Durham City Transit Company

2023 BENEFITS GUIDE
NON-UNION EMPLOYEES

GO Durham

CONTENTS

ENROLLMENT GUIDE

Plan Year

Open Enrollment will begin **October 31st, 2022** and extend through **November 4, 2022**. Benefits are administered on a plan year from **January 1, 2023** through **December 31, 2023**.

▸ Who Is Eligible?

If you're a full-time employee at Durham City Transit who has completed 60 days of service, you're eligible to enroll in the benefits outlined in this guide. Please note that benefits are effective on the first of the month following the completion of service requirements. Full-time employees are those who work 30 or more hours per week.

▸ How to Enroll

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all of your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

▸ How to Make Changes

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Qualifying events include things like:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child, or other qualified dependent
- Change in residence
- Change in employment status or change in coverage under another employer-sponsored plan

▸ Medical/Dental Bonus

Employees that are eligible for medical and dental benefits who do not elect Medical and Dental during Open Enrollment will receive an annual bonus of $500

Please note: should an employee subsequently opt for coverage during the year due to "change of circumstance", they would be required to return a pro-rated share of the bonus (i.e. six months of coverage = $250).

YOUR COST IN 2023

Please see below for your **bi-weekly payroll deductions*** for January 1, 2023 – December 31, 2023.

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Medical	$20.00	$219.74	$188.03	$314.07
Dental	$3.95	$10.56	$14.29	$34.34
Vision	$3.11	$5.91	$6.22	$9.14

*Deductions reflect 24 pay periods

Aetna OAMC 2000 ACO			
Benefits	**Maximum Savings**	**Standard Savings**	**Out-of-Network**
Annual Deductible	Single | $1,000 Family | $2,000	Single | $1,200 Family | $2,400	Single | $ 2,000 Family | $4,000
Annual Out-of-Pocket Maximum	Single | $3,000 Family | $6,000	Single | $3,200 Family | $6,400	Single | $6,000 Family | $12,000
Co-Insurance (Your responsibility)	20%	40%	50%
Office Visits Primary Care Physician Specialist Adult & Child Preventative	 $25 Copay per Visit $50 Copay per Visit Covered 100%	 $60 Copay per Visit $65 Copay per Visit Covered 100%	 30% after deductible 30% after deductible 30% after deductible
Labs, X-Rays & Diagnostics Outpatient Major Diagnostics (MRI, CAT, PET Scans)	20% after deductible*	40% after deductible*	50% after deductible*
Hospital Services Emergency Room Urgent Care Inpatient Hospitalization Outpatient Services Surgical Expenses	 $250 Copay per Visit $75 Copay per Visit 20% after deductible 20% after deductible 20% after deductible	 $250 Copay per Visit $75 Copay per Visit 40% after deductible 40% after deductible 40% after deductible	 $250 Copay per Visit 30% after deductible 50% after deductible 50% after deductible 50% after deductible
Mental Health & Substance Abuse Inpatient Hospital Outpatient / Office Visit	 20% per admission after deductible $50 Copay per Visit	 40% per admission after deductible $65 Copay per Visit	 50% after deductible 30% after deductible

Aetna OAMC 2000 ACO		
Pharmacy	**In Network****	**Out-of-Network**
Retail Prescription Drugs Value Drugs Tier 1A Preferred Generic Drugs Preferred Brand Name Drugs Non-Preferred Generic and Brand-Name Drugs **Aetna Value Plus** Preferred Specialty Non-Preferred Specialty	 $3 Copay $10 Copay $35 Copay $60 Copay 20% (Maximum $300) 20% (Maximum $500)	 20% of submitted cost after applicable copay
Mail Order Value Drugs Tier 1A Preferred Generic Drugs Preferred Brand Name Drugs Non-Preferred Generic and Brand-Name Drugs	3x Retail Copays	Not Applicable

**If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.*
***In-network pharmacy expenses apply towards the Maximum Savings tier only. Out-of-network pharmacy expenses apply towards the out-of-network tier.*

MAXIMUM SAVINGS VS. STANDARD SAVINGS

Aetna OAMC 2000 ACO			
Benefits	**Maximum Savings**	**Standard Savings**	**Out-of-Network**
Annual Deductible	Single | $1,000	Single | $1,200 Family | $2,400	Single | $ 2,000 Family | $4,000
Annual Out-of-Pocket Maximum	Single | $3,000	Single | $3,200 Family | $6,400	Single | $6,000 Family | $ 12,000

▸ WHY ARE THERE THREE DIFFERENT DEDUCTIBLES?

You will save the most money if you use doctors and facilities in the **Aetna Whole Health – Duke Health, WakeMed & THN-Cone Health** network. Doctors and facilities in this network are held accountable by Aetna to make smarter healthcare decisions and are rewarded for keeping patients healthy. This plan focuses on the Primary Care Physician relationship that you have with your in-network doctor. If you need it, your PCP will generally refer you to other doctors and facilities in the network and help you coordinate your care so you can stay healthy.

If you choose to see a doctor that is not in the Aetna Whole Health – Duke Health, WakeMed & THN-Cone Health network, your deductible will accumulate towards the "Standard Savings" tier. Please note though, that applicable covered expenses accumulate simultaneously toward both the Maximum Savings and Standard Savings Deductibles but separately towards the non-preferred Deductible. This means that you are not required to satisfy both Maximum Savings and Standard savings deductible separately.

▸ HOW CAN I FIND A DOCTOR IN THE AETNA WHOLE HEALTH – DUKE HEALTH, WAKEMED & THN-CONE HEALTH NETWORK?

Visit www.aetna.com/docfind to search the Aetna directory of doctors and facilities. Enter your network ((NC) Aetna Whole Health – Duke Health, WakeMed & THN-Cone Health – Managed Choice). Providers that participate in the Aetna Whole Health (Maximum Savings) will have a green Aetna Whole Health logo next to their name while providers that participate in the Aetna National Network (Standard Savings) will have a red logo next to their name.

▸ DO I NEED TO SEE MY PRIMARY CARE DOCTOR FOR REFERRALS?

While your plan doesn't require a referral to see a specialist, it's always a good idea to consult with your primary care doctor on your care plan. They can then better coordinate your care across all facilities and specialists in your Aetna Whole Health plan network.

▸ WHAT IF I'M NOT AT HOME AND NEED CARE?

If your health or life is in serious danger, call 911 or go to the nearest hospital. You'll be covered as though you stayed within the network.

▸ HOW CAN I USE MY BENEFITS EFFECTIVELY?

First, register for your member website at www.Aetna.com. Next, pick a primary care doctor to lead your care team (if you haven't already). Then, schedule your annual wellness exam. Finally, check out www.myaetnawholehealth.com for a member welcome guide and video.

▸ WHAT IF I'M IN THE MIDDLE OF CARE OR TREATMENT WITH A DOCTOR OUTSIDE OF THE AETNA WHOLE HEALTH NETWORK?

You can work with your current doctor and request transition-of-care coverage. If Aetna approves your request, you can stay with your current out-of-network doctor for a limited time at the highest benefits level. However, transition-of-care coverage is for your current doctor only. It doesn't cover health care facilities, durable medical equipment (DME) or prescription drugs. So, you'll need to use Aetna Whole Health – Duke Health, WakeMed & THN – Cone Health network facilities, DME vendors and pharmacies while you're in treatment with your current doctor. And before your grace period ends, Aetna can help transfer you to a new doctor within the Aetna Whole Health – Duke Health, WakeMed & THN – Cone Health network.

Paying for health care can be stressful. That's why Durham City Transit Company offers an employer-sponsored flexible spending account (FSA) through Flores & Associates.

What is a Healthcare FSA?

An FSA is an employer-sponsored savings account for health care expenses. You are not taxed on the money put into the FSA, and you can then use the account to pay for qualified out-of-pocket health care costs, such as your deductible and copays, but not your premium.

What are the Benefits of an FSA?

There are a variety of different benefits of using an FSA, including the following:

- **It saves you money.** Allows you to put aside money tax-free that can be used for qualified medical expenses.
- **It's a tax-saver.** Since your taxable income is decreased by your contributions, you'll pay less in taxes.
- **It is flexible.** You can use your FSA funds at any time, even if it's the beginning of the year.

You cannot stockpile money in your FSA. **If you do not use it, you lose it.** You should only contribute the amount of money you expect to pay out of pocket that year. The maximum amount that you can contribute to your FSA for 2023 is $3,050.

What is a Dependent Care FSA?

Dependent Care FSAs allow you to contribute pre-tax dollars to qualified dependent care. The maximum amount you may contribute each year is $5,000 (or $2,500 if married and filing separately).

In general, eligible dependents include your child who is under the age of 13, or your spouse or relative who is physically or mentally incapable of self-care and lives in your home.

How Do I Enroll?

Fill out the FSA Enrollment Form during Open Enrollment. Even if you signed up last year, you must re-enroll for 2023.

Examples of FSA Eligible Expenses

Healthcare:

- Doctor and pharmacy copay
- Hospital, surgery and lab expenses
- Dental, orthodontic and vision expenses
- Certain medical equipment

Dependent Care:

- Care at licensed nursery school or day-care facility
- Before and after school care for children
- Certain day camps
- Nannies and au pairs
- In-home day care

A complete list of FSA eligible expenses is available at **www.irs.gov.**

FSA and HSA

You cannot contribute to both a Healthcare FSA and HSA during the same plan year. You can contribute to both an HSA and Dependent FSA during the same plan year.

TELEMEDICINE

Virtual appointments are now available 24/7!

With virtual appointments through **Teladoc** you can easily connect with a doctor from your mobile device or computer. Doctors can do things like write prescriptions or diagnose and treat a range of nonemergency medical conditions through this virtual platform. Additionally, the cost of a virtual appointment is typically lower than going to a doctor's office, urgent care center or emergency room.

A virtual appointment is good for a number of mild conditions but is not suitable for severe symptoms like a higher fever or a debilitating cough. A virtual appointment could be appropriate for the following circumstances:

- Bronchitis
- Mild coughs
- Allergies
- Mild fevers
- Pinkeye

You should **not** use a virtual appointment in any of the following situations:

- Chronic conditions
- Anything requiring a hands-on exam
- Cancer or other complex conditions
- Anything requiring a test
- Broken bones, sprains or injuries requiring bandaging

It's easy to set up your account at **Teladoc.com/Aetna.** Select "Set up account" and enter the required Information.

The Dental Plan is available to each eligible employee and eligible family members to cover routine care such as regular check-ups, cleanings, and X-rays. Receiving dental care can protect you and your family from the high cost of dental disease and surgery.

The chart below outlines the dental benefits we offer:

Dental Plan			
	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
	Plan Pays	Play Pays	Plan Pays*
Annual Deductible	None	None	None
Annual Maximum	$1,250	$1,250	$1,250
Orthodontic Lifetime Maximum	$1,000	$1,000	$1,000
Preventative Services	100%	100%	100%
Basic Services	80%	80%	80%
Major Services	50%	50%	50%
Orthodontics (to age 19)	50%	50%	50%

*When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what that dentist charges and you are responsible for that difference. Please refer to the plan documents for additional information.

Dental Plan Costs (per pay period)	
Employee Only	$3.95
Employee + Spouse	$10.56
Employee + Child(ren)	$14.29
Employee + Family	$34.34

The Vision Plan entitles you to specific eye care benefits. Having vision benefits can help you maintain your vision as well as detect various health problems. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

The chart below provides an overview of covered services and benefits under the Vision Plan.

Vision Summary of Service		
	In Network	**Out-Of-Network**
Copay		
Exams	$10	Up to $30 Reimbursement
Materials	$25	Varies
Frequencies		
Exams	12 months	12 Months
Lenses	12 months	12 Months
Frames	24 months	24 Months
Eye Exams	Covered in full after copay	Up to $30 Reimbursement
Lenses		
Single Vision	$25 Copay	Up to $25 Reimbursement
Lined Bifocal	$25 Copay	Up to $40 Reimbursement
Lined Trifocal	$25 Copay	Up to $60 Reimbursement
Frames Allowance	$0 Copay, $130 allowance, 20% off balance over $130	Up to $65 Reimbursement
Contact Lenses Allowance		
Conventional	$0 Copay, $130 Allowance, 15% off balance over $130	Up to $104 Reimbursement
Disposable	$0 Copay, $130 Allowance, plus balance over $130	Up to $104 Reimbursement
Medically Necessary	$0 Copay, Paid in full	Up to $200 Reimbursement

Vision Plan Costs (per pay period)	
Employee Only	$3.11
Employee + Spouse	$5.91
Employee + Child(ren)	$6.22
Employee + Family	$9.14

Please refer to the plan documents for additional information.

Basic Life Insurance

Life Insurance can help provide for your loved ones if something were to happen to you. Durham City Transit Company provides eligible **full-time union** employees with $20,000 in group life and accidental death and dismemberment (AD&D) insurance.

Durham City Transit Company provides eligible **part-time union** employees with $10,000 in group life and accidental death and dismemberment (AD&D) insurance.

Durham City Transit Company pays for the full cost of this benefit–meaning you are not responsible for paying any monthly premiums. Contact HR if you would like to update your beneficiary information.

EMPLOYEE ASSISTANCE PROGRAM (EAP) *Business Health Services (BHS)*

What is an Employee Assistance Program(EAP)?

The EAP is a free and completely confidential counseling program. EAP counselors are available to help develop solutions through brief counseling, information and referrals to community and professional resources.

Who is eligible?

The Employee Assistance Program (EAP) is offered to all employees and immediate family members of Durham City Transit Company through Business Health Services.

What does the EAP cover?

Your EAP covers a variety of areas that you may be having trouble with, such as:

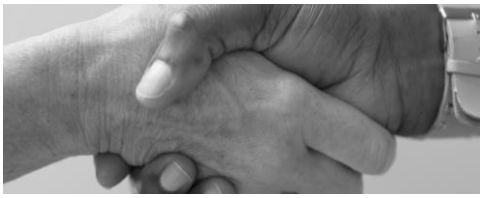
- Substance abuse
- Stress management
- Financial problems
- Divorce/marital problems
- Crisis intervention
- Legal problems

To start getting help today call: 919-872-4786 for local calls or 1-800-327-2251 for 24-hour toll free assistance. Online resources are available at bhsonline.com through the BHS Portal (username: DCTC)

Durham City Transit Company provides eligible employees with the option to purchase long-term disability income benefits. Without disability coverage, you and your family may struggle to get by if you miss work due to an injury or illness.

In the event that you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income.

Long Term Disability Summary of Benefits		
Maximum Benefit Amount	60% of monthly earnings to a maximum of $5,000 per month	
Benefits Begin	After a 90 Day Elimination Period	
Maximum Benefit Period	**Age When Disabled**	**Benefits Payable**
	Prior to Age 63	To Normal Retirement Age or 48 months, if greater
	Age 63	To Normal Retirement age or 42 months, if greater
	Age 64	36 months
	Age 65	30 months
	Age 66	27 months
	Age 67	24 months
	Age 68	21 months
	Age 69 and over	18 months
Premiums	**Employee Age**	**Rate for each $100 of insured payroll per month**
	Less than 25	$0.15
	25-29	$0.30
	30-34	$0.43
	35-39	$0.64
	40-44	$0.77
	45-49	$1.21
	50-54	$1.67
	55-59	$2.56
	60-64	$3.50
	65+	$3.26



A 401(k) is an account in which employees can contribute pre-tax dollars through paycheck deductions that are directly deposited into said account. As a result, employee contributions to a 401(k) are not included in the employee's taxable income for the year. 401(k) contributions are also not taxed until the money is withdrawn, either at retirement or earlier. If withdrawals are made prior to retirement age (set by the IRS), they are generally taxed at a higher amount than if they money had stayed in the account until retirement. When the money is distributed, it must be included in the employee's taxable income. Penalties for this type of early withdrawal are also likely to apply.

401(k) Guidelines	
Eligibility	Employees are eligible to participate in the plan on the first day of the month on or after the day you reach age 21 and complete 6 consecutive months of service
Deferral Type	After meeting eligibility requirements, contributions are deferred on a pre-tax basis
Matching Contributions	Durham City Transit Company will match employee contributions to the 401(k) plan at 40% of the employee contribution up to 10% of total wages
Qualified Matching Contributions (QMACs)	You will enter the plan and become eligible to receive QMACs at the same time you are eligible to receive matching contributions
Maximum Contribution	You can contribute a maximum of $22,500 to your 401(k) in 2023. In addition, if you are aged 50 or older, you can contribute a Catch-Up Contribution of $7,500 per year.

▸ How do I enroll in the Durham City Transit Company retirement plan?

- If you'd like help enrolling in a 401k account call: 800-986-3343 and the Principal Call Center will assist you.
- If you'd like to enroll in a 401k account, on-line go to: Principal Financial Group - Welcome
- Select the "**Get Started**" button. Complete the form on the Create your Account screen and follow the instructions.

The Durham City Transit Company Pension Plan is a defined benefit plan, which means that 100% of the funds are contributed by Durham City Transit Company.

Pension Guidelines	
Eligibility	Employees who have attained 21 years of age will be eligible to enter the plan as of the first day of the month coinciding with or next following their date of hire
Years of Service	A Participant is granted one year of service upon accumulation of 1,000 hours of service with the company (or predecessor company) during twelve consecutive months of employment. No service is granted prior to age 18.
Accrued Benefit	A Participant's accrued benefit will be determined in the same manner as their normal retirement benefit, calculated using his or her completed years of service and average compensation at the determination date
Average Monthly Compensation	The average rate of monthly compensation during the highest paid five plan years out of the total period of participation
Normal Retirement vs. Early Retirement	A Participant is eligible for normal retirement benefits at age 65. The normal form of benefit is straight life annuity. Early retirement is defined as the month coinciding with or next following the date on which a Participant has completed 10 Benefit Years and is at least 55 years old

Vesting Schedule

A Participant shall have no vested interest in his or her Accrued Benefit until he or she has completed five (5) Vesting Years at which time his or her interest in the Accrued Benefit becomes 100% vested.

Service for calculating the minimum benefit is granted based on the number of hours of service worked in accordance with the following schedule:

Hours Worked During the Year	Vesting Service Granted
Less than 1,000	0.00
1,000 – 1,249	0.50
1,250 – 1,499	0.75
1,500 or more	1.00

Principal Contact Info:

800-547-7754 (401K & Pension), M – F, 7am – 9pm CT
Principal.com

NOTES

HAVE QUESTIONS, PROBLEMS OR CONCERNS?

The following are your carrier numbers and websites should you need assistance understanding your benefits, claims or other insurance related information.

Medical	Aetna	888-802-3862 www.aetna.com
Telemedicine	Teladoc	1-855-835-2362 Teladoc.com/Aetna
Dental	Delta Dental of North Carolina	800-662-8856 www.deltadentalnc.com
Vision	EyeMed	888-581-3648 www.eyemedvisioncare.com
Life & Disability	The Hartford	800-523-2233 www.thehartford.com
Flexible Spending Accounts	Flores & Associates	800-532-3327 www.flores-associates.com
401K	Principal	800-547-7754 (M-F, 7am-9pm CT) Principal.com Account #: 537432 – DCTC Union Plan Account #: 537434 – DCTC Non-Union Plan
Pension	Principal	800-547-7754 (M-F, 7am-9pm CT) Principal.com Account #: 472413
Durham City Transit Company	Stephen Miller, Director, Human Resources	919-560-1545 ext. 36103 Stephen.miller@GoDurhamNC.org

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Beginning in 2014, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. The open enrollment period each year for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the preceding year. After the open enrollment period ends, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year (adjusted to 9.56% for 2018), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

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

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

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

SPECIAL ENROLLMENT NOTICE

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

Marriage, Birth or Adoption

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

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

Medicaid or CHIP

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

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

For More Information or Assistance

To request special enrollment or obtain more information, please contact HR.

Women's Health and Cancer Rights Act

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

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.

Newborns' and Mothers' Health Protection Act

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

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, 2021. 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: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	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 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ 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: https://www.mass.gov/info-details/masshealth-premium-assistance-pa 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: 1-844-854-482

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/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
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, 2021, 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 20220 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

This proposal is based upon the financial and underwriting information provided by your company. In the event there have been significant changes, or we are missing material data, we will need that information in order to forward it to underwriters. Any additional information may change the rates shown.

This proposal is issued by the carrier as a courtesy and for the sake of expediency. Actual rates will depend upon underwriting, final enrollment and final rate approval.

Never terminate your existing coverage until advised that replacement coverage has been confirmed by the replacement carrier.

This proposal is intended to be a summary of the premium costs of the plans under consideration. Please refer to the carrier's proposal for the actual terms, conditions, limitations, and exclusions. Each carrier administers benefits in a unique manner, a change in carriers may result in a change in how the benefits are administered.

It is imperative we be informed of any employee or dependent that is hospitalized or otherwise disabled and not actively at work on the effective date of any new contract. Coverage may not be available for these individuals.

It is imperative we be informed of any employee or dependent that is covered under your group's COBRA provision or retiree plan.

This proposal is provided only for your internal use. No further use or distribution is authorized without our prior written consent.

All insurance carriers have their own operating procedures. A change in carrier could, therefore, affect the way certain plan coverages are evaluated.

Scott Insurance, a division of James A. Scott & Son, Inc., may qualify to receive compensation from insurance carriers in the form of contingency payments. Contingency payments are based on the volume and persistency of all business Scott Insurance, a division of James A. Scott & Son, Inc., has with certain insurance carriers and is not charged to your account directly nor does it affect placement of coverage. It is calculated into the carriers overall fixed cost.

In performing this review, and analysis, Scott Insurance Agency is not providing legal advice or legal opinion with respect to the PPACA laws (aka, "healthcare reform"), ERISA and /or any state or federal laws with which employers must comply. The information within is intended to serve as general guidance, estimations and advice. Compliance is the sole responsibility of the Employer client. We recommend that you consult with your attorney for final decisions to ensure proper compliance.

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