



**ARCH TELECOM**  
EMPLOYEE OWNED

# EMPLOYEE BENEFITS GUIDE

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# 2026

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For more information, you  
can contact HR at:  
[benefits@archtelecom.net](mailto:benefits@archtelecom.net)



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# Welcome!

At Arch Telecom, we are proud to offer a benefits program that provides various coverage options to meet your personal needs. We encourage you to focus on things that matter: making time for preventive care, living a healthier life, and choosing the Arch Telecom benefits program that works best for you and your family. We encourage you to take the time to read this benefit guide.

This guide is designed to assist you in making benefit choices. It provides key information on the various aspects of the plans and helps you sort through your options. Please review the material, discuss it with your family, and make an informed choice when selecting coverage.

Additional benefit details can be found on our dedicated Benefits website ([archtelecombenefits.net](http://archtelecombenefits.net)), in the Plan documents, available from Human Resources, or at the various carrier websites and customer service numbers for each Plan. If there is a conflict between the group insurance contracts and this guide, the group insurance contracts prevail.

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# Benefits At A Glance

## We've Got You Covered

The Benefits Plan year begins on **January 1, 2026 and ends the following December 31, 2026**. You and Arch Telecom share the cost of your medical coverage. Arch Telecom pays the majority of the premium for your medical and prescription drug benefits. Your cost will vary based on the plan you select and whether you elect single or family coverage. Arch Telecom offers you and your eligible dependents a variety of benefits options, including:

- Medical and Prescription Drug coverage
- Dental coverage
- Vision coverage
- **Short Term Disability – NEW BENEFIT!**
- **Life and AD&D Insurance – NEW BENEFIT!**
- Flexible Savings Account (FSA) for Healthcare and Dependent Care
- Employee Assistance Program (EAP) - **New Vendor**
- Pet Insurance

## Eligibility

All full-time employees regularly scheduled to work at least 30 hours per week are eligible to participate in the Benefits Plan. If you are enrolling during Open Enrollment, coverage begins January 1, 2026. If you are enrolling as a New Hire, coverage starts on the first day of the month following 60 days from the date of hire.

## Eligible Dependents

Your eligible dependents include:

- Your spouse (unless you are legally separated) or registered domestic partner
- Your unmarried dependent children up to age 26; also includes step-children through marriage or a domestic partnership, legal guardianship of a child, a foster child is placed with the employee, legal adoption or placement for adoption; a child who is mentally or physically incapable of sustaining his or her living, regardless of age.



## Changing Benefit Elections

Once you make your election, your benefits will be effective until the end of the Plan Year (**December 31, 2026**) unless you have a **qualifying change** in status. The following list highlights the most common qualifying events:

- change in marital status (marriage, death of spouse, divorce, legal separation);
- change in the number of dependents (birth, death, adoption, eligibility status, child support order);
- change in employment status for you or your spouse or domestic partner (commencement, termination, leave of absence, full-time to part-time or vice versa);
- change in residence or worksite for you, your spouse or your child;
- special enrollment rights under HIPAA; or
- you, your spouse or domestic partner, or your child gains or loses Medicare or Medicaid coverage.

For further information on eligible qualifying events, please contact Human Resources at [benefits@archtelecom.net](mailto:benefits@archtelecom.net)

## How to Enroll

When you login to your employee portal in Paycom, you'll receive a notification to complete your open enrollment. All enrollments are completed in Paycom. You will need to login and elect or decline your plans for 2026 during the open enrollment period. If you miss the enrollment window, you will not be able to elect benefits unless you have a qualifying life event. If you are a new hire, you will be notified via an alert from Paycom 21 days after your start date. You will then have 21 days to elect coverage. Coverage will begin on the 1<sup>st</sup> day of the month following your 60<sup>th</sup> day of employment.

## Termination of Benefits

Your coverage will end on the day you terminate employment from Arch Telecom. This would apply to your dependents as well. You may be eligible to continue your benefits under COBRA. For more details regarding termination of benefits and COBRA, please refer to the Employee Handbook and Summary Plan Description. Both documents can be found at [archtelecombenefits.net](http://archtelecombenefits.net).



When you login to Paycom you'll be prompted to complete your open enrollment.

## Medical Plan

We are excited to announce that starting **January 1, 2026**, we will be partnering with a new medical insurance carrier. Our network is Anthem and the plan will be administered by Leading Edge Administrators. This decision comes after careful consideration and evaluation of our current health benefits, and we believe that this new partnership will provide you with enhanced health coverage.

Please refer to the following to learn more about how to utilize the carrier website and mobile app. You will also find details on how to access your benefits, find a provider, research claims, and more once you register on the member portal, which will be accessible to all members on January 1st:

<https://mesa.leadingedgeadmin.com/>.

Every team member will receive a new ID card, which will be sent to your residence. You can also access a copy once you've logged into the member portal.

Along with the new medical plan, you will have access to Health Advocacy, a concierge-level service. The knowledgeable coaches will help you and your family navigate your healthcare with ease and confidence. Enrolled team members and dependents can call the **Arch Telecom** dedicated phone number: [844-356-2207](tel:844-356-2207)

## SPECIALTY MEDICATION PROGRAM

Payer Matrix is an advocacy provider who focuses on Specialty Drug Cost Containment and will work with you and your dependents if a specialty medication is needed.

High-Touch Customer Service:

- Welcome Call
- Onboarding
- Research Programs Available
- Enrollment and Clinical Review
- Program Fulfillment





# Medical Plan Comparison

The table below outlines coverage for some of the most common services. The deductible is based on the plan year (**January 1st – December 31st**).

Plan Name	Anthem Bronze Plan	Anthem Silver Plan	Anthem Gold Plan
<b>Benefits</b>			
<b>Deductible (Ded)</b>			
Individual	\$6,000	\$1,500	\$500
Family	\$12,000	\$4,500	\$1,000
<b>Coinsurance</b>	0%	30%	20%
<b>Out-of-pocket max.</b>			
Individual	\$6,000	\$6,000	\$2,000
Family	\$12,000	\$12,000	\$4,000
<b>Hospitalization</b>	\$0 after Ded	30% after Ded	20% after Ded
<b>Outpatient Surgery</b>	\$0 after Ded	30% after Ded	20% after Ded
<b>Emergency room</b>	\$0 after Ded	30% after Ded	\$200 Copay
<b>Ambulance</b>	\$0 after Ded	30% after Ded	20% after Ded
<b>Urgent care</b>	\$50 Copay	\$50 Copay	\$0 Copay
<b>Physician office visit</b>	\$0 Copay	\$0 Copay	\$20 Copay
<b>Specialist visit</b>	\$50 Copay	\$50 Copay	\$20 Copay
<b>Preventive care</b>	100%	100%	100%
<b>Mental Health Office</b>	\$0 Copay	\$0 Copay	\$20 Copay
<b>Durable Medical Equipment</b>	\$0 after Ded	30% after Ded	20% after Ded
<b>Physical Therapy</b>	\$50 Copay per visit (30 Visits per year)	\$50 Copay per visit (30 Visits per year)	\$20 Copay (60 Visits per year)
<b>Lab &amp; X-Ray</b>	\$0 Copay	\$0 Copay	In-Office: \$0 Copay; Facility: \$50 Copay
<b>Advanced Imaging</b>	\$300 Copay	\$300 Copay	20% after Ded
<b>Prescription drugs</b>			
Deductible	None	None	None
Generic brand	\$20	\$20	\$20
Preferred brand	\$60	\$30	\$30
Non-preferred brand	\$90	\$60	\$60
Mail order	2x Retail	2x Retail	2x Retail

# Medical Rates



Your pre-tax cost for medical and prescription drug coverage will vary depending on the plan you choose. Your pre-tax cost is only one portion of your health care costs. Your out-of-pocket costs, incurred when you or a covered family member utilizes the plan, should also be factored into the total cost when determining which plan is best for you.

Medical Plan Contributions (Biweekly)	Anthem Bronze	Anthem Silver	Anthem Gold
Employee only	\$54.17	\$115.10	\$321.74
Employee + Spouse	\$204.06	\$361.23	\$679.23
Employee + Child(ren)	\$188.36	\$331.03	\$697.10
Family	\$286.97	\$406.96	\$983.09





Anthem 

## The Sydney Health mobile app makes healthcare easier

Access personalized health and wellness information wherever you are

Use SydneySM Health to keep track of your health and benefits—all in one place. With a few taps, you can quickly access your plan details, Member Services, virtual care, and wellness resources. Sydney Health stays one step ahead—moving your health forward by building a world of wellness around you.

### Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you, such as gender, languages spoken, or location. You'll be matched with the best results based on your personal needs.

### My Health Dashboard

Use My Health Dashboard to find news on health topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals. It also offers a customized experience just for you, such as syncing your fitness tracker and scanning and tracking your meals.

### Chat

If you have questions about your benefits or need information, Sydney Health can help you quickly find what you're looking for and connect you to an Anthem representative.

### Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker or talk to a doctor via chat or video session.

### Community Resources

This resource center helps you connect with organizations offering no-cost and reduced-cost programs to help with challenges such as food, transportation, and child care.

### My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

### ¿Prefieres obtener información en español?

Tienes opciones. Si tu teléfono móvil ya está configurado en español, la aplicación Sydney Health también estará en español. Si no es así, selecciona el **menú** dentro de la aplicación Sydney Health y elige **el idioma de la aplicación**. También puedes visitar **espanol.anthem.com**.



### Download the Sydney Health app today

Use the app anytime to:

- Find care and compare costs.
- See what's covered and check claims.
- Check your plan progress.
- Fill prescriptions.



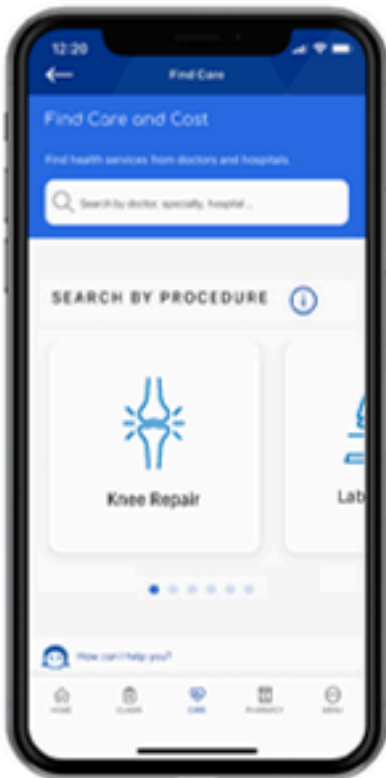
Scan the QR code to download the Sydney Health app.

You can also set up an account at [anthem.com/register](https://www.anthem.com/register) to access most of the same features from your computer.



## Find high-quality doctors nearby and compare costs

Choosing a doctor you trust is important — and choosing one in your plan’s network can keep your costs down. The **Find Care** tool on the SydneySM Health app and [anthem.com](https://www.anthem.com) can help you meet both needs.



### Helping you find the right care

The **Find Care** tool brings together details about doctors in your plan’s network. You can customize your search by name, location, specialty, or procedure. You also can compare information such as costs, languages spoken, and office hours.\* To make sure a care provider is in your plan’s network, view the doctor or facility profile.

To help you find care providers who would be a good fit for you, we sort your search results and provide the top three matches using **Personalized Match**. There are more options available below your top three, and you can always re-sort these search results by distance or name.

After viewing your initial search results, you can filter your results by selecting the relevant boxes on the left or browsing by list or map views.



Search by name, specialty, or procedure.



Customize and refine results.



Compare <doctors> and costs.



### Download the Sydney Health app

Scan the QR code to download the Sydney Health mobile app. Then select **Find Care and Cost** from the Care menu. Or you can log in to [anthem.com](https://www.anthem.com) and select **Find Care and Cost** from the Care menu.



## How to search for a doctor in your plan's network

### A step-by-step guide to finding care at [anthem.com](https://www.anthem.com)

Finding the care you need when and where you need it is important. That's why we've made it easier for you to find doctors in your plan's network at [anthem.com](https://www.anthem.com)

#### Follow these steps to find care in your plan:

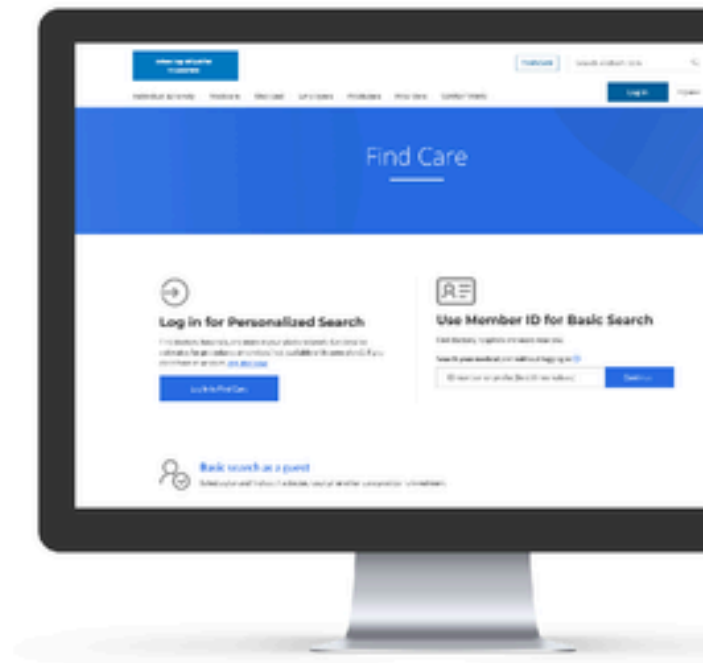
- 1 Go to [anthem.com/find-care](https://www.anthem.com/find-care).
- 2 Search as a member or guest.

**For members** — Select **Log in for Personalized Search** on the left. To help you find care providers who would be a good fit for you, we sort your search results and provide the top three matches using **Personalized Match**. There are more options available below your top three, and you can always re-sort these search results by distance or name.

**For guests** — If you are not enrolled yet in an Anthem plan, you also can search as a guest. Choose **Basic search as a guest**. Then answer the questions regarding the type of care you need, the state you need care in, and the type of plan you want to search under.

- Select the type of plan or network — **Medical Plan or Network**
- Choose the state where the plan or network is located. **ie: New York**
- Select how you get health insurance - **Medical (Employer-Sponsored)**
- Choose a plan or network — **National PPO (BlueCard PPO)**
- Select the **Continue** button.

- 3 Enter your city, county, or ZIP code. You also can search by doctor, dentist, or procedure, as well as using other care-related terms.
- 4 View your search results. You can filter your results by selecting the relevant boxes on the left or browsing by list or map views.



#### Find care

You can start using the **Find Care** tool by visiting [anthem.com/find-care](https://www.anthem.com/find-care).

## Health Advocacy

The ConciergeCARE advocacy coaches possess extensive knowledge of your health plan and individual healthcare requirements. Their primary objective is to ensure that you receive suitable care from the right providers and in the right place. ConciergeCARE advocacy coaches work with you personally to provide personalized and high-quality guidance throughout your patient journey, easing your path to improved health.

This program is accessible to you at no additional cost and matches you with a dedicated ConciergeCARE advocacy coach. If you seek comprehensive care with one point of contact that always places the patient at the center of care, you can contact a ConciergeCARE advocacy coach today.

## Concierge-level service that will improve your health journey

- **Helps you to find** high-quality healthcare providers with your insurance network.
- **Connects** you to useful resources.
- **Assists with claim** denials and appeals.
- **Coordinates cost-effective** medication solutions.
- **Answers questions** on out-of-pocket costs and plan benefits.
- **Assistance with bill** review, including balanced bills.

### Advantages of using ConciergeCARE Services

- **Navigate your healthcare journey across multiple care settings with ease and confidence.**
- **Minimizing out-of-pocket costs by ensuring that you receive the appropriate care, in a suitable place, and at the right time.**
- **Enjoy an enhanced experience that will positively impact your health journey from start to finish.**



## Dental Plan Comparison

Dental care is an important part of overall health with prevention as the key. You can choose between two PPO plans or an HMO plan. The deductible for dental insurance is based on the calendar year (**January 1<sup>st</sup> – December 31<sup>st</sup>**). Cigna is your dental provider.

### DPPO Plan

You can select the dentist of your choice, but seeing a participating dentist reduces your costs. There are deductibles and coinsurance, but preventive care is covered 100% if you use a network dentist. Orthodontics is included for both adults and children. To locate a provider in your network, visit [www.myCigna.com](http://www.myCigna.com) or call [800-CIGNA24](tel:800-CIGNA24)

	PPO – Option 1	PPO Max – Option 2
<b>In &amp; Out of Network Benefits</b>		
Deductible	\$100 single, \$300 family	\$100 single, \$300 family
Annual Benefit Max.	\$1,000	\$5,000
Diagnostic & Preventive	Covered 100%	Covered 100%
Basic Restorative	Covered 80%	Covered 80%
Major Restorative	Covered 50%	Covered 50%
Oral Surgery	Covered 50%	Covered 50%
Endodontics	Covered 50%	Covered 50%
Periodontics	Covered 50%	Covered 50%
Prosthodontics	Covered 50%	Covered 50%
Orthodontics	Covered 50%, \$1,500 Lifetime Max	Covered 50%, \$1,500 Lifetime Max



## DHMO Plan

The DHMO plan requires that you select a Primary Care Dentist and obtain referrals to a specialist. Members must use providers within the network. Employees that use providers outside of the network will not have coverage for these claims.

*(Please note, the DHMO plan is not available in AK, ME, MT, NH, NM, ND, SD, VT, and WY.)*



To locate a provider in your network and to view the fee scheduled, visit [www.myCigna.com](http://www.myCigna.com) or call [800-CIGNA24](tel:800-CIGNA24)

	Patient Charge Schedule (In-Network Only)
<b>Deductible</b>	\$0
<b>Annual Benefit Max.</b>	Unlimited
<b>Office Visit</b>	\$5 Copay
<b>Preventive</b>	Covered 100% after Copay
<b>Basic Services</b>	See Fee Schedule
<b>Major Services</b>	See Fee Schedule
<b>Orthodontics</b>	See Fee Schedule

## Dental Rates



Dental PPO Plan Contributions (Biweekly)	PPO	PPO Max
Employee only	\$14.92	\$17.19
Employee + Spouse	\$29.44	\$33.92
Employee + Child(ren)	\$37.48	\$43.18
Family	\$51.24	\$59.04

Dental HMO Plan Contributions (Biweekly)	
Employee only	\$5.74
Employee + Spouse	\$9.50
Employee + Child(ren)	\$11.42
Family	\$16.17



# Vision Plan Comparison

Your vision benefits are provided through VSP. To locate a vision provider, visit [www.vsp.com](http://www.vsp.com)

Vision Service	Frequency	In-Network Member Cost	Out-of-Network Benefit
Routine Eye Exam	Every 12 Months	\$10 Copay	Up to \$52
Prescription Lenses Single Vision	Every 12 Months	\$25 Copay	Up to \$55
Lined Bifocal	Every 12 Months	\$25 Copay	Up to \$75
Lined Trifocal	Every 12 Months	\$25 Copay	Up to \$95
Frames	Every 24 Months	\$130 Allowance	\$57
Contacts* (Including Exam)	Every 12 Months	\$130 Allowance	Up to \$105

\*\*\* If you choose contact lenses you will be eligible for frames 12 months from the date the contact lenses were obtained.

Members are also eligible for 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your exam. Or, get 20% off from any VSP doctor within 12 months of your last exam.

## Vision Rates



Vision Plan Contributions (Biweekly)	
Employee	\$5.23
Employee + Spouse	\$8.96
Employee + Child(ren)	\$9.15
Family	\$14.75





## Colonial Voluntary Plans

For **2026**, we are pleased to announce that we have partnered with Colonial Life to manage our Life, AD&D, and Short-Term Disability plans.

### Life and Accidental Death & Dismemberment (AD&D) Insurance

If something happened to you, would your family be able to maintain their way of life? Funeral expenses and medical bills could be just the beginning. How would they cover ongoing living expenses, such as a mortgage, utilities, and health care?

Colonial Life & Accident Insurance Company's group term life insurance can help provide financial security for your family. You can also apply for coverage for your spouse and eligible dependent children with no health questions. You must elect coverage for yourself before selecting coverage for a spouse or dependent.



Scan to schedule a call with a Benefits Specialist

### Get the most out of your coverage

- **Portability:** If you retire or change jobs, you may still be able to take your coverage with you at an affordable rate. Eligibility may be based on your health.
- **Conversion:** You may be eligible to convert your coverage to a whole life policy without proof of good health when coverage ends under the group certificate.
- **Waiver of Premium:** If included in your plan, premium payments are waived if you become disabled.

### Available Benefit Amounts Per Coverage

#### Employee

- Available in \$1,000 increments
- Minimum of \$10,000 to a maximum of five times your salary, up to \$250,000
- Guarantee issue up to \$250,000

#### Spouse

- Available in \$1,000 increments
- Minimum of \$5,000 to a maximum of \$30,000
- Spouse coverage cannot exceed your coverage amount
- Guarantee issue up to \$30,000

#### Dependent Child(ren)

- Available in \$1,000 increments
- Minimum of \$1,000 to a maximum guaranteed amount of \$10,000 per dependent child
- Each dependent child is covered for the same amount, except children from live birth to six months for whom the death benefit is \$1,000



## Life + AD&D Insurance - Rates

All Rates listed are Monthly per \$1,000 of coverage

*Rates applicable for all states except NY*

Age Band	Employee	Spouse	Dependent Children
<b>0-24</b>	0.083	0.077	0.243
<b>25-29</b>	0.084	0.089	0.243*
<b>30-34</b>	0.100	0.115	Dependent children coverage is available up to age 26.
<b>35-39</b>	0.132	0.160	
<b>40-44</b>	0.188	0.230	
<b>45-49</b>	0.280	0.340	
<b>50-54</b>	0.400	0.491	
<b>55-59</b>	0.569	0.701	
<b>60-64</b>	0.735	0.945	
<b>65-69</b>	1.027	1.350	
<b>70-74</b>	1.919	2.529	
<b>75+</b>	5.872	7.764	

*Rates applicable for NY only*

Age Band	Employee	Spouse	Dependent Children
<b>0-24</b>	0.081	0.072	0.242
<b>25-29</b>	0.083	0.083	0.2432*
<b>30-34</b>	0.099	0.107	Dependent children coverage is available up to age 26.
<b>35-39</b>	0.130	0.149	
<b>40-44</b>	0.185	0.212	
<b>45-49</b>	0.276	0.314	
<b>50-54</b>	0.396	0.453	
<b>55-59</b>	0.562	0.646	
<b>60-64</b>	0.727	0.871	
<b>65-69</b>	1.017	1.244	
<b>70-74</b>	1.900	2.329	
<b>75+</b>	5.815	7.149	



## Short-Term Disability Insurance

You never know when a disability could impact your way of life. Fortunately, there's a way to help protect your income. If a covered injury or sickness prevents you from earning a paycheck, disability insurance can provide a monthly benefit to help you cover your ongoing expenses. The plan covers 60% of your income up to \$4,000/mo. In states with a State Disability Program or Paid Family Leave, the plan covers 35% of your income. (States with a program: CA, CO, CT, DE, HI, MA, MD, ME, MN, NH, NY, NJ, RI & WA - Subject to Change).

### **6 Month Benefit Period**

*Rates in all states except NY*

Issue Age	Elimination Period 7/7
17-49	\$4.10
50-64	\$5.44
65-74	\$6.58

*Rates for NY only*

Issue Age	Elimination Period 7/7
17-49	\$4.20
50-64	\$5.56
65-74	\$7.60

## Product information and features

### **Total disability**

Totally disabled or total disability means that as a result of sickness or injury, you are unable to perform with reasonable continuity the substantial and material acts necessary to pursue your usual occupation and you are not working in your usual occupation.

### **Partial disability or residually disabled**

If you are able to return to work part-time after at least one day of being paid for a total disability, you may be able to still receive 50% of your total disability benefit.

### **Waiver of premium**

We will waive your premium payments after 90 consecutive days of a covered disability.

### **Geographical limitations**

If you are disabled while outside of the United States, you may receive benefits for up to 60 days before you have to return to the U.S.

### **Issue age**

Coverage is available from ages 17 to 74.

### **Portability**

You may be able to keep your coverage even if you change jobs.



# Flexible Spending Account (FSA)

An FSA is a way to set aside money on a pre-tax basis for your out-of-pocket medical, dental, vision, and dependent care expenses. THP is the plan administrator.

## Advantages:

- Saves you tax dollars – set aside out-of-pocket expenses on a pre-tax basis
- Gives you flexibility –you can choose one or both FSA options

Healthcare FSA	
Eligible Expenses	Ineligible Expenses
Deductible	Over-the-Counter Drugs
Copayments	Health Insurance Premiums
Coinsurance	Cosmetic Items
Dental Expenses	Cosmetic Surgery
Vision Expenses	Controlled Substances
Prescriptions	Items that Improve General Health

Dependent Care FSA	
Eligible Expenses	Ineligible Expenses
Day Care Center	Overnight Camp
In-Home Care	Nursing Home Expenses
Nursery & Preschool	Educational Expenses (Kindergarten and above)
After School Care	Registration Fees
Summer Day Camp	Transportation Fees
Sick Child Facility	

## Annual Contributions

**(Contributions are based on the calendar year – January 1st to December 31st)**

Healthcare FSA - \$3,400 maximum annual contribution, \$680 maximum carryover amount

Dependent Care FSA - \$7,500 maximum annual contribution for a single employee, \$3,750 maximum annual contribution for a married couple filing separately

## Debit Card

The debit card is convenient, automatic, and simple to track. You do not have to pay cash up front, file a claim or wait for reimbursement.

- Swipe the card like any debit/credit card
- Funds are immediately transferred from your FSA
- Track your card balance on the website listed on the back of the card or the mobile app
- Save your EOBs and detailed bills for possible substantiation requests (Prescriptions and co-pays are automatically substantiated)

## Reimbursements

Documents can also be uploaded through the online portal or sent by mail. For healthcare, submit your Explanation of Benefits. For dependent care, submit a bill. The typical turnaround for reimbursement is 7 business days and the reimbursement is sent in the form of a check. Direct deposit is also available through the online portal.

## Online Portal

The consumer online portal is available 24/7.

Use it to:

- Sign up for direct deposit
- Track available balances
- Submit reimbursement requests
- Submit receipts
- View account history
- 

## Mobile App

The mobile app has similar functionality to the portal.

- Available for iOS and Android devices.
- Sign up for text messages and alerts.
- View your balance from the convenience of your mobile device.



## Employee Assistance Program (EAP)

Each day comes with its own set of challenges— expected and unexpected. At **Colonial Life**, we're here to help you. That's why we're offering Health Advocate's Employee Assistance Program and Work/Life Balance Program (EAP + Work/Life) with our group term life insurance, at no additional cost.

More assistance, more ways to find balance. Health Advocate provides confidential counseling\* and resources via phone, in-person, or online chat for a variety of personal and work issues:

- Stress, anxiety, and depression
- Substance dependency/addiction
- Child care, camps, and after-school care
- Grief and loss
- Special needs services
- Identity theft resources
- Retirement planning
- Staying healthy



## Pet Insurance



We have partnered with Spot to provide peace of mind in the event of unexpected vet bills. This insurance covers dogs and cats with no upper age limits or breed restrictions.

With a Spot plan, you can go to any licensed vet, emergency clinic, or specialist in the US or Canada and receive **UP TO 90% CASH BACK** on eligible accident and illness bills. There are several plan options for all budgets!

- Accident Only
- Accident & Illness
- Optional Preventative Care and Wellness Add-ons

Preventive coverage is effective once your application is approved. Accident/Illness coverage has a 15-day waiting period.

Coverage also includes access to a 24/7 vet telehealth helpline through VetAccess. As an employee of Arch Telecom, you will receive **UP TO A 20% DISCOUNT** on a Spot policy!

You can learn more, get a quote, and enroll through our unique link here: <https://spotpet.link/archtelecom>. You can apply for this plan year-round as this benefit does not coincide with open enrollment. You may be eligible for a \$25 Amazon gift card depending on the state you reside.

You can also call the Member Center at [800-905-1595](tel:800-905-1595) and use the code **EB\_ARCH** to enroll or ask questions. Available M-F 8am-8pm EST and Saturday 9am-5pm EST.





America's Favorite Pet Insurance!

# Get Peace Of Mind Today With Our Pet Coverage

## Accidents

Spot plans help ensure your pet is covered from head-to-tail for unexpected accidents and injuries.

## Illnesses

Spot plans cover exams for qualified illnesses and related treatment, including things like surgeries & medications.

## Wellness

Spot's optional Preventive Care plans focus on routine care and regular check-ups to help ensure their routine wellbeing.

## We Take Care of Our Pack

-  Vet Exam Fees
-  Microchip Implantation
-  Diagnostics
-  Behavioral Issues
-  Unexpected Emergencies
-  X-rays & Tests
-  Dental illnesses
-  Hereditary Conditions
-  Cancer & Growths
-  Surgery
-  Prescription Medications
-  And Much More...

## Flexible Plans For Any Budget

Customize your annual limit, deductible and reimbursement rate to make your pet and wallet happy.

## Simple & Easy Claims Process

- 1 Visit Any Vet in the U.S or Canada
- 2 Submit Your Claim Online
- 3 Get Cash Back for Covered Vet Bills!



### Unleash More with Spot



#### Spot Perks

Special discounts on pet products and services from your favorite brands.



#### 24/7 Pet Telehealth Line

Get unlimited 24/7 virtual pet care from vet experts for your pet.



**> Scan me! <**

**Get Your Special Discount\***  
[spotpet.link/archtelecom](https://spotpet.link/archtelecom)

\*10% employee discount available on all pets, not available in IL or TN. Waiting periods, annual deductibles, co-insurance, benefit limits and exclusions may apply. For all terms visit [spotpet.com/simple-policy](https://spotpet.com/simple-policy). Products, schedules, discounts, and rates may vary and are subject to change. More information available at checkout. Insurance plans are underwritten by either Independence American Insurance Company (NAIC #2058), a Delaware insurance company located at 1333 N. Scottsdale Rd, Ste. 900, Scottsdale, AZ 85254 or United States Fire Insurance Company (NAIC #2013, Meriden, CT), and are produced by Spot Pet Insurance Services, LLC (NAIC # 10248285, 990 Broadway Blvd Suite 600, Miami, FL 33132, CA license #0000084).

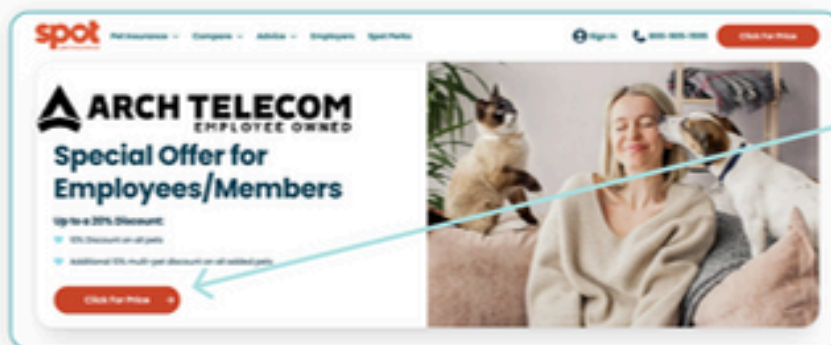
# How to Get a Quote & Enroll: A Step-By-Step Guide



Whether you're a new pet parent or exploring your options, follow this easy guide to help find the right plan for your BFF today.

## 1 Start the Quote Process

- ♥ Open your browser and go to your company's designated landing page: [spotpet.link/archtelecom](https://spotpet.link/archtelecom)
- ♥ Click on the "Click for Price" button.



Click for Price

## 2 Enter Your Pet's and Your Own Information

- ♥ You will be prompted to enter information about your pet. This includes:
  - ♥ Pet's name, age, whether it's a dog or cat, gender, and breed.
- ♥ You can also "Add Another Pet" and receive a 10% multi-pet discount on each additional pet after the first!



- ♥ Finish off the section by entering your own basic information.
  - ♥ Your zip code, email address, first & last name, and mobile number (optional).

## 3 Create Your Plan

- ♥ After clicking "Select your coverage," you'll be presented with two different plan options (accompanied by an overview of what can be covered under each):

Accident + Illness

OR

Accident Only

- ♥ Once you choose your plan, customize it even more by adjusting:

- ♥ The annual limit
- ♥ The reimbursement rate
- ♥ The annual deductible



Get Your Special Discount\*  
[spotpet.link/archtelecom](https://spotpet.link/archtelecom)

# How to Get a Quote & Enroll: A Step-By-Step Guide



## 4 Explore Preventive Coverage Plans

- ♥ For an additional fee, you'll have the option to add a wellness plan.
- ♥ You can choose between our **Gold Plan** or our more comprehensive **Platinum Plan**.

Gold Up to \$250/yr in benefits		Platinum <small>Recommended for dogs ages 3-5</small> More reimbursements More benefits	
Dental Cleaning	\$100	Dental Cleaning or Spray/Sealer	\$150
Dog (DHPP or Cat FVRCP) Vaccines/Year	\$25	Dog (DHPP or Cat FVRCP) Vaccines/Year	\$25
Fleas and/or Dog Lyme or Cat FIP Vaccines/Year	\$25	Fleas and/or Dog Lyme or Cat FIP Vaccines/Year	\$25
Fecal Test	\$20	Fecal Test	\$25
Wellness Exam	\$100	Wellness Exam	\$150
Dog Heartworm or Flea Screening	\$20	Dog Heartworm or Flea Screening	\$25
Desparasiting	\$20	Desparasiting	\$75
		Heart/Respiratory Prescription	\$25
		Dog Wellness or Lab Test Vaccines/Year	\$25
		Blood Test	\$25
		Urinanalysis	\$25

Note: Preventive care plans can help prevent future illnesses and help support your pet's overall health and longevity.

## 5 Review and Compare Plans

- ♥ Once you've selected and customized your plan, click **"Proceed to Checkout."** You will see a summary of the costs and coverage details.
- ♥ Review the details carefully to ensure the plan meets your needs.

## 6 Choose a Payment Plan and Finalize

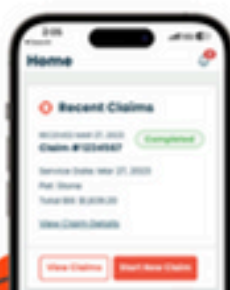
- ♥ Choose between being billed **monthly**, or **annually**.
- ♥ Provide your payment details and billing information.
- ♥ Read and accept the policy terms and conditions, and click **"Complete Purchase."**

**That's it! Following these steps should help you get a quote and enroll in a Spot Pet Insurance Plan.**



### Additional Tips:

- ♥ If you need further assistance, please contact our team by calling **800.905.1595**
- ♥ Get convenient access to your policy details, claim status, and more by downloading the Spot Pet Insurance app on your smartphone.



**ARCH TELECOM**  
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[spotpet.link/archtelecom](https://spotpet.link/archtelecom)

## FEDlogic

FEDlogic provides state and federal benefits information and advocacy to you and your household. This service is confidential, unlimited, and free to all Employees.

### Reasons to call FEDlogic:

- You've reached or are approaching Medicare age and need to learn more
- You're approaching retirement age and want to learn more about your Social Security Benefits
- You or a household family member have been diagnosed with a major illness
- You have a child with a disability or born prematurely
- You have lost a spouse
- You need assistance navigating Medicaid, Marketplace or COBRA
- You need help exploring alternative healthcare avenues based on your income
- You are currently on Dialysis (ESRD)

### How It Works:

- Make a phone consultation appointment - be sure family members are available to listen and ask questions if needed.
- Tell your story, ask questions and learn - FEDlogic provides unbiased information you need to make the best decision for your situation.
- Enroll in your benefits - FEDlogic will walk you through the application and approval process.
- Relax with peace of mind that you are getting all the benefits you deserve.



### Contact Information:

- Phone: [\(877\) 837-4196](tel:(877)837-4196)
- Resource Page:
  - <https://employees.fedlogicgroup.com>
  - Access code - arch25

## Daily Pay

Arch Telecom offers a cutting-edge Pay program through DailyPay. DailyPay allows you to access your pay on demand. You can think of DailyPay as an online ATM, offering real-time visibility into your pay and the option to access those earnings. Signing up for DailyPay is free. Similar to an ATM, you only pay a fee when you make an early transfer.

With DailyPay, you can track, save, and transfer your earnings on your schedule. Benefits of DailyPay include the ability to get paid on day one, track your daily income with updates after every shift you work, transfer your pay instantly or the next day, and automatically save a portion of your paycheck. You can also use DailyPay to avoid late fees and interest charges and to help you plan for expenses.

**ARCH TELECOM**  
**MAKES ANY DAY PAYDAY!**

GET PAID TODAY  
BY SCANNING THIS  
QR CODE TO  
DOWNLOAD THE  
DAILYPAY APP!

[dailypay.tm/signup](https://dailypay.tm/signup)

OR TEXT START  
TO 66867

**ARCH TELECOM**  
EMPLOYEE OWNED

**daily pay.**

**PAYDAY EVERY DAY**

The advertisement features a central smartphone displaying the DailyPay app interface. The app shows a balance of \$239.07, a last shift report of Nov 5, 06:43 AM, and options to choose a transfer amount (\$20, \$40, \$60, Other, or Entire Balance). A 'Start Transfer' button is visible. Below the app, there is a QR code and a referral offer: 'Get \$5.00, Give \$5.00. Refer a coworker to DailyPay to get a \$5.00 bonus.' The background is dark with teal and white chevron patterns on the sides.



# EMPLOYEE REFERRAL PROGRAM



Employee referrals are a valuable and cost-effective source of hiring new employees! To encourage and reward the recruiting efforts of employees, Arch Telecom has established the program of providing a bonus to employees whose referrals are hired!

## MAKE UP TO **\$500** PER REFERRAL!

**\$200 BONUS**

After 30 days of employment



**\$100 BONUS**

After 60 days of employment



**\$200 BONUS**

After 90 days of employment

**There is no limit to the number of applicants an employee may refer!**

## DETAILS

- If the new hire successfully completes their 1st 30 days of employment the referring Arch Telecom employee will receive a \$200 referral bonus (minus applicable state and federal taxes).
- If the new hire successfully completes their 1st 60 days of employment the referring Arch Telecom employee will receive another \$100 referral bonus (minus applicable state and federal taxes).
- If the new hire successfully completes their 1st 90 days of employment the referring Arch Telecom employee will receive a final \$200 referral bonus (minus applicable state and federal taxes) for a total potential of a \$500 referral bonus.

\* Referral bonus payments will be payable in line with regular paycheck payment schedules each month and are subject to all applicable taxes. Referring employee must ensure that their referred candidate indicates the Arch Telecom employee name in the Applicant Tracking System on the application at the time of applicant's application and prior to the New Hire start date. Please see official policy for detailed rules and procedure.

# Benefit Plans Pricing Summary

## Medical

Medical Plan Contributions (Biweekly)	Anthem Bronze	Anthem Silver	Anthem Gold
Employee only	\$54.17	\$115.10	\$321.74
Employee + Spouse	\$204.06	\$361.23	\$679.23
Employee + Child(ren)	\$188.36	\$331.03	\$697.10
Family	\$286.97	\$406.96	\$983.09

## Dental

Dental PPO Plan Contributions (Biweekly)	PPO	PPO Max
Employee only	\$14.92	\$17.19
Employee + Spouse	\$29.44	\$33.92
Employee + Child(ren)	\$37.48	\$43.18
Family	\$51.24	\$59.04

Dental HMO Plan Contributions (Biweekly)	
Employee only	\$5.74
Employee + Spouse	\$9.50
Employee + Child(ren)	\$11.42
Family	\$16.17

## Vision

Vision Plan Contributions (Biweekly)	
Employee	\$5.23
Employee + Spouse	\$8.96
Employee + Child(ren)	\$9.15
Family	\$14.75

## Questions & Contacts



Topic	Who You Can Contact	How
Questions about your health plan, enrollment, and eligibility	Human Resources	(714) 829-1618 benefits@archtelecom.net
Questions about specific medical claims and coverage, as well as prescriptions	Leading Edge	(844) 356-2207 <a href="https://mesa.leadingedgeadmin.com">https://mesa.leadingedgeadmin.com</a>
What physicians are in-network?	Anthem	<a href="http://www.anthem.com">www.anthem.com</a>
Health Advocacy	ConciergeCARE	Phone: (844) 356-2207
Telehealth	LiveHealth Online	(844) 784-8409, <a href="http://livehealthonline.com">livehealthonline.com</a>
Dental Insurance Questions	Cigna	(800) 244-6224, <a href="http://www.mycigna.com">www.mycigna.com</a>
Vision Insurance Questions	VSP	(800) 877-7195, <a href="http://www.vsp.com">www.vsp.com</a>
Life and AD&D Insurance	Colonial	(800) 325-4368 <a href="http://ColonialLife.com">ColonialLife.com</a>
Short Term Disability	Colonial	(800) 325-4368 <a href="http://ColonialLife.com">ColonialLife.com</a>
Flexible Spending Account (FSA) Questions	The Health Plan (THP)	(866) 347-3640 <a href="http://www.healthplan.org">www.healthplan.org</a>
Employee Assistance Program (EAP)	Colonial Life	(800) 422-5142 <a href="http://HealthAdvocate.com/members">HealthAdvocate.com/members</a>

# Definitions



## Glossary

- THP – The Health Plan (Medical Insurance Provider)
- PHCS – Physician Network
- VBP – Value-Based Payments
- HST – HS Technology (The vendor that handles the Value-Based Payments negotiations as well as manages the PAC)
- PAC – Patient Advocacy Center (Balance Billing)
- CIGNA – Dental Provider
- VSP – Vision Provider
- EAP – Employee Assistance Program (ComPsych)
- Paycom – HRIS System/Benefits Portal
- RMA – Risk Management Advisors (Broker)

## Key Medical Terms

- **Balance Bill:** A bill sent to a patient by a provider for charges not covered by the medical plan.
- **Coinsurance:** The additional amount of the medical bill that you pay once you meet your deductible; applicable for the Silver and Gold plans only.
- **Copay:** The flat dollar amount that you pay for certain services and prescriptions.
- **Deductible:** The amount you pay out of your pocket for covered health expenses before your plan begins paying a percentage of your costs.
- **In-Network:** Healthcare providers that offer services to participants in a medical plan at a negotiated rate.
- **Out-of-Network:** Healthcare providers that do not participate in your health plan. If you visit a provider who is out of network, your costs may be higher.
- **Out-of-Pocket Maximum:** The most you will pay each year in deductibles and your share of coinsurance before your plan begins paying most of your covered expenses at 100% for the rest of the year.
- **Pre-certification:** When your physician recommends an expensive test or procedure, they first obtain authorization from the medical plan, ensuring that both the cost and quality of the provider are appropriate.

## Key Prescription Terms

- **Generic:** Generic drugs contain the same active ingredients as brand-name drugs, but they cost less.
- **Formulary:** Your medical plan has a list of approved brand-name drugs called a “formulary,” chosen for their price and effectiveness. Your costs for these drugs are typically lower than with other brand-name drugs.
- **Non-Formulary:** These are brand-name drugs that are not on the formulary list. These drugs will cost you more.

# Annual Compliance Notices

## COBRA RIGHTS

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Company 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. 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 coverage would otherwise end because of a life event known as a "qualifying event." 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. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 days of the event.

If applicable, your participation in the Health Care Flexible Spending Account (FSA) can also continue on an after-tax basis through the remainder of the plan year in which you qualify for COBRA. The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all qualified beneficiaries. If you make contributions to the Health Care FSA for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the plan year.

You may be offered to continue your coverage under the Health Care FSA if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the qualified beneficiary for the plan year; (2) the total reimbursable claims submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is

overspent. You may not re-enroll in the Health Care FSA during any annual enrollment for any plan year that follows your qualifying event.

Supporting documentation like a divorce decree, death certificate or proof of other insurance may be required as proof of a qualifying event. This general notice does not fully describe COBRA or the plan. More complete information is available from the Plan Administrator and in the summary plan document.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- 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 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee must notify the Plan Administrator of the qualifying event.

### **How is COBRA 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. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare

entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

#### **Disability extension of 18-month period of continuation coverage.**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.

Documentation from the Social Security administration certifying a disability will be required.

#### **Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the 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](http://www.HealthCare.gov)

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

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

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

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation

coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

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

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

### **If you have questions**

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator indicated above or in the summary plan description. 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](http://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](http://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.

## **THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 ("GINA")**

GINA protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

## **HIPAA SPECIAL ENROLLMENT RIGHTS**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, including: if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in

effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event.

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) provided that you meet participation requirements. You must request enrollment, however, within 30 days or any longer period that applies under the plan, 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 or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Plan Administrator mentioned above.

If you have declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. You must, however, request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. You must, however, request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the Plan Administrator indicated in this notice.

## **MEDICARE PART D NOTICE (NOTICE OF CREDITABLE COVERAGE)**

### About Your Prescription Drug Coverage and Medicare

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

Two important things 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.
- We have determined the prescription drug coverage offered by your provider 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. Plan participants are eligible if they are within three months of turning age 65, are already 65 years old or if they are disabled. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

#### What Happens to your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected, and benefits will be coordinated with Medicare. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the Plan Administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare-eligible individuals when you become eligible for Medicare Part D.

Visit [www.cms.hhs.gov/CreditableCoverage](http://www.cms.hhs.gov/CreditableCoverage) which outlines the prescription drug plan provisions/options Medicare-eligible individuals may have available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and current coverage is dropped, be aware you and your dependents will not be able to get this coverage back. Refer to plan documents or contact your provider or the Plan Administrator before making any decisions.

*Note: In general, different guidelines exist for retirees regarding cancellation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language or other agreement exists. Contact the Plan Administrator for details.*

#### When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 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 Plan Administrator for details*. You will get this notice each year. You will also get it before the next Medicare part D drug plan enrollment period and if this coverage changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage

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

For more information about Medicare prescription drug coverage:

Visit [www.Medicare.gov](http://www.Medicare.gov) or 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 800-MEDICARE (800-633-4227) (TTY: 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](http://www.socialsecurity.gov) or call 800-772-1213 (TTY: 800- 325-0778).

*Remember to 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).*

## MENTAL HEALTH PARITY

The Mental Health Parity and Addiction Equity Act (MHPA/ MHPAEA) of 2008 requires that group health plans must not unfairly restrict treatment with respect to coverage and cost sharing requirements for mental health or substance use disorders relative to the coverage and cost sharing requirements offered under the plan's medical and surgical benefits. Additional information and details can be found by visiting the Department of Labor's Mental Health Parity website: [www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity](http://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity)

## NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Newborns' and Mothers' Health Protection Act (NMHPA) requires that group health plans and health insurance issuers who offer childbirth coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or *contact your Plan Administrator*.

For additional information about NMHPA provisions and how self-funded non-Federal governmental plans may opt-out of the NMHPA requirements, visit [www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhcpa\\_factsheet.html](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhcpa_factsheet.html).

## 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 20220 or email [ebsa.opr@dol.gov](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.

# 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](http://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](http://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](http://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, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="https://health.alaska.gov/dpa/Pages/default.aspx">https://health.alaska.gov/dpa/Pages/default.aspx</a>
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: <a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a> Phone: 916-445-8322 Fax: 916-440-5676 Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid

<p>Health First Colorado Website:  <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a>  Health First Colorado Member Contact Center:  1-800-221-3943/State Relay 711  CHP+: <a href="https://hcpf.colorado.gov/child-health-plan-plus">https://hcpf.colorado.gov/child-health-plan-plus</a>  CHP+ Customer Service: 1-800-359-1991/State Relay 711  Health Insurance Buy-In Program  (HIBI): <a href="https://www.mycohibi.com/">https://www.mycohibi.com/</a>  HIBI Customer Service: 1-855-692-6442</p>	<p>Website:  <a href="https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html">https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html</a>  Phone: 1-877-357-3268</p>
<b>GEORGIA – Medicaid</b>	<b>INDIANA – Medicaid</b>
<p>GA HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a>  Phone: 678-564-1162, Press 1  GA CHIPRA Website:  <a href="https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a>  Phone: 678-564-1162, Press 2</p>	<p>Health Insurance Premium Payment Program  All other Medicaid  Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a>  <a href="http://www.in.gov/fssa/dfr/">http://www.in.gov/fssa/dfr/</a>  Family and Social Services Administration  Phone: 1-800-403-0864  Member Services Phone: 1-800-457-4584</p>
<b>IOWA – Medicaid and CHIP (Hawki)</b>	<b>KANSAS – Medicaid</b>
<p>Medicaid Website:  <a href="http://iowa.gov/health-human-services">iowa Medicaid   Health &amp; Human Services</a>  Medicaid Phone: 1-800-338-8366  Hawki Website:  <a href="http://iowa.gov/health-human-services">Hawki - Healthy and Well Kids in Iowa   Health &amp; Human Services</a>  Hawki Phone: 1-800-257-8563  HIPP Website: <a href="http://iowa.gov/health-human-services">Health Insurance Premium Payment (HIPP)   Health &amp; Human Services (iowa.gov)</a>  HIPP Phone: 1-888-346-9562</p>	<p>Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a>  Phone: 1-800-792-4884  HIPP Phone: 1-800-967-4660</p>
<b>KENTUCKY – Medicaid</b>	<b>LOUISIANA – Medicaid</b>
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:  <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a>  Phone: 1-855-459-6328  Email: <a href="mailto:KIHIPP.PROGRAM@ky.gov">KIHIPP.PROGRAM@ky.gov</a>  KCHIP Website: <a href="https://kynect.ky.gov">https://kynect.ky.gov</a>  Phone: 1-877-524-4718  Kentucky Medicaid Website:  <a href="https://chfs.ky.gov/agencies/dms">https://chfs.ky.gov/agencies/dms</a></p>	<p>Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a>  Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
<b>MAINE – Medicaid</b>	<b>MASSACHUSETTS – Medicaid and CHIP</b>

<p>Enrollment Website:  <a href="https://www.mymaineconnection.gov/benefits/s/?language=en_US">https://www.mymaineconnection.gov/benefits/s/?language=en_US</a>  Phone: 1-800-442-6003  TTY: Maine relay 711  Private Health Insurance Premium Webpage:  <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a>  Phone: 1-800-977-6740  TTY: Maine relay 711</p>	<p>Website: <a href="https://www.mass.gov/masshealth/pa">https://www.mass.gov/masshealth/pa</a>  Phone: 1-800-862-4840  TTY: 711  Email: <a href="mailto:masspremassistance@accenture.com">masspremassistance@accenture.com</a></p>
<b>MINNESOTA – Medicaid</b>	<b>MISSOURI – Medicaid</b>
<p>Website:  <a href="https://mn.gov/dhs/health-care-coverage/">https://mn.gov/dhs/health-care-coverage/</a>  Phone: 1-800-657-3672</p>	<p>Website:  <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a>  Phone: 573-751-2005</p>
<b>MONTANA – Medicaid</b>	<b>NEBRASKA – Medicaid</b>
<p>Website:  <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a>  Phone: 1-800-694-3084  Email: <a href="mailto:HSHIPPProgram@mt.gov">HSHIPPProgram@mt.gov</a></p>	<p>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a>  Phone: 1-855-632-7633  Lincoln: 402-473-7000  Omaha: 402-595-1178</p>
<b>NEVADA – Medicaid</b>	<b>NEW HAMPSHIRE – Medicaid</b>
<p>Medicaid Website: <a href="http://dhcftp.nv.gov">http://dhcftp.nv.gov</a>  Medicaid Phone: 1-800-992-0900</p>	<p>Website: <a href="https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a>  Phone: 603-271-5218  Toll free number for the HIPP program: 1-800-852-3345, ext. 15218  Email: <a href="mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov">DHHS.ThirdPartyLiabi@dhhs.nh.gov</a></p>
<b>NEW JERSEY – Medicaid and CHIP</b>	<b>NEW YORK – Medicaid</b>
<p>Medicaid Website:  <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>  Phone: 1-800-356-1561  CHIP Premium Assistance Phone: 609-631-2392  CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>  CHIP Phone: 1-800-701-0710 (TTY: 711)</p>	<p>Website:  <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a>  Phone: 1-800-541-2831</p>
<b>NORTH CAROLINA – Medicaid</b>	<b>NORTH DAKOTA – Medicaid</b>
<p>Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a>  Phone: 919-855-4100</p>	<p>Website: <a href="https://www.hhs.nd.gov/healthcare">https://www.hhs.nd.gov/healthcare</a>  Phone: 1-844-854-4825</p>
<b>OKLAHOMA – Medicaid and CHIP</b>	<b>OREGON – Medicaid and CHIP</b>
<p>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>  Phone: 1-888-365-3742</p>	<p>Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a>  Phone: 1-800-699-9075</p>

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
<p>Website: <a href="https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html">https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html</a>  Phone: 1-800-692-7462  CHIP Website: <a href="http://www.pa.gov/childrens-health-insurance-program">Children's Health Insurance Program (CHIP) (pa.gov)</a>  CHIP Phone: 1-800-986-KIDS (5437)</p>	<p>Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a>  Phone: 1-855-697-4347, or  401-462-0311 (Direct Rlte Share Line)</p>
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
<p>Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a>  Phone: 1-888-549-0820</p>	<p>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a>  Phone: 1-888-828-0059</p>
TEXAS – Medicaid	UTAH – Medicaid and CHIP
<p>Website: <a href="http://www.texas.gov/health-insurance-premium-payment-program">Health Insurance Premium Payment (HIPP) Program   Texas Health and Human Services</a>  Phone: 1-800-440-0493</p>	<p>Utah's Premium Partnership for Health Insurance (UPP)  Website: <a href="https://medicaid.utah.gov/upp/">https://medicaid.utah.gov/upp/</a>  Email: <a href="mailto:upp@utah.gov">upp@utah.gov</a>  Phone: 1-888-222-2542  Adult Expansion Website:  <a href="https://medicaid.utah.gov/expansion/">https://medicaid.utah.gov/expansion/</a>  Utah Medicaid Buyout Program Website:  <a href="https://medicaid.utah.gov/buyout-program/">https://medicaid.utah.gov/buyout-program/</a>  CHIP Website: <a href="https://chip.utah.gov/">https://chip.utah.gov/</a></p>
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
<p>Website: <a href="http://www.vermont.gov/health-insurance-premium-payment-program">Health Insurance Premium Payment (HIPP) Program   Department of Vermont Health Access</a>  Phone: 1-800-250-8427</p>	<p>Website:  <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select">https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select</a>   <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a>  Medicaid/CHIP Phone: 1-800-432-5924</p>
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
<p>Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a>  Phone: 1-800-562-3022</p>	<p>Website: <a href="https://dhr.wv.gov/bms/">https://dhr.wv.gov/bms/</a>  <a href="http://mywvhpp.com/">http://mywvhpp.com/</a>  Medicaid Phone: 304-558-1700  CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
<p>Website:  <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a>  Phone: 1-800-362-3002</p>	<p>Website:  <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a>  Phone: 1-800-251-1269</p>

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://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](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565

## PREVENTIVE CARE

Health plans will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, visit: [www.HealthCare.gov/coverage/preventive-care-benefits](http://www.HealthCare.gov/coverage/preventive-care-benefits)

## PRIVACY PRACTICES NOTICE REMINDER

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information.

We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

## SUMMARY OF BENEFITS AND COVERAGE (SBCs)

You may request a paper copy of the SBCs (free of charge), from your employer. Your employer is required to make SBCs available that summarize important information about health benefit plan options in a standard format, to help you compare across plans and make an informed choice. The health benefits available to you provide important protection for you and your family and choosing a health benefit option is an important decision.

## USERRA NOTICE

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

## **Reemployment Rights**

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

## **Right to Be Free From Discrimination and Retaliation**

If you are a past or present member of the uniformed service, have applied for membership in the uniformed service or are obligated to serve in the uniformed service, an employer may not deny you initial employment, reemployment, retention in employment, promotion or any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

## **Health Insurance Protection**

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

## **Enforcement**

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 866-4-USA-DOL or visit [www.dol.gov/vets](http://www.dol.gov/vets). An interactive online USERRA Advisor can be viewed at <https://webapps.dol.gov/elaws/vets/userra/>.

If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: [www.dol.gov/vets/programs/userra/poster.htm](http://www.dol.gov/vets/programs/userra/poster.htm).

## **WOMEN'S HEALTH AND CANCER RIGHTS ACT**

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

a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your Plan Administrator at the number above.