VOORHEES UNIVERSITY

2024
Employee Benefit Guide

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Your Benefits Package

Your health and the health of your family are important to Voorhees University which is why we offer comprehensive health care coverage with ancillary benefit options to eligible employees and their families. Our benefits package is designed to focus on your total well-being.

This guide describes our employee benefits package. Please read through all of your materials very carefully. You have many resources available for any questions related to your plans as you enroll and throughout the year. Take advantage of those resources to be sure you receive the full benefits you need and all that is available to you. The health care coverage you elect begins with your initial eligibility date and continues through the end of the plan year.

This brochure summarizes the coverage that is available to you during the 2024 plan year. If you have any questions, please contact Human Resources. Additional contact information is shown at the end of this guide.

The information in this Benefit Guide is presented for illustrative purposes. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

Welcome

Eligibility

Voorhees University is committed to providing a health care benefits program that offers comprehensive and valuable coverage for you and your family. If you are an active, full-time employee working at least 30 hours per week, then you are eligible to enroll in the benefits described in this benefit guide.

The following family members are eligible for Medical, Dental, Vision, Basic Dependent Life, Voluntary Life/AD&D, Accident, Cancer, and Hospital Indemnity:

- Legal Spouse
- Child(ren) up to age 26. *Extended coverage available for children with special needs. Please see policy for details.*

New Hires

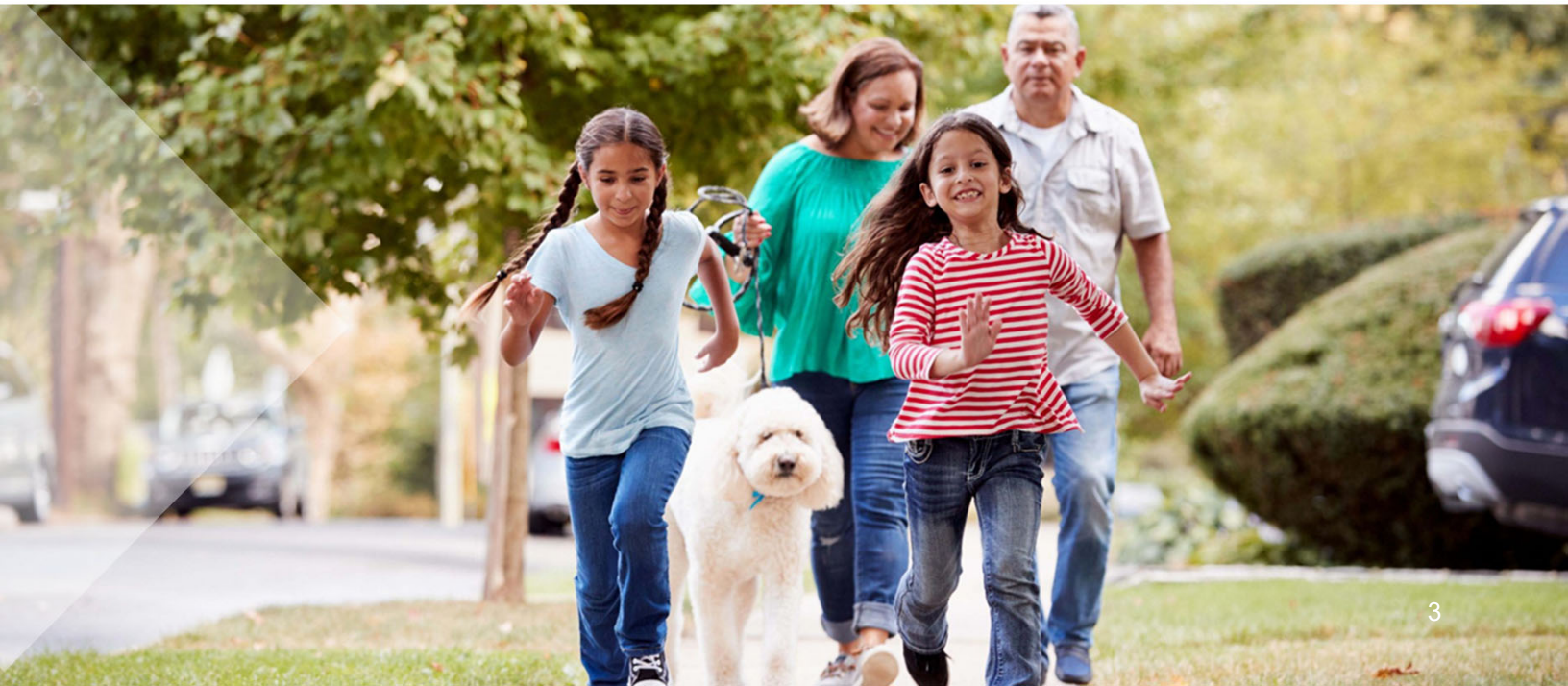
Medical benefits start the First of the month following 60 days.

Qualifying Events

Under IRS Section 125 regulations after your Initial or Annual Enrollment period is closed, you cannot make changes to the benefits you elect or waive until the next annual enrollment period unless you experience a qualifying event. Events falling within the following categories are considered qualifying events:

- Marriage, divorce, death of spouse, legal separation, or annulment
- Birth, adoption, placement for adoption, death, qualified medical child support order (QMCSO), or dependent ceases to satisfy eligibility requirements
- Employee or spouse termination / commencement of employment
- Change from part-time to full-time

In order to be eligible to make changes, you must notify HR within 30 days of a qualifying event.



Medical and Prescription Drugs

MEDICAL BENEFITS – POWER OF CHOICE

Voorhees University offers an Individual Coverage Health Reimbursement Arrangement (ICHRA) plan for you and your eligible dependents.

Voorhees University has partnered with a third-party administrator, SureCo, to provide our employees with the "Power of Choice" regarding your medical benefits. SureCo's Enrollment Platform leverages the existing direct to carrier market to provide you with the most plan choices as possible. You will be able to choose from a selection of individual plans offered in your state for you and your dependents with your portion of the premium withheld from your paycheck as pre-tax payroll deduction.

The Power of Choice

INDIVIDUAL COVERAGE HEALTH REIMBURSEMENT ARRANGEMENT

With the introduction of Individual Coverage HRA, you can purchase your own individual plan and your employer can still contribute to the cost –all pre-tax.

With SureCo's Enrollment Platform, you will have access to the right coverage for the right price that fits your needs.

Choose from a variety of medical carriers with various plan structures and premiums (pre-tax), in the individual market.

Shop and Enroll Online

SURECO ENROLLMENT PLATFORM

SureCo's Enrollment Platforms makes it easy to browse and make your choices. All medical plan descriptions are available on the platform.

Depending upon which medical carrier and plan you elect; your pharmacy services will accompany that carrier's pharmacy policies, preferred vendors, and formularies.

Please log into SureCo's Enrollment Platform to view all Summary Plan Disclosure Documents and Pricing.

VOORHEES UNIVERSITY EMPLOYER MONTHLY CONTRIBUTION

Employee – 85% of the lowest cost silver plan*

**LCS = lowest cost silver plan. Monthly premiums for all ICHRA plans are calculated based on the age and rating area of employee. SureCo's Enrollment Platform will identify the LCS tier plan available for employee and calculate the corresponding percentage. That amount will be used as the employer contribution.*

MEDICAL BENEFITS – FOR EMPLOYEES 65 AND OVER

Under ICHRA, if you are 65 or older you must enroll in Medicare Part A and Part B or Part C for your health care coverage to be eligible to receive the non-taxed employer contribution and reimbursement.

Medicare is a federal health insurance program for people who are 65 or older, certain younger people with disabilities and people with permanent kidney failure. You are eligible to sign up for Medicare 3 months before you turn 65 and until 3 months after the month you turn 65.

Go to www.Medicare.gov to understand your Medicare options and enroll*.

**Please be aware, Medicare enrollment is not automatic and is not managed within the SureCo Enrollment Platform.*

Enrolling in Medicare does not sacrifice your employer's contribution towards your health care premiums. In fact, as a Medicare eligible employee, you are eligible to receive a non-taxed expense reimbursement from COMPANY to offset the cost of your Medicare premiums. To finalize the amount of your non-taxed reimbursement, you will be asked to verify your enrollment status in Medicare Part A and Part B or Part C and your monthly out of pocket premiums.

Next Steps:

1. Understand your Medicare options
2. Call the Social Security Administration at (800) 772-1213. To get an immediate estimate of when you're eligible for Medicare and your premium amount, use the Medicare Eligibility and Premium Calculator.
3. Please report your Medicare enrollment update to SureCo as soon as possible. Once updated, SureCo will contact you to send a copy of your premium notices so your employer can begin applying your non-taxed expense reimbursement to future payroll checks.

Know your Medicare basics

Medicare Advantage Insurance Plans

Dental

Regular dental cleanings and check-ups are extremely important to your overall health, and you are encouraged to take advantage of your preventive dental benefits.

We offer dental coverage through Companion. The cost is entirely paid by the employee.

For forms and questions, employees can visit www.CompanionLife.com.

The chart below shows in-network benefits.

Companion: Dental Select		
Dental Services	**In-Network**	**Out-of-Network**
Annual Deductible Individual Family *Waived for Preventive Services*	$50 $150	
Annual Plan Maximum	$1,500 per member	
Preventive Services *Exams, cleanings, X-rays*	100%, deductible waived	100%, deductible waived
Basic Services *Fillings, simple extractions, periodontal services, root canals*	100% after deductible	80% after deductible
Major Services *Bridges, dentures, crowns, surgical extractions, general anesthesia*	60% after deductible	50% after deductible

12 Month Employee Semi-Monthly Cost			
Employee Only	**Employee & Spouse**	**Employee & Child(ren)**	**Employee & Family**
$14.14	$28.33	$32.18	$43.11

9/10 Month Employee Semi-Monthly Cost			
Employee Only	**Employee & Spouse**	**Employee & Child(ren)**	**Employee & Family**
$16.97	$33.99	$38.62	$51.73

Vision

Our vision plan with Companion offers you and your family a comprehensive vision program that reduces the cost of eye exams, eyeglasses, and contact lenses. The cost is entirely paid by the employee

To receive the highest level of benefits, use a provider within the Companion National network. To find an in-network vision provider, please visit www.CompanionLife.com. The chart below shows in-network benefits.

Companion Vision	
Vision Services	**In-Network**
Vision Exam	$10 Copay, once every 12 months
Contact Lens Fitting	$25 Copay, once every 12 months
Eyeglasses, Frames, Contacts	
Lenses	Single Vision, Bifocal, Trifocal, or Lenticular - $25 copay, once every 12 months
Frames	$130 retail allowance + 20% off amount over allowance, once every 24 months
Contact Lenses	Medically Necessary - paid in full, once every 12 months Elective - $130 retail allowance, once every 12 months
Laser Vision Correction	10-20% discount

YOUR VISION INSURANCE COSTS IN 2024

There are no changes to the vision payroll deductions for the 2024 plan year.

12 Month Employee Semi-Monthly Cost			
Employee Only	**Employee & Spouse**	**Employee & Child(ren)**	**Employee & Family**
$3.32	$6.06	$6.45	$9.94

9/10 Month Employee Semi-Monthly Cost			
Employee Only	**Employee & Spouse**	**Employee & Child(ren)**	**Employee & Family**
$3.98	$7.27	$7.73	$11.93

Basic Life and AD&D

Voorhees University provides Basic Employee Term Life and Accidental Death & Dismemberment (AD&D) coverage in the amount of $25,000 for all full-time employees. The University pays the full cost of this employee coverage.

Basic Dependent Term Life coverage in the amount of $2,000 is available for spouses and children ages 14 days to 23 years (or 25 if full-time student). Employees pay the full cost of this dependent coverage.

Basic Life/AD&D Coverage	
Life Benefit	Employee: $25,000 Spouse: $2,000 Child(ren): $2,000
Accidental Death & Dismemberment Benefit	Employee: $25,000

YOUR BASIC LIFE/AD&D INSURANCE COSTS IN 2024

There are no changes to the basic life/AD&D payroll deductions for the 2024 plan year.

12 Month Employee Semi-Monthly Cost	
Employee Only	**Dependent(s)**
No Cost	$0.11

9/10 Month Employee Semi-Monthly Cost	
Employee Only	**Dependent(s)**
No Cost	$0.025

Important! Remember to update your beneficiary information today!

Voluntary Life and AD&D

Voorhees University offers full-time employees the option to purchase additional Voluntary Term Life and Accidental Death & Dismemberment (AD&D) coverage for themselves and their family members.

Employees pay the full cost of this coverage. The cost for coverage depends on your age and benefit volumes and will be available on the Benefitfirst system during open enrollment.

You must elect coverage for yourself in order to elect coverage for your spouse and/or children.

	Employee	Spouse	Child(ren)
Benefit Amount	Increments of $5,000	Increments of $5,000	Increments of $2,500
Minimum Benefit	$10,000	$5,000	$2,500
Maximum Benefit	$500,000 or 7 x salary	100% of employee amount up to $150,000	$10,000 not to exceed 100% of covered employee
Guarantee Issue*	$100,000 until age 69	$50,000 until age 69	$10,000
Benefits reduced to:	35% to 65% at age 65 50% at age 70	35% to 65% at age 65 50% at age 70	N/A

* If you wish to purchase an amount above the listed Guarantee Issue amounts or if you wish to add coverage or increase your Voluntary Life/AD&D insurance after your original hire date, then you will need to submit an Evidence of Insurability form to and receive approval from Guardian.

Important! Remember to update your beneficiary information today!

Voluntary Short-Term Disability

Short-Term Disability insurance provides income assistance and a way to help you pay your bills and keep your life as normal as possible if you become sick or injured and cannot work. Benefits would begin on the 1st day for an accident and on the 8th day for an illness and would last as long as you remain disabled, up to a maximum of 13 weeks.

Employees pay the full cost of this coverage. The cost for coverage depends on your age and benefit volume and will be available on the Benefitfirst system during open enrollment.

If you wish to add coverage or increase your Voluntary Short-Term Disability benefit after your original hire date, then you will need to submit an Evidence of Insurability form to and receive approval from Guardian.

Voluntary Short-Term Disability	
Waiting Period: Illness / Injury	7 days / 0 days
Weekly Benefit Amount	You choose an amount from $150 up to $1,000 in $50 increments, amount cannot exceed 66.76% of your weekly earnings
Maximum Weekly Benefit	$1,000
Benefit Duration	13 weeks

Long-Term Disability

Voorhees University provides Long-Term Disability coverage for all full-time employees and pays the full cost of this coverage. In the event you become disabled from a non-work-related injury or sickness, long-term disability income benefits are provided as a source of income.

Long-Term Disability	
Waiting Period: Illness / Injury	90 days
Monthly Benefit Amount	50% of your monthly earnings
Maximum Monthly Benefit	$5,000 (non-taxable)
Benefit Duration	Social Security Normal Retirement Age (if you remain disabled)

COMPANION LIFE INSURANCE COMPANY'S DISABILITY GUIDANCE PROGRAM CAN HELP MEMBERS FOCUS ON BEING THEIR BEST — IN THE WORKPLACE AND AT HOME.

People are most successful when they achieve a good work-life balance. But life is unpredictable and can quickly place hurdles in our path to success. That's why we offer the DisabilityGuidance Employee Assistance Program (EAP) at no additional cost to eligible members enrolled in group Long Term Disability Insurance (LTD) coverage.

What Is DisabilityGuidance?

Companion Life's DisabilityGuidance EAP is a service that offers direct professional support for members and their families when they become overwhelmed with life's challenges or face serious emotional issues. In addition, all DisabilityGuidance services are confidential.

The program can help employees manage personal problems that may affect job performance, and can help employers address employee emotional issues early, before they become workplace distractions. Members can find support for a wide spectrum of issues, such as stress and anxiety, coping with a disability, help with child and elder care, substance abuse, family relationships, and other work-life challenges.

Services are offered by ComPsych Corporation, one of the largest providers of employee assistance programs, managed behavioral health, work-life and crisis intervention services.

DisabilityGuidance is here to help members cope with job pressures, financial difficulties, legal advice, child care or the impact of a disability.

- All services available to employees and their families
- 24/7 toll-free phone access to counselors and an interactive website
- Up to five in-person counseling visits per year, plus five more once approved for disability
- Insurance benefits
- Large network coverage

ComPsych®
GuidanceResources® Worldwide

How Does DisabilityGuidance Work?

Easy, Immediate Access to Assistance: A policyholder has access to DisabilityGuidance services both before a disability and after he or she has been approved for an LTD insurance claim and is receiving LTD insurance benefits. A policyholder enrolled in an LTD insurance program will receive information that explains the services and provides ComPsych's toll-free number. When an insured policyholder calls the toll-free number, a ComPsych counselor will help him or her develop an individualized plan of action.

Members can benefit from:

- Access to counselors with a master's or doctoral degree in counseling. This comes via a dedicated toll-free telephone number 24 hours a day, 365 days a year
- Telephone assessments and counseling
- Referrals to services in callers' communities, such as community and governmental agencies serving the disabled, homemaker services, assistive equipment, and day care for children and elderly parents
- Access to self-assessment tools, information and other resources through the password-protected GuidanceResources
- Online interactive web services
- Multilingual capabilities
- TTY technology available to assist the deaf and hearing impaired
- Confidential consultation with a counselor, financial planner and/or attorney

Valuable Support for Members and Their Families: Before a disability insurance claim, DisabilityGuidance offers members up to five counseling sessions per year. Following an approved LTD insurance claim, claimants are entitled to five additional counseling sessions. The sessions may be used with a counselor, financial planner or attorney, or split among the three types of professionals.

Counselors provide an assessment of concerns and referrals to appropriate resources and providers. Financial and legal advisers will assist with financial planning and certain legal matters such as tax filing questions, debt issues, guardianship or power of attorney.

To Learn More

To receive more information about Companion Life's DisabilityGuidance plan, call Companion Life Group Marketing at 800-753-0404.

For more information about ComPsych, visit www.compsych.com.

Call: **888-327-7502** TDD: **800-697-0353** Online: **GuidanceResources.com** Our company web ID: **YC1055R**

Consumer Benefits

Voluntary benefits for all eligible Voorhees University employees in 2024 will still be offered. The costs for these benefits are paid entirely by the employee and will be available on the Benefitfirst system during open enrollment.

Voluntary Accident – Mutual of Omaha

For covered accidental injuries, fixed benefits are paid directly to you regardless of your other coverage and you can spend that money any way you choose. Benefits are paid according to a fixed schedule that includes benefits for hospitalization, fractures and dislocations, emergency room visits, and more.

We offer two accident plans with Guardian: Value and Premier.

Voluntary Cancer - Guardian

Cancer insurance provides fixed benefits for early detection and treatment of certain kinds of cancer, including related expenses such as screenings, hospital confinement, radiation, chemotherapy, surgery, and more. Benefits are paid directly to you regardless of any other coverage you may have, and you can spend it any way you choose.

We offer two cancer plans with Guardian: Value and Premier.

Voluntary Hospital Indemnity – Mutual of Omaha

Hospital Indemnity insurance can help cover unexpected out-of-pocket expenses when you have a hospital stay. Fixed benefits are paid directly to you regardless of your other coverage, and you can spend it any way you choose. Our plan includes a once-per-year $50 health screening benefit.

Please refer to the benefit summaries for more details on these plans.

TIAA 403(b) Retirement Plan

Saving for retirement is an important piece of your overall financial wellness. Because of this, Voorhees University offers a robust 403(b) retirement plan through the Teachers Insurance and Annuity Association (TIAA), where you can contribute pre-tax dollars and save for your future.

- Full-time employees are eligible to participate and make voluntary contributions beginning on your date of hire.
- Voorhees University will match the employee's contribution up to a maximum of 4.5% of his/her annual salary after one year of continuous employment.
- Your 403(b) contributions cannot exceed the IRS annual limit of $22,500 during 2024.

Please see your Human Resources representative for more details.

Flexible Spending Accounts (FSAs)

Voorhees University provides you the opportunity to pay for out-of-pocket medical, dental, vision, and dependent care expenses with pre-tax dollars through Flexible Spending Accounts. You can save approximately 25% of each dollar spent on these expenses when you participate in an FSA since you will not be paying federal income tax, Social Security taxes, and state and local income taxes on your FSA contribution. The IRS has rules regarding eligibility, contributions and reimbursements for these accounts.

Our FSAs will continue to be offered through ProBenefits which is now known as Flores. Due to this name change, employees can now visit flores247.com to create or log in to your online access to your FSA account.

Current enrollees should receive a new Flores debit card at your home addresses. The Flores debit card may be used by participants enrolled in the Medical FSA.

Please note: You must re-enroll for the FSA on Benefitfirst for the upcoming plan year, January 1, 2024, through December 31, 2024.

Healthcare Reimbursement FSA

A healthcare reimbursement FSA offers a convenient way to prepare for out-of-pocket medical expenses. Your healthcare FSA funds can be used for your medical expenses as well as those of your spouse and dependents.

Dependent Care FSA

A dependent care FSA is used to reimburse expenses related to care of eligible dependents while you and your spouse work. Eligible dependent care expenses include elder care, after-school care, and preschool. There are rules re: who qualifies as an eligible dependent or relative for expenses under the Dependent Care FSA.

Annual FSA Contribution Limits for 2024:

- Healthcare FSA: $3,050
- Dependent Care FSA: $5,000 for individuals or married couples filing jointly or $2,500 for a married person filing separately

Our Healthcare FSA plan is designed to automatically increase the annual contribution limit for each year based on the IRS limits. The Dependent Care FSA contribution limit is set by statute and is not subject to inflation-related adjustments.

Use-It-or-Lose-It

FSAs operate under a use-it-or-lose-it rule, meaning that if you don't use the money in your FSA by the end of the plan year, then you will lose it. The Healthcare FSA plan allows you to carry over up to a certain amount to the next year, but any remaining amount above that limit will be forfeited. You can roll over up to $610 from 2023 to 2024.

The Dependent Care FSA does not allow any carryover, so any remaining balance will be forfeited at the end of the plan year.

For the **2024** calendar year, an individual can contribute up to $3,150 to a healthcare **FSA** and $5,000 to a dependent care **FSA** (or $2,500 for a married person filing separately).

Important Contacts

BENEFIT	CARRIER	WEBSITE	PHONE
Medical & Rx	SureCo / ICHRA	Employee.experience@sureco.com	949-989-4906
Dental	Companion	CompanionLife.com	800-753-0404
Vision, Life, Disability	Companion	CompanionLife.com	800-753-0404
Cancer	Guardian	GuardianAnytime.com	888-482-7342 Option 3
Accident, Hospital Indemnity	Mutual of Omaha	MutualofOmaha.com	800-769-7159
FSA	Flores (previously known as ProBenefits)	flores247.com	800-532-3327
403(b) Retirement Plan	Teachers Insurance and Annuity Association (TIAA)	TIAA.org	800-842-2252

CONTACT	COMPANY / ROLE	EMAIL	PHONE
Human Resources	Voorhees University	humanresources@voorhees.edu	803-780-1181
Jaimee Stephen-Turner	McGriff Insurance Services Senior Account Manager	Jaimee.Stephen-Turner@mcgriff.com	803-231-6185

Annual Notices

Health Plan Compliance Notices

Disclaimer: This document contains many of the required Health and Welfare Plan model notice templates provided by the Department of Labor and other Federal agencies. Most employers prefer to include required notices in their open enrollment materials for ease of distribution.

Some of these notices may require distribution outside of the open enrollment period or to both employees as well as dependent participants. For example, the General COBRA Notice must be provided to not only participating employees but also to participating spouses.

In addition, some notices may require further customization, based on the specific terms of your plan. For example, if you offer a fully-insured plan and any state-mandated billing requirements apply to your plan, a state summary or state-developed model language may need to be added to your Surprise Medical Bills Notice.

Employers may also be subject to additional State laws and Federal disclosures not outlined in these materials. For example, the ACA requires that employers distribute a Marketplace Notice to all employees within 14 days of the employee's start date; because this notice is required to be distributed to all employees upon hire and not on an annual basis and must be highly customized, this notice is not included in this packet. Similarly, if you offer a wellness program that asks participants health-related questions (e.g., a health risk assessment) or involves a medical examination (e.g., biometric testing), then an additional ADA Notice will be required that contains customized information relating to your specific wellness plan. For a more detailed overview of commonly required health plan compliance notices, ask your McGriff Account Team for our annual Employee Benefit Plan Reporting and Disclosure Guide.

If you have questions about or need additional clarity on the notices provided herein, please reach out to your McGriff Account Team. You are also encouraged to retain ERISA counsel to review all notices for proper customization and accuracy and to determine which additional disclosures you may be required to provide to your employees and plan participants.

Medicare Part D Creditable Coverage Notice
Important Notice from Voorhees University
About your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage offered by the ICHRA through Voorhees University 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. **Voorhees University has determined that the prescription drug coverage offered by the ICHRA 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 coverage through Voorhees University will be affected. For those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.

If you decide to join a Medicare drug plan and drop your current group health coverage through Voorhees University, be aware that you and your dependents will not be able to get this coverage back. If you are able to get this coverage back, reentry into the plan is subject to the underlying terms of the Plan.

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 group health coverage through Voorhees University 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 Plan Administrator listed below for further information. NOTE: You'll get this notice each year or if the creditable coverage status of this plan through Voorhees University changes. You 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 (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

For purposes of this notice, the Plan Administrator is:

Constance Colter-Brabham
803-780-1189

WHCRA Enrollment/Annual Notice

Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator as identified at the end of these notices.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 803-780-1189 for more information.

For purposes of this notice, the plan administrator is:

Constance Colter-Brabham
803-780-1189

Newborns' 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

Continuation Coverage Rights Under COBRA

Introduction:

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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 of the following qualifying events:

- 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."

If the Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in a bankruptcy is filed with respect to Voorhees University and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of coverage under the Plan.

When is COBRA continuation 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. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- If the Plan provides retiree health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator in writing within 60 days. You must provide this written notice to Constance Colter-Brabham at 481 Porter Dr. Denmark, SC. 29042.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months 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.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you timely notify the Plan Administrator **in writing**, you and your covered dependents 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 COBRA continuation coverage.

In order for this disability extension to apply, you must timely notify the Plan Administrator **in writing** of the SSA disability determination before the end of the 18-month period of continuation coverage and within 60 days after the later of (i) the date of the initial qualifying event; (ii) the date on which coverage would be lost because of the initial qualifying event; or (iii) the date of the SSA disability determination. **This notice must be mailed to Constance Colter-Brabham at 481 Porter Dr. Denmark, SC. 29042**. Oral notice, including notice by telephone, is not acceptable. The written notice must include the name and address of the employee covered under the plan; the name of the disabled qualified beneficiary; the date that the qualified beneficiary became disabled; and the date that the SSA made its determination of disability. Your notice must also include a copy of the SSA disability determination. If these procedures are not followed or if written notice is not provided to the Plan Administrator within the required time period, there will be no disability extension of COBRA continuation coverage. You must also notify the Plan Administrator within 30 days of any revocation of Social Security disability benefits.

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

If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), 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.

(see https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods).

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 the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

ICHRA
Voorhees University
481 Porter Dr. Denmark, SC. 29042
803-780-1189

Special Enrollment Notice

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

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

Finally, if you or an eligible dependent has coverage under a state Medicaid or child health insurance program and that coverage is terminated due to a loss of eligibility, or if you or an eligible dependent become eligible for state premium assistance under one of these programs, you may be able to enroll yourself and your eligible family members in the Plan. However, you must request enrollment no later than 60 days after the date the state Medicaid or child health insurance program coverage is terminated or the date you or an eligible dependent is determined to be eligible for state premium assistance.

To request special enrollment or obtain more information, contact the plan administrator listed below:

Constance Colter-Brabham
803-780-1189

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan'snetwork.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the No Surprises Helpdesk, operated by the U.S. Department of Health and Human Services, at 1.800.985.3059.

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

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, 2023. Contact your State for more information on eligibility –

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, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 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: 678-564-1162, Press 2	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)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US 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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2023, 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 1/31/2026)

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This Summary of Benefits Guide does not provide all the details about all the Benefit Plans. If you have additional questions, please contact HR. Should a discrepancy arise between this document and the plan documents, the plan documents will prevail.