2022-2023

EMPLOYEE BENEFITS GUIDE

RESEARCH CORPORATION

Welcome to your 2022- 2023 Employee Benefits!

West Virginia University Research Corporation recognizes the important role employee benefits play as a critical component of your overall compensation. We strive to maintain a benefits program that is competitive within our industry and designed to protect your health, your family, and your way of life.

This guide was created to answer some of the questions you may have and provide the tools and resources you will need to take full advantage of the programs and plans being offered. Please read it carefully along with any supplemental materials you receive.

For any questions about the benefits outlined in the guide, please contact your Human Resources Department.

What's Inside

PLEASE NOTE: This booklet provides a summary of the benefits available but is not your Summary Plan Description (SPD). Your company reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans since the written descriptions in the insurance contracts or plan documents will always govern.

Carrier Contacts

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. Follow these steps if you require assistance:

- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.
- For claims assistance, please contact the insurance carrier. You will need your ID number or Social Security number along with date of service and provider name.

West Virginia University Research Corporation Carriers	Group #	Website	Phone
Medical			
Highmark	0910-3950, 0980-3222	www.highmarkbcbswv.com	1.888.809.9121
Health Savings Account			
Highmark	0980-3222	www.highmarkbcbswv.com	1.888.809.9121
Dental			
Principal	1133645-10001	www.principal.com	1.800.843.1371
Vision			
Principal	1133645-10001	www.principal.com	1.800.843.1371
Basic Life and AD&D			
Principal	1133645-10001	www.principal.com	1.800.843.1371
Voluntary Life			
Principal	1133645-10001	www.principal.com	1.800.843.1371
Short-Term Disability			
Principal	1133645-10001	www.principal.com	1.800.843.1371
Long-Term Disability			
Principal	1133645-10001	www.principal.com	1.800.843.1371
Dependent Flexible Spending Account			
The Health Plan		https://cds.healthplan.org	1.855.577.7123
Hospital Indemnity, Critical Illness			
Guardian	00564651	www.guardianlife.com	1.888.482.7342 Option 3

Eligibility

West Virginia University Research Corporation shares in the cost by paying for a portion of the employee and dependent health insurance costs. Dependents are eligible to participate in the health & welfare plan. Your completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

Any elections made will remain in effect and cannot be changed or revoked until the next annual Open Enrollment period unless the change is due to and consistent with a family/life status change.

Who is eligible for Benefits?

- For new employees working 30 hours per week, benefits begin on the first of the month following date of hire.
- All current employees working 30 hours per week.

Eligible Dependents

- A spouse whom you are legally married
- A dependent child under the age of 26. Coverage terminates at the end of the month of the dependents 26th birthday

Coverage for eligible dependents generally begins on the same day your coverage is effective.

**Additional carrier conditions may apply.*

Please Note: If you cover an individual on your benefit plan who is not an eligible dependent, this is considered fraud and theft. Claims may be reprocessed and become your responsibility. Providing false statements regarding Tobacco usage is against company policy. Anyone found providing false statements will be subject to discipline up to and including termination of employment.

Benefit Change in Status

West Virginia University Research Corporation sponsors a cafeteria plan which allows eligible employees to choose from a menu of different benefits to suit their needs and to pay for some or all of those benefits with pre-tax dollars.

Participant elections made under a cafeteria plan are generally irrevocable and run from the beginning of the Plan Year (or date of initial eligibility) through the end of the Plan Year. With the exception of HSA contribution elections, you will not be able to change or revoke your elections during the Plan Year unless you experience an IRS permitted qualifying event. Any change you make must be consistent with the qualifying event. Examples of qualifying events that may entitle you to make a mid-year change in your election during a Plan Year, include:

- Birth / Adoption
- Divorce
- Death
- FMLA Related Leave
- Dependent Child Age Limit
- Marriage
- Loss of Coverage
- Eligible for Medicare

Employers do not have to permit any exceptions to the election irrevocability rule for cafeteria plans. Please consult your Plan Administrator for the specific qualifying events permitted by your plan.

You must notify your Human Resources Department within 30 days from the date of your qualifying event in order to make a change in your benefit selections.

Medical Insurance

Highmark medical plans offer freedom of choice with access to a large national network of physicians, hospitals and health care professionals (clinics, labs, care centers, etc.). To find a network provider, visit www.highmarkbcbswv.com or call Toll-Free 1.888.809.9121.

Get the most out of your Highmark benefit plan, register online and take advantage of the easy-to-use tools and resources available to members.

Super Blue Plus 2000[1] WVHTC – Option 2B (Non-Grandfathered) $250 Deductible *Group #: 0910-3950*			
	In-Network		Out of Network
Deductible *(Individual / Family)*	$250 / $500		$500 / $1,000
Coinsurance Limit	$1,250 / $2,500		$2,500 / $5,000
Out of Pocket Maximum *(Individual / Family)*	$6,600 / $13,200		Unlimited
Physician Office Visits – Primary Care	BDTC $20 copay, 0% thereafter, No Deductible	Non-BDTC $25 copay, 0% thereafter, No Deductible	$25 copay, 20% thereafter, No Deductible
Physician Office Visits – Specialist	$35 copay, 0% thereafter, No Deductible		$35 copay, 20% thereafter, No Deductible
Telemedicine Visits	$10 copay, 0% thereafter, No Deductible		Not Covered
Preventive Care	0%		40% after Deductible
Emergency Room Services	$150 copay per visit 0% thereafter No Deductible		
Urgent Care Copay	$50 copay, 0% thereafter – visit only		$50 copay, 20% thereafter – visit only
Inpatient & Outpatient Professional Services	Deductible, 20% thereafter		Deductible, 40% thereafter
Outpatient Surgery Hospital / Alternative Care Facility	Deductible, 20% thereafter		Deductible, 40% thereafter
Prescription Drugs			
Retail 34-day supply	**Generic/Brand:** Member pays 30% or $20 Minimum Coinsurance, whichever is greater. No Deductible. Maximum out of pocket $100 **Specialty Drugs:** Member pays 30% Coinsurance, No Deductible. Maximum out of pocket $200 Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a 30-day supply		No Benefits
Mail Order 90-day supply	**Generic/Brand:** Member pays 30% or $20 Minimum Coinsurance, whichever is greater. No Deductible. Maximum out of pocket $100 **Specialty Drugs:** Member pays 30% Coinsurance, No Deductible. Maximum out of pocket $200 Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a 30-day supply		No Benefits
Employee Payroll Deductions (24 Pays)			
Employee	$108.53		
Employee + Spouse or Child	$334.85		
Employee + Children / Family	$384.29		

Medical Insurance *continued...*

	Super Blue Plus QHDHP[1] HDHP Mix Emb 80% *Group #: 0980-3222*	
	In-Network	Out of Network
Deductible *(Individual / Family)*	$1,500 / $3,000	$6,000 / $12,000
Coinsurance Limit	$3,500/ $7,000	$6,000 / $12,000
Out of Pocket Maximum *(Individual / Family)*	$5,000 / $10,000 (Max $6,550 for one person)	Unlimited
Physician Office Visits – Primary Care	Deductible, 20% thereafter	Deductible, 40% thereafter
Physician Office Visits – Specialist	Deductible, 20% thereafter	Deductible, 40% thereafter
Telemedicine Visits	Deductible, 20% thereafter	No Benefits
Preventive Care	0%, No Deductible	Deductible, 40% thereafter
Emergency Room Copay	Deductible, 20% thereafter	Deductible, 20% thereafter
Urgent Care Copay	Deductible, 20% thereafter	Deductible, 40% thereafter
Inpatient & Outpatient Professional Services	Deductible, 20% thereafter	Deductible, 40% thereafter
Outpatient Surgery Hospital / Alternative Care Facility	Deductible, 20% thereafter	Deductible, 40% thereafter
Prescription Drugs		
Retail 34-day supply	Deductible, 20% thereafter Cost sharing for Prescription Insulin Drugs will not exceed $100 for a 30-day supply (deductible does not apply)	No Benefits
Mail Order 90-day supply	Deductible, 40% thereafter Cost sharing for Prescription Insulin Drugs will not exceed $100 for a 30-day supply (deductible does not apply)	No Benefits
Employee Payroll Deductions (24 Pays)		
Employee	$0.00	
Employee + Spouse or Child	$74.29	
Employee + Children / Family	$106.60	

Health Savings Account

What is a High Deductible Health Plan

Sometimes referred to as consumer-driven health insurance, a HDHP still covers you for catastrophic illness and injury—what health insurance was originally intended to do.

Office visits and prescription drugs are subject to the deductible. This means you pay a negotiated discount price instead of a fixed co-pay until you reach your deductible.

What is a Health Savings Account (HSA) and how does it work?

A Health Savings Account is a tax-advantaged trust account that allows you to put away tax-free dollars to help pay for your eligible healthcare expenses including medical, prescription drugs, dental, vision, certain premium expenses like COBRA and Medicare premiums, etc., both today and in the future.

The 2022 maximum annual contribution to an HSA is $3,650 for single coverage and $7,300 for family coverage. The IRS determines the contribution maximums annually.

Advantages of an HSA

- Money you put into your account is deducted pretax therefore reducing your taxable income.
- Money that stays in your account earns tax-free interest.
- Money you pay from your account to pay for your qualified healthcare expenses is not taxed.
- Money rolls over from year-to-year – no “use it or lose it” restriction.

Who is eligible for an HSA?

- You must be enrolled in a qualified High Deductible Health Plan (HDHP).
- You cannot be covered by any other health plan that is not a qualified HDHP (certain exceptions). Disqualifying health plans include general-purpose health FSAs and HRAs provided by your employer or your spouse’s employer.
- You cannot be enrolled in Medicare, Social Security or received VA benefits at any time over the past 3 months.
- You cannot be claimed on another person’s tax return.

Basic Benefits of the High Deductible Health Plan

- Visits to any doctor or facility for covered service, just as usual.
- Your plan includes deductibles, coinsurance and a limit on what you pay out-of-pocket.
- Annual routine preventive care services are included in your plan. You generally do not pay for these services; not even an office visit co-pay.
- Certain Preventive Prescriptions are also included. On these the deductible is waived and you only pay the coinsurance.

When do I use my HSA?

- After visiting a physician, facility, or pharmacy, your medical claim will be submitted to your HDHP for payment. Your HSA dollars can be used to pay your out-of-pocket expenses (deductibles and coinsurance) billed by the physician, facility, or pharmacy, or you can choose to save your HSA dollars for a future medical expense. In addition, HSA dollars are available to pay for dental, vision and other expenses as well.

How does the HDHP Deductible Work?

Under the HDHP, your annual deductible and out-of-pocket maximum includes both medical and pharmacy expenses. All expenses are your responsibility until the deductible is reached (except qualified preventive care). For family coverage, expenses are your responsibility until the entire family deductible is satisfied. One or more persons may satisfy the family deductible.

How are benefits covered after the deductible is satisfied?

Once you have satisfied the in-network deductible, remaining qualified expenses are covered by the HDHP plan at 80% up to the out-of-pocket maximum.

How does the HDHP work if I go out-of-network?

Out-of-network coverage is covered in the same manner as it is today under your current PPO plans. You must satisfy the out-of-network deductible then expenses are covered at the out-of-network coinsurance level of 60%.

Can ineligible expenses be reimbursed from an HSA?

Ineligible disbursements from an HSA are subject to a 20% penalty. Neither the trustee, bank, insurance company nor your company are required to determine if a claim submitted for reimbursement is a qualifying medical expense.

The employee is responsible to include the amount withdrawn from an HSA for a non-qualifying medical expense is added to the account beneficiary’s income and subject to a 20% penalty. Where funds are distributed as a result of the account beneficiary’s death, disability, or after he or she is eligible for Medicare, the 20% penalty does not apply.

Why should I elect an HSA?

- Tax Benefits
  - ✓ HSA contributions are excluded from federal income tax
  - ✓ Interest earnings are tax-deferred
  - ✓ Withdrawals for eligible expenses are exempt from federal income tax
- Unused money is held in an interest-bearing savings or investment account
- Lower employee contribution
- Company contribution

Long-Term Financial Benefits

- Save for future medical expenses
- Funds roll over year to year
- This is your account, you take it with you if your employment at the company ends.

Choice

- You control and manage your healthcare expenses.
- You choose when to use your HSA dollars to pay for your healthcare expenses.
- You choose when to save your HSA dollars and pay healthcare expenses out of pocket.

The Basics

of a Health Savings Account

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Pay for health care costs now and save for the future.

A Health Savings Account — or HSA — pairs perfectly with a qualified high-deductible health plan. While you'll have a low monthly premium, the HSA helps you pay for deductible expenses that may occur. It will cover costs for things like medical, dental and vision costs, prescriptions, and certain over-the-counter items.

The best part?

HSA funds roll over year after year, so they're available when you need them. Not to mention, it's simple to use and offers big long-term financial benefits. Just take a look.

TAX-FREE SAVINGS

Your money can go into the HSA tax free, earns interest tax free, and comes out tax-free.* Talk about a trifecta.

EASY TO USE

An HSA comes with a debit card. When it's time to pay for qualified medical expenses, just give it a swipe and you're good-to-go.

STAYS WITH YOU

Get a new job? Change health plans? Retire? No problem. An HSA is always **your** account – so your funds stay with you. And, since the money rolls over, funds are accessible no matter what.

FAMILY FRIENDLY

An HSA can be used for qualified medical expenses for you and your dependents. That's right – it's good for the whole family.

LONG-TERM BENEFITS

Once your HSA hits a certain balance, you can invest in mutual funds — a great way to prepare, plan, and pay for medical expenses in retirement. Your future self will thank you.

EASY ACCESS

The HSA app and member website give you quick access to your HSA information. You can even sign up for text or email alerts. And, if you need a hand with something, just call the Member Service team.

Ready to learn more?

Visit HighmarkSpendingAccounts.com for helpful videos, a tax savings calculator, an eligible expenses list, and other HSA details.

*Not all states follow federal tax rules with respect to contributions made to HSAs. Please consult your tax advisor to determine the extent to which these contributions may be subject to state income tax and wage withholding rules.

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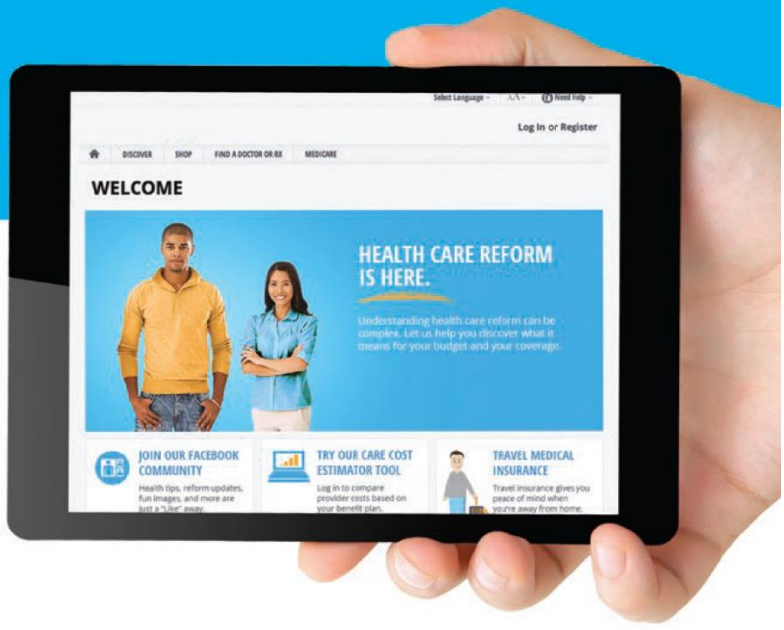
HOW TO REGISTER ON YOUR MEMBER WEBSITE

JUST A FEW CLICKS AND YOU ARE CONNECTED!



1. Go to **highmarkbcbswv.com**.
2. Click on **Register**.

DURING REGISTRATION, YOU WILL BE ASKED TO PROVIDE:

- Your member ID number (enter numbers only; no spaces, no letters)
- Your first and last name
- Your date of birth
- Your relationship to the policyholder
- Your address
- Your email address

You will also need to choose a user login ID and password, and then re-enter that password.

YOU ARE NOW REGISTERED TO USE YOUR MEMBER WEBSITE. HERE'S WHAT YOU CAN DO:

- Check the status of a claim
- View your explanation of benefits (EOB)
- Request eDelivery (No more paper copies of EOBs)
- Request ID cards
- Locate providers
- Check Rx history
- Access health reference tools

If you need help registering, please call 1-866-306-1059.

Highmark Blue Cross Blue Shield West Virginia is an independent licensee of the Blue Cross and Blue Shield Association.

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

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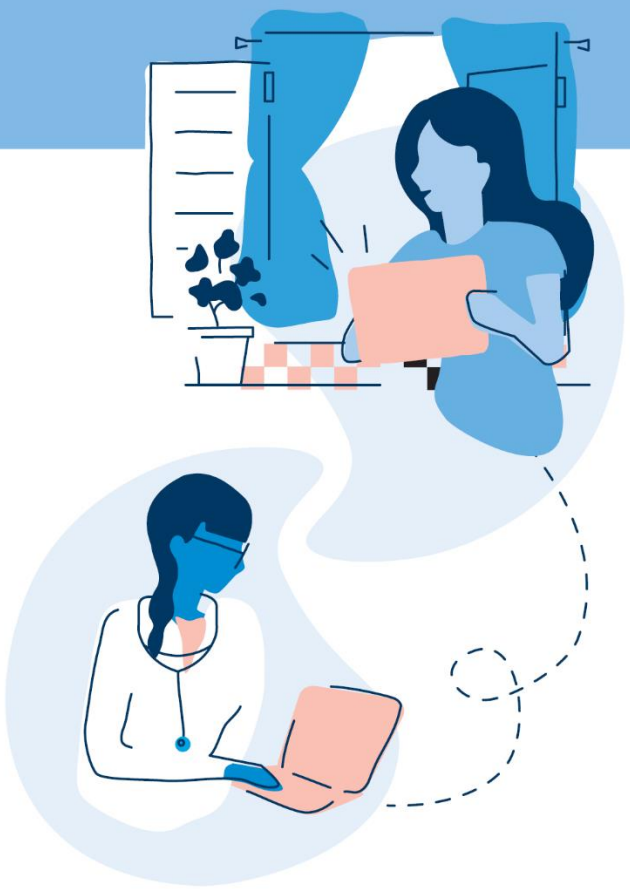
Let the care come to you



Get quality care from the comfort of home with telemedicine.

With telemedicine, you have access to your doctor's office from your phone, tablet, or computer. Your doctor can treat most non-emergency illnesses and, in some cases, they can even prescribe medications. Pretty great, right? That's not all. Take a look:

Perks of telemedicine

- **It's safe.** No more sitting elbow-to-elbow in waiting rooms.
- **It's affordable.** A telemedicine visit will likely cost the same as a normal visit to the doctor.
- **It's convenient.** Save yourself a trip to the doctor's office and chat with your provider from the comfort of your couch.
- **It's accessible.** You can receive care from just about anywhere via video or phone.
- **It's versatile.** From a bad case of the sniffles to the seasonal flu, telemedicine can treat a variety of non-emergency health conditions.

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Your telemedicine options

We want you to receive care in a way that's convenient and comfortable for you, which is why we give you access to telemedicine through your doctor's office or through a vendor. Though both of these options could work for you, there are specific perks to each that you may want to consider.

Telemedicine through your doctor's office

- You'll be chatting with someone you already know, which is sure to put your mind at ease.
- Your doctor is familiar with your medical history, which means your condition may be easier to diagnose.
- You can replace simple in-office follow-ups with your doctor with a convenient and quick telehealth appointment.
- Keep in mind that telemedicine may not be available to you, so make sure to check with your health care provider.

Telemedicine through a vendor

- When you use a vendor such as American Well (AmWell for short), you have access — day or night, seven days a week — to U.S. licensed, board-certified doctors.
- Setting up a telehealth appointment is quick and only takes a few steps.

How to get started with telemedicine

Contact your doctor to learn about the telemedicine options that are available to you.

If your doctor's office doesn't offer telemedicine services, **visit AmWell.com** and create an account using your member ID card.

From there, you'll be on your way to more convenient and comfortable care.

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Dependent Flexible Spending Account

WVU Research Corporation
December 1, 2022 – November 30, 2023

Your Dependent Flexible Spending Account (DFSA) Snapshot

You have 90 days post DFSA plan year to submit reimbursement requests for payment from your DFSA.

Dependent Flexible Spending Account	**DFSA Maximum Declared Amount**
Annual Contribution to Employee Dependent FSA	**$5,000**

- Your balance can only be used as it is deducted from your paycheck
- No claim minimum
- Funds may be used for child or elderly dependent care expenses

✓ Day Care-IRS qualified
✓ Nursery & Pre School Care
✓ In home Care
✓ After School Care

If you leave the Company

If you are no longer employed, your Dependent FSA benefit is limited to funds already deducted from your pay.

Owned by employer

- All un-used (DFSA) amounts at year-end are forfeited back to the employer.

Dental Insurance

With Principal you have freedom of choice when selecting a dentist. To find a participating dentist in the Principal network, visit www.principal.com or call 1.800.843.1371.

High Plan	Network	Out of Network
Deductible	$50 Single / $150 Family	
Maximum Benefit	$1,500	
Preventive Services • *Routine Exams & Cleanings - once per 6 months* • *Bitewing X-rays - once per calendar year* • *Full mouth X-rays - once every 60 months* • *Fluoride & Sealants - once per calendar year (dependent children under age 16)* • *Emergency exams - once per 6 months*	Covered in Full, deductible waived	Covered in Full, deductible waived
Basic Services • *Periodontal maintenance - if 3 months have passed since active surgical periodontal treatment; subject to Routine cleaning frequency limit* • *Fillings - covered once every 24 months* • *Simple oral surgery (simple extractions)* • *Complex oral surgical procedures (impacted teeth)* • *General anesthesia / IV sedation (covered only for specific procedures)* • *Endodontics- root canal therapy* • *Non-surgical periodontics, including scaling and root planing - once per quadrant per 24 months* • *Periodontal surgical procedures - once per quadrant per 36 months*	80%, subject to deductible	80%, subject to deductible
Major Services • *Crowns - each 120 months per tooth* • *Core buildup - each 120 months per tooth* • *Implants - each 120 months* • *Bridges (initial placement / replacement) - 120 months old* • *Dentures (initial placement / replacement) - 60 months old*	50%, subject to deductible	50%, subject to deductible
Orthodontic Services *(dependent children to the end of the month in which they turn 19)*	50%, deductible waived	50%, deductible waived
Orthodontia Lifetime Maximum	$1,500	

Employee Payroll Deductions (24 Pays)	
Employee	$9.73
Employee + Family	$29.56

Vision Insurance

West Virginia University Research Corporation provides employees with vision coverage through Principal. The Principal vision plan provides rich, flexible vision plans covering exams and materials, making it more affordable to keep your eyes healthy. For more information or to locate a participating provider please visit www.principal.com or call 1.800.843.1371.

	Network	Out of Network
Routine Eye Exam *(every 12 months)*	$10 copay	Up to $45
Eyeglass Frames *(every 12 months)*	$130 frame allowance	Up to $70
Standard Plastic Lenses		
Single	$25 Copay	Up to $30
Bifocal		Up to $50
Trifocal		Up to $65
Lenticular		Up to $100
Contact Lenses *(every 12 months)*	In lieu of eye glasses	
Contact Lens Fit & Follow-up	$60 copay	N/A
Elective Contacts	$130 allowance	Up to $105
Medically Necessary	Covered in Full after $25 copay	Up to $210

Employee Payroll Deductions (24 Pays)	
Employee	$1.53
Employee + Spouse or Child	$3.58
Employee + Children / Family	$3.58

Basic Life and AD&D Insurance

West Virginia University Research Corporation provides Basic Life and AD&D in the amount of 100% of your annual salary to a maximum of $165,000. There is no cost to you for this coverage. Coverage reduces 35% upon the person's attainment of age 70, with an additional 20% at age 75.

Voluntary Life

In addition to the provided life insurance, you may also purchase additional life insurance coverage through Principal for yourself, your spouse, and your dependent children.

Voluntary Life	
Employee Benefit	Increments of $10,000 up to a maximum of $300,000 Guarantee Issue - $100,000 under age 70, $10,000 age 70 or older. Coverage reduces 35% upon the person's attainment of age 65, with an additional 15% at age 70.
Spouse Benefit	Coverage is available in $5,000 increments up to a maximum of $150,000 (cannot exceed 100% of the employee's coverage amount) Guarantee Issue - $30,000 under age 70, $10,000 age 70 or older. Coverage reduces 35% upon the person's attainment of age 65, with an additional 15% at age 70.
Child Benefit	$10,000

Group life insurance

Easily get life insurance during open enrollment

Then gradually increase your coverage every year.

Protecting the people who mean the most to you is important. That's why Principal® makes it easy for you to purchase—or increase—voluntary term life insurance. It's available through your employer for yourself, your spouse, and children.

Increase your voluntary term life insurance

Open enrollment is a great time to increase your coverage. You can add an additional $10,000 or $20,000[1] in coverage for yourself—with no health questions asked. That means no medical appointments and quick approval. And every year during open enrollment, you can continue to increase your coverage—up to the maximum benefit. If you have coverage for yourself, you can also add or increase coverage for your spouse and children[2]—with no health questions asked.

Purchase coverage for the first time

Don't already have voluntary term life insurance? Easily get coverage for the first time during open enrollment. You can purchase $10,000 or $20,000[1] in coverage for yourself—with no health questions asked. And when you have coverage, your spouse and children[2] can also get coverage.

Higher levels of coverage

During open enrollment, you or your spouse[2] can request to add or increase even more coverage by providing proof of good health.

Let's look at an example

When Valerie started working for her employer, she didn't purchase voluntary term life insurance. A few years later, she bought a house and saw the need for coverage. She purchased $20,000 in coverage for herself during her company's open enrollment—and has plans to increase her coverage by $10,000 each year after that. She also bought $10,000 of coverage for her spouse and an additional $5,000 for her children.

Short-Term Disability Insurance

Principal short-term disability insurance pays a portion of your earnings if you cannot work due to a non-work-related illness or injury. You must meet the definition of disability for benefits to be payable.

Short-Term Disability	
Benefits Begin	8th Day after accident or illness
Maximum Benefit Duration	Up to 12 weeks
Maximum Benefit You Receive	66 2/3% of weekly salary to a max of $1,000

Long-Term Disability Insurance

West Virginia University Research Corporation also offers full-time employees long-term disability income benefits. In the event you become disabled from a non-work-related injury or sickness, disability income benefits can represent a source of income.

Long-Term Disability - All members (annual salary $80,000 or less)	
Benefits Begin	90 days
Maximum Benefit Duration	Under 65 - Social Security Normal Retirement Age (SSNRA) or 36 months Age 65-67 – SSNRA or 24 months Age 68-69 – SSNRA or 18 months Age 70-71 – SSNRA or 15 months Age 72+ - SSNRA or 12 months
Percentage of Income Replaced	66 2/3% of your earnings to a maximum of $8,000

Long-Term Disability - All members (annual salary greater than $80,000)	
Benefits Begin	90 days
Maximum Benefit Duration	Under 65 - Social Security Normal Retirement Age (SSNRA) or 36 months Age 65-67 – SSNRA or 24 months Age 68-69 – SSNRA or 18 months Age 70-71 – SSNRA or 15 months Age 72+ - SSNRA or 12 months
Percentage of Income Replaced	66 2/3% of your earnings to a maximum of $10,000

Hospital Indemnity

The Hospital Indemnity plan will pay you a lump-sum benefit you can use as you feel necessary. This can supplement existing medical coverage and help provide financial support to pay for out-of-pocket expenses such as deductibles, co-payments, and non-covered medical services.

Benefit Overview	
Hospital Admission (3x per Year)	$500/Day
Hospital Confinement (31 Days)	$100/Day
Health Screenings	$50
Dependent Age Limits	Childbirth to 26 years

Critical Illness

The Critical Illness policy will pay you a lump sum benefit upon the diagnosis of a covered critical illness. Critical Illness insurance can help with expenses that medical insurance does not cover like deductibles or out-of-pocket costs, or services like experimental treatment. The lump sum benefit is paid when you need it the most, upon diagnosis, so you can rest assured that you will have funds to offset upcoming out-of-pocket expenses.

Benefit Overview	1st Occurrence	2nd Occurrence
Benefit Amount	Employee: Lump sum increments of $5,000 Spouse: Up to 50% of member's benefit increments of $2,500 up to $10,000 Child: 25% of Member's benefit to a maximum of $5,000	
Heart Attack / Stroke	100%	50%
Organ Failure (Refer to policy details)	100%	50%
Kidney Failure (Refer to policy details)	100%	50%
ALS (Lou Gehrig's Disease)	100%	N/A
Coma	100%	N/A
Loss of Hearing, Sight or Speech	100%	N/A
Parkinson's Disease	100%	N/A
Severe Burns	100%	N/A

Your life's journey—made easier

No matter where you are on your journey, there are times when a little help can go a long way. From checking off daily tasks to working on more complex issues, your program offers a variety of resources, tools and services available to you and your household members.

Your program is here to help you along the journey of life. No situation is too big or too small. When you and your household members need assistance, reach out anytime and we will help get you on the right path to meet your needs.

Key features

- Provided at no cost
- Includes up to 5 counseling sessions
- Confidential service provided by a third party
- Available 24/7/365

Core services

Counseling—Help for challenges such as anxiety, grief, depression, relationships and more. Meet with a counselor in-person, by text message, live chat, phone or video.

Coaching—Set, define and reach your goals with the help of a coach. Receive individualized support to handle work stress, parenting, weight loss and more.

Online programs—Self-guided, interactive programs help improve your emotional well-being.

Here's how to get started

Give us a call and we will connect you with the right resource or professional.

Visit MagellanAscend.com to browse all of the services available.

Work-Life Web Services

Save time and money on life's most important needs. Access webinars, live talks and articles that offer insights and strategies focused on key life events and day-to-day challenges for parents and seniors. Topics include: child and elder care, education, parenting and more.

Legal assistance, financial coaching & identity theft resolution

Expert consultation to help with your legal, financial and identity theft needs. Access a free online library with resources for identity theft resolution, budgeting, debt management, family law, wills and more.

Smoking cessation

You may have tried to quit in the past without success. Now, you can quit using an innovative mobile app. Designed with clinically-driven technology, the app helps you create and stick to a quit plan and overcome nicotine cravings. Get the boost you need to quit for good.

Employee Assistance Program

Up to 5 in-person sessions per concern

1-800-356-7089

TTY Users: 1-800-456-4006

To access MagellanAscend.com, enter company name

B-F1144rev3 (8/20)

Magellan HEALTHCARE®

Magellan HEALTHCARE®

Legal assistance, financial coaching, identity theft resolution

Help for simple to complex problems

When you or your household members need help with legal, financial or identity theft issues you can talk to an expert or research the matter using the extensive array of personal services and education.

☑ Legal assistance

- Free 60-minute consultation per issue, per year on the phone or in person
- Discounted fees for services needed beyond 60 minutes
- Online tools, education and resources for help with:
  - Divorce
  - Real estate
  - Taxes and audits
  - Trusts
  - Wills

☑ Financial coaching

- Two free 30-minute telephone consultations per issue, per year
- Discounted fees if you elect to continue working with a financial coach beyond initial consultations
- Online tools, education and resources for help with:
  - Budget planning
  - Debt and credit
  - College and retirement planning
  - Taxes and audits
  - Loan and mortgage assistance

☑ Identity theft resolution

- Free 60-minute telephone consultation with a highly-trained Fraud Resolution Specialist™ (FRS) who conducts seven emergency response activities, listens to issues, answers questions and gives directions and tools to help resolve the situation
- Free ID Theft Emergency Response Kit℠

Employee Assistance Program

Up to 5 in-person sessions per concern

1-800-356-7089

TTY Users: 1-800-456-4006

To access MagellanAscend.com, enter company name

MagellanAscend.com

Compliance Notices

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

Website: http://myalhipp.com/
Phone: 1-855-692-5447

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

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

FLORIDA – Medicaid

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

GEORGIA – Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid

Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 916-440-5676

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

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

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

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

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

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)

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: -800-977-6740.
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

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

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

NEW HAMPSHIRE – Medicaid

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

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid

Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

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, 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 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in the Company-sponsored health and welfare benefit plan are reminded that the Company's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

Group health plans and health 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).
- You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Company asks Employees not to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits hall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance

abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and

surgical benefits covered by the plan (or coverage), and there are

no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment, and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules. If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives conflict, the Plan document will control.

Health Insurance Marketplace

The Patient Protection Affordability Care Act ("PPACA") was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit dol.gov/ebsa/healthreform.

Currently, as a result of the 2017 Tax Cuts and Jobs Act, as of 2019, the Federal Penalty for individuals that do not have (or maintain) health insurance coverage for themselves, their spouse and children was reduce to $0. However, several states have implemented an ACA-like-individual mandate penalty. If you are considering not having health coverage, please contact your tax advisor about any potential penalties/fines in your state.

PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace ("Marketplace"), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying as low income); subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in the Company's medical plan, then PPACA may have little effect on you. The Company's medical plan meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plan, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by the Company, your payments for coverage will be made on an after-tax basis. (See https://www.healthcare.gov/have-job-based-coverage/)

If you are not eligible to enroll in the Company's medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered though the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: healthcare.gov).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit healthcare.gov or call 800-318- 2596.