2023 FCCI INSURANCE GROUP BENEFIT GUIDE

FCCI®
INSURANCE GROUP

FCCI Teammates:

Welcome to the 2023 Benefits Plan Year!

FCCI recognizes that our teammates are the key to our success. We care deeply about your health and wellbeing and strive to provide a variety of comprehensive benefit offerings that allow you to make the best choices for you and your family members.

We hope that you enjoy this benefit guide as one of many valuable tools available to assist you in learning more about our great benefits. The information provided is a summary only. For detailed plan information, please review the official benefit plan documents located within the UKG Benefits & HR Resource Library.

Please reach out to us with any questions that you have along the way.

Happy enrolling!

Your FCCI Benefits Team

fccibenefits@fcci-group.com

2023 Benefits Table of Contents

BE READY FOR ENROLLMENT

FCCI Insurance Group (FCCI) is committed to providing our employees with a benefits program that is both comprehensive and competitive. Our benefits program offers health care, dental and vision coverage, as well as financial security to our employees and their families. This guide provides a general overview of your benefit choices and enrollment information to help you select the coverage that is right for you.

Eligibility

All regular full-time and regular part-time employees working 30 hours or more per week are eligible for benefits on the first of the month following 1 calendar month of employment. Employees are eligible for the following benefits in the chart below. If you have any questions regarding eligibility, benefit plans or enrollment periods or would like additional information, contact **fccibenefits@fcci-group.com**.

BENEFIT	CARRIER	WEBSITE
Medical	UMR	umr.com
Prescription Drug	CVS Caremark	caremark.com
Dental	Delta Dental	deltadentalins.com
Vision	EyeMed	eyemedvisioncare.com/member
Flexible Spending Accounts	UMR	umr.com
Health Savings Account	HSA Bank	hsabank.com
Basic Life & Accidental Death & Dismemberment Claims	Guardian	guardiananytime.com
Voluntary Life & Accidental Death & Dismemberment	Guardian	guardiananytime.com
Short & Long-Term Disability Claims	Guardian	guardiananytime.com
Critical Illness	Guardian	guardiananytime.com
Accident	Guardian	guardiananytime.com
Hospital Indemnity	Guardian	guardiananytime.com
Employee Assistance Program	Guardian	ibhworklife.com
Pet Insurance	Trupanion	trupanion.qualtrics.com/jfe/form/SV_dnFXOfa1nt3dbFz?employer=FCCI1912
Identity Theft Protection	IDShield	legalshield.com/info/fccigroup
Legal Services	LegalShield	legalshield.com/info/fccigroup
Virgin Pulse	Virgin Pulse	virginpulse.com
MyQHealth	Quantum Health	fccihealthplan.com

Dependent Eligibility

You can enroll your dependents in plans that offer dependent coverage. Eligible dependents are defined as your legal spouse and eligible children who reside in your household and depend primarily on you for support. This includes: your own children, legally adopted children, stepchildren, a child for whom you have been appointed legal guardian, and/or a child for whom the court has issued a Qualified Medical Child Support Order (QMCSO) requiring you or your spouse to provide coverage.

Medical, Dental, and Vision Plan Dependent Coverage

You may cover your eligible dependent children up to age 26, regardless of marital or student status (this does not include spouses of adult children).

Dependent coverage will cease for your covered dependent children at the end of the month in which an eligible dependent reaches age 26.

Paying for Your Benefits

Some benefits are provided to you at no cost. The cost of other benefits, such as medical, dental, and vision are shared by you and FCCI. Additional voluntary benefits are paid for by you at discounted group rates. Having benefit options available means you can build a benefits program that meets your needs and your lifestyle.

BENEFIT	WHO CONTRIBUTES?	TAX BASIS
Medical & Prescription Drug	Employee/FCCI	Pre-Tax
Dental	Employee/FCCI	Pre-Tax
Vision	Employee/FCCI	Pre-Tax
Basic Life & Accidental Death & Dismemberment	FCCI	N/A
Dependent Life & Accidental Death & Dismemberment	Employee	Post-Tax
Voluntary Life & Accidental Death & Dismemberment	Employee	Post-Tax
Short-Term Disability	FCCI	N/A
Long-Term Disability	FCCI	N/A
Flexible Spending Accounts	Employee	Pre-tax
Dependent Care Flexible Spending Account	Employee	Pre-tax
Health Savings Account (HSA)	Employee/FCCI	Pre-tax

Enrollment Periods

New Employees

As a new employee of FCCI, you become eligible for benefits on the first of the month following date of hire. Our benefits plan year runs from January 1st through December 31st.

Open Enrollment

As a benefits-eligible employee, you have the opportunity to enroll in or make changes to your benefit plans during our annual open enrollment period. Annual Open Enrollment is held in November with benefit elections effective January 1st of the following year.

Making Changes During the Year

Choose your benefits carefully. Medical, dental, vision, and flexible spending account contributions are made on a pre-tax basis and IRS regulations state that you cannot change your pre-tax benefit options during the year unless you have a qualified life event. Qualified life events include:

- Marriage or divorce;
- Death of your spouse or dependent;
- Birth or adoption of a child;
- Your spouse terminating or obtaining new employment (that affects eligibility for coverage); You or your spouse switching employment status from full-time to part-time or vice versa (that affects eligibility for coverage); Significant cost or coverage changes; or
- Your dependent no longer qualifies as an eligible dependent.

You must submit a life event in UKG and upload supporting documentation of the event within 30 calendar-days of the event. Only benefit changes which are consistent with the qualified life event are permitted.

Medical Benefits

FCCI seeks to provide the best possible medical benefits at a reasonable cost. Employees are provided with two medical plan options that include prescription drug coverage.

Please refer to the chart on the next page for a comparison of medical plan benefits.

In-Network Advantage

Within some of the medical, dental and vision plans, you have the freedom to use any provider. However, when you use an in-network provider, the amount you pay out-of-pocket will be based on a negotiated fee, which is usually lower than the actual charges. If you use a provider who is outside of the network, you may be responsible for paying for the difference between the Usual, Customary, and Reasonable (UCR) charges and what the provider charges. You also may need to submit claim forms.

Medical Benefits — UMR
Prescription Drug Benefits — CVS Caremark

The information below is a summary of medical coverage only. Please contact your Human Resources Department for plan summaries detailing coverage information, limitations, and exclusions.

Any deductibles and copays shown in the chart below are amounts for which **you** are responsible.

Cost of Coverage

BENEFIT	HDHP/HSA PLAN		PPO PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual/Calendar Year Deductible (Individual/Family)	$2,500/$5,000*	$5,000/$15,000	$1,500/$3,000	$5,000/$15,000
Out-of-Pocket Maximum (Individual/Family)	$3,500/$7,000	$15,000/$45,000	$6,000/$12,000	$15,000/$45,000
Lifetime Maximum	Unlimited		Unlimited	
Coinsurance	10%	40%	20%	40%
Physician Services				
Doctor's Office Visit	10% after Deductible	40% after Deductible	$30 Copay	40% after Deductible
Specialist Office Visit	10% after Deductible	40% after Deductible	$60 Copay	40% after Deductible
Preventive Care	100%	40% after Deductible	100%	40% after Deductible
Lab & X-ray Services	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
Hospital Services				
Inpatient	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
Outpatient	10% after Deductible	40% after Deductible	20% after Deductible	40% after Deductible
Emergency Care	10% after Deductible		20% after Deductible	
Urgent Care	10% after Deductible	40% after Deductible	$50 Copay	40% after Deductible
Teladoc	$49 Copay			
Teladoc Psychiatrist Initial Visit	$220 Copay applied to Deductible		$30 Copay	
Teladoc Psychiatrist Ongoing Visit	$100 Copay applied to Deductible		$30 Copay	
Teladoc Non-Psychiatrist Visit	$90 Copay applied to Deductible		$30 Copay	
PRESCRIPTION DRUGS				
Retail (30-day Supply)				
Preventative Generic	$10	N/A	$10	N/A
Generic	10% after Deductible	N/A	$10	N/A
Preferred Brand	10% after Deductible	N/A	$70	N/A
Non-preferred Brand	10% after Deductible	N/A	$110	N/A
Mail Order (90-day Supply)				
Preventative Generic	$20	N/A	$20	N/A
Generic	10% after Deductible	N/A	$20	N/A
Preferred Brand	10% after Deductible	N/A	$140	N/A
Non-preferred Brand	10% after Deductible	N/A	$220	N/A
BI-WEEKLY PAYCHECK DEDUCTIONS				
Employee Only	$52.13		$117.82	
Employee + Spouse	$137.42		$280.66	
Employee + Child(ren)	$108.99		$224.23	
Family	$184.81		$378.66	

NOTE: *Deductibles, copays, and coinsurance accumulate toward the out-of-pocket maximums. Usual, Customary, and Reasonable charges apply for all out-of-network benefits.*

***NOTE:** With dependent or family coverage, 1 member must satisfy a $2,800 deductible with remaining members satisfying $2,200 (IRS regulation).*

Health Savings Account (HSA) — HSA Bank

An HSA is a tax-advantaged account available to those enrolled in the HDHP, and it is funded by you and FCCI. This account can be used to pay for qualified out-of-pocket expenses that you or your dependents incur for medical care. Here are a few other features:

- FCCI makes a generous annual contribution to your account and you have the option to contribute your own pre-tax dollars through bi-weekly payroll deductions.
- HSA funds can be used for your spouse and dependent children, even if they are not covered under your medical plan.
- If HSA funds are used for eligible expenses (medical, rx, dental, and vision) withdrawals are tax free. After age 65, HSA funds can be used for any purpose penalty free (subject to income tax).
- Unused funds can be rolled over and added to your balance for the next year, unused funds are yours to keep even if you leave FCCI.
- HSA funds can be invested through TD Ameritrade or Devenir once you have over $1,000 in your account, adding another tool to that retirement toolbox!

Health Savings Account (HSA) Contribution Limits

ANNUAL MAXIMUM CONTRIBUTIONS			
HSA DESCRIPTION	**EMPLOYEE LIMIT**	**FCCI CONTRIBUTION***	**IRS LIMIT**
Individual	$3,250.00	$600.00	$3,850.00
Individual w Catch-Up**	$4,250.00	$600.00	$4,850.00
EE + Spouse OR Child(ren)	$6,850.00	$900.00	$7,750.00
EE + Spouse OR Child(ren) w Catch-Up**	$7,850.00	$900.00	$8,750.00
Family	$6,550.00	$1,200.00	$7,750.00
Family w Catch-Up	$7,550.00	$1,200.00	$8,750.00

*FCCI Contribution amount is based on January 1st effective date and are deposited with the first payroll of the year. Contributions will be pro-rated for mid-year enrollments and will be deposited with the first payroll following your benefit effective date and enrollment.

**Allowed $1,000.00 Catch-Up for employees 55 or older (includes year turning 55).

Visit **hsabank.com** to login and access your account.

Flexible Spending Accounts — UMR

FSAs help you save money by allowing you to pay for certain types of health care and dependent care expenses on a pre-tax basis. You decide how much money to put aside each payday to cover these expenses up to the maximum.

This amount is then deducted from your pay before taxes and deposited into your FSA. When you need money to cover an eligible expense, you can get reimbursed using a variety of reimbursement methods. Remember to always keep your receipts.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)	
Use for:	Copays, deductibles, orthodontia, over-the-counter medications, etc.
Annual contribution:	$3,050
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)	
Use for:	Day care, nursery school, elder care expenses, etc.
Annual contribution:	$5,000

IMPORTANT: USE IT OR LOSE IT!

According to IRS rules, any money remaining in a Health Care or Dependent Care Spending Account after the grace period for filing claims will be forfeited. It will not roll over into the next plan year. Members can incur expenses through 1/31 following the end of the plan year, with a claim submission deadline of 2/15. This rule applies each subsequent calendar year. Please refer to the plan document for Dependent Care grace period extensions in accordance with the relief provided by the Consolidated Appropriations Act.

Dental Benefits — Delta Dental

Dental coverage is key to your overall health. FCCI offers employees two dental plan options through Delta Dental. Review the details about each plan carefully so you can determine which plan meets your needs. Your dental plans offer choices that cover four main types of expenses:

- Preventive and diagnostic services like routine exams and cleanings, fluoride treatments, sealants, and x-rays
- Basic services such as simple fillings and extractions, root canals, oral surgery, and gum disease treatment
- Major services such as crowns and dentures
- Orthodontia

Cost of Coverage

BENEFIT	BASIC PPO	SELECT PPO
Annual/Calendar Year Maximum	$1,000	$1,500
Annual/Calendar Year Deductible (Individual/Family)	$50/$150	$50/$150
Preventive Services	Plan pays 100% 2 cleanings per year	Plan pays 100% 3 cleanings per year
Basic Services	Plan pays 90%	Plan pays 80%
Major Services	Plan pays 60%	Plan pays 50%
Orthodontia Lifetime Maximum	Not Applicable	$1,500
BI-WEEKLY PAYCHECK DEDUCTIONS		
Employee Only	$0.26	$3.73
Employee + Spouse	$11.55	$17.70
Employee + Child(ren)	$12.98	$19.89
Family	$16.41	$25.14

Vision Benefits — EyeMed

FCCI offers employees two vision plans through EyeMed that include coverage for eye exams and eyeglasses or contact lenses.

Cost of Coverage

BENEFIT	BASIC	BUY-UP
Exam — Available Once Every 12 Months	Plan pays 100% after $15 copay	Plan pays 100% after $15 copay
Lenses (Single, Bifocal, Trifocal, Progressive)	Varies by type: $50, $70, $105, $135	Plan pays 100% after $25 copay
Frames	Discount of 35% off retail	Plan pays 100% up to $150 and 20% off the retail amount over $150
Contact Lenses Instead of Glasses		
Conventional	Discount of 15% off retail	Plan pays 100% up to $120 and 15% off the retail amount over $120
Disposable	Not Applicable	Plan pays 100% up to $120
Medically Necessary	Not Applicable	Plan pays 100%
BI-WEEKLY PAYCHECK DEDUCTIONS		
Employee Only	$0.54	$3.33
Employee + Spouse	$1.09	$6.32
Employee + Child(ren)	$1.28	$6.66
Family	$1.67	$9.78

NOTE: *Refer to plan documents for out-of-network Dental and Vision benefits.*

Income Protection Benefits — Guardian

Basic Life & Accidental Death & Dismemberment (AD&D)

FCCI provides you with Basic Life Insurance and AD&D coverage at 2x basic annual earnings rounded to the next thousand, up to $700,000 maximum.

Dependent Life/Accidental Death & Dismemberment (AD&D)

You can purchase Dependent Life and Accidental Death and Dismemberment coverage for your family. You can elect $10,000 for spouse coverage and $5,000 coverage on each child up to the age of 26 for a biweekly cost of $1.47 for all covered family members.

Short-Term Disability (STD)

FCCI provides you with STD benefits for a qualified non-work related illness or injury that prevents you from working for a period longer than 7 days at no cost to you. Paid disability benefits will lower after a specified time. Refer to table below:

Weeks 2-5	Benefits are paid at 100% of bi-weekly salary
Weeks 6-13	Benefits are paid at 80% of bi-weekly salary and PTO may be used for 20%

Long-Term Disability (LTD)

FCCI provides, at no cost to you, LTD Insurance which pays a monthly benefit in the event you cannot work because of a long-term illness or injury. LTD benefits provide you with 60% of your monthly salary, up to a $14,000 monthly maximum after 90 consecutive days of a qualified non-work related illness or injury. Benefits end upon recovery or at normal Social Security age (whichever comes first).

Employee Assistance Program (EAP)

The WorkLifeMatters Employee Assistance Program, available through Integrated Behavioral Health, provides you and your family members with confidential, personal and web-based support on a wide variety of important and relevant topics — such as stress management, dependent/elder care, nutrition, fitness, and legal and financial issues. Services include, but are not limited to:

Consultative Services

- Telephonic Counseling — unlimited 24/7
- Face-to-face counseling — 3 visits per employee/household member per year
- Bereavement
- Tobacco Cessation Coaching
- College Planning Resources

Work/Life Assistance

- Worklife Services
- Child and Elder Care Referral
- Legal/Financial Assistance

Legal/Financial Assistance

- Legal Consultation
- Financial Consultation
- ID Theft
- Will Prep
- Tax Consultation
- Legal Document Preparation

To access your EAP, visit **https://worklife.uprisehealth.com/**
Username: Matters
Password: wlm70101
Phone: **1-800-386-7055**
Available 24 hours a day, 7 days a week

Voluntary Benefits

Voluntary Life/Accidental Death & Dismemberment (AD&D) — Guardian

You can purchase Supplemental Life coverage for you and your family. Please refer to table below for benefits, and see rate table included in benefit enrollment system.

Yourself:	Increments of $10,000 up to a maximum of $300,000 or 5x salary Guaranteed Issue: $200,000
Your Spouse:	Increments of $5,000 up to a maximum of $150,000 Guaranteed Issue: $50,000 Spouse coverage is limited to 50% of employee volume
Your Child(ren) (Up to the Age of 26):	Flat $10,000

To purchase coverage for your spouse or child(ren), you must enroll yourself for coverage. Please refer to your UKG enrollment or the plan summaries for rates. Statement of Health application may be required if you elect coverage over the guaranteed issue amount or if you enroll after your initial eligibility period. Age reductions may apply to life insurance amounts.

WHAT DOES GUARANTEED ISSUE MEAN?
Guaranteed issue refers to the amount of insurance you may buy without the insurance company requiring you to provide evidence of insurability (EOI), or Statement of Health.

Critical Illness Insurance — Guardian

Critical Illness Insurance is designed to protect your income and personal assets when your out-of-pocket expenses increase as a result of an illness. Health insurance is not always enough to cover all of the unforeseen expenses associated with a serious medical condition like a heart attack or cancer. Critical Illness Insurance pays a lump sum benefit that can be used any way you choose, and benefits are paid in addition to any other insurance coverage you may have.

COVERED ILLNESSES	PAYMENT PERCENTAGES
Heart Attack	100%
Stroke	100%
Invasive Cancer	100%
Kidney Failure	100%
Loss of Hearing	100%

NOTE: *Please refer to Summary Plan Description (SPD) to see full list of benefits and covered illnesses.*

Plan Features

- You do not have to be terminally ill to receive benefits.
- Coverage options are available for your spouse and children as riders to your coverage.
- Coverage is portable — you can take your policy with you if you change jobs or retire.

NOTE: *The policy/certificate of coverage has exclusions and limitations which may affect any benefits payable.*

NOTE: *$50 Annual Wellness Benefit included with Critical Illness and Accident coverage.*

Accident Insurance — Guardian

You don't have to be especially clumsy to experience accidents. These events are all too common, and so are the high medical expenses that come with them.

Accidents are unplanned and unpredictable, but the financial impact that they have on you doesn't have to be either of those things. Voluntary Accident Insurance pays direct benefits for a range of injuries and accident-related expenses such as:

- Fractures
- Dislocations
- Concussion
- Emergency Room Treatment
- Hospitalization
- Accidental Death

Benefit amounts are based on the type of injury and treatment needed. No matter how great your medical plan is, you will have to share the costs of medical care and rehabilitation that follow an accident. Accident Insurance is designed to help you pay for out-of-pocket expenses that insurance doesn't cover, like copays and deductibles, but the benefit payout can be used however you'd like.

Plan Features

No health questions or physical exams are required for enrolling yourself, your spouse or your children in the plan. If you retire or leave FCCI, the plan also offers the option for portability.

NOTE: *The policy/certificate of coverage or its provisions may vary or be unavailable in some states. The policy/certificate of coverage has exclusions and limitations which may affect any benefits payable.*

Hospital Indemnity Insurance — Guardian

If you've ever been in the hospital, you know that it may be difficult to focus on your recovery. You'd rather be in your own bed, eating your own food, and your family might be spending a ton of money to stay at a hotel near you.

The last thing you want to think about is the bill you will receive after your insurance company covers its portion of your hospital stay. Since out-of-pocket costs including deductibles and coinsurance can build quickly, the bills that result from a hospital stay can be overwhelming for anyone — with or without Medical Insurance.

Hospital Indemnity Insurance can help to ease the sticker shock by paying a benefit directly to you (not to the hospital, or to an insurance company) if you or a covered family member has to stay in the hospital. Includes benefits such as:

- Hospital/ICU Admission — $1,000
- Hospital/ICU Confinement — $100/$200 per day

Plan Features

Employees who are newly eligible are able to enroll without answering medical questions, meaning acceptance is guaranteed. The plan includes coverage options for spouses and children, and can be taken with you if you leave FCCI or retire.

NOTE: *The policy/certificate of coverage or its provisions may vary or be unavailable in some states. The policy/certificate of coverage has exclusions and limitations, which may affect any benefits payable. The benefits explained in the example above are for illustrative purposes only. Please see your Summary Plan Description (SPD) for complete details.*

Other Voluntary Benefits

IDShield — Identity Theft Protection

IDShield is an identity theft protection service that includes:

- Continuous Credit Monitoring
- High Risk Application Transaction Monitoring
- Dark Web Monitoring
- Username/Password (Credential Monitoring)
- Identity Threat & Credit Threat Alerts
- Unlimited Consultation on any cyber security issue
- Full-Service Restoration of your identity to pre-theft status
- 24/7 Emergency Access

LegalShield — Legal Assistance

LegalShield membership allows direct access to a dedicated law firm that provides legal advice/consultation. They provide a variety of services including:

- Contract and Document review
- Will Preparation
- Moving Traffic Violation consultation
- IRS Audit Assistance
- Trial Defense
- 25% Preferred Member Discount for bankruptcy, criminal charges, DUI, and others
- 24/7 Emergency Access

PLAN	BI-WEEKLY INDIVIDUAL PRICE	BI-WEEKLY FAMILY PRICE
Legal Shield	$8.75	$8.75
IDShield	$4.13	$8.75
Combined	$12.88	$15.65

IDShield and Legal Shield require enrollment through individual carrier website.

To enroll, visit:
www.legalshield.com/info/fccigroup

Pet Insurance — Trupanion

Your FCCI benefits can protect your furry family too. The Trupanion policy offers one simple plan that pays 90% of diagnostic tests, medications, surgeries, hospital stays and so much more — with no annual or lifetime payout limits. There is a one-time per condition $250 deductible where dogs cost $52.72 per month and cats cost $31.10 per month.

- All dogs and cats younger than 14 years of age can enroll for lifelong coverage
- Coverage begins after waiting periods: 5 days for injuries and 30 days for illnesses
- Visit any veterinary, emergency care, or specialty hospital in the U.S.

Trupanion Pet Insurance requires enrollment through individual carrier website.

Website: trupanion.qualtrics.com/jfe/form/SV_dnFXOfa1nt3dbFz?employer=FCCI1912

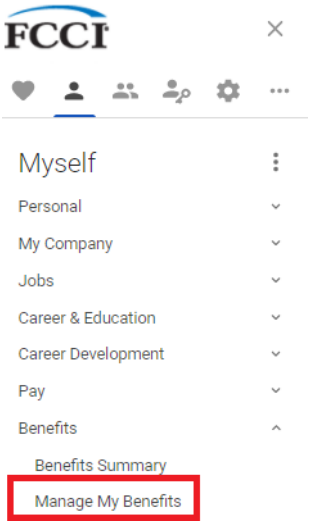
Call: 1-855-235-3134

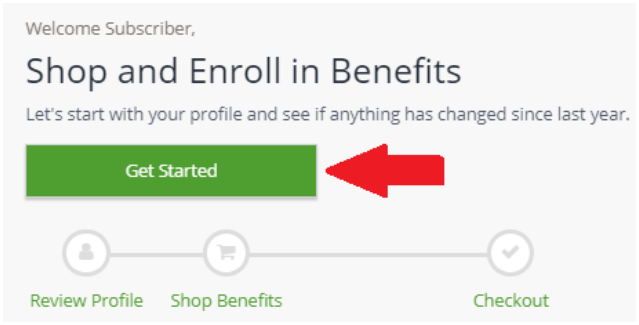
Email: groupbenefits@trupanion.com

How To Complete Your Benefit Enrollment

1. If adding dependents or beneficiaries, have birth dates and social security numbers ready.

2. Log into UKG and navigate to Myself > Benefits > Manage My Benefits. Select **Get Started** or **Update My Benefits** for Life Event Changes.





NOTE: *For mid-year life event changes (e.g. marriage, birth of a child) you will be prompted to select the appropriate life event and date of the event. Remember that you have 30 days from the event to make the change. You will also need to upload supporting documentation of the event (e.g. marriage, birth certificate).*

3. Review your Profile: If you need to make any changes, enter them through the UKG Main Menu — Myself > Personal > Employee Summary. Under **Things I Can Do,** select the item to be changed.

4. Review your Family: Add and remove family members as needed.

5. Shop for Benefits: Complete each survey question and benefit election. **Even if you are not enrolling in a particular benefit, you do need to decline it**. Please read the information on each page and view any videos for helpful information. Select the appropriate benefit plan and coverage tier (i.e. Employee, Employee + Family). Click on the family members that should be covered (uncheck to remove). Click **Update Cart** to finalize election or **Decline**. **Note:** For Open Enrollment of Life Event Changes, click on **View or Change Plan** to make changes to specific benefits.

For company paid benefits (Basic Life, AD&D, Short, and Long-Term Disability), click on **Update Cart** only. You are not able to decline these benefits.

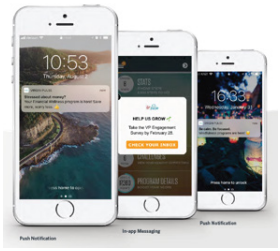
For HSA and FSA accounts, highlight either the Total Annual Contribution or Per Pay Period Contribution, and then enter the desired Personal Contribution based on you highlighted contribution preference.

6. Review and Checkout: Once you have made all of your elections or benefit changes, click on **Review and Checkout**. **You must select or decline all benefits before you can access this step**. Take one final review of your elections before selecting **Checkout** as this will finalize your elections and no changes can be made. Click on **Send by Email** to receive a copy of your enrollment confirmation.

It's Your Time to Thrive!

*FCCI's **FREE** Virgin Pulse wellbeing program gives you the tools to get active, get healthy, and get rewarded through a technology based, interactive, and customizable platform dedicated to a holistic approach to your overall wellness. Take small steps that lead to big changes and rewards!*

How to Begin:



- Create your account – **join.virginpulse.com/FCCI**
- Download the Virgin Pulse mobile app for iOS or Android
- Track your healthy activities
- Participate in challenges with FCCI teammates or individually
- Discover health tips and new ideas for a healthier lifestyle
- Earn reward points for all of the healthy things that you do – including logging in for the first time

Rewards: The more you do, the more you earn!

We're excited to introduce *Virgin Pulse Plus* which allows all FCCI teammates access to these amazing wellness platforms.

RethinkCare

A leading digital training platform for mindfulness, stress resilience, sleep and mental & emotional well-being.

Wellbeats

A premier on-demand fitness provider empowering habit forming, physical and mental health.

Enrich

An award-winning financial wellness program personalized for you based on your financial goals.

Did we mention that you can earn up to $700 annually?

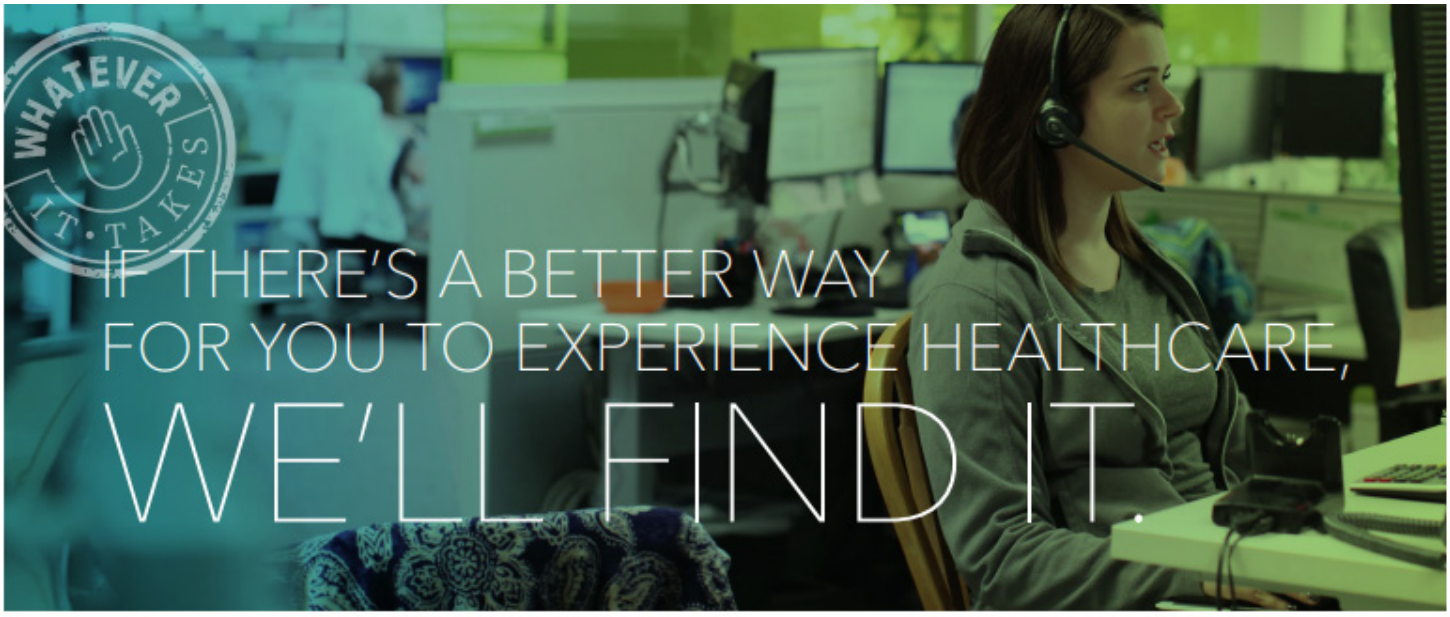
MyQHealth®
by QUANTUM HEALTH

Your first point of contact for everything health care!
Visit fccihealthplan.com or call 1-855-497-1223
Download the app MyQHealth — Care Coordinators

Think of MyQHealth as your personal team of nurses, benefits experts, and claims specialists who will provide personalized support and guidance any time you need assistance with medical claims, health benefits, prescriptions, and so much more — at no additional cost to you. MyQHealth Care Coordinators:

- Answer medical claim, billing, and benefits questions
- Help manage chronic conditions
- Understand how to get the most out of your health benefits
- Search for providers
- Help reduce unnecessary out-of-pocket costs
- Help ensure you receive high-quality, safe, and cost-effective care
- Issue and replace medical ID cards
- Connect you with our other non-medical benefit providers

Don't be surprised if they contact you first! They will begin working with you the minute they are aware that you have begun your own health care journey. Their goal is to help you get the most out of your benefits while simplifying the process.



FCCI INSURANCE GROUP | MyQHealth® by QUANTUM HEALTH

Updated 09/2022

Important Notices

About This Guide

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan descriptions (SPDs), plan document, or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail. FCCI Group reserves the right to make changes at any time to the benefits, costs, and other provisions relative to benefits.

Reminder of Availability of Privacy Notice

This is to remind plan participants and beneficiaries of the FCCI Group Health and Welfare Plan (the "Plan") that the Plan has issued a Health Plan Privacy Notice that describes how the Plan uses and discloses protected health information (PHI). You can obtain a copy of the FCCI Group Health and Welfare Plan Privacy Notice upon your written request to the Human Resources Department, at the following address:

FCCI Group, Human Resources
FCCI Insurance Group, 6300 University Parkway, Sarasota, FL 34240

If you have any questions, please contact the FCCI Group Human Resources Office at **fccibenefits@fcci-group.com**.

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, email **fccibenefits@fcci-group.com**.

Newborns' and Mothers' Health Protection Act Disclosure

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

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted and you will continue to pay the same amount as if you were not absent. If the absence is for more than 31 days and not more than 24 months, you may continue to maintain your coverage under the Plan by paying up to 102% of the full amount of premiums. You and your dependents may also have the opportunity to elect COBRA coverage. Contact the Human Resources Department for more information.

Also, if you elect not to continue your health plan coverage during your military service, you have the right to be reinstated in the Plan upon your return to work, generally without any waiting periods or pre-existing condition exclusions, except for service connected illnesses or injuries, as applicable.

This guide contains important information about the Medicare Part D creditable status of your prescription drug coverage later in this document.

Medicare Part D Notice of Creditable Coverage

Your Options

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

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

1. 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.
2. FCCI has determined that the prescription drug coverage offered by the Medical Plan through UMR 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 through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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 FCCI coverage will be affected. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage:

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through FCCI Group 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**
- Call your State Health Insurance Assistance Program for personalized help. See the inside back cover of your copy of the "Medicare & You" handbook for their telephone number.
- Call **1-800-MEDICARE** (**1-800-633-4227**) TTY users should call **1-877-486-2048**

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at:

- **www.socialsecurity.gov**
- or call: **1-800-772-1213** (TTY: **1-800-325-0778**)

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 1, 2022
Name of Entity/Sender: FCCI
Contact: FCCI Insurance Group
Address: 6300 University Parkway
Sarasota, FL 34240
Phone Number: **1-941-907-7660**

Your ERISA Rights

As a participant in the FCCI Group benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan participants shall be entitled to receive information about their plan and benefits, continue group health plan coverage, and enforce their rights. ERISA also requires that plan fiduciaries act in a prudent manner.

Receive Information About Your Plan and Benefits

You are entitled to:

- Examine, without charge, at the plan administrator's office, all plan documents—including pertinent insurance contracts, trust agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the plan's administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary report of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continued Group Health Plan Coverage

You are entitled to:

- Continued health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have credible coverage from another plan. You should be provided a certificate of credible coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the plan;
  - You become entitled to elect COBRA continuation coverage;
  - You request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plans. The people who operate your plans are called "fiduciaries," and they have a duty to act prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to:

- Know why this was done;
- Obtain copies of documents relating to the decision without charge; and
- Appeal any denial.

All of these actions must occur within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, you may file suit in a federal court if:

- You request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator;
- You have followed all the procedures for filing and appealing a claim (as outlined earlier in this summary) and your claim for benefits is denied or ignored, in whole or in part. You may also file suit in a state court.
- You disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order; or
- The plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. This should occur if the court finds your claim frivolous.

Assistance With Your Questions

If you have questions about how your plan works, contact the Human Resources Department. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office listed on EBSA's website: **https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/regional-offices**.

Or you may write to the:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee and Employer Hotline of the Employee Benefits Security Administration at: **1-866-444-3272**. You may also visit the EBSA's web site on the Internet at: **https://www.dol.gov/agencies/ebsa**.

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 additional 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 (**www.healthcare.gov**). 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." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you 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 happen:

- 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's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility or coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: FCCI Group Human Resources or COBRA Administrator.

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. Any qualified beneficiary who does not elect COBRA within the 60-day election period specified in the election notice **will lose his or her right to elect COBRA**.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's 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.

Continuation Coverage Rights Under COBRA

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.

The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of the date of the Social Security Administration's disability determination; the date of the covered employee's termination of employment or reduction in hours; and the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction in hours. You must also provide this notice within 18 months after the covered employee's termination or reduction in hours in order to be entitled to this extension.

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.

Other Coverage Options

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**.

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 contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at **https://www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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.

Plan Contact Information

For further information regarding the plan and COBRA continuation, please email **fccibenefits@fcci-group.com**.

Summaries of Benefits and Coverage (SBCs)

As required by the Affordable Care Act, Summaries of Benefits and Coverage (SBCs) are available by contacting FCCI. If you would like a paper copy of the SBCs (free of charge), you may also email **fccibenefits@fcci-group.com**.

FCCI 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.

Glossary

Affordable Care Act and Patient Protection (ACA)
Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, reduced FSA contributions, covering preventive care without cost-sharing, etc, among other requirements.

Brand Name Drug
The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

Coinsurance
A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

Copayment (Copay)
A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Deductible
The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Employer Contribution
Each month, the company provides you with an amount of money that you can apply toward the cost of your health care premiums. The amount of the employer contribution depends on who you cover. You can see the amount you'll receive when you enroll. If you're enrolling as a new hire, the employer contribution amount will be prorated based on your date of hire.

Generic Drug
Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)
High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

Health Savings Account (HSA)
A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

Out-of-Pocket Maximum
The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

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, 2022. Contact your state for more information on eligibility –

1. ALABAMA – Medicaid
   Website: http://myalhipp.com/
   Phone: 1-855-692-5447
2. ALASKA – Medicaid
   The AK Health Insurance Premium Payment Program
   Website: http://myakhipp.com/
   Phone: 1-866-251-4861
   Email: CustomerService@MyAKHIPP.com
   Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
3. ARKANSAS – Medicaid
   Website: http://myarhipp.com/
   Phone: 1-855-MyARHIPP (1-855-692-7447)
4. CALIFORNIA – Medicaid
   Health Insurance Premium Payment (HIPP) Program
   Website: http://dhcs.ca.gov/hipp
   Phone: 1-916-445-8322
   Fax: 1-916-440-5676
   Email: hipp@dhcs.ca.gov
5. COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
   Health First Colorado Website: https://www.healthfirstcolorado.com/
   Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
   CHP+: 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
6. FLORIDA – Medicaid
   Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
   Phone: 1-877-357-3268
7. GEORGIA – Medicaid
   GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
   Phone: 1-678-564-1162, Press 1
   GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra
   Phone: 1-678-564-1162, Press 2
8. INDIANA – Medicaid
   Healthy Indiana Plan for low-income adults 19-64
   Website: http://www.in.gov/fssa/hip/
   Phone: 1-877-438-4479
   All other Medicaid
   Website: https://www.in.gov/medicaid/
   Phone 1-800-457-4584
9. IOWA – Medicaid and CHIP (Hawki)
   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
10. KANSAS – Medicaid
    Website: https://www.kancare.ks.gov/
    Phone: 1-800-792-4884
11. KENTUCKY – 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
12. LOUISIANA – 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)
13. MAINE – Medicaid
    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: 1-800-977-6740
    TTY: Maine relay 711
14. MASSACHUSETTS – Medicaid and CHIP
    Website: https://www.mass.gov/masshealth/pa
    Phone: 1-800-862-4840 TTY: 1-617- 886-8102
15. MINNESOTA – 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
16. MISSOURI – Medicaid
    Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
    Phone: 1-573-751-2005
17. MONTANA – Medicaid
    Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
    Phone: 1-800-694-3084
    Email: HHSHIPPProgram@mt.gov
18. NEBRASKA – Medicaid
    Website: http://www.ACCESSNebraska.ne.gov
    Phone: 1-855-632-7633
    Lincoln: 1-402-473-7000
    Omaha: 1-402-595-1178
19. NEVADA – Medicaid
    Medicaid Website: http://dhcfp.nv.gov
    Medicaid Phone: 1-800-992-0900
20. NEW HAMPSHIRE – Medicaid
    Website: : https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
    Phone: 1-603-271-5218
    Toll free number for the HIPP program: 1-800-852-3345, ext 5218
21. NEW JERSEY – Medicaid and CHIP
    Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
    Medicaid Phone: 1-609-631-2392
    CHIP Website: http://www.njfamilycare.org/index.html
    CHIP Phone: 1-800-701-0710
22. NEW YORK – Medicaid
    Website: https://www.health.ny.gov/health_care/medicaid/
    Phone: 1-800-541-2831
23. NORTH CAROLINA – Medicaid
    Website: https://medicaid.ncdhhs.gov/
    Phone: 1-919-855-4100
24. NORTH DAKOTA – Medicaid
    Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
    Phone: 1-844-854-4825
25. OKLAHOMA – Medicaid and CHIP
    Website: http://www.insureoklahoma.org
    Phone: 1-888-365-3742
26. OREGON – Medicaid
    Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html
    Phone: 1-800-699-9075
27. PENNSYLVANIA – Medicaid
    Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
    Phone: 1-800-692-7462
28. RHODE ISLAND – Medicaid and CHIP
    Website: http://www.eohhs.ri.gov/
    Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)
29. SOUTH CAROLINA – Medicaid
    Website: https://www.scdhhs.gov
    Phone: 1-888-549-0820
30. SOUTH DAKOTA – Medicaid
    Website: http://dss.sd.gov
    Phone: 1-888-828-0059
31. TEXAS – Medicaid
    Website: http://gethipptexas.com/
    Phone: 1-800-440-0493
32. UTAH – Medicaid and CHIP
    Medicaid Website: https://medicaid.utah.gov/
    CHIP Website: http://health.utah.gov/chip
    Phone: 1-877-543-7669
33. VERMONT – Medicaid
    Website: http://www.greenmountaincare.org/
    Phone: 1-800-250-8427
34. VIRGINIA – Medicaid and CHIP
    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
35. WASHINGTON – Medicaid
    Website: https://www.hca.wa.gov/
    Phone: 1-800-562-3022
36. WEST VIRGINIA – Medicaid and CHIP
    Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/
    Medicaid Phone: 1-304-558-1700
    CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699- 8447)
37. WISCONSIN – Medicaid and CHIP
    Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
    Phone: 1-800-362-3002
38. WYOMING – Medicaid
    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, 2022, 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

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