up to $1,000 per year. The maximum amount (including employer contributions) you can deposit into your account for calendar year 2022 is $3,650 if you have single coverage and $7,300 for family coverage.

Tax Benefits

- Cash contributions you make to an HSA during the tax year are deductible from your federal gross income. Contributions made through payroll deduction are made pre-tax and not subject to Federal, State, Local or FICA taxes. Contributions made by your employer are not included in your gross income.
- Interest earnings are tax-deferred meaning you will not pay taxes on the contributions if the funds are used for qualified medical expenses.
- Withdrawals from your HSA for qualified medical expense are free from taxation. Withdrawals for non qualified medical expenses are subject to ordinary income tax and a 20% penalty.

Health Savings Account (HSA)

Qualified Expenses

Use an HSA to pay for hundreds of health care treatments and services.

A health savings account (HSA) can be used to pay for many covered health care services for yourself, your spouse and even tax dependents. It can also be used to pay for many other health care services and items that may not be covered by your health plan, as long as they qualify.

- Acupuncture
- Alcoholism treatment
- Ambulance
- Artificial limbs
- Artificial teeth
- Blood sugar test kits for diabetics
- Breast pumps and lactation aids
- Chiropractor
- Contact lenses and solutions
- Crutches
- Dental treatments including X-rays, cleanings, fillings, braces and tooth removals
- Doctor's office visits and procedures
- Drug addiction treatment
- Drug prescriptions
- Eyeglasses and vision exams
- Fertility treatment
- Health plan deductibles and copayments
- Health plan premiums for COBRA plans, long-term care insurance and health continuation insurance while receiving unemployment benefits
- Hearing aids and batteries
- Hospital services
- Insulin
- Laboratory fees
- Laser eye surgery
- Long-term care services (limited)
- Physical therapy
- Psychiatric care if the expense is for mental health care provided by a psychiatrist, psychologist or other licensed professional
- Special education for learning disabilities
- Speech therapy
- Stop-smoking programs including nicotine gum or patches
- Surgery, excluding cosmetic surgery
- Vasectomy
- Walker
- Weight-loss program if it is a treatment for a specific disease diagnosed by a physician
- Wheelchair

This is not a complete list.
The Internal Revenue Service (IRS) decides which expenses can be paid from an HSA and can change the list at any time.

Visit **IRS.gov** for more information on HSAs and qualified expenses.

UnitedHealthcare®

You cannot use an HSA to buy the following health care services and items.

- Costs or expenses reimbursed from another source, such as health coverage or a flexible spending account
- Cosmetic surgery
- Diaper service
- Electrolysis or hair removal
- Health club dues
- Household help
- Maternity clothes
- Nutritional supplements, such as multi-vitamins, for general good health
- Over-the-counter medicines not prescribed by a doctor
- Personal use items, such as toothbrush, toothpaste, etc.
- Swimming lessons
- Teeth whitening

Know the penalty.

If an HSA is used to pay for care or services that is not a "qualified medical expense," you will have to pay a 20 percent penalty, plus taxes on the money spent. For example, if the expense was $100, the penalty would be another $20, plus taxes. This penalty does not apply if you are 65 or older.

For more information

If you have a health plan with an HSA, visit myuhc.com® to see your coverage details. You can also call Customer Care using the phone number listed on the back of your health plan ID card.

Keep your receipts.

Keep all records of your medical expenses in case of an IRS audit. That way, you can prove that your HSA was used for qualified expenses.

What does that mean?

Do you find health care and insurance terms confusing? Go to **justplainclear.com** for easy-to-understand definitions (English and Spanish).

UnitedHealthcare®

Digital Support | UnitedHealthcare app

Get on-the-go access to your health plan.

The UnitedHealthcare® app puts your plan at your fingertips.

When you're out and about, you can do everything from managing your plan to getting convenient care. Just download the app to:

- Find nearby care options in your network.
- Estimate costs.
- Video chat with a doctor 24/7.*
- View and share your health plan ID card.
- See your claim details and view progress toward your deductible.

Get the app and log on with Touch ID®.

The UnitedHealthcare app is available for download for iPhone® or Android®.

United Healthcare

*Data rates may apply.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone and Touch ID are trademarks of Apple, Inc., registered in the U.S. and other countries. Android is a registered trademark of Google LLC.

All UnitedHealthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under Find Care & Costs section.

Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

UHC Sanvello App

On-demand help with stress, anxiety and depression.

Sanvello is an app that offers clinical techniques to help dial down the symptoms of stress, anxiety and depression – anytime. Connect with powerful tools that are there for you right as symptoms come up. Stay engaged each day for benefits you can feel. Escape to Sanvello whenever you need to, track your progress and stay until you feel better.

Download the app today.
More information on **Sanvello.com**.

The Sanvello app is available to you at no extra cost as part of your plan's behavioral health benefits.

Daily mood tracking
Answer simple questions each day to capture your current mood, identify patterns and self-assess your progress.

Coping tools
Reach for just the right tool to relax, be in the moment or manage stressful situations, like test-taking, public speaking or morning dread.

Guided journeys
Designed by experts for a range of needs, journeys use clinical techniques to help you feel more in control and build long-term life skills.

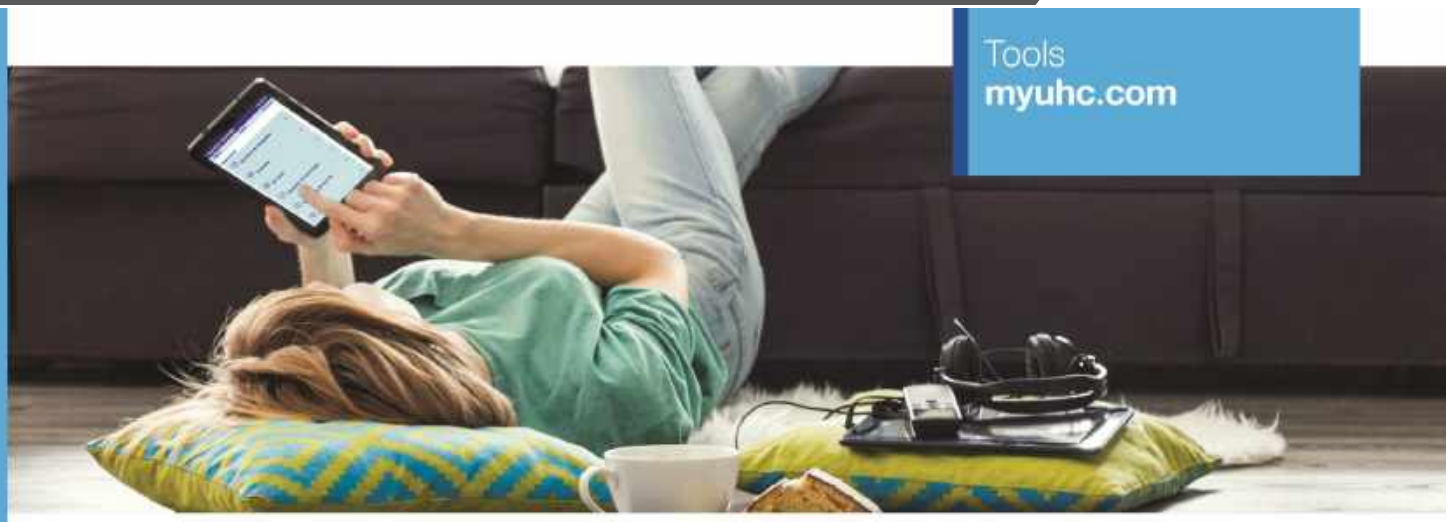
Personalized progress
Through weekly check-ins, Sanvello creates a roadmap for improvement. Track where you are, set goals and make strides week by week.

Community support
Connect with one of the largest peer communities in the field and share advice, stories and insights – anonymously, anytime.

3 Steps to Upgrade to Premium for Free: **1.** download and open the app **2.** create an account and choose "upgrade through insurance" **3.** search for and select UnitedHealthcare, then enter the information available on your UnitedHealthcare medical insurance card. Questions? Email **info@sanvello.com**

UnitedHealthcare®

UHC Cost Estimator



Find care that fits your budget with help from myuhc.com®

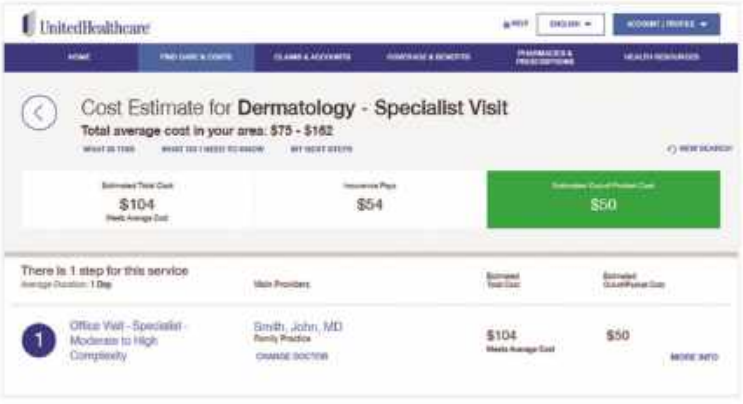
When you're deciding where to go for care, take a look at cost, as well as quality and convenience. Often you can get the care you need—and save money at the same time. Just go to **myuhc.com** to:

Find and compare costs.

Compare costs for providers and services in your network, including doctors, behavioral health resources, hospitals, office visits, labs, convenience and urgent care clinics and more. For minor health concerns, you can register for a Virtual Visit[1] and pay $50 or less to talk to a doctor on your phone or computer.

Get personalized estimates.

Before your visit, you can generate an out-of-pocket estimate based on your specific health plan status.



Did you know?

You could pay an average of 36 percent less[2] for care by checking your costs on myuhc.com.

It's all in one easy-to-use search tool!

UnitedHealthcare®

[1] Check your official health plan documents to see what services and providers are covered by your health plan. Virtual visits are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times or in all locations. The Designated Virtual Visit Provider's reduced rate for a virtual visit is subject to change at any time.

[2] UnitedHealthcare Internal Claims Analysis, 2016.

The UnitedHealth Premium® designation program is a resource for informational purposes only. Designations are displayed in UnitedHealthcare online physician directories at myuhc.com®. You should always visit myuhc.com for the most current information. **Premium designations are a guide to choosing a physician and may be used as one of many factors you consider when choosing a physician. If you already have a physician, you may also wish to confer with him or her for advice on selecting other physicians. You should also discuss designations with a physician before choosing him or her. Physician evaluations have a risk of error and should not be the sole basis for selecting a physician.** Please visit **myuhc.com** for detailed program information and methodologies.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Facebook.com/UnitedHealthcare Twitter.com/UHC Instagram.com/UnitedHealthcare YouTube.com/UnitedHealthcare

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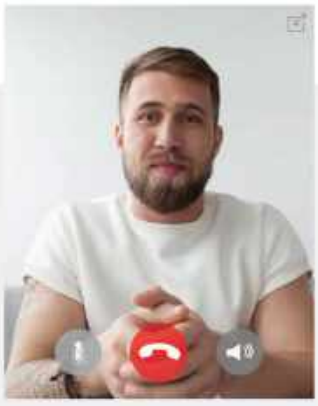
Managing your wellbeing

Life is busy. When you need more resources to manage it all or to manage an issue, we have professionals that can help.

Your **Employee Assistance Program (EAP)** benefit offers information, guidance, and support to help you and your family reach your personal and professional goals. It is part of the benefits offered by your employer, and is available at no cost to you.

Choose how you want support


Video


Phone


In-person

How it works

Go online or call the toll-free number below any time. Professional counselors are available to help identify your issue and guide you to the appropriate support.

Counseling services

Talk with a licensed counselor for support with concerns such as managing stress, strengthening relationships, work/life balance, and grief and loss.

Legal and financial services

Talk to a financial or legal expert for consultations and discounts on services provided for divorce, real estate concerns, debt management, and budgeting.

Work/life services

Obtain professional resource and referral services related to child and eldercare, education, growing families, consumer resources, home maintenance and repair, and daily living resources.

Online resources

You can find information to help improve your health, manage life events, as well as search for providers in your area.

Telehealth counseling

When you need someone to talk to, but find in-person visits don't work for you, schedule a video or telephonic session with a licensed counselor. Choose from a network of caring clinicians about concerns such as:

- Adolescent issues
- Anxiety
- Child issues
- Depression
- Grief and loss
- LGBTQ support
- Life changes
- Marriage issues
- Parenting issues
- Relationship issues
- Stress
- Workplace issues

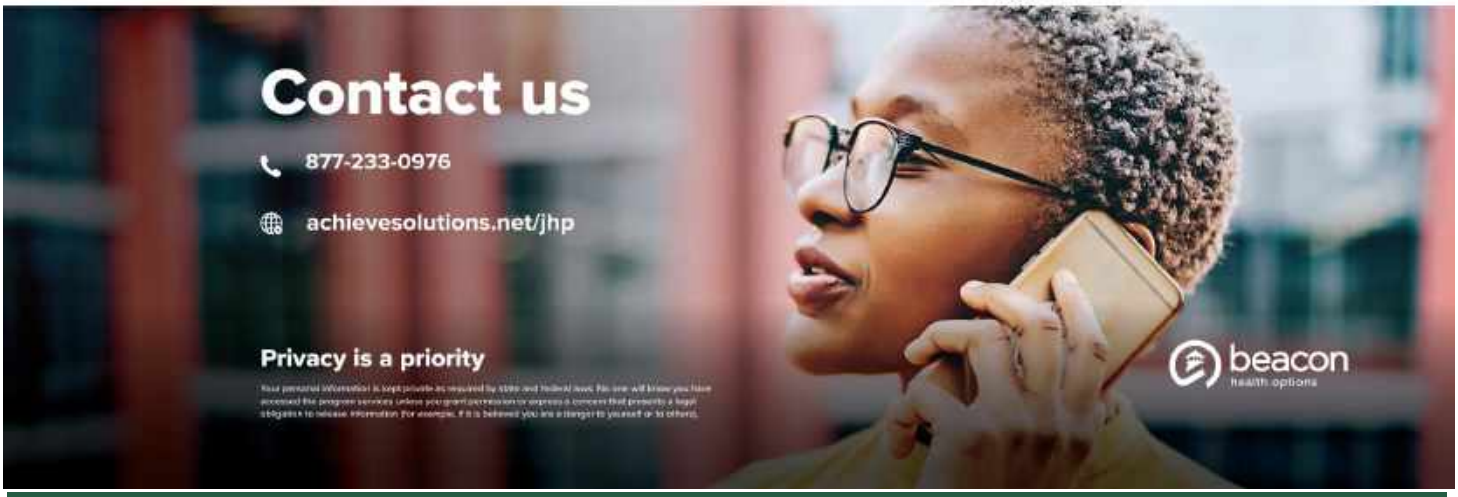
Convenient for you

- Secure, private video sessions with licensed counselors in the comfort of your own home
- Schedule sessions during times that work for your schedule, even evenings and weekends

SERVICES INCLUDE:

5

no-cost sessions as defined by your benefit.



Dental Benefit Summary

Administered by: Trustmark

	Trustmark	
Dental Benefits	**In-Network**	**Out-of-Network**
Deductible	Calendar Year	
Single	$25	$25
Family	$50	$50
Deductible is waived for Preventive services		
Services		
Preventive Care	0%	0%
Basic Care	20%	20%
Major & Restorative Care	20%	20%
Orthodontia (includes adults)	40%	40%
Benefit Maximums		
Calendar Year Maximum	$1,500	
Orthodontia Maximum (per person/per lifetime)	$2,000	

Covered Services and Frequency	
Preventive Services	
Oral Exams (twice in any consecutive 12-month period)	Space Maintainers (limited to dependent children)
Cleanings (twice in any consecutive 12-month period)	Fluoride Treatment (twice per calendar year)
Bitewing X-rays (every 6 months)	Topical Sealants (once 36 months up to age 14)
Full mouth X-rays (every 36 months)	Laboratory Test
Basic Services	
Fillings (amalgam, silicate, acrylic)	Endodontic Services/Root Canal Therapy
Repairs (dentures, bridgework, crowns, etc.)	Periodontal Services
Oral Surgery (extractions and dental surgery)	General/Local Anesthesia (surgical procedures only)
Major Services (Once in any 5 consecutive year period per tooth)	
Replacement of Existing Bridgework or Dentures	Installation of Fixed Bridgework
Inlays, Onlays, Gold Fillings, or Crown Restorations	Installation of Partial or Complete Dentures
Orthodontia	
Full-Banded Orthodontia Treatment	Appliances to Control Harmful Habits
Appliances for Tooth Guidance	Retention Appliance
**This list does not include all covered dental services and descriptions. Please refer to the certificate of benefits for a full list.*	

3 Reasons Why Networks Matter for Dental Care

Staying in-network can make a big difference for your bottom line

Dental care is vital to your health, and going to dentists and other dental care providers in your network gives you the best benefits from your health benefits plan. Through your plan, you have access to dental care at a discounted price versus what you would pay if you went to providers outside of your network.

Benefits of staying in-network

IN-NETWORK DISCOUNTS

PLAN USUALLY COVERS MORE

EASY TO FIND PROVIDERS AT myTrustmarkBenefits.com

Finding an In-network Dental Provider

Trustmark Health Benefits, your third party administrator of your self-funded group health benefit plan, makes it easy to find a dentist or dental care professional in your network. Just follow these easy steps:

1. Log on to your member portal, **myTrustmarkBenefits.com**.

(If you've never used the portal before, you'll have to complete a quick one-time registration process)

2. On your portal home screen, click the "find a provider" link in the *My Links* section.
3. Follow the on-screen directions to search for a provider in your area.

Expect **more.**
Benefit more.

Remember, going in-network saves you money! If you need any help finding an in-network provider, just call the number at the top of your ID card.

Self-funded plans are administered by Trustmark Health Benefits, Inc. | 400 Field Drive • Lake Forest, IL 60045
800.832.3332 • TrustmarkHB.com

Trustmark
benefits beyond benefits

R450-2438hb_(10-20)

Active&Fit DIRECT®

Trustmark
benefits beyond benefits

Vision Benefit Summary

Administered by: VSP

Vision Benefits	In-Network
WellVision Exam	Copay
Comprehensive Exam	$10
Prescription Glasses	$10
Lenses	
Single vision, lined bifocal, and lined trifocal lenses Impact-resistant lenses for dependent children	Included in Prescription Glasses
Lens Enhancements	
Standard progressive lenses Premium progress lenses Custom progressive lenses Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175
Frames	
$150 featured frame brands allowance $130 frame allowance 20% savings on the amount over your allowance $70 Walmart, Sam's Club, and Costco frame allowance	Included in Prescription Glasses
Contact Lenses	
Contact lens exam (fitting and evaluation) $130 allowance for contacts; copay does not apply	Up to $60
Service Frequencies	Plan year is March through February
Exams Lenses (glasses or contacts) Frames	Every plan year Every plan year Every plan year
Extra Savings	
Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. 20% savings on additional glasses and sunglasses including lens enhancements, from any VSP provider within 12 months of your las WellVision Exam. No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam. Average 15% off the regular price or 5% off the promotional price for laser vision corrections; discounts only available from contracted facilities.	

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Basic Life and AD&D

Administered by: AUL/OneAmerica

Basic Term Life and Accidental Death & Dismemberment (AD&D) Benefits	
Benefit Amount	
Basic Term Life and AD&D	A program to provide group term life insurance in the amount of $49,000 for each regular, full-time classified employee who elects it. The Board shall pay the full cost of the premium.
Additional Features	
Portability	Allows you to take your coverage with you if you terminate employment. (Age and other restrictions may apply including evidence of insurability).
Conversion	Allows you to continue your coverage after your group plan has terminated. (Restrictions may apply; refer to your certificate of benefits).
Waiver of Premiums	Premium will not need to be paid if you are totally disabled. (For employees disabled prior to age 60, with premiums waived until age 65, if conditions are met).

Voluntary Life and AD&D

Administered by: AUL/OneAmerica

Voluntary Life and Accidental Death & Dismemberment (AD&D) Benefits	
Benefit Amount	
Employee Voluntary Life	You may elect an amount in increments of $1,000 with a minimum of $10,000 up to a maximum of $300,000 (Guaranteed Issue: $200,000).
Spousal Voluntary Life	You may elect one of the following benefit options: $5,000, $10,000, $15,000, or $20,000 (Guarantee Issue: None).
Child(ren) Voluntary Life	You may elect one of the following benefit options $2,500, $5,000, $7,500, or $10,000
Additional Features	
Portability	Allows you to take your coverage with you if you terminate employment. (Age and other restrictions may apply including evidence of insurability).
Conversion	Allows you to continue your coverage after your group plan has terminated. (Restrictions may apply; refer to your certificate of benefits).
Waiver of Premiums	Premium will not need to be paid if you are totally disabled. (For employees disabled prior to age 60, with premiums waived until age 65, if conditions are met).
Accelerated Life Benefit	A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.

Voluntary Life and AD&D

Administered by: AUL/OneAmerica

Employee Monthly Premium

Amounts/Age	0—29	30—34	35—39	40—44	45—49	50—54	55—59	60—64	65—69	70+
$10,000	$0.75	$0.75	$0.95	$1.35	$1.95	$3.25	$5.25	$6.95	$10.45	$24.15
$20,000	$1.50	$1.50	$1.90	$2.70	$3.90	$6.50	$10.50	$13.90	$20.90	$48.30
$25,000	$1.88	$1.88	$2.38	$3.38	$4.88	$8.13	$13.13	$17.38	$26.13	$60.38
$30,000	$2.25	$2.25	$2.85	$4.05	$5.85	$9.75	$15.75	$20.85	$31.35	$72.45
$40,000	$3.00	$3.00	$3.80	$5.40	$7.80	$13.00	$21.00	$27.80	$41.80	$96.60
$50,000	$3.75	$3.75	$4.75	$6.75	$9.75	$16.25	$26.25	$34.75	$52.25	$120.75
$60,000	$4.50	$4.50	$5.70	$8.10	$11.70	$19.50	$31.50	$41.70	62.70	$144.90
$70,000	$5.25	$5.25	$6.65	$9.45	$13.65	$22.75	$36.75	$48.65	$73.15	$169.05
$75,000	$5.63	$5.63	$7.13	$10.13	$14.63	$24.38	$39.38	$52.13	$78.38	$181.13
$80,000	$6.00	$6.00	$7.60	$10.80	$15.60	$26.00	$42.00	$55.60	$83.60	$193.20
$90,000	$6.75	$6.75	$8.55	$12.15	$17.55	$29.25	$47.25	$62.55	$94.05	$217.35
$100,000	$7.50	$7.50	$9.50	$13.50	$19.50	$32.50	$52.50	$69.50	$104.50	$241.50
$110,000	$8.25	$8.25	$10.45	$14.85	$21.45	$35.75	$57.75	$76.45	$114.95	$265.65
$120,000	$9.00	$9.00	$11.40	$16.20	$23.40	$39.00	$63.00	$83.40	$125.40	$289.80
$125,000	$9.38	$9.38	$11.88	$16.88	$24.38	$40.63	$65.63	$86.88	$130.63	$301.88
$130,000	$9.75	$9.75	$12.35	$17.55	$25.35	$42.25	$68.25	$90.35	$135.85	$313.95
$135,000	$10.13	$10.13	$12.83	$18.23	$26.33	$43.88	$70.88	$93.83	$141.08	$326.03
$140,000	$10.50	$10.50	$13.30	$18.90	$27.30	$45.50	$73.50	$97.30	$146.30	$338.10
$150,000	$11.25	$11.25	$14.25	$20.25	$29.25	$48.75	$78.75	$104.25	$156.75	$362.25
$175,000	$13.13	$13.13	$16.63	$23.63	$34.13	$56.88	$91.88	$121.63	$182.88	$422.63
$200,000	$15.00	$15.00	$19.00	$27.00	$39.00	$65.00	$105.00	$139.00	$209.00	$483.00
$250,000	$18.75	$18.75	$23.75	$33.75	$48.75	$81.25	$131.25	$170.75	$261.25	$603.75
$300,000	$22.50	$22.50	$28.50	$40.50	$58.50	$97.50	$157.50	$208.50	$313.50	$724.50

Dependent Monthly Premium Options

Dependent Type	Option 1	Option 2	Option 3	Option 4
Spouse	$5,000	$10,000	$15,000	$20,000
Dependent Child(ren) - live birth to age 26	$2,500	$5,000	$7,500	$10,000
Dependent Group Premiums	$2.00	$4.00	$6.00	$8.00

Important Notice from Chillicothe City Schools About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Chillicothe City Schools 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 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.

Chillicothe City Schools has determined that the prescription drug coverage offered by the Chillicothe City Schools 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 two (2) MONTH Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Chillicothe City Schools coverage will (or will not) be affected. If you decide to join a Medicare drug plan, your current coverage with Chillicothe City Schools and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back later. In addition, the Chillicothe City Schools pays for other health expenses, in addition to prescription drugs, and you may not be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan. Be sure to contact Chillicothe City Schools if you have questions about dropping coverage under the Chillicothe City Schools Health Benefit Plan and getting that coverage back later.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently

be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage . . .

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

For More Information About Your Options Under Medicare Prescription Drug Coverage . . .

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare rug 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 or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	September 23, 2020
Name of Entity:	Chillicothe City Schools
Contact Person:	Deborah Lawwell
Address:	425 Yotangee Pkwy Chillicothe, OH 45601
Phone Number:	740-775-4250

NOTICE OF PRIVACY PRACTICES
Effective Date: March 29, 2018

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact, Deborah L. Lawwell, Treasurer, at 740-775-4250.

Who Will Follow the Requirements of This Notice. This notice describes the Jefferson Health Plan Participating Member's practices and those of its employees (who are responsible for the operation and administration of the Participating Member in the Jefferson Health Plan) and its business associates with regard to the Jefferson Health Plan. The Jefferson Health Plan, the employees of the Participating Member and the business associates (as described above and referred to as "we" or "us" in this notice) may share medical information with each other for the purposes of treatment, payment, or other operations of the Jefferson Health Plan as described in this notice.

Privacy of Health Information. We understand that medical information about you and your health is personal. This notice will tell you about the ways in which we may use and disclose medical information about you. We will also describe your rights and certain obligations that we have regarding the use and disclosure of medical information. We are required by law to:

- Assure the medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

Use and Disclosure of Medical Information. The following describes the different ways that we may use and disclose your medical information. Generally, private health information may be released without your authorization for the purposes of treatment, payment, or other healthcare operations of the Jefferson Health Plan. However, if we disclose your medical information for underwriting purposes, we will not use or disclose your genetic information for this purpose. Medical information may also be released for the following purposes:

- As required by, or to comply with, law.
- For public health services.
- In connection with the investigation of abuse, neglect, or domestic violence.
- To health oversight agencies in connection with health oversight activities.

- For judicial and administrative proceedings.
- For law enforcement purposes.
- To coroners, medical examiners, and funeral directors with respect to decedents.
- For research if a waiver of authorization has been obtained.
- To prevent serious and imminent harm to the health or safety of a person or the public.
- For specialized governmental functions.
- For military and veterans' activities.
- For national security and intelligence.
- For protective services for the President and others.
- To the Department of the State to make medical suitability determinations.
- To correctional institutions and law enforcement officials regarding an inmate.
- For workers' compensation if necessary to comply with the laws relating to workers' compensation and other similar programs.

Rights Regarding Medical Information. You have the following rights regarding medical information that we maintain about you:

- Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about you, including medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information about you, you must submit your request in writing to the Treasurer, Fiscal Agent or Human Resources Designee. If you request a copy of this information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances, and if you are denied access to medical information, you may request that the denial be reviewed.

- Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Jefferson Health Plan. To request an amendment, your request must be made in writing and submitted to the Treasurer, Fiscal Agent or Human Resources Designee. In addition, you must provide a reason that supports your request. We may deny your request if it is not in writing or properly supported by a reason; or the information was not created by us; is not part of the medical record kept by the Jefferson Health Plan; is not part of the information that

you would be permitted to inspect and copy; or is accurate and complete. If we deny your request, we will provide a basis for the denial.

- Right to an Accounting. You have the right to request an accounting of disclosures. This is a list of the disclosures we have made of medical information about you. To request this list, you must submit your request in writing to the Treasurer. Your request must state a time period that may not be longer than the 6 years prior to the date of your request. Your request must also indicate in what form you want the list (for example, on paper or electronically). The first list that you request within a 12-month period will be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request before any cost is incurred.

- If we use or maintain an electronic health record ("EHR") with regard to your medical information, you have the right to receive an accounting of disclosures which includes all disclosures for purposes of payment, healthcare operations or treatment over the past 3 years, in accordance with the laws and regulations currently in effect. You have the right to access your medical information contained in an EHR and to direct us to send a copy of the EHR to a designated third party.

- Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information that we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the medical information that we disclose about you to someone who is involved in your care or the payment for your care. However, we are not required to agree to your request, except as described below. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must make a written request to the Treasurer telling us what information you want to limit; whether you want to limit our use, disclosure or both; and to whom you want the limits to apply, for example disclosures to your spouse. We will also consider your request for restrictions if the disclosure is to a health plan for purposes of carrying out treatment, payment or healthcare operations and the medical information relates solely to treatment or services for which the healthcare provider has been paid out-of-pocket and in full, however, we are not required to agree to this request.

- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters is a certain way or at a certain location, for example by mail or only at work. To request confidential communications, you must make your request in writing to the Treasurer specify how or where you wish to be contacted. We will not ask you the reason for your request and will accommodate all reasonable requests.

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. You may obtain a copy of this notice by contacting the Treasurer.

you would be permitted to inspect and copy; or is accurate and complete. If we deny your request, we will provide a basis for the denial.

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- Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information that we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the medical information that we disclose about you to someone who is involved in your care or the payment for your care. However, we are not required to agree to your request, except as described below. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must make a written request to the Treasurer telling us what information you want to limit; whether you want to limit our use, disclosure or both; and to whom you want the limits to apply, for example disclosures to your spouse. We will also consider your request for restrictions if the disclosure is to a health plan for purposes of carrying out treatment, payment or healthcare operations and the medical information relates solely to treatment or services for which the healthcare provider has been paid out-of-pocket and in full, however, we are not required to agree to this request.

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- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. You may obtain a copy of this notice by contacting the Treasurer.

- Right to Notice of a Data Breach. We are required to notify you upon an unauthorized disclosure of any unsecured medical information. The notice must be made within 60 days from when we become aware of the unauthorized disclosure and will include: (a) a brief description of the disclosure, including the date it occurred and the date it was discovered; (b) a description of the types of unsecured medical information disclosed or used during the breach; (c) steps you can take to protect yourself from potential harm; (d) a description of our actions to investigate the disclosure and mitigate any harm now and in the future; and (e) contact procedures (including a toll-free phone number) for affected individuals to find additional information. We will notify you in writing by first class mail (unless you have opted for electronic communications). However, if we have insufficient contact information for you, an alternative notice method (posting on a website, broadcast media, etc.) may be used.

- Right to Assign a Designee. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action. You have both the right and choice to tell us to share information with your family, close friends, or others involved in your care, or share information in a disaster relief situation. If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest.

Changes to This Notice. We reserve the right to make changes to this notice, and to make the revision or change applicable to medical information we already have about you. The Participating Member will post a copy of the current notice in each building within the Jefferson Health Plan Participating Member's jurisdiction. We will notify you or any revisions or amendments within 60 days of the effective date of the revision or amendment.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Jefferson Health Plan Participating Member. To file a complaint, please contact Deborah L. Lawwell, Treasurer, Jefferson Health Plan Participating Member, 425 Yoctangee Pkwy, Chillicothe, Ohio 45601 or 740-775-4250. All complaints must be submitted in writing and must name the entity that is the subject of the complaint and describe any acts or omissions believed to be in violation of this notice. A complaint must be filed within 180 days of when you knew or should have known of the violation. You can also file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201-0004, (800) 368-1019 or http://hhs.gov/ocr/privacyhowtofile.htm. You will not be retaliated against for filing any complaint.

Other Uses of Medical Information. Other uses and disclosures of medical information not covered by this notice will be made only with your written permission. In addition, we cannot make a communication to you about a product or service which encourages you to purchase or use the product or service, or make any use or disclosure of your psychotherapy notes (where appropriate) without your authorization. If you provide us with permission to use or disclose

medical information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reason covered by your written authorization. However, we will not be able to take back any disclosures that we already made during any period in which your permission was in effect.

In addition, we are prohibited from receiving direct or indirect payments in exchange for your private medical information without your valid authorization. However, this prohibition does not apply if the purpose of the exchange is for: (a) public health activities; (b) research purposes (if the price charged reflects the cost of preparation and transmittal of the information); (c) your treatment; (d) health care operations related to the merger or consolidation of the Jefferson Health Plan Participating Member; (e) performance of services by a business associate on behalf of the Jefferson Health Plan; (f) providing you with a copy of your private medical information; or (g) other reasons determined to be necessary and appropriate by the Secretary of Health and Human Services.

Adopted: March 29, 2018

097234.000001 602262283.3

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, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – 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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	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

Required Employee Notices

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – 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	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – 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)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	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, 2020, 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., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Notes

This employee benefits guide presents an overview of your current benefits, but is not a contract. This guide does not include all plan rules and details and is not considered a summary plan description or a certificate of coverage. The terms of your benefits are governed by legal plan documents including insurance contracts. If there are any differences between the benefit descriptions in this guide and the legal plan documents and insurance contracts, the legal plan documents and insurance contracts are the final authority. Your employer reserves the right to change, discontinue or terminate the benefit plans at any time.

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