Pulaski County Public Schools

"One Team, One School, One Family"







2026–2027

EMPLOYEE BENEFITS GUIDE

PULASKI COUNTY VIRGINIA

PULASKI COUNTY PUBLIC SCHOOLS · PATHWAY TO A BRIGHTER TOMORROW ·



PULASKI COUNTY PUBLIC SCHOOLS

Getting Started

YOUR 2026 - 2027 BENEFITS

July 1, 2026 - June 30, 2027

Whether you are enrolling for the first time, nearing retirement, or somewhere in between, Pulaski County Public Schools supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

EXPLORE YOUR BENEFITS

Review medical, dental, vision, savings accounts, and supplemental voluntary benefits in this guide.

MAKE THE MOST OF YOUR COVERAGE

Understand your options, save time and money on healthcare, reduce taxes, and find resources to help balance work and home life.

FIND ANSWERS & BENEFIT SUPPORT

Review the coverage and tools available to make the most of your benefit package. Contact your Human Resources Department with questions or for enrollment assistance.

MEDICARE PART D NOTICE

If you or your dependents have Medicare, or expect to become eligible within the next 12 months, review the **Important Notices** section for information about your prescription drug coverage choices.

Who Is Eligible for Benefits?

2026 - 2027 BENEFIT GUIDE

EMPLOYEE ELIGIBILITY

Full-time employees working **30 hours or more** and part-time employees working **at least 30 hours** are eligible.



ELIGIBLE DEPENDENTS

SPOUSE ELIGIBILITY & REQUIRED AFFIDAVIT

A legally married spouse is eligible if they do **not** have access to minimum essential coverage to which their employer contributes at their place of employment. To cover an eligible spouse, complete and return the **spousal affidavit to HR** by the end of open enrollment or within new-hire eligibility.

Eligible children: Natural, adopted, or stepchildren up to age 26; children over age 26 who are disabled and depend on you for support; and children named in a Qualified Medical Child Support Order (QMCSO). **A domestic partner's children are not eligible.**

WHEN CAN I ENROLL?

Enroll during annual Open Enrollment or as a new hire. New-hire coverage is based on your hire date:

Hire date	Coverage begins
1st - 15th of the month	First day of the next month
16th - last day of the month	First day of the month following 30 days

If you miss the enrollment deadline, you generally must wait until the next Open Enrollment unless you experience a qualifying event that permits a change.

PAYROLL DEDUCTIONS

June 2026: Anthem Medical and Delta Dental.
July 2026: Anthem Voluntary Vision, HSA, FSA, Colonial Life supplemental insurance, MassMutual Whole Life, and AirMed.

PULASKI COUNTY PUBLIC SCHOOLS

Your Benefits. Your Next Step.

HOW TO ENROLL

2026 - 2027 BENEFIT GUIDE



START HERE

www.pcvabenefits.com

Explore your benefits, enrollment options, and support team in one place.

1 OPEN YOUR BENEFITS PORTAL

From a computer or phone browser, go to **www.employeenavigator.com** and click **Login**.

2 NEW USER? REGISTER. RETURNING? LOG IN.

Choose **Register as New User** if this is your first visit. Already registered? Enter your existing username and password.

3 VERIFY YOUR ACCOUNT

New users: enter your first and last name, last four digits of your SSN, date of birth, and the company identifier below.

Employer	Company identifier
Pulaski School Board	**PCSB**

Use PCSB when registering your Schools account.

BEFORE YOU CLICK: GET READY

- ✓ Have each covered dependent's date of birth, Social Security number, and address ready.
- ✓ Review and update your beneficiary information.
- ✓ Bring exam dates to your meeting for annual health screening benefit claims.
- ✓ Review benefit options and costs in your enrollment materials.

YOU DON'T HAVE TO FIGURE IT OUT ALONE

Enrollment help: 888-650-3003

Benefit questions: Innovative Insurance Group | 888-676-9496

During Open Enrollment, benefits counselors offer on-site, one-on-one assistance.

Personalized Enrollment Support

YOUR OPTIONS. A REAL CONVERSATION. A CLEAR NEXT STEP.

2026 - 2027 BENEFIT GUIDE

You do not have to navigate your benefits alone. During Open Enrollment or when you become newly eligible, review your options with a benefits professional. Use this guide and the benefits website to prepare for your conversation.

CONNECT WITH YOUR ENROLLMENT TEAM

888-650-3003

www.pcvabenefits.com

CHOOSE THE SUPPORT THAT WORKS FOR YOU

In-person guidance

During Open Enrollment, on-site representatives can review your options and help with enrollment.

Telephone assistance

Call the enrollment team for personalized support and help with the enrollment process.

One-on-one virtual sessions

Visit the benefits website for virtual enrollment options when newly eligible, including video chat and co-browsing.

Online self-service

Review benefit information, explore enrollment options, and find your support team through the benefits website.

MAKE THE MOST OF YOUR CONVERSATION

Review your available benefits and costs. Bring your questions, dependent information, and beneficiary detail Benefits Counselors can help you understand your options and guide you through enrollment.

Support beyond Open Enrollment: Pulaski County employees have access to benefit counseling throughout the year. Contact the team or visit the benefits website to get started.

Questions? Start with Innovative.

YOUR BENEFITS ADVOCATE

2026 - 2027 BENEFIT GUIDE



REAL HELP FOR REAL BENEFIT QUESTIONS

Your Innovative Insurance Group Benefits Advocate can help you understand your coverage, navigate questions, and make the most of your benefits.

HOW YOUR BENEFITS ADVOCATE CAN HELP

Understand your benefits

Get answers to general benefit questions and help understanding your coverage.

Check eligibility

Ask about spouse or dependent eligibility and what your plan covers.

Find a network provider

Get help locating a doctor, dentist, or other provider in your plan's network.

Resolve claim or billing issues

Get assistance with healthcare claim or billing concerns, when warranted.

LIFE CHANGES? LET'S TALK.

Getting married, welcoming a child, or going through a divorce? Ask your Benefits Advocate how a life event may affect your coverage and what steps or deadlines may apply.

CONTACT INNOVATIVE INSURANCE GROUP

888-676-9496

customerservice@thinkinnovative.net

Monday - Friday | 8 a.m. - 5 p.m. Eastern Time

Life Changes. Benefits Can Too.

CHANGING YOUR BENEFITS | QUALIFYING LIFE EVENTS

2026 - 2027 BENEFIT GUIDE

Outside Open Enrollment, certain qualifying life events may allow you to enroll in coverage or change your benefit elections. The change must be permitted by your plan and consistent with the event.

30 DAYS

Act promptly after a qualifying event. Contact HR and submit your change request and written supporting documentation within 30 days, unless a different special enrollment deadline applies.

EVENTS THAT MAY ALLOW A CHANGE

Family changes

Marriage, divorce, a new dependent through birth or adoption, or a change in dependent eligibility.

Employment or coverage changes

A change in employment affecting eligibility for you, your spouse, or dependent children; or loss of other eligible health coverage.

A move or eligibility change

A residence change affecting access to network providers, or a change in eligibility for Medicare or Medicaid.

Court orders & special enrollment

A court order requiring coverage for your child, or another special enrollment event recognized under the plan and applicable rules.

MEDICAID & CHIP: A 60-DAY SPECIAL ENROLLMENT WINDOW

You have 60 days to request enrollment after losing Medicaid or Children's Health Insurance Program (CHIP) coverage because of loss of eligibility, or after becoming eligible for Medicaid or CHIP premium assistance toward employer coverage.



START WITH HR

Report your event, ask which benefits you may change, and provide documentation for review. Confirm your enrollment deadline and the effective date of any approved change.

Source: U.S. Department of Labor special enrollment guidance; County enrollment outline.



PULASKI COUNTY PUBLIC SCHOOLS

Medical Plans

ANTHEM | 2026 - 2027 BENEFIT GUIDE

TWO OPTIONS. ONE IMPORTANT CHOICE.

The right plan depends on your healthcare needs, preferred providers, and budget. Start with the two Anthem options below, then review the detailed plan summaries and premiums.

KeyCare Plus

20 / 500 / 20% / 4,000

KeyCare HSA

2000NE / 20% / 4,000

WHAT MATTERS MOST TO YOU?

1. **Your care**

   Think about doctor and urgent care visits, specialists, and the services you use most often.

2. **Your providers & prescriptions**

   Compare network access and prescription coverage for the doctors and medications you rely on.

3. **Your total cost**

   Look beyond payroll deductions. Compare deductibles, copays, coinsurance, and out-of-pocket limits.

Explore plan details and resources: www.pcvabenefits.com

Anthem Plan Comparison

2026 - 2027 BENEFIT GUIDE

Network	Benefit / service	KeyCare 20 / 500 / 20% / 4,000	KeyCare HSA 2000NE / 20% / 4,000
In-network	Annual deductible (individual / family)	$500 / $1,000	$2,000 / $4,000
	Embedded or non-embedded	Embedded	Non-embedded
	Annual out-of-pocket maximum (individual / family)	$4,000 / $8,000	$4,000 / $8,000
	Coinsurance	20% after deductible	20% after deductible
	Preventive care	Covered 100%	Covered 100%
	Office visits (PCP / specialist)	$20 copay / $40 copay	20% coinsurance after deductible
	Telemedicine (LiveHealth Online)	No charge	20% coinsurance after deductible
	Diagnostic labs / X-rays (in office)	20% coinsurance after deductible	20% coinsurance after deductible
	Advanced diagnostics (MRI, CAT, PET, etc.)	20% coinsurance after deductible	20% coinsurance after deductible
	Urgent care	$40 copay	20% coinsurance after deductible
	Emergency room	20% coinsurance after deductible	20% coinsurance after deductible
	Inpatient hospital	20% coinsurance after deductible	20% coinsurance after deductible
	Outpatient hospital	20% coinsurance after deductible	20% coinsurance after deductible
	Mental health & substance abuse	$20 copay virtual or office visit	20% coinsurance after deductible
	Hospice care	20% coinsurance after deductible	20% coinsurance after deductible
	Physical, occupational & speech therapy	$20 copay; combined limit of 30 visits	20% coinsurance after deductible; combined limit of 30 visits
	Spinal manipulation	$20 copay; limited to 30 visits per benefit period	20% coinsurance after deductible; limited to 30 visits per benefit period
	Adult vision exam	$15 copay; limited to 1 visit	$15 copay; limited to 1 visit
	PRESCRIPTION DRUGS		
	Deductible	Not applicable	Combined with in-network medical deductible
	Out-of-pocket maximum	Combined with in-network medical out-of-pocket limit	Combined with in-network medical out-of-pocket limit
	Retail copays (30-day supply)	$10 / $30 / $50 / $50 Preventive Rx Enhanced @ 100%	$10 / $30 / $50 / $50 after deductible Preventive Rx Enhanced @ 100%
	Mail order copays (90-day supply)	$10 / $60 / $150	$10 / $60 / N/A / N/A after deductible
OUT-OF-NETWORK			
Out-of-network	Deductible (individual / family)	$1,000 / $2,000	$4,000 / $8,000
	Coinsurance	30% employee	40% employee
	Out-of-pocket maximum (individual / family)	$8,000 / $16,000	$8,000 / $16,000

Red text indicates changes from the prior year. For illustrative purposes only. Refer to the plan summary or Summary of Benefits for the full description of benefits.

PULASKI COUNTY PUBLIC SCHOOLS

Monthly Insurance Premiums

2026 - 2027 BENEFIT GUIDE | FY 2027

ANTHEM HEALTH | HDHP / HSA PLAN

Coverage tier	Employee	Employer	HSA deposit	Total premium	Dual
Employee only	$65.00	$835.00	$1,000.00	$900.00	-
Employee + children	$285.00	$1,560.00	$2,000.00	$1,845.00	-
Employee + spouse	$300.00	$1,700.00	$2,000.00	$2,000.00	$130.00
Family	$478.00	$2,522.00	$2,000.00	$3,000.00	$350.00

Non-embedded deductible: $2,000 individual / $4,000 family. All members must reach the total deductible before the plan pays 80%. Out-of-pocket maximum: $4,000 individual / $8,000 all other levels.

ANTHEM HEALTH | KEYCARE PPO

Coverage tier	Employee	Employer	HSA deposit	Total premium	Dual
Employee only	$200.00	$960.00	N/A	$1,160.00	-
Employee + children	$530.00	$1,795.00	N/A	$2,235.00	-
Employee + spouse	$545.00	$1,955.00	N/A	$2,500.00	$400.00
Family	$915.00	$2,335.00	N/A	$3,250.00	$730.00

Embedded deductible: $500 individual; members will not pay more than the single deductible. Plan pays 80% after deductible. Out-of-pocket maximum: $4,000 individual / $8,000 all other levels.

COBRA | PREMIUMS INCLUDE 2% ADMINISTRATION FEE

Coverage tier	KeyCare 500	Dental	PPO total	HSA plan	Dental	HSA total
Employee only	$1,183.20	$32.64	$1,215.84	$918.00	$32.64	$950.64
Employee + children	$2,374.50	$67.32	$2,438.82	$1,881.90	$67.32	$1,949.22
Employee + spouse	$2,550.00	$64.26	$2,614.26	$2,040.00	$64.26	$2,104.26
Family	$3,315.00	$102.00	$3,417.00	$3,060.00	$102.00	$3,162.00

ANTHEM VISION | ENHANCED VOLUNTARY PLAN

Coverage tier	Monthly premium
Employee only	$7.55
Employee + spouse	$15.84
Employee + children	$16.60
Family	$25.57



Access virtual care and support

through our Sydney Health mobile app

When you aren't feeling your best—physically, mentally, or emotionally—or you need guidance managing a health condition, help is available. You can connect to the care you need using our **Sydney℠ Health** mobile app. You can have a video visit with a doctor 24/7 for common health issues and annual wellness visits. Care for mental and emotional health is available by appointment. [1] Plus, the Sydney Health app is your avenue to specialized programs designed to help you improve your habits and your health.

Visit with a doctor for common medical concerns

Doctors are available anytime, with no long wait times and no appointments needed. They can help you with health issues, such as a cold or the flu, allergies, sore throat, migraines, or skin rashes. During your private and secure video visit, the doctor will assess your condition, provide a treatment plan, and send prescriptions to the pharmacy of your choice, if needed. [3]

Receive care for your behavioral health

If you're feeling anxious or depressed, or having trouble coping, you can set up a video visit with a therapist, psychologist, or psychiatrist. [4] Appointments can be scheduled within one to two weeks. [1] Psychiatrists help manage medications; they do not provide counseling or talk therapy. [5]

What people say about virtual care visits[2]

92% were able to book a virtual visit

89% said the doctor they saw

92% thought the doctor visit sooner than an in-person was professional and helpful understood their concerns

How to download our Sydney Health app:

Scan the QR code with your phone's camera.

Download on the App Store

GET IT ON Google Play

sydney℠



Use Sydney Health app to:

Help you manage your blood pressure

Our Healthy Blood Pressure program connects you with a health coach, doctor, and therapist to help you reach your blood pressure goals through virtual visits. The program also includes a free, smart blood-pressure cuff mailed directly to your home. Of those in the program, 71% indicated that the health coach had an impact on how they manage their blood pressure. [6]

Help you avoid diabetes

Our Prevent Diabetes program combines the latest in telehealth technology, biometric data, and artificial intelligence to provide you with a personalized behavior-change experience. If you qualify, you will work with a health coach to achieve your health goals and help you prevent diabetes.

Connect with a sleep specialist

Through our app, you can have a virtual care visit with a sleep specialist who can help diagnose sleep issues and treat them. Schedule an online visit through Sydney Health and a sleep specialist will assess your habits and history. They may suggest therapy or a sleep test. You will have a follow-up visit to discuss your results, next steps, and further treatment.

Here's how to access the program through virtual care:

Download our Sydney Health app or visit anthem.com.

1 . Register (if you haven't yet) and log in.
2 . Once you register, your username and password are the same for our app and **anthem.com.**
3 . Select **Care** and then select **Virtual Care**.

Health Savings Account

HSA FUNDING & 2027 CONTRIBUTION LIMITS

Available to eligible employees enrolled in the HSA health plan option. An HSA lets you set aside money for qualified medical expenses now or in the future. Open your HealthEquity HSA to receive Schools funding.

SCHOOLS HSA FUNDING

$1,000

Employee-only coverage

$2,000

Employee + spouse, employee + child(ren), or family coverage

Schools deposit for the 2026 - 2027 plan year: July 2026.

2027 IRS CONTRIBUTION LIMITS

Coverage / eligibility	2027 maximum
Self-only coverage	$4,500
Family coverage	$9,000
Age 55 or older: additional catch-up	$1,000

The limit includes contributions from you, the Schools, and anyone else. These limits apply to calendar year 2027, not the benefit plan year. The July 2026 Schools deposit applies to the 2026 contribution year; subtract Schools contributions made for 2027 when deciding how much you may contribute for 2027.

HOW YOUR HSA WORKS

Tax advantages. Contributions may be made through pre-tax payroll deductions or claimed as a tax deduction if eligible. Earnings and withdrawals for qualified medical expenses are federally tax-free.

Keep your balance. Unused funds roll over each year. The account belongs to you and stays with you if you change jobs or retire.

Keep your receipts. Save documentation showing that withdrawals paid for qualified medical expenses.

Eligibility matters: You generally must have HSA-qualified HDHP coverage, have no disqualifying other coverage, not be enrolled in Medicare, and not be claimable as another person's tax dependent. Partial-year eligibility can affect your limit. Eligible individuals age 55 or older may make the additional catch-up contribution.

Sources: IRS Rev. Proc. 2026-24; IRS Publication 969; Schools funding and rate sheets.

Pulaski County & Pulaski County Public Schools

Get reimbursed for out-of-pocket healthcare and child/aged adult day care expenses with tax free dollars!

MAXIMIZE YOUR INCOME!

Flexible Spending Accounts (FSAs) allow you to pay certain health-care and dependent care expenses with pre-tax money. You will not pay any Federal, State or FICA taxes on funds placed in the Plan. You will save approximately $27.65 to $37.65 on every $100 you place in the Plan. The amount of your savings will depend on your Federal tax bracket.

ELIGIBILITY

Participation in the plan begins on July 1, 2026 and ends on June 30, 2027. You will be eligible to join the Plan if you are a full-time or part-time employee working at least 20 hours or more per week on a regular basis on the first of the month following your date of hire. Those employees having a qualifying event are eligible to enroll within 30 days of the qualifying event. Deductions begin on the first pay period following your Plan start date. You must complete an enrollment to participate in the Flexible Spending Accounts each year during the enrollment period. If an enrollment is not completed during open enrollment, you will not be enrolled in the Plan and you will not be able to join until the next Plan Year or if you have a qualifying event.

ELECTION CHANGES

Election changes are only allowed if you experience one of the following qualifying events:

- Marriage or divorce
- Birth or adoption
- Involuntary loss of spouse's medical or dental coverage
- Death of dependent (child or spouse)
- Unpaid FMLA or Non-FMLA leave
- Change in dependent care providers

REIMBURSEMENT SCHEDULE

All manual or paper claims received by Flexible Benefit Administrators, Inc. will be processed within one week via direct deposit. If direct deposit information is not on file for you, your reimbursement will be held until we receive that information. You may also use your Benefits Card to pay expenses. Please refer to the Benefits Card section for details.

ONLINE ACCESS

Flexible Benefit Administrators, Inc. provides online account access for all FSA participants. Please visit their website at:

https://fba.wealthcareportal.com/ to view the following features:

- FSA Login – View account transactions, create account alerts and download participation forms.
- FSA Educational Tools – FSA calculator: estimate how much you can save by utilizing an FSA.

THE HEALTHCARE ACCOUNT IS A PRE-FUNDED ACCOUNT

This means that you can submit a claim for medical expenses on the first day of the Plan Year and you will be reimbursed your total claim amount up to your annual election. The funds that you are pre-funded will be recovered as deductions which are taken from your paycheck on a pre-tax basis.

Contribution Limits: The maximum you may place in this account for the Plan Year is $3,400.

HEALTHCARE REIMBURSEMENT

With this account, you can pay for your out-of-pocket healthcare expenses for yourself, your spouse and all your tax dependents for healthcare services that are incurred during your Plan Year and while an active participant. Eligible expenses are those incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for affecting any structure or function of the body.

EXAMPLES OF ELIGIBLE HEALTH CARE EXPENSES

Fees/Co-Pays/Deductibles For:

- Acupuncture
- Prescription eyeglasses/ reading glasses/ Contact lens and supplies/ Eye exams/ Laser eye surgery
- Physician
- Ambulance
- Psychiatrist
- Psychologist
- Anesthetist
- Hospital
- Chiropractor
- Laboratory/ diagnostic
- Fertility treatments
- Surgery
- Dental/ Orthodontic fees
- Obstetrician
- X-Rays
- Eye exams
- Prescription drugs
- Artificial limbs & teeth
- Orthopedic shoes/ inserts
- Therapeutic care for drug and alcohol addiction
- Vaccinations & immunizations
- Mileage
- Take-home screening kits
- Diabetic supplies
- Routine physicals
- Oxygen
- Physical therapy
- Hearing aids and batteries
- Medical equipment
- Antacids
- Pain relivers
- Allergy & Sinus Medication

OVER-THE-COUNTER EXPENSES

Examples of medications and drugs that may be purchased in reasonable quantities with a prescription:

- Acne Treatment
- Humidifiers
- Multivitamins
- Herbal Supplements
- Baby Formula
- Fiber Supplements

DAY CARE/AGED ADULT CARE REIMBURSEMENT

The Day Care/Aged Adult Care FSA allows you to pay for day care expenses for your qualified dependent with pre-tax dollars. Eligible Dependent Care expenses are expenses you must pay for the care of an eligible dependent so that you and your spouse can work. Eligible dependents, as revised under Section 152 of the Code by the Working Families Tax Act Gross Monthly Income of 2005, are defined as either dependent children or dependent relatives Eligible Pre-Tax Medical Expenses that you claim as dependents on your taxes. Refer to the Employee Guide for more details. Taxable Income Eligible dependents are Federal Tax (15%) further defined as:

- Under age 13
- Physically or mentally unable to care for themselves such as:
  - Disabled spouse
  - Children who became disabled prior to age 19.
  - Elderly parents that live with you

Contribution Limits: The annual maximum contribution may not exceed the lesser of the following:

- $7,500 ($3,750 if married filing separately) per household
- Your wages for the year or your spouse's if less than above
- Maximum is reduced by spouse's contribution to a Day Care/Aged Adult Care FSA

HOW THE FLEXIBLE BENEFIT PLAN WORKS

	Without Flex Benefits	With Flex Benefits
	$ 2,500.00	$ 2,500.00
Eligible Pre-Tax employer medical insurance	$ 0.00	$ 200.00
	$ 0.00	$ 100.00
Eligible Pre-Tax Dependent Child Care Expenses	$ 0.00	$ 300.00
	$ 2500.00	$ 1900.00
	$ 375.00	$ 285.00
State Tax (5.75%)	$ 143.75	$ 109.25
FICA Tax (7.65%)	$ 191.25	$ 145.35
After-Tax employer medical insurance	$ 200.00	$ 0.00
After-Tax medical expenses	$ 100.00	$ 0.00
After-Tax dependent child care expenses	$ 300.00	$ 0.00
Monthly Spendable Income	$ 1190.00	$ 1360.40

By taking advantage of the Flexible Benefit Plan this employee was able to increase his/her spendable income by $170.40 every month! This is an annual tax savings of $2,044.80. Remember, with the FLEXIBLE BENEFIT PLAN, the better you plan the more you save!

ELIGIBLE DAY CARE/AGED ADULT CARE EXPENSES

- Au Pair
- Nannies
- Before and After Care
- Day Camps
- Babysitters
- Daycare for an Elderly Dependent
- Daycare for a Disabled Dependent
- Nursery School
- Private Pre School
- Sick Child Center
- Licensed Day Care Centers

Ineligible Expenses

- Overnight camps
- Babysitting for social events
- Food expenses (if separate from dependent care expenses)
- Care provided by children under 19 (or by anyone you claim as a dependent)
- Days your spouse doesn't work (though you may still have to pay the provider)
- Kindergarten expenses are ineligible as an expense because it is primarily educational, regardless if it is half or full day, private, public, state mandated or voluntary.
- Transportation, books, clothing, food, entertainment and registration fees are ineligible if these expenses are shown separately on your bill.
- Expenses incurred while on a leave of absence or vacation.

HOW TO RECEIVE REIMBURSEMENT

To obtain a reimbursement from your Flexible Spending Account, you must complete a Claim Form. This form is available to you on our website. You must attach a receipt or bill from the service provider which includes all the pertinent information regarding the expense:

- Date of service
- Patient's name
- Amount charged
- Provider's name
- Nature of the expense
- Amount covered by insurance (if applicable)

Canceled checks, bankcard receipts, credit card receipts and credit card statements are NOT acceptable forms of documentation. You are responsible for paying your healthcare or dependent care provider directly.

FORFEITING FUNDS

Plan carefully! Unused funds will be forfeited back to your employer as governed by the IRS's "use-it-or-lose-it" rule. Your employer has elected to adopt the IRS offered 2 month 15-day grace period. Please see the Employee Guide for more information.

HOW TO ENROLL IN OUR FSA PLAN

Step 1

Carefully estimate your eligible Healthcare and Day Care/Aged Adult Care expenses for the upcoming Plan Year. Then use our online FSA Educational Tools located at https://fba.wealthcareportal.com/ to help you determine your total expenses for the Plan Year.

Step 2

Complete your enrollment during the open enrollment period, which instructs payroll to deduct a certain amount of money for your expenses. This amount will be contributed on a pre-tax basis from your paychecks to your FSA. Remember the amount you elect will be set aside before any Federal, State, and FICA taxes are calculated.

BENEFITS CARD

The Benefits Card can be used as a direct payment method for eligible expenses incurred at approved service providers and merchants. Using your card allows you instant access to your funds with no out-of-pocket expense. Please keep all your itemized receipts. Flexible Benefit Administrators, Inc. may request documentation to substantiate Benefits Card transactions to determine eligibility of an expense. Benefits Cards are available upon request of the account holder for dependents over the age of 18. Please contact Flexible Benefit Administrators, Inc. to order additional cards.

Pulaski County & Pulaski County Public Schools

With the Limited Purpose FSA, get reimbursed for out-of-pocket dental and vision care expenses with tax free dollars!

MAXIMIZE YOUR INCOME!

Limited Purpose Flexible Spending Accounts (FSAs) allow you to pay certain dental, vision and/or preventative care expenses with pre-tax money. You will not pay any Federal, State or Social Security taxes on funds placed in the Plan. You will save between approximately $27.65 and $37.65 on every $100 you place in the Plan. The amount of your savings will depend on your Federal tax bracket.

Participation in the Plan begins on July 1, 2026 and ends on June 30, 2027. You will be eligible to join the Plan if you are a full-time or part-time employee working at least 20 hours or more per week on a regular basis on the first of the month following your date of hire. You must also be enrolled in a High-Deductible Health Plan (HDHP). Those employees having a qualifying event are eligible to enroll within 30 days of the qualifying event. Deductions begin on the first pay period following your Plan start date. You must complete an enrollment to participate in the Flexible Spending Accounts each year during the enrollment period. If an enrollment is not completed during open enrollment, you will not be enrolled in the Plan and you will not be able to join until the next Plan Year

ELECTION CHANGES

Election changes are only allowed if you experience one of the following qualifying events:

- Marriage or divorce
- Birth or adoption
- Involuntary loss of spouse's medical or dental coverage
- Death of dependent (child or spouse)
- Unpaid FMLA or Non-FMLA leave

REIMBURSEMENT SCHEDULE

All manual or paper claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week via direct deposit. If direct deposit information is not on file for you, your reimbursement will be held until we receive that information. You may also use your Benefits Card to pay for expenses. Please refer to the Benefits Card section for details.

ONLINE ACCESS

Flexible Benefit Administrators, Inc. provides on-line account access for all FSA participants. Please visit their website at:

https://fba.wealthcareportal.com/ to view the following features:

- FSA Login – View balances, check status and view claims history-download participation forms.
- FSA Educational Tools – FSA calculator: Estimate how much you can save by utilizing an FSA.

THE LIMITED FSA ACCOUNT IS A PRE-FUNDED ACCOUNT

This means that you can submit a claim for dental and/or vision expenses on the first day of the Plan Year and you will be reimbursed your total claim amount up to your annual election. The funds that you are pre-funded will be recovered as deductions which are taken from your paycheck on a pre-tax basis.

Contribution Limits: The maximum you may place in this account for the Plan Year is $3,400.

With this account, you can pay for your out-of-pocket dental, vision, and preventative care expenses for yourself, your spouse and all your dependents for services that are incurred during your Plan Year and while an active participant. Funds contributed to your Health Savings Account (HSA) can also cover these expenses, so why would someone choose to make a second contribution to a Limited FSA along with an HSA? Below are a few key reasons to contribute to both to get the most out of your HSA.

You will likely have dental and/or vision expenses early in the Plan Year.
or if you have a qualifying event.
A Limited Purpose FSA is pre-funded at the beginning of the Plan Year while HSA funds are only available as they are deposited into your account. For this reason, if you are planning on incurring dental and/or vision expenses early in the Plan Year, a Limited Purpose FSA is a great way to pay for those expenses. With the Limited FSA, you can use your full election as soon as you need it. Since it acts like a tax-free, interest free loan. This is particularly useful for those who have just opened their HSA and/or who haven't been able to build up a balance in their HSA account.

You want to use your HSA contributions primarily for medical expenses.
Since you are covered by a High-Deductible Health Plan, you know you may be required to pay higher amounts for medical expenses you incur. If you know you'll use most of your HSA contributions for these medical expenses, it makes sense to set aside separate contributions to cover any vision or dental expenses.

You wish to use your HSA as a retirement or investment account.
HSAs offer a triple-tax advantage, meaning you get a tax advantage towards your contributions, distributions (if used for eligible expenses), and any interest you earn from your HSA. Medicare expenses for those 65 years and older can easily add up to $200,000 for a couple over the course of 20 years. This does not include dental, vision, hearing aids, and out-of-pocket drugs. By using funds from a Limited Purpose FSA, you can allow more money to remain in your HSA to gain interest while still getting the same tax advantage on your vision and dental expenses.

ELIGIBLE VISION AND DENTAL EXPENSES

The Limited FSA allows you to pay for dental and vision expenses for you and your eligible dependents with pre-tax dollars. Eligible dental expenses include dental procedures that are not for cosmetic purposed and not covered by your insurance such as those listed below.

Examples of Eligible Dental Expenses:

- Orthodontia (Braces)
- Crowns
- Fillings
- Checkups

For orthodontia expenses, you can use funds in your Limited FSA to either be reimbursed for a payment made in full on the first orthodontic visit (up to your annual election). If you pay for your orthodontia treatments over the span of multiple plan years, you can pay the monthly payment directly to your orthodontist, then send a claim form in each month to be reimbursed or you can pay your monthly payments with your Benefits Card and send FBA a copy of your orthodontic contract to keep on file so that we can setup a recurring expense on your account.

Examples of Eligible Vision Expenses:

- Eyeglasses
- Prescription Sunglasses
- Routine Eye Exam

ELIGIBLE PREVENTATIVE CARE EXPENSES

In order for an expense to be considered "preventative care" you will need to acquire a prescription or Letter of Medical Necessity from your medical provider that specifically states that the treatment is for the prevention of the onset of an illness. Once you are officially diagnosed with a condition, any expenses used towards treating the condition would not be eligible. Below are two examples of preventative care to prevent the onset of illnesses.

Diabetes

Your doctor may write you a letter of medical necessity stating that they recommend you get a gym membership and exercise in order to prevent the onset of Type II Diabetes.

High Blood Pressure

If you have a family history of high blood pressure, your doctor may write you a prescription for blood pressure medication preventing high blood pressure.

Other eligible "preventative care" expenses include tobacco cessation programs, cancer screening, heart and vascular care screenings, substance abuse screenings, routine prenatal care, and child and adult immunizations.

Please refer to IRS Notice 2004-23 for a more comprehensive list of preventative care expenses.

HOW THE FLEXIBLE BENEFIT PLAN WORKS

	Flex Benefits Without	Flex Benefits With
Gross Monthly Income	$ 2,500.00	$ 2,500.00
Eligible Pre-Tax employer medical insurance	$ 0.00	$ 200.00
Eligible Pre-Tax Medical Expenses	$ 0.00	$ 60.00
Eligible Pre-Tax Dental and Vision Expenses	$ 0.00	$ 150.00
Taxable Income	$ 2500.00	$ 2090.00
Federal Tax (15%)	$ 375.00	$ 313.50
State Tax (5.75%)	$ 143.75	$ 120.18
FICA Tax (7.65%)	$ 191.25	$ 159.89
After-Tax employer medical insurance	$ 200.00	$ 0.00
After-Tax Medical expenses	$ 60.00	$ 0.00
After-Tax Dental and Vision expenses	$ 150.00	$ 0.00
Monthly Spendable Income	$ 1380.00	$ 1496.43

By taking advantage of the Limited FSA to cover dental and vision expenses and the HSA to cover their Medical expenses, this employee was able to increase his/her spendable income by $116.43 every month! This means an annual tax savings of $1,397.16. Remember, with the FLEXIBLE BENEFIT PLAN, the better you plan the more you save!

HOW TO RECEIVE REIMBURSEMENT

To obtain a reimbursement from your Flexible Spending Account, you must complete a Claim Form. This form is available to you on our website. You must attach a receipt or bill from the service provider which includes all the pertinent information regarding the expense:

- Date of service
- Patient's name
- Amount charged
- Provider's name
- Nature of the expense
- Amount covered by insurance (if applicable)
- Lasik Eye Surgery
- Contact Lenses
- Diagnostic Services

Canceled checks, bankcard receipts, credit card receipts and credit card statements are NOT acceptable forms of documentation. You are responsible for paying your dental and vision provider directly.

FORFEITING FUNDS

Plan carefully! Unused funds will be forfeited as governed by the IRS's "use-it-or-lose-it" rule. Your employer has elected to adopt the IRS offered 2 month 15-day grace period. Please see the Employee Guide for more info.

HOW TO ENROLL IN OUR FSA PLAN

Step 1

Carefully estimate your eligible dental, vision and/or preventative care expenses for the upcoming Plan Year. Then use our online FSA Educational Tools located at https://fba.wealthcareportal.com/ to help you determine your total expenses for the Plan Year.

Step 2

Complete your enrollment during the open enrollment period, which instructs payroll to deduct a certain amount of money for your expenses. This amount will be contributed on a pre-tax basis from your paychecks to your FSA. Remember the amount you elect will be set aside before any federal, social security, and state taxes are calculated.

BENEFITS CARD

The Benefits Card can be used as a direct payment method for eligible expenses incurred at approved service providers and merchants. Using your card allows you instant access to your funds with no out-of-pocket expense. Please keep all your itemized receipts. Flexible Benefit Administrators, Inc. may request documentation to substantiate Benefits Card transactions to determine eligibility of an expense. Benefits Cards are available upon request of the account holder for dependents over the age of 18. Please contact Flexible Benefit Administrators, Inc. to order additional cards.

PULASKI COUNTY PUBLIC SCHOOLS

Your FSA. More Everyday Value.

SHOP ELIGIBLE HEALTH & WELLNESS ESSENTIALS

2026 - 2027 BENEFIT GUIDE

STRETCH YOUR HEALTHCARE DOLLARS

A healthcare Flexible Spending Account (FSA) lets you set aside pre-tax dollars for eligible expenses. Your tax savings depend on your income and tax situation.



WHAT CAN YOUR HEALTHCARE FSA HELP PAY FOR?

Medical care

Eligible doctor visit costs and prescription or over-the-counter medicines.

Vision & dental

Prescription glasses, contact lenses, and eligible dental care.

Everyday essentials

Eligible menstrual care, first aid, and pain relief products.

Health & sun protection

Eligible diagnostic products, sunscreen, and other qualifying products.

KNOW BEFORE YOU SHOP

Use your FSA for eligible expenses for you, your spouse, and qualifying dependents. Check your plan's contribution limit, deadlines, and eligible expenses with HR or your FSA administrator.

Keep your receipts. Save itemized documentation in case your administrator requests it. Not every skincare product or health tracker qualifies. A limited-purpose FSA generally covers eligible dental and vision expenses, not general medical purchases.

EXPLORE ELIGIBLE PRODUCTS

FSAstore.com

Product eligibility and reimbursement are subject to your FSA plan and administrator review.



PULASKI COUNTY PUBLIC SCHOOLS

Dental Benefits

2026 - 2027 BENEFIT GUIDE

YOUR PLAN

Delta Dental PPO Plus Premier

A HEALTHY SMILE STARTS WITH REGULAR CARE

Brushing and flossing are important, and regular dental visits can help identify concerns early. Dental coverage helps make care more affordable and supports your oral health.

1. **Preventive care**
   Exams, cleanings, and X-rays.

2. **Basic care**
   Restorative services such as fillings, root canals, and gum disease treatment.

3. **Major care**
   Services such as bridges, crowns, and dentures.

4. **Orthodontic care**
   Treatment to help properly align teeth. Check your plan for eligibility and limits.

KNOW YOUR COVERAGE BEFORE TREATMENT

Review the plan summary for covered services, deductibles, coinsurance, annual maximums, and orthodontic benefits. Service categories and coverage are determined by the plan.

PULASKI COUNTY PUBLIC SCHOOLS

Dental Benefit Summary

2026 - 2027 BENEFIT GUIDE | DELTA DENTAL PPO PLUS PREMIER

YOUR PLAN AT A GLANCE

Annual deductible	None (N/A)
Annual maximum	$1,000 per person, per contract year
Orthodontic lifetime maximum	$1,000 per person
Group number	00000700222

WHAT THE PLAN PAYS

The plan pays the following percentages of its plan allowance for Delta Dental PPO, Delta Dental Premier, and out-of-network dentists.

DIAGNOSTIC & PREVENTIVE SERVICES — 100%

- Oral exams and cleanings: twice in a 12-month period.
- Periodontal cleanings: twice in a 12-month period.
- Fluoride: twice in a 12-month period for enrollees under age 19.
- X-rays: bitewings once in 12 months, up to four films or a set of seven to eight vertical bitewings; full-mouth X-rays once in five years.
- Sealants: one per tooth every five years, under age 16, on first and second permanent molars.

BASIC SERVICES — 80%

- Fillings: one per surface in 24 months; composite (white) fillings limited to upper and lower six front teeth.
- Root canal therapy; gum disease treatment; simple extractions; oral surgery, including surgical extractions; denture repair and recementation.

MAJOR SERVICES — 50%

- Crowns: one per tooth in 84 months, age 12 and older.
- Prosthodontics, dentures and bridges: once in 84 months, age 16 and older.
- Implants: one per site, age 16 and older.

ORTHODONTIC SERVICES — 50%

- Treatment for proper alignment of teeth for dependent children under age 19. Subject to the $1,000 lifetime maximum.

Questions or finding a dentist? Delta Dental of Virginia | 800-237-6060 | DeltaDentalVA.com

Summary of the supplied Schools plan sheet, effective July 1, 2025. The source indicates additional information continues on the next page. Plan terms, allowances, exclusions and limitations govern coverage; review the complete plan documents.



PULASKI COUNTY PUBLIC SCHOOLS

Vision Benefits

2026 - 2027 BENEFIT GUIDE

YOUR PLAN

Anthem Blue View Vision | Insight Network

SEE CLEARLY. MAKE EYE HEALTH A PRIORITY.

Vision coverage helps with the cost of routine eye exams, eyeglasses, and contact lenses. Even if you do not need vision correction, regular eye exams help you stay informed about your eye health.

Routine exams

Review vision changes and check the health of your eyes.

Eyewear support

Use available benefits for eligible glasses or contact lenses.

Your overall health

An eye exam may reveal signs that warrant follow-up with your healthcare provider.



MAKE THE MOST OF YOUR VISION PLAN

Review the benefit summary for exam and eyewear frequencies, copays, allowances, and network details before scheduling care.

Find resources: www.pcvabenefits.com

Anthem Blue View Vision

2026 - 2027 BENEFIT GUIDE | BENEFIT SUMMARY

Benefit / service	In-network cost	Out-of-network reimbursement
EXAMS, CONTACT LENS FITTING & FRAMES		
Routine Eye Exam	$15 copay	up to $40 reimbursement
Exam Frequency	Once every 12 months	
Contact lens fit & follow-up frequency	Once every 12 months	
Standard contact lens fit & follow-up	$0 copay	up to $40 reimbursement
Premium contact lens fit & follow-up	10% off retail price, then apply $40 allowance	up to $40 reimbursement
Frames	$130 allowance, then 20% off any balance	up to $45 reimbursement
Frame Frequency	Once every 24 months	
EYEGLASS LENSES | INSTEAD OF CONTACT LENSES		
Single Vision	$15 copay	up to $40 reimbursement
Bifocal	$15 copay	up to $60 reimbursement
Trifocal	$15 copay	up to $80 reimbursement
Lenticular	$15 copay	up to $80 reimbursement
Lens Frequency	Once every 12 months	
LENS OPTIONS		
UV Coating	$0 copay	up to $5 reimbursement
Tint (Solid and Gradient)	$0 copay	up to $5 reimbursement
Standard Factory Scratch Coating	$0 copay	up to $5 reimbursement
Standard Polycarbonate	$0 copay	up to $5 reimbursement
Progressive - Standard	$0 copay	up to $60 reimbursement
Progressive - Premium tier 1	$20 copay	up to $60 reimbursement
Progressive - Premium tier 2	$30 copay	up to $60 reimbursement
Progressive - Premium tier 3	$45 copay	up to $60 reimbursement
Progressive - Premium tier 4	20% off retail price	up to $60 reimbursement
Standard Anti-Reflective Coating	$0 copay	up to $5 reimbursement
Premium Tier 1 Anti-Reflective Coating	$12 copay	up to $5 reimbursement
Premium Tier 2 Anti-Reflective Coating	$23 copay	up to $5 reimbursement
Premium Tier 3 Anti-Reflective Coating	20% off retail price	N/A
CONTACT LENSES | INSTEAD OF EYEGLASS LENSES		
Elective - Disposable	$150 allowance	up to $150 reimbursement
Elective - Conventional	(non disposable) $150 allowance, 15% off any balance	up to $150 reimbursement
Non-Elective Contact Lenses	Covered in full	up to $150 reimbursement
Contact Lens Frequency	Once every 12 months	

Illustrative purposes only. Please review plan summaries for complete details.



Blue View Vision

Benefits that focus on your eye care

Many of us put our vision to the test every day with reading, driving, and spending time on a computer or phone. That's why we want to make it easier for you to take care of your eyes — and help catch health issues earlier.

Working together for your total health

Eye doctors are often the first to find signs of chronic health conditions, such as diabetes, high blood pressure, and high cholesterol[1] — all through an eye exam. So, if they notice any signs of one of these conditions during your eye checkup, they can share that information with your primary care doctor to get a better picture of your overall health.

Accessible care on your terms

Blue View Vision gives you options to receive care when and where you need it with one of the nation's largest vision networks.

- **More doctors and locations.** With over 42,000 eye doctors and other eye care providers at more than 30,000 locations[2] in your plan's network, you're sure to find care that's close to home or work.
- **Convenience and flexibility.** Visit an independent eye doctor or choose from a variety of popular regional and national retail and online stores included in our standard network. Many of these stores have evening and weekend hours to work with most schedules.

Eyewear to fit your style

Access eye care and buy eyewear at a price that works with your budget. Keep in mind you'll receive discounts[3] when you go to an independent eye doctor or optical retail store that's in your plan's network. You can also include the following options at no additional cost:

- Factory scratch coating on standard/basic eyeglass lenses.
- Polycarbonate and Transitions® lenses for covered dependents under age 19.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 OPTICAL℠

GLASSES.COM contactsdirect 1800contacts Ray-Ban befitting

PULASKI COUNTY PUBLIC SCHOOLS

Support for Life. Support for You.

SENTARA EAP | WORK/LIFE RESOURCES

2026 - 2027 BENEFIT GUIDE

LIFE HAS UPS AND DOWNS.

Balancing everyday responsibilities with the demands of work can feel stressful. Sentara work/life resources offer guidance and practical tools to help you find balance.



1 Work/life consultations

Confidential guidance to help you find childcare, eldercare, pet care, and education resources and address everyday needs.

2 Legal assistance

Qualified attorneys offer assistance with civil, consumer, criminal, estate, financial, immigration, tax, family, and real estate matters.

3 Financial guidance

Financial planners, CPAs, and credit counselors offer support with budgeting, debt, credit, identity theft, retirement planning, and more.

4 24/7 online resources

Explore articles, webinars, calculators, videos, assessments, and interactive tools on health, wellness, family, aging, education, legal, and financial topics.

CONNECT TO YOUR WORK/LIFE RESOURCES

1. Visit **sentaraEAP.com** and enter your organization's username.
2. Choose **Work/Life**, then **Access Enhanced Online Resources**. Enter the company code below.
3. Create a unique username and password to access the resources.

ORGANIZATION USERNAME
PulaskiSchools

COMPANY CODE
Sentara20

Call Sentara EAP: 1-800-899-8174

Sentara EAP is administered by Sentara Behavioral Health Services, Inc.

PULASKI COUNTY PUBLIC SCHOOLS

5 Things to Know About Your EAP

SENTARA EMPLOYEE ASSISTANCE PROGRAM

2026 - 2027 BENEFIT GUIDE

SUPPORT FOR LIFE'S EVERYDAY CHALLENGES

Personal concerns. Family needs. Work-related stress. Your EAP offers confidential, short-term, solution-focused support when you need it.



1 A helpful resource

Get support with personal concerns, life's challenges, and work-related issues. Services focus on practical solutions.

2 For you and your household

Services are available to all members of your household at no cost, with **up to five counseling sessions per presenting issue**.

3 Free and convenient

Your employer pays for EAP services. Call to speak with a representative who can help schedule an appointment with a counselor near you.

4 Confidential support

Counseling discussions and protected health information are safeguarded under applicable privacy laws. Contact Sentara EAP for details about confidentiality and legally required exceptions.

5 Easy to reach, day or night

Phones are personally staffed **24 hours a day, 365 days a year**. You can contact the EAP directly without going through your manager or HR.

1-800-899-8174

sentaraEAP.com

ORGANIZATION USERNAME

PulaskiSchools

Protect Your Family & Finances

AIRMEDCARE NETWORK | EMPLOYEE MEMBERSHIP

2026 - 2027 BENEFIT GUIDE

HELP WITH EMERGENCY AIR MEDICAL TRANSPORT COSTS

Pulaski County offers employees the opportunity to join AirMedCare Network (AMCN) at a special discounted rate. AMCN providers respond to emergencies and provide hospital-to-hospital transport to the nearest appropriate medical facility.

Air medical transport can result in significant out-of-pocket expenses, even with medical insurance. Membership offers financial protection for eligible transport by an AMCN provider.



IMPORTANT: THE PROVIDER MATTERS

Members have no out-of-pocket expense for medically necessary flights **only when transported by an AMCN provider**, subject to membership terms. Membership does not guarantee transport by an AMCN provider.

1. ### Household protection

   Membership covers you and anyone who resides in your home.

2. ### Coverage while traveling

   Membership is valid in AMCN service areas, at home and while traveling.

3. ### Optional Teladoc access

   Discounted physician access is listed for $3 per month plus a copay. Confirm current availability and cost when enrolling.

READY TO JOIN?

Contact Joy Skovira for the enrollment portal and instructions. Current members also need to complete the employer enrollment steps to activate membership.

Membership terms and conditions apply. Membership is not insurance.

AirMedCare: Your Questions

MEMBERSHIP DETAILS & CONTACTS

What happens in a medical emergency?

Call 911. Medical professionals determine whether air ambulance transport is needed. You or a family member should tell responders that you are an AMCN member. Dispatch decisions are made by emergency medical personnel.

What should I keep handy?

New members receive a packet with a welcome letter, car/house stickers, and membership cards. Display membership stickers on your vehicle and keeping your card in your wallet, behind your driver's license.

What should I do after a flight?

Once flown and upon recovery, you or a family member should contact the membership call center or your local Membership Sales Manager and report the transport.

What if I receive a bill?

If AMCN has been notified of your eligible flight, you should not receive an invoice. If you receive a bill in error, call **800-793-0010** for help.

What if I leave my employer?

Your selected membership continues until it expires. AMCN may contact you about continuing at its regular membership rate. Confirm current renewal pricing directly with AMCN.

Where does the network operate?

Membership applies in AMCN service areas. The enrollment materials list more than 320 locations in 38 states; check **www.amcnrep.com** for current locations and specific coverage details.

YOUR MEMBERSHIP CONTACT

Joy Skovira | Membership Sales Manager

540-679-6887 | joy.skovira@gmr.net

www.amcnrep.com/joy-skovira

Track code: 15185 | Plan code: 17293

Dispatch decisions are made by emergency medical personnel. Membership does not guarantee transport by an AMCN provider. Confirm current service areas, enrollment pricing, and optional features with AMCN.

Membership terms and conditions apply. Membership is not insurance.

Supplemental Benefits

COLONIAL LIFE

2026 - 2027 BENEFIT GUIDE

Your benefit needs are personal. Voluntary supplemental coverage lets you customize your benefits package to fit your needs and budget. These plans can help with financial challenges caused by an unexpected injury, illness, or loss.

EXPLORE YOUR OPTIONS

Accident

Helps with out-of-pocket expenses after a covered accidental injury.

Critical illness with cancer

Helps with expenses associated with a covered critical illness, including cancer.

Disability | Paycheck protection

Helps replace income if a covered injury or illness prevents you from working.

Hospital confinement

Helps with out-of-pocket expenses associated with a covered hospital stay.

Term life | Group & individual

Provides benefits to your loved ones in the event of your passing.

CONVENIENT COVERAGE THAT FITS YOUR BUDGET

Premiums are conveniently deducted from payroll. Choose coverage and premium levels that fit your budget while helping protect against life's unexpected expenses.

Benefits when you need them. Depending on the plan, benefits can help replace lost income, pay expenses such as deductibles and copays, or provide financial support for your loved ones. Benefits are generally paid directly to you or your designated beneficiary, subject to policy terms.

Enrollment made easier. Guaranteed issue coverage with no medical questions is available for eligible enrollments, subject to each plan's coverage limits and requirements. Ask your Colonial Life benefits counselor about available options and how coverage works with your other insurance.

See the following benefit summaries and policy documents for complete coverage details.

PULASKI COUNTY PUBLIC SCHOOLS

Disability Insurance

COLONIAL LIFE

2026 - 2027 BENEFIT GUIDE

Help protect your income from the unexpected. If a covered illness or injury keeps you from working, disability insurance can help replace missing income so you can pay everyday expenses while you focus on recovery.

COVERAGE AT A GLANCE

60% of monthly income

Up to a maximum benefit of $4,000 per month.

14-day waiting period

For covered accidents and illnesses.

3 or 6 months

Choose a 3-month or 6-month benefit period.

Guaranteed issue

No medical questions.

Premiums are quoted per pay period, based on 24 pay periods per year.

IMPORTANT ELIGIBILITY NOTE

Employees need **more than one year of employment** to qualify for VLDP. Make sure you have a plan to protect your income.

HOW THE BENEFIT WORKS

Choose your coverage. At enrollment, select a disability benefit amount that fits your needs, subject to your income.

Receive regular payments. For a covered illness or injury, benefits become payable after the elimination (waiting) period.

Use the money where you need it. Benefits are payable directly to you unless otherwise specified. Use them for rent or mortgage payments, utilities, groceries, or other expenses.

Other coverage and part-time work. Benefit payments do not coordinate at the time of claim with other insurance or state paid medical leave benefits. Disability benefits may also be available if you return to work part-time.

WHEN DISABILITY COVERAGE CAN HELP

Examples include a covered injury that keeps you off the job, recovery after surgery or a serious illness, or covered maternity leave. Benefits can help with ongoing household expenses and reduce the need to use savings.

Injuries may include falls, overexertion, transportation incidents, or contact with objects or equipment. Illnesses may include musculoskeletal conditions, heart disease, cancer, stroke, or kidney disease. Coverage depends on policy terms.

Learn more: ColonialLife.com/ee-disability

This is a summary. Review the policy for complete benefits, limitations, and exclusions.

Accident Insurance

COLONIAL LIFE

2026 - 2027 BENEFIT GUIDE

Help with unexpected expenses after an accident. Even with medical insurance, you may have deductibles, coinsurance, and copays to pay. Colonial Life Accident Insurance provides a lump-sum benefit for a covered accident to help with out-of-pocket costs while you focus on recovery.

COVERAGE AT A GLANCE

Benefits paid to you

Benefits are payable directly to you unless otherwise specified.

Coverage for your family

Coverage is available for you, your spouse, and eligible dependent children.

No medical questions

No medical questions or physical exam are needed to obtain accident coverage.

Works with other insurance

Benefits are not reduced by other insurance you may have with another company.

HOW THE BENEFIT WORKS

A set benefit amount is payable based on the covered injury and treatment needed. You decide how to use the money: emergency room costs, doctor's bills, travel costs, or other bills and everyday expenses.

EXAMPLES OF HOW BENEFITS CAN HELP

Car accident. After breaking ribs in an automobile accident, Jayden used his benefits for emergency room out-of-pocket costs and a rental car while his car was being repaired.

Bicycle injury. After Isabella dislocated her ankle, her family used benefits to help with clinic coinsurance and a copay, X-rays, crutches, and follow-up treatment.

Fall while camping. After Robert broke his collarbone, he used benefits toward his deductible, coinsurance, and copays for surgery, hospital confinement, and physical therapy.

These examples are for illustrative purposes only.

ACCIDENTS CAN HAPPEN DURING EVERYDAY ACTIVITIES

Exercise, cycling, basketball, skateboarding or scooter riding, football, and playground activities are examples of situations where injuries can occur.

This is a summary. Review the policy for complete benefits, limitations, and exclusions.

Hospital Confinement

COLONIAL LIFE | MEDICAL BRIDGE

2026 - 2027 BENEFIT GUIDE

Help with out-of-pocket costs from a hospital stay. An unexpected hospital stay may leave you with a deductible and coinsurance to pay. Colonial Life Medical Bridge benefits can help with these expenses, as illustrated below.

ONE FAMILY'S JOURNEY

Nathan was doing yard work with his wife when he began having chest pains. After a doctor examined him, the couple was relieved to learn it was a false alarm.

A 24-HOUR HOSPITAL STAY

Nathan was admitted to the hospital while doctors ran additional tests. After the tests confirmed there were no issues, he was released the following day.

ILLUSTRATIVE COSTS & BENEFIT

Nathan's out-of-pocket expenses	Amount
Deductible	$1,500
Coinsurance	$1,800
Total out-of-pocket expenses	**$3,300**

HOSPITAL CONFINEMENT BENEFIT

$1,500

Illustrative benefit shown in Nathan's example.

In this example, Nathan's Medical Bridge benefit helped pay the out-of-pocket expenses associated with his medical care. **The amounts above illustrate one scenario and are not a statement of your elected benefit.**

QUESTIONS ABOUT YOUR COVERAGE?

Talk with your Colonial Life benefits counselor for more information about your available benefits and coverage details.

Illustrative purposes only. Review the policy for complete benefits, limitations, and exclusions.

Critical Illness Insurance

COLONIAL LIFE

2026 - 2027 BENEFIT GUIDE

Help protect your finances during treatment and recovery. A critical illness can create unexpected expenses and time away from work for you or your family. Critical illness insurance may help with these costs so you can focus on recovery.

COMMON CRITICAL ILLNESSES

Heart attack | Stroke | Major organ failure | Cancer

These are examples of critical illnesses. Covered conditions depend on the policy.

HOW COVERAGE MAY HELP

Lost income

You, your spouse, or another family member may need time away from work for treatment or recovery.

Travel and lodging

Specialty treatment may require travel and an extended stay away from home.

Medical expenses

Out-of-pocket costs can include copays and deductibles.

Rehabilitation

Recovery may require additional help, such as speech therapy or physical therapy.

PROTECT YOUR WAY OF LIFE

Treatment and recovery can affect both your household budget and your savings. Consider how you would manage ongoing bills, medical expenses, and family needs if you or a loved one experienced a critical illness.

LEARN MORE ABOUT YOUR OPTIONS

Talk with your Colonial Life benefits counselor about available coverage, covered conditions, and benefit amounts, and how critical illness insurance may help protect what you have worked to build.

ColonialLife.com

This is a summary. Review the policy for complete benefits, limitations, and exclusions.

PULASKI COUNTY PUBLIC SCHOOLS

Group Term Life Insurance

COLONIAL LIFE | VOLUNTARY COVERAGE

2026 - 2027 BENEFIT GUIDE

Protect the people who matter most. Life insurance can help your family replace lost income, pay housing and everyday expenses, cover burial and final expenses, or leave an inheritance.

COVERAGE OPTIONS

Who is covered	Available coverage
Employee	$1,000 increments; $10,000 minimum. Maximum: five times your salary, up to $500,000.
Spouse	$1,000 increments; $5,000 minimum to $500,000 maximum. Spouse coverage cannot exceed employee coverage.
Dependent children (up to age 26)	$1,000 increments; $1,000 minimum to $10,000 maximum per child. Each child has the same amount, except children from live birth to six months, whose death benefit is $1,000.

GUARANTEED ISSUE | NO MEDICAL QUESTIONS

Employee	Spouse	Children
Up to $150,000*	Up to $25,000	Up to $10,000

Amounts above the guaranteed issue limit may require health information. Confirm enrollment eligibility and guaranteed issue availability with your benefits counselor.

ADDITIONAL BENEFITS & SERVICES

Accelerated death benefit. Built-in advance of up to 75% of the death benefit, to a maximum of $150,000, if diagnosed with a terminal illness.

Health Advocate Employee Assistance Program. 24-hour personal support and referral service, a medical bill saver service, and face-to-face sessions and video counseling with mental health professionals. ColonialLife.com/EAP | 1-888-645-1772.

Life planning services. Financial and legal counseling, grief support, and referrals for up to 12 months after a claim.

LawAssure legal assistance. Employees who speak with a Colonial Life benefits counselor are eligible at no cost. Enrollment in benefits is not required.

*Employee guaranteed issue amount requires confirmation with your Colonial Life benefits counselor.

Summary only. Policy terms, eligibility, exclusions, and limitations apply.

Term Life & AD&D

COLONIAL LIFE | BENEFITS & COVERAGE DETAILS

2026 - 2027 BENEFIT GUIDE

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

AD&D can provide benefits for a covered accidental death or dismemberment. The full AD&D benefit equals your group term life insurance death benefit. Benefits can be used for any purpose, including recovery or rehabilitation.

Covered loss	% of full benefit
Loss of life	100%
Loss or loss of use of both hands or both feet; or sight of both eyes	100%
Loss or loss of use of one hand and one foot	100%
Loss or loss of use of one hand and sight of one eye	100%
Loss or loss of use of one foot and sight of one eye	100%
Loss of speech and hearing	100%
Loss or loss of use of one hand or one foot	50%
Loss of sight of one eye	50%
Loss of speech or hearing	50%
Loss or loss of use of thumb and index finger on the same hand	25%

Seatbelts and airbags: An additional benefit is available for a covered car accident causing death or dismemberment when the covered person was using a seatbelt or airbag. **Family coverage:** AD&D is available with group term life coverage for you and covered family members.

CONTINUING YOUR COVERAGE

Portability: You may be able to continue coverage if you change jobs or retire. **Conversion:** After the group term period ends, you may be eligible to convert to whole life insurance without health questions. **Waiver of premium:** Premium payments may be eligible for waiver if you become disabled.

PREMIUMS & AGE REDUCTIONS

Semi-monthly premium: Add the applicable age/smoking-status life rate and AD&D rate. Multiply by your coverage amount divided by $1,000, then multiply by 12 and divide by 24. Ask your counselor for applicable rates.

Age reductions: Benefits reduce at ages 70 and 75. Refer to your certificate for the reduction schedule and rules for coverage elected at those ages.

Summary only. Policy terms, eligibility, exclusions, and limitations apply.

Employee Assistance Program

COLONIAL LIFE | HEALTH ADVOCATE

2026 - 2027 BENEFIT GUIDE

WHO IS ELIGIBLE?

Employees enrolled in **Colonial Life Group Term Life with AD&D** receive EAP services.

Support when you need it most. The Employee Assistance Program (EAP) and Life Planning Services from Health Advocate offer resources for life's challenges at home and work.

CONFIDENTIAL COUNSELING & SUPPORT

Access 24-hour confidential counseling and resources, with unlimited phone support, online chat, and **up to three face-to-face sessions** for a variety of personal and work concerns.

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

MEDICAL BILL SAVER

Get help navigating medical and dental out-of-pocket expenses. This Health Advocate EAP resource can:

- Negotiate out-of-pocket medical and dental costs over **$400**.
- Provide a Savings Results Statement summarizing the outcome.
- Explain how to maximize savings and get the most value from your benefits.

ACCESS YOUR EAP

Online: ColonialLife.com/EAP

Call: 1-888-645-1772

Contact Health Advocate for complete service details and applicable program terms.

Individual Term Life

COLONIAL LIFE

2026 - 2027 BENEFIT GUIDE

Protection for your working years. Individual term life insurance provides financial protection for you and your loved ones during your working years. Benefits can help your loved ones pay ongoing expenses if you pass away.

CHOOSE A TERM THAT FITS YOUR NEEDS

10, 15, 20 or 30 years

Level premium | Guaranteed renewable | Portable

BENEFIT FEATURES

Financial support for loved ones. Helps pay ongoing expenses after your passing.

Typically tax-free benefits. Benefit payments are typically tax-free.

Conversion option. Coverage may be eligible to convert to a whole life policy without health questions.

Guaranteed issue. No medical questions for eligible coverage within the issue-age and benefit limits below.

GUARANTEED ISSUE AMOUNTS

Covered person	Issue age	Guaranteed issue amount
Employee	16 - 50	$125,000
Employee	51 - 60	$75,000
Employee	61 - 75	$30,000
Spouse	16 - 50	$25,000
Spouse	51 - 75	$10,000

Talk with your Colonial Life benefits counselor about available term lengths, eligibility, and coverage options.

Summary only. Review the policy for complete benefits, eligibility, limitations, and exclusions.

Group Whole Life Insurance

MASSMUTUAL | BENEFITS AT A GLANCE

2026 - 2027 BENEFIT GUIDE

Lifelong protection for the people you love. MassMutual Group Whole Life Insurance provides coverage at a set premium, builds cash value over time, and pays a death benefit to your loved ones.

GUARANTEED PROTECTION

Coverage offers a guaranteed death benefit, guaranteed level premiums, and guaranteed cash-value accumulation, subject to certificate terms.

PORTABLE, LIFELONG COVERAGE

You own the certificate and its accumulated cash value. You can take the coverage with you if you leave the company. If you leave and keep your certificate, you may change your dividend option and choose to have dividend payments reduce your premiums.

DIVIDEND ELIGIBILITY

Certificate owners are eligible to receive dividends beginning on the second anniversary. During enrollment, you may select a dividend option such as **cash, dividend accumulations, or paid-up additional insurance**. Dividends are not guaranteed.

TAX ADVANTAGES

Whole life insurance offers a generally income-tax-free death benefit and tax-deferred cash-value growth. Individual tax results depend on your circumstances.

ACCESS TO CASH VALUE

Cash value may be accessed through borrowing or partial surrenders. These transactions reduce cash value and the death benefit, increase the chance the certificate will lapse, and may create a tax liability if the certificate ends before the insured dies.

REVIEW YOUR OPTIONS

Ask your benefits counselor about available coverage, premiums, dividend options, and certificate features. Review all coverage details before enrolling.

Summary only. Certificate terms, state variations, restrictions, and limitations apply.

Accelerated Benefits

MASSMUTUAL | ACCESS TO A PORTION OF YOUR DEATH BENEFIT

2026 - 2027 BENEFIT GUIDE

As certificate owner, you may receive an advance of a portion of the death benefit if the insured is diagnosed with a terminal illness or has a chronic illness certified by a Qualified Medical Practitioner.

CHRONIC ILLNESS

Generally, this benefit is payable when the insured permanently loses the ability to perform two activities of daily living (eating, toileting, transferring, bathing, dressing, or continence) due to loss of functional capacity, or requires substantial supervision due to permanent severe cognitive impairment. In North Carolina and Washington, the definition generally requires continuous confinement in an eligible institution where the insured is expected to remain for life.

TERMINAL ILLNESS

In most states, this benefit is payable when the insured meets the definition of terminal illness, generally an illness expected to result in death within 12 months (24 months in some states).

IMPORTANT EFFECTS ON YOUR COVERAGE

Accelerated benefits are **not long-term care insurance** and may be used for any purpose. Payment reduces the certificate death benefit, cash value, and loan values. Premiums are then based on the reduced amount of insurance at the current rate. There is no premium required for either accelerated benefit provision, but exercising the Chronic Care Benefit involves a fee.

CHRONIC CARE FEE

The fee is a present-value adjustment to the eligible benefit amount and depends on age when exercised: **18% for age 45 and older; 27% for ages 35 - 44; 36% under age 35**. State terminology and rules vary. Review the accelerated death benefit disclosure provided at application.

BENEFIT COORDINATION

After exercising the terminal illness benefit, the certificate owner cannot use the Chronic Care Benefit. A terminal illness benefit may still be available on the remaining face amount after a Chronic Care Benefit payment.

TAX & PUBLIC ASSISTANCE CONSIDERATIONS

Benefits may be taxable and may affect eligibility for Medicaid or Supplemental Security Income. Tax treatment and illness definitions vary by state, including Washington and North Carolina. Seek advice from your tax or legal adviser before requesting payment, and contact the applicable public assistance agency about eligibility effects.

Summary only. Certificate terms, state variations, restrictions, and limitations apply.

Riders & Family Coverage

MASSMUTUAL | ADDITIONAL FINANCIAL PROTECTION

2026 - 2027 BENEFIT GUIDE

Riders can add protection beyond your base certificate. Review the options below for employee and family protection.

WAIVER OF PREMIUM RIDER

The employer-elected rider is attached to certificates for employees ages **18 - 60** at an additional cost. If the insured becomes totally disabled, it activates after a continuous **six-month waiting period**. Certificate and included rider premiums are waived during the disability, and cash value continues to grow. The rider terminates at attained age **67** (state variations may apply). You may cancel it, but it cannot be reinstated.

ACCIDENTAL DEATH BENEFIT RIDER

The employer-elected rider is attached to certificates for employees ages **18 - 60** at an additional cost. It pays beneficiaries an additional death benefit if death results from an accident. The rider ends at age **67**. You may cancel it, but it cannot be reinstated.

SPOUSE TERM LIFE INSURANCE RIDER

Available at an additional cost for spouses ages **18 - 65**. Coverage of **$10,000 or $20,000** cannot exceed the amount issued to the employee. If the insured spouse dies while the rider is in force, the death benefit is paid to the certificate owner.

CHILDREN'S TERM LIFE INSURANCE RIDER

Available at an additional cost for all eligible children ages **14 days - 26 years**. Children must be dependents under federal tax rules. Coverage of **$10,000 or $20,000** cannot exceed the amount issued to the employee. If an insured child dies while the rider is in force, the death benefit is paid to the certificate owner.

SEPARATE WHOLE LIFE COVERAGE FOR FAMILY

You may apply for **$25,000** of whole life coverage for your spouse and each dependent child or grandchild. Coverage provides separate certificates with the same features as employee basic coverage; riders are not available. Eligible ages are **18 - 60** for spouses and **14 days - 26 years** for children and grandchildren, who must be dependents under federal tax rules.

Issued by Massachusetts Mutual Life Insurance Company, Springfield, MA 01111-0001. Product and feature availability varies by state. The Chronic Care Benefit is not available in Massachusetts. Consult your certificate and benefits counselor for complete details.

Summary only. Certificate terms, state variations, restrictions, and limitations apply.

PULASKI COUNTY PUBLIC SCHOOLS

Whole Life. Lasting Protection.

MASSMUTUAL GROUP WHOLE LIFE INSURANCE

2026 - 2027 BENEFIT GUIDE

Lifetime coverage + cash-value accumulation. Help protect your loved ones with a guaranteed death benefit and level premiums while building cash value over time. Coverage continues for life as long as required premiums are paid.

Lifelong protection

Whole life insurance provides coverage for your entire lifetime, with a guaranteed death benefit.

Fixed premiums

Guaranteed level premiums do not increase because you get older or your health changes.

Simple application

No medical exam is required. Answer eligibility questions when applying for coverage.

Dividend potential

Eligible certificates may receive dividends that can purchase paid-up additional insurance. Dividends are not guaranteed.

Portable coverage

You own the certificate and can take it with you if you leave the company.

Access to cash value

Available cash value may be accessed through certificate loans or partial surrenders, subject to policy terms.

CHRONIC CARE BENEFIT

If the insured meets the certificate's chronic illness definition, you may receive a lump-sum advance of a portion of the death benefit to help ease financial stress. This is not long-term care insurance.

Important: Loans, partial surrenders, and accelerated benefits reduce certificate values and the death benefit. Loans and surrenders may increase lapse risk and may have tax consequences. Chronic Care Benefit fees, restrictions, and state variations apply.

Ask your benefits counselor about coverage options and complete certificate details.

Issued by Massachusetts Mutual Life Insurance Company. Summary only; certificate terms apply.



PULASKI COUNTY PUBLIC SCHOOLS

Engage With Your Benefits

2026 - 2027 BENEFIT GUIDE

MAKE THE MOST OF YOUR HEALTHCARE

Knowing how to use your coverage can help you make informed decisions and manage out-of-pocket expenses. Start with a few practical habits that put your benefits to work for you.

Find the right care

Compare care options and check network participation before scheduling non-emergency services.

Know your care options

Explore alternatives to hospital care when appropriate, such as office visits, telemedicine, and urgent care.

Use preventive benefits

Review eligible screenings and preventive services, including network and frequency requirements.

Spend wisely on prescriptions

Check the formulary and ask your prescriber or pharmacist about appropriate lower-cost options.





Before care: check your coverage. After care: review your claims and ask questions.

Preventive Care & Screenings

MAKE TIME FOR YOUR HEALTH

2026 - 2027 BENEFIT GUIDE



A SMALL STEP FOR YOUR LONG-TERM HEALTH

Preventive visits help you review your health and identify concerns early. Screening needs depend on your age, health history, and risk factors.

$0

ELIGIBLE IN-NETWORK PREVENTIVE CARE

Recommended preventive services are generally covered without a copay, coinsurance, or deductible when network, eligibility, and frequency requirements are met.

COMMON PREVENTIVE SCREENINGS

Screening examples	Coverage considerations
Blood pressure, cholesterol, and diabetes	Eligibility may depend on age and risk factors.
Colorectal cancer screening	Recommended ages, methods, and screening intervals apply.
Depression screening	Discuss screening and follow-up needs with your provider.
Breast and cervical cancer screening	Mammograms and cervical screening are covered when guideline criteria are met.

This is not a complete list. Not every test or examination is a covered preventive service. Ask your provider which screenings are appropriate and confirm benefits with your medical plan.

PREVENTIVE OR DIAGNOSTIC?

Preventive care looks for problems before symptoms develop. **Diagnostic care** evaluates symptoms, a known condition, or certain abnormal findings. Diagnostic services may be subject to your deductible, copay, or coinsurance. Some follow-up services are included under preventive screening rules.

Specialists may provide covered preventive care. Additional evaluation or treatment during a preventive visit may generate a separate charge.

BEFORE YOUR APPOINTMENT

Confirm your provider and testing facility are in network. Check preventive versus diagnostic billing and screening frequency limits. For coverage questions, call the number on your medical ID card.

Learn more: HealthCare.gov/coverage/preventive-care-benefits

Sources: HealthCare.gov preventive care benefits and adult preventive services. Plan terms apply.

Company Nurse

WORKPLACE INJURY HOTLINE | 2026 - 2027 BENEFIT GUIDE

COMPANY NURSE Injury Hotline

The Right Call for Workplace Injuries

HURT ON THE JOB? START HERE.

1-888-770-0925

Report your workplace injury to **Company Nurse and your supervisor**. A nurse will assess your injury and provide guidance on next steps, including available physicians if you need medical care.

LIFE- OR LIMB-THREATENING INJURY?

Dial 911.

WHEN YOU CALL

1. **Report your injury**

   Call 1-888-770-0925 and identify your employer as Pulaski County Public Schools. Use employer ID V071B.

2. **Speak with a nurse**

   The nurse will triage your injury and provide a list of available physicians if you need to see a doctor.

3. **Keep your confirmation number**

   You will receive a confirmation number. Keep it handy if you need to call Company Nurse back about your injury.

4. **Notify your supervisor**

   Make sure your supervisor knows about the injury as part of the reporting process.

EMPLOYER	EMPLOYER ID
Pulaski County Public Schools	V071B

PULASKI COUNTY PUBLIC SCHOOLS

Prescription Benefits

UNDERSTAND YOUR COVERAGE. EXPLORE YOUR OPTIONS.

2026 - 2027 BENEFIT GUIDE

KNOW YOUR FORMULARY

A formulary is your plan's list of covered prescription drugs. Checking it can help you understand medication options and compare your expected out-of-pocket costs.

DRUG TIERS HELP DETERMINE YOUR COST

Your plan groups covered drugs into cost categories called tiers. The examples below show general patterns; your plan's actual tiers and benefits may differ.

$

Generic drugs

Often the lowest-cost option.

$$

Brand-name drugs

Preferred brands often cost less than non-preferred brands.

$$$

Specialty drugs

May have higher costs or special dispensing requirements.

THREE WAYS TO GET MORE FROM YOUR COVERAGE

1. Check before you fill

Look up your medication's coverage and tier. Check whether prior authorization, step therapy, quantity limits, or a specific pharmacy applies.

2. Ask about lower-cost options

Ask your prescriber or pharmacist whether a generic or preferred alternative is appropriate. FDA-approved generics provide the same clinical benefit as their brand-name equivalents.

3. Confirm your expected cost

Your cost depends on your plan, the drug tier, pharmacy, and any deductible or coinsurance. Confirm costs before filling an ongoing prescription.

FIND YOUR PLAN'S COVERED DRUG LIST

Visit the member website listed on your ID card or call the customer service number on the card for formulary and prescription benefit details.

Sources: FDA generic drug information; HealthCare.gov prescription drug coverage.

General guidance only. Refer to your plan documents for covered drugs, tiers, and cost-sharing.

PreventiveRx Drug List
Enhanced Plan (National Drug List)

Anthem
And Its Affiliate HealthKeepers, Inc.

PreventiveRx covers drugs that may keep you healthy because they may prevent illness and other health conditions. You can get the products on this list at low or no cost to you depending on your benefit.

This list includes only prescription products. Brand-name drugs are listed with a first capital letter. Non-brand drugs (generics) are in lowercase letters.

Brand-name drugs that have a generic equivalent available are not covered under this PreventiveRx benefit.

*Not all drugs on this list may be covered by your plan. Some drugs, such as those used for cosmetic purposes, may be excluded from your benefits. Please refer to your Certificate or Evidence of Coverage for coverage limitations and exclusions.

Please note: The drug list is subject to change and all previous versions of the drug list are no longer in effect.

This list is not all-inclusive; but many examples of preventive medications in each category are listed.

ASTHMA

albuterol sulfate nebulization solution
albuterol sulfate nebulization syrup
albuterol sulfate nebulization tablets
albuterol sulfate HFA
Breo Ellipta
breyna
budesonide inhalation suspension
budesonide/formoterol aerosol
cromolyn nebulization solution
elixophyllin
Flovent Diskus
Flovent HFA
fluticasone ellipta
fluticasone HFA
fluticasone diskus (generic for Flovent Diskus)
fluticasone/ salmeterol HFA (generic for Advair HFA)
fluticasone/ salmeterol powder (generic for Advair Diskus)
fluticasone/ salmeterol powder (generic for Airduo RespiClick)
fluticasone/ vilanterol ellipta
formoterol nebulization solution
levalbuterol nebulization solution
levalbuterol HFA
montelukast
ProAir RespiClick
QVAR RediHaler
Serevent Diskus
Spiriva Respimat
terbutaline tablets
Theo- 24
theophylline elixer
theophylline solution
theophylline ER
Trelegy Ellipta
wixela inhub
zafirlukast

BLOOD CLOTS AND STROKE

aspirin-dipyridamole ER
cilostazol
clopidogrel bisulfate
dipyridamole
Eliquis
heparin
jantoven
prasugrel
rivaroxaban
ticagrelor
warfarin
Xarelto

DIABETES

{Diabetic supplies including blood glucose meters, test strips and lancets require a prescription to be covered by this plan. Only blood glucose meters & blood glucose test strips for Accu-Chek and FreeStyle products will be covered by this benefit. Continuous Glucose Monitors (CGMs) are not included in PreventiveRx Coverage.

acarbose
alogliptin
alogliptin/metformin
alogliptin/pioglitazone
dapagliflozin
dapagliflozin/ metformin
glimepiride (1mg, 2 mg, 4mg)
glipizide
glipizide ER/XL
glipizide/ metformin
glyburide
glyburide micronized
glyburide/ metformin
Glyxambi
Humalog
Humalog Junior KwikPen
Humalog KwikPen
Humalog Mix 50/50
Humalog Mix 50/50 KwikPen
Humalog Mix 75/25
Humalog Mix 75/25 KwikPen
Humulin 70/30
Humulin 70/30 KwikPen
Humulin N
Humulin N KwikPen
Humulin R
Humulin R KwikPen
Insulin Glargine (100U/ml)
Insulin Glargine Solostar (100U/ml)
Insulin Lispro
Insulin Lispro Junior KwikPen
Insulin Lispro KwikPen
Insulin Lispro Protamine
Janumet
Janumet XR
Januvia
Jardiance
Lantus
Lantus SoloStar
liraglutide
Lyumjev
Lyumjev KwikPen
metformin (500 mg, 850 mg, 1000 mg)
metformin ER (Generic for Glucophage XR)
miglitol
Mounjaro
nateglinide
Ozempic
pioglitazone
pioglitazone/ glimepiride
pioglitazone/ metformin
repaglinide
Rybelsus
Soliqua
SymlinPen
Synjardy
Synjardy XR
Toujeo
Toujeo Max
Toujeo SoloStar
Tresiba
Tresiba Flextouch
Trijardy XR
Trulicity

Xultophy

HEART HEALTH AND HIGH BLOOD PRESSURE

acebutolol
acetazolamide
acetazolamide ER
aliskiren
amiloride
amiloride/ hctz
amlodipine besylate
amlodipine/ benazepril
amlodipine/ olmesartan
amlodipine/ valsartan
amlodipine/ valsartan/ hctz
atenolol
atenolol/ chlorthalidone
benazepril
benazepril/ hctz
betaxolol
bisoprolol fumarate
bisoprolol fumarate/ hctz
bumetanide
candesartan
candesartan/ hctz
captopril
captopril/ hctz
cartia XT
carvedilol
carvedilol ER
chlorthalidone
clonidine tablets
clonidine patches
digitek
digox
digoxin
diltiazem
diltiazem CD
diltiazem ER
dilt-XR
doxazosin
enalapril oral solution
enalapril tablets
enalapril/ hctz
eplerenone
ethacrynic acid tablets
felodipine ER
fosinopril sodium
fosinopril/ hctz
furosemide
guanfacine
hydralazine
hydrochlorothiazide
indapamide
irbesartan
irbesartan/ hctz
isosorbide dinitrate
isosorbide dinitrate/ hydralazine
isosorbide mononitrate
isosorbide mononitrate ER
isradipine
labetalol
levamlodipine
lisinopril
lisinopril/ hctz
losartan
losartan/ hctz
matzim LA
methazolamide
methyldopa
metolazone
metoprolol succinate ER
metoprolol tartrate
metoprolol tartrate/ hctz
minoxidil
moexipril
nadolol
nebivolol
nicardipine
nifedipine
nifedipine ER
nimodipine
nisoldipine ER
Nitro-Dur 0.3, 0.8mg/ hr
nitroglycerin
nitroglycerin 400 mcg spray
nitroglycerin sublingual tablets
olmesartan
olmesartan/ amlodipine/ hctz
olmesartan/ hctz
perindopril
pindolol
prazosin
propranolol
propranolol ER
quinapril
quinapril/ hctz
ramipril
ranolazine ER
sorine
sotalol
sotalol AF
spironolactone suspension
spironolactone tablets
spironolactone/ hctz
taztia XT
telmisartan
telmisartan/ amlodipine
telmisartan/ hctz
terazosin
tiadylt
timolol tablets
torsemide
trandolapril
trandolapril/ verapamil
triamterene
triamterene/ hctz
valsartan solution
valsartan tablets
valsartan/ hctz
verapamil
verapamil ER
verapamil SR

HEART RATE AND RHYTHM

amiodarone
disopyramide
dofetilide
flecainide
mexiletine
Norpace CR
pacerone
propafenone
propafenone ER
quinidine
quinidine CR
quinidine ER

HIGH CHOLESTEROL

atorvastatin
atorvastatin/ amlodipine
cholestyramine
cholestyramine lite
colesevelam tablets
colestipol granules
colestipol tablets
ezetimibe
ezetimibe/ simvastatin
fenofibrate (43, 50, 67, 130, 134, 150, 200 mg capsules & 48, 54, 145, 160 mg tablets)
fenofibric acid
fluvastatin
gemfibrozil
lovastatin
niacin ER
pravastatin
prevalite
rosuvastatin
simvastatin

MALARIA

atovaquone/proguanil
chloroquine
hydroxychloroquine
mefloquine
primaquine

MENTAL HEALTH

amitriptyline
amoxapine
aripiprazole
aripiprazole ODT
brivaracetam
bupropion
bupropion SR
bupropion XL
carbamazepine
carbamazepine ER
chlorpromazine
citalopram solution
citalopram tablets
clomipramine
clozapine
clozapine ODT
desipramine
desvenlafaxine ER
Dilantin
divalproex sodium DR, ER
doxepin
duloxetine
Epitol

escitalopram
eslicarbazepine
ethosuximide
felbamate
fluoxetine capsules
fluoxetine solution
fluoxetine tablets
fluoxetine DR
fluphenazine
fluvoxamine
fluvoxamine ER
gabapentin
haloperidol solution
haloperidol tablets
imipramine capsules
imipramine tablets
lacosamide
lamotrigine chewable
lamotrigine ER
lamotrigine ODT
lamotrigine tablets
levetiracetam
levetiracetam ER
lithium
lithium ER
loxapine
mirtazapine
mirtazapine ODT
molindone
nefazodone
nortriptyline
olanzapine
olanzapine ODT
olanzapine/ fluoxetine
oxcarbazepine
oxcarbazepine ER
paliperidone ER
paroxetine
paroxetine ER
perphenazine
phenelzine
phenytek
phenytoin
phenytoin chewable
phenytoin ER
phenytoin infatabs
pregabalin
primidone
prochlorperazine
protriptyline
quetiapine
quetiapine ER
risperidone ODT
risperidone solution
risperidone tablets
roweepra
sertraline tablets
subvenite
thioridazine
thiothixene
tiagabine
topiramate
topiramate ER
tranylcypromine
trazodone
trifluoperazine
trimipramine
Trintellix
valproic acid
venlafaxine
venlafaxine ER 225 mg tablets
venlafaxine ER capsules
vilazodone
Vraylar
ziprasidone
zonisamide

OSTEOPOROSIS
abigale
abigale lo
alendronate
amabelz
calcitonin- salmon
Climara Pro
Combipatch
dotti
estradiol gel
estradiol patch
estradiol tablets
estradiol/ norethindrone
Fosamax Plus D
Fyavolv
ibandronate tablets
jinteli
lyllana
medroxyprogesterone
Menest
mimvey
norethindrone-ethinyl estradiol
Premarin tablets
Premphase
Prempro
raloxifene
risedronate
risedronate DR

Pathway to a brighter tomorrow

Pulaski County Public Schools

202 N. Washington Avenue ❖ Pulaski, VA 24301 ❖ (540) 994-2519 ❖(540) 994-2514 (fax)
Robert Graham, Division Superintendent ❖ robert.graham@pcva.us

Effective July 1, 2025, employees' spouses who have access to affordable employer sponsored health care coverage will no longer be eligible for enrollment in Pulaski County Public Schools health insurance plans. This eligibility change will allow Pulaski County to maintain affordable coverage for its employees. Spouses, who do not have access to employer sponsored health care coverage that provides affordable coverage and minimum value through his /her employer, will continue to be eligible for enrollment as a dependent.

Employees who want to cover their eligible spouse on the Pulaski County Public Schools Plan must complete the Spousal Affidavit. Employees whose spouse is currently enrolled on the health plan and does not meet the new eligibility criteria should not sign the affidavit. **If this affidavit is not signed and submitted, spouses will be considered ineligible and will be dropped from the plan.**

Spousal Affidavit

I certify that my spouse does not have access to employer sponsored health insurance coverage.

If my spouse does not currently have access to employer sponsored health care that provides affordable coverage at minimum value through his/her employer but gains it at a later date, I agree to notify Pulaski County Public Schools within 60 days. I further understand that on the 1st day of the month following the date my spouse becomes eligible for affordable health care that provides minimum value; I will no longer be allowed to cover my spouse under Pulaski County Public Schools Plan unless a mid-year qualifying event changes the ineligibility of my spouse.

I attest that the above information is accurate to the best of my knowledge as of the date that I sign and submit this affidavit.

Employee Name: _____

Employee Signature: _____

Spouse Name: _____

Date: _____

PULASKI COUNTY PUBLIC SCHOOLS

Benefit Contacts & Resources

GET HELP WITH YOUR EMPLOYEE BENEFITS

2026 - 2027 BENEFIT GUIDE

YOUR BENEFITS, ALL IN ONE PLACE

www.pcvabenefits.com

Find employee benefit details and contact information.

NEED HELP WITH ENROLLMENT?

Enrollment team: 888-650-3003

MEDICAL
Anthem
833-592-9956
anthem.com

DENTAL
Delta Dental
800-237-6060
deltadentalva.com

VISION
Anthem Blue View
833-592-9956
anthem.com

HEALTH SAVINGS ACCOUNT (HSA)
HealthEquity
866-346-5800
healthequity.com

FLEXIBLE SPENDING ACCOUNTS
Flexible Benefit Administrators
800-437-3539
flex-admin.com

EMPLOYEE ASSISTANCE PROGRAM
Sentara | Access code: Sentara18
800-899-8174
sentaraEAP.com

TRAVEL ASSISTANCE
AirMedCare
800-793-0010
amcnrep.com

SUPPLEMENTAL BENEFITS
Colonial Life | Existing policyholders
800-325-4368
coloniallife.com

WHOLE LIFE INSURANCE
MassMutual
800-272-2216
massmutual.com

AFLAC
Debra Hancock
540-577-6639
debra_hancock@us.aflac.com

GENERAL BENEFIT QUESTIONS | INNOVATIVE INSURANCE GROUP

888-676-9496 customerservice@thinkinnovative.net

For claims, billing, ID cards, coverage questions, and enrollment support.

Benefits Glossary

2026 - 2027 BENEFIT GUIDE | A - D

AD&D insurance
Accidental death and dismemberment insurance pays benefits for a covered accidental death or specified losses, such as loss of a limb, sight, speech, or hearing.

Allowed amount
The amount a plan recognizes for a covered healthcare service. It may also be called an eligible expense or negotiated rate.

Ambulatory surgery center (ASC)
A facility that provides outpatient surgical procedures that generally do not require an overnight stay.

Annual limit
A yearly cap on certain plan benefits or services. Limits may apply to dollars, visits, or services, subject to applicable law and plan rules.

Balance billing
A provider bills you for the difference between its charge and the plan's allowed amount. Network contracts and surprise-billing protections may prohibit this in certain situations.

Beneficiary
The person or people you name to receive a benefit after your death. Keep beneficiary designations current.

Brand-name drug
A prescription drug sold under a trademarked name.

Claim
A request for payment submitted to your health plan after you receive services that may be covered.

COBRA
A federal law that may allow temporary continuation of group health coverage after certain qualifying events. Qualified beneficiaries generally pay the full premium plus a permitted administrative fee.

Coinsurance
Your percentage share of the allowed cost of a covered service, often after you meet the deductible. For example, 20% coinsurance means you pay 20% and the plan pays 80%, subject to plan terms.

Copayment (copay)
A fixed amount you pay for a covered service or prescription. Copays may not count toward your deductible; check your plan.

Deductible
The amount you pay for covered services before the plan starts paying for services subject to the deductible. Some services may be covered before it is met.

Dependent care FSA
An employer-sponsored account used to pay eligible care expenses with pre-tax dollars so you and, if applicable, your spouse can work or look for work. Eligibility rules apply.

Dental basic services
Services often categorized as fillings, routine extractions, and some oral surgery. Classifications vary by plan.

Dental diagnostic and preventive services
Services such as exams, cleanings, X-rays, and fluoride treatments. Coverage and frequency limits depend on the plan.

Dental major services
Services often categorized as crowns, bridges, dentures, inlays, or onlays. Classifications vary by plan.

Plain-language definitions. Your plan documents and policy terms determine actual benefits.

Benefits Glossary

2026 - 2027 BENEFIT GUIDE | E - O

Eligible expense
A service or product that meets the plan's requirements for coverage or reimbursement.

Embedded vs. aggregate deductible
With an embedded family deductible, an individual may receive benefits after meeting an individual deductible. With an aggregate (non-embedded) deductible, the family deductible generally must be met before deductible-based benefits begin.

Excluded service
A service or treatment the plan does not cover.

Formulary
Your plan's list of covered prescription drugs, often organized into cost-sharing tiers.

Generic drug
A drug with the same active ingredient as its brand-name counterpart. It is sold under its generic name and must meet applicable approval standards.

Grandfathered plan
A health plan exempt from certain Affordable Care Act requirements because it meets the rules for grandfathered status.

Health reimbursement arrangement (HRA)
An employer-funded arrangement that reimburses eligible medical expenses, subject to plan rules.

Healthcare FSA
An employer-sponsored flexible spending account that lets you use pre-tax dollars for eligible medical, dental, and vision expenses. Limited-purpose FSAs generally cover dental and vision expenses.

High-deductible health plan (HDHP)
A plan with a higher deductible. Only HDHPs meeting applicable requirements support HSA eligibility; other eligibility conditions also apply.

In-network
Providers and facilities that contract with your plan. Using network providers generally reduces your cost.

Life insurance
Coverage that pays a death benefit to your designated beneficiary when you die, subject to policy terms.

Long-term disability insurance
Insurance that replaces a portion of income during a covered longer-term disability. Waiting periods and benefit durations vary by policy.

Mail order
A pharmacy service that delivers eligible prescriptions to your home, often in a 90-day supply.

Open Enrollment
The annual period when eligible employees may enroll in or change benefits. Outside this period, changes generally require new-hire eligibility or a permitted qualifying event.

Out-of-network
Providers or facilities that do not contract with your plan. Costs may be higher, and some plans do not cover non-emergency out-of-network services.

Out-of-pocket cost
Healthcare expenses you pay yourself, such as deductibles, copays, and coinsurance.

Plain-language definitions. Your plan documents and policy terms determine actual benefits.

Benefits Glossary

2026 - 2027 BENEFIT GUIDE | O - V

Out-of-pocket maximum
The most you pay for covered services that count toward the limit during the plan year. After the limit is met, the plan generally pays 100% of eligible covered costs. Premiums, noncovered services, and certain other charges do not count.

Outpatient care
Care that generally does not require an overnight hospital admission.

Participating pharmacy
A pharmacy that contracts with your medical or prescription plan. Using it generally results in lower costs.

Plan year
The 12-month period used for benefit coverage. It may differ from the calendar year.

Preferred drug
A drug the plan places on a preferred tier, generally with lower member cost-sharing than a non-preferred option.

Preventive services
Recommended screenings, checkups, immunizations, and counseling intended to prevent illness or detect problems early. No-cost coverage depends on plan rules, network use, and eligibility criteria.

Primary care provider (PCP)
Your main healthcare provider for routine care and coordination. Some plans require you to select a PCP.

Short-term disability insurance
Insurance that replaces part of income while you cannot work because of a covered temporary disability. Waiting periods and covered conditions vary.

Telehealth / telemedicine
Healthcare delivered remotely, such as by phone or video. Availability and member costs depend on your plan and provider.

UCR (usual, customary, and reasonable)
A method of determining a service amount based on charges for similar services in a geographic area. Plans may use other methods to determine allowed amounts.

Urgent care
Care for a non-life-threatening illness or injury that needs prompt attention. For a life-threatening emergency, call 911.

Vaccinations
Immunizations that help prevent infectious diseases. Coverage depends on eligibility and plan rules.

Voluntary benefit
An optional employer-offered benefit for which employees generally pay some or all of the premium, often through payroll deduction.

Plain-language definitions. Your plan documents and policy terms determine actual benefits.

Plan Documents

KEEP YOUR BENEFIT INFORMATION CLOSE

Important health plan and retirement plan documents are available through the **Employee Navigator portal**. Keep these documents with your benefit records and refer to them when you have questions about your coverage.

SUMMARY PLAN DESCRIPTIONS (SPD)

The SPD is the legal document describing benefits provided under the plan, as well as plan rights and obligations for participants and beneficiaries.

Review your SPD for the details that apply to your benefits.

PREFER A PAPER COPY?

Paper copies of plan documents and notices are available upon request. Contact your Human Resources Department to request a copy.

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a **Summary of Material Modifications (SMM)** to the Pulaski County Government & Schools Health & Welfare Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

ACCESS YOUR DOCUMENTS

www.employeenavigator.com

Important Plan Information

HEALTH PLAN NOTICES & YOUR RIGHTS

2026 - 2027 BENEFIT GUIDE

The following section contains the full **Pulaski County 2026 - 2027 Plan Year Notice Packet**, provided by Innovative Insurance Group. Keep these notices with your benefit records and review the information that applies to you and your dependents.

WHAT YOU WILL FIND

The packet includes the following notices and disclosures:

- Medicaid and Children's Health Insurance Program (CHIP) premium assistance
- COBRA continuation coverage and general FMLA information
- Genetic Information Nondiscrimination Act (GINA) disclosures
- Health Insurance Marketplace coverage options
- Medicare Part D creditable prescription drug coverage
- Mental Health Parity and Addiction Equity Act (MHPAEA) disclosure
- Newborns' and Mothers' Health Protection Act
- Surprise billing protections and patient protections
- HIPAA privacy practices and special enrollment rights
- Uniformed Services Employment and Reemployment Rights Act (USERRA)
- Women's Health and Cancer Rights Act (WHCRA)

PAY SPECIAL ATTENTION TO PRESCRIPTION COVERAGE

If you or your dependents have Medicare or may become eligible, review the **Medicare Part D Creditable Coverage Notice** before making prescription coverage decisions. Keep that notice for your records.

QUESTIONS ABOUT YOUR BENEFITS?

Contact your Human Resources Department or Innovative Insurance Group.
888-676-9496
customerservice@thinkinnovative.net
Benefit resources: **www.pcvabenefits.com**

Full notices follow as supplied in the plan-year packet dated April 27, 2026.

PULASKI COUNTY PUBLIC SCHOOLS

2026 - 2027

Health Plan Compliance Notices

IMPORTANT INFORMATION ABOUT YOUR BENEFITS & RIGHTS



PLAN-YEAR NOTICE PACKET

April 27, 2026

Provided by

Innovative Insurance Group

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CHIP Notice

COBRA General Notice

General FMLA Notice

Genetic Information Nondiscrimination Act (GINA) Disclosures

Health Insurance Exchange Notice (for companies who offer a health plan)

Medicare Part D Creditable Coverage Notice

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

Newborns' and Mothers' Health Protection Act Notice

No Surprise Billing

Notice of Patient Protections

Notice of Privacy Practices

Special Enrollment Rights Notice

Uniformed Services Employment and Reemployment Rights Act (USERRA) Notice

WHCRA Notice

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 January 31, 2026. 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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
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/health-care-coverage/ Phone: 1-800-657-3672	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	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 and CHIP**
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.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 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	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
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 January 31, 2026, 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. 6156

Asistencia con las primas bajo Medicaid y el Programa de Seguro de Salud para Menores (CHIP)

Si usted o sus hijos son elegibles para Medicaid o CHIP y usted es elegible para cobertura médica de su empleador, su estado puede tener un programa de asistencia con las primas que puede ayudar a pagar por la cobertura, utilizando fondos de sus programas Medicaid o CHIP. Si usted o sus hijos no son elegibles para Medicaid o CHIP, usted no será elegible para estos programas de asistencia con las primas, pero es probable que pueda comprar cobertura de seguro individual a través del mercado de seguros médicos. Para obtener más información, visite **www.cuidadodesalud.gov**.

Si usted o sus dependientes ya están inscritos en Medicaid o CHIP y usted vive en uno de los estados enumerados a continuación, comuníquese con la oficina de Medicaid o CHIP de su estado para saber si hay asistencia con primas disponible.

Si usted o sus dependientes NO están inscritos actualmente en Medicaid o CHIP, y usted cree que usted o cualquiera de sus dependientes puede ser elegible para cualquiera de estos programas, comuníquese con la oficina de Medicaid o CHIP de su estado, llame al **1-877-KIDS NOW** o visite **espanol.insurekidsnow.gov/** para información sobre como presentar su solicitud. Si usted es elegible, pregunte a su estado si tiene un programa que pueda ayudarle a pagar las primas de un plan patrocinado por el empleador.

Si usted o sus dependientes son elegibles para asistencia con primas bajo Medicaid o CHIP, y también son elegibles bajo el plan de su empleador, su empleador debe permitirle inscribirse en el plan de su empleador, si usted aún no está inscrito. Esto se llama oportunidad de "inscripción especial", y **usted debe solicitar la cobertura dentro de los 60 días de haberse determinado que usted es elegible para la asistencia con las primas**. Si tiene preguntas sobre la inscripción en el plan de su empleador, comuníquese con el Departamento del Trabajo electrónicamente a través de **www.askebsa.dol.gov** o llame al servicio telefónico gratuito **1-866-444-EBSA (3272)**.

Si usted vive en uno de los siguientes estados, tal vez sea elegible para asistencia para pagar las primas del plan de salud de su empleador. La siguiente es una lista de estados actualizada al 31 de enero de 2026. Comuníquese con su estado para obtener más información sobre la elegibilidad –

ALABAMA – Medicaid	ALASKA – Medicaid
Sitio web: http://myalhipp.com Teléfono: 1-855-692-5447	El Programa de Pago de AK primas del seguro médico Sitio web: http://myakhipp.com Teléfono: 1-866-251-4861 Por correo electrónico: CustomerService@MyAKHIPP.com Elegibilidad de Medicaid: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Sitio web: http://myarhipp.com/ Teléfono: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Sitio web: http://dhcs.ca.gov/hipp Teléfono: 916-445-8322 Fax: 916-440-5676 Por correo electrónico: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Programa Medicaid de Colorado) y Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Sitio web de Health First Colorado: https://www.healthfirstcolorado.com/es Centro de atención al cliente de Health First Colorado: 1-800-221-3943/ retransmisor del estado: 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus Atención al cliente de CHP+: 1-800-359-1991/retransmisor del estado: 711 Programa de compra de seguro de salud (HIBI, por sus siglas en inglés): https://www.mycohibi.com/ Atención al cliente de HIBI: 1-855-692-6442	Sitio web: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Teléfono: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
Sitio web de GA HIPP: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Teléfono: 678-564-1162, Presiona 1 Sitio web de GA CHIPRA: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Teléfono: 678-564-1162, Presiona 2	Programa de pago de primas de seguro de salud Todos los demás son Medicaid Sitio web: https://www.in.gov/medicaid/ https://www.in.gov/fssa/dfr Administración de familias y servicios sociales Teléfono: 1-800-403-0864 Teléfono de servicios para miembros: 1-800-457-4584
IOWA – Medicaid y CHIP (Hawki)	**KANSAS – Medicaid**
Sitio web de Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid Teléfono de Medicaid: 1-800-338-8366 Sitio web de Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki Teléfono de Hawki: 1-800-257-8563 Sitio web de HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp Teléfono de HIPAA: 1-888-346-9562	Sitio web: https://www.kancare.ks.gov/ Teléfono: 1-800-792-4884 Teléfono de HIPP: 1-800-967-4660

KENTUCKY - Medicaid	LOUISIANA – Medicaid
Sitio web del Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://www.chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Teléfono: 1-855-459-6328 Por correo electrónico: KIHIPP.PROGRAM@ky.gov Sitio web de KCHIP: https://kidshealth.ky.gov/es/Pages/default.aspx Teléfono: 1-877-524-4718 Sitio web de Medicaid de Kentucky: https://chfs.ky.gov/agencies/dmsSitio web de Medicaid de Kentucky: https://chfs.ky.gov/agencies/dms	Sitio web: https://www.ldh.la.gov/healthy-louisiana Teléfono: 1-888-342-6207 (línea directa de Medicaid) o 1-855-618-5488 (LaHIPP) Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	**MASSACHUSETTS – Medicaid y CHIP**
Sitio web por inscripción: https://www.mymaineconnection.gov/benefits/s/?language=en_US Teléfono: 1-800-442-6003 TTY: Maine relay 711 Página web por primos de seguro de salud privado: https://www.maine.gov/dhhs/ofi/applications-forms Teléfono: 1-800-977-6740 TTY: Maine relay 711	Sitio web: https://www.mass.gov/masshealth/pa Teléfono: 1-800-862-4840 TTY: 711 Por correo electrónico: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Sitio web: https://mn.gov/dhs/health-care-coverage/ Teléfono: 1-800-657-3672	Sitio web: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Teléfono: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Sitio web: https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Teléfono: 1-800-694-3084 Por correo electrónico: HHSHIPPProgram@mt.gov	Sitio web: http://www.ACCESSNebraska.ne.gov Teléfono: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NUEVO HAMPSHIRE – Medicaid**
Sitio web de Medicaid: http://dhcfp.nv.gov Teléfono de Medicaid: 1-800-992-0900	Sitio web: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Teléfono: 603-271-5218 Teléfono gratuito para el programa de HIPP: 1-800-852-3345, ext. 15218 Por correo electrónico: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NUEVA JERSEY – Medicaid y CHIP	NUEVA YORK – Medicaid
Sitio web de Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Teléfono: 1-800-356-1561 Teléfono de asistencia de prima de CHIP: 609-631-2392 Sitio web de CHIP: http://www.njfamilycare.org/index.html Teléfono de CHIP: 1-800-701-0710 (TTY:711)	Sitio web: https://www.health.ny.gov/health_care/medicaid/ Teléfono: 1-800-541-2831
CAROLINA DEL NORTE – Medicaid	**DAKOTA DEL NORTE – Medicaid**
Sitio web: https://medicaid.ncdhhs.gov Teléfono: 919-855-4100	Sitio web: http://www.hhs.nd.gov/healthcare Teléfono: 1-844-854-4825
OKLAHOMA – Medicaid y CHIP	**OREGON – Medicaid y CHIP**
Sitio web: http://www.insureoklahoma.org Teléfono – 1-888-365-3742	Sitio web: https://cuidadodesalud.oregon.gov/Pages/index.aspx Teléfono: 1-800-699-9075
PENSILVANIA – Medicaid y CHIP	**RHODE ISLAND– Medicaid y CHIP**
Sitio web: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Teléfono: 1-800-692-7462 Sitio web de CHIP: https://www.pa.gov/en/agencies/dhs/resources/chip.html Teléfono de CHIP: 1-800-986-JIDS (5437)	Sitio web: http://www.eohhs.ri.gov/ Teléfono: 1-855-697-4347 o 401-462-0311 (Direct RIta Share Line)
CAROLINA DEL SUR – Medicaid	**DAKOTA DEL SUR – Medicaid y CHIP**
Sitio web: https://www.scdhhs.gov Teléfono: 1-888-549-0820	Sitio web: http://dss.sd.gov Teléfono: 1-888-828-0059
TEXAS – Medicaid	**UTAH– Medicaid y CHIP**
Sitio web: https://www.hhs.texas.gov/es/servicios/finanzas/programa-de-pago-de-las-primas-del-seguro-medico Teléfono: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Sitio web: https://medicaid.utah.gov/upp/ Por correo electrónico: upp@utah.gov Teléfono: 1-888-222-2542 Sitio web de expansión para adultos: https://medicaid.utah.gov/expansion/ Sitio web de Programa de compra de Medicaid de Utah: https://medicaid.utah.gov/buyout-program/ Sitio web de CHIP: https://chip.utah.gov/espanol/

VERMONT – Medicaid	VIRGINIA – Medicaid y CHIP
Sitio web: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Teléfono: 1-800-250-8427	Sitio web: https://cubrevirginia.dmas.virginia.gov/learn/premium-assistance/famis-select https://cubrevirginia.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Teléfono de Medicaid/CHIP: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid y CHIP**
Sitio web: http://www.hca.wa.gov Teléfono: 1-800-562-3022	Sitio web: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Teléfono de Medicaid: 304-558-1700 Teléfono gratuito de CHIP: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid y CHIP	**WYOMING – Medicaid**
Sitio web: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Teléfono: 1-800-362-3002	Sitio web: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Teléfono: 1-800-251-1269

Para saber si otros estados han agregado el programa de asistencia con primas desde el 31 de enero de 2026, o para obtener más información sobre derechos de inscripción especial, comuníquese con alguno de los siguientes:

Departamento del Trabajo de EE.UU.
Administración de Seguridad de Beneficios de los Empleados
www.dol.gov/agencies/ebsa/es/about-ebsa/our-activities/informacion-en-espanol
1-866-444-EBSA (3272)

Departamento de Salud y Servicios Humanos de EE.UU.
Centros para Servicios de Medicare y Medicaid
www.cms.hhs.gov
1-877-267-2323, opción de menú 4, Ext. 6156

General Notice of COBRA 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 doesn't 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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Pulaski County, 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 their 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;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other 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 within 60 days after the qualifying event occurs. You must provide this notice to:

Tammy Nichols
143 Third Street, NW
Pulaski, Virginia 24301

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 Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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.

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[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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

2026-2027 Plan Year
Tammy Nichols
143 Third Street, NW
Pulaski, Virginia 24301

Modelo de aviso general de los derechos de la cobertura de continuación de COBRA

(para que usen los planes de salud grupales de un solo empleador)

Derechos de la cobertura de continuación conforme a la ley COBRA

Introducción

Le enviamos este aviso porque recientemente obtuvo la cobertura de un plan de salud grupal (el Plan). Este aviso contiene información importante acerca de su derecho a recibir la cobertura de continuación de COBRA, que es una extensión temporal de la cobertura del Plan. **Este aviso explica la cobertura de continuación de COBRA, el momento en el que usted y su familia pueden recibirla, y lo que usted puede hacer para proteger su derecho a obtenerla.** Al ser elegible para la cobertura de COBRA, también puede ser elegible para otras opciones que pueden costarle menos que la cobertura de continuación de COBRA.

El derecho a recibir la cobertura de continuación de COBRA se originó gracias a una ley federal, la Ley Ómnibus Consolidada de Reconciliación Presupuestaria (COBRA, por sus siglas en inglés) de 1985. Usted y otros familiares suyos pueden disponer de la cobertura de continuación de COBRA cuando se termine la cobertura de salud grupal. Para obtener más información acerca de sus derechos y obligaciones conforme al Plan y a la ley federal, debe revisar el resumen de la descripción del Plan o comunicarse con el administrador del Plan.

Al perder la cobertura de salud grupal, puede haber otras opciones disponibles. Por ejemplo, puede ser elegible para comprar un plan individual a través del mercado de seguros médicos. Al inscribirse en la cobertura a través del mercado de seguros médicos, puede cumplir con los requisitos para tener menores costos en las primas mensuales y gastos propios más bajos. Asimismo, puede tener derecho a un período de inscripción especial de 30 días en otro plan de salud grupal para el cual sea elegible (como un plan del cónyuge), aunque ese plan generalmente no acepte afiliados de último momento.

¿Qué es la cobertura de continuación de COBRA?

La cobertura de continuación de COBRA es la continuación de la cobertura del Plan cuando esta debería terminar debido a un evento determinado de la vida. Este acontecimiento también se conoce como “evento especifico”. Los eventos específicos se incluyen más abajo en este aviso. Después de un evento especifico, la cobertura de continuación de COBRA debe ofrecerse a cada persona considerada un “beneficiario que cumple con los requisitos”. Usted, su cónyuge y sus hijos dependientes podrían convertirse en beneficiarios que cumplan con los requisitos si la cobertura del Plan se pierde debido al evento especifico. Según el Plan, los beneficiarios que cumplan con los requisitos y que elijan la cobertura de continuación de COBRA debe pagar la cobertura de continuación de COBRA.

Si usted es un empleado, se convertirá en un beneficiario que cumple con los requisitos si pierde la cobertura del Plan debido a estos eventos especificos:

- sus horas de empleo se reducen; o
- su empleo termina por un motivo que no sea una falta grave de su parte.

Si usted es el cónyuge del empleado, se convertirá en un beneficiario que cumple con los requisitos si pierde la cobertura del Plan debido a estos eventos especificos:

- su cónyuge muere;
- las horas de empleo de su cónyuge se reducen;
- el empleo de su cónyuge termina por un motivo que no sea una falta grave por parte de su cónyuge;
- su cónyuge adquiere el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas); o
- se divorcia o se separa legalmente de su cónyuge.

Sus hijos dependientes se convertirán en beneficiarios que cumplen con los requisitos si pierden la cobertura del Plan debido a estos eventos especificos:

- el empleado cubierto muere;
- las horas de empleo del empleado cubierto se reducen;
- el empleo del empleado cubierto termina por un motivo que no sea una falta grave por parte del empleado cubierto;
- el empleado cubierto adquiere el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas);
- los padres se divorcian o se separan legalmente; o el hijo deja de ser elegible para la cobertura del Plan como “hijo dependiente”.

A veces, presentar una solicitud de declaración de quiebra conforme al Título 11 del Código de Estados Unidos puede ser un evento habilitante. Si se presenta una solicitud de declaración de quiebra con respecto a Pulaski County y esa quiebra causa la pérdida de la cobertura de cualquier empleado jubilado cubierto por el Plan, el empleado jubilado se convertirá en un beneficiario que cumple con los requisitos. El cónyuge del empleado jubilado, el cónyuge sobreviviente y los hijos dependientes también se convertirán en beneficiarios que cumplen con los requisitos si la quiebra causa la pérdida de la cobertura del Plan.

¿Cuándo está disponible la cobertura de continuación de COBRA?

El Plan ofrecerá la cobertura de continuación de COBRA a los beneficiarios que cumplan con los requisitos solamente después de que se le informe al administrador del Plan que ha ocurrido un evento especifico. El empleador debe notificar los siguientes eventos habilitantes al administrador del Plan:

- la terminación del empleo o la reducción de las horas de empleo;
- la muerte del empleado;
- el hecho de que el empleado adquiera el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas).

Para todos los otros eventos especificos (divorcio o separación legal del empleado y el cónyuge, o hijo dependiente que pierde la elegibilidad para la cobertura como hijo dependiente), debe avisarle al administrador del Plan en los 60 días posteriores a que se produzca el evento habilitante. Debe proporcionarle este aviso a:

Tammy Nichols
143 Third Street, NW
Pulaski, Virginia 24301

¿Cómo se proporciona la cobertura de continuación de COBRA?

Después de que el administrador del Plan recibe el aviso de que se ha producido un evento especifico, la cobertura de continuación de COBRA se ofrecerá a cada uno de los beneficiarios que cumplan con los requisitos. Cada beneficiario que cumpla con los requisitos tendrá su propio derecho a elegir la cobertura de continuación de COBRA. Los empleados cubiertos pueden elegir la cobertura de continuación de COBRA en nombre de su cónyuge y los padres pueden elegir la cobertura de continuación de COBRA en nombre de sus hijos.

La cobertura de continuación de COBRA es la continuación temporal de la cobertura debido a la terminación del empleo o a la reducción de las horas de trabajo, y en general dura 18 meses. Determinados eventos especificos, o un segundo evento especifico durante el período inicial de cobertura, pueden permitir que el beneficiario reciba un máximo de 36 meses de cobertura.

También hay otros motivos por los cuales este período de 18 meses de la cobertura de continuación de COBRA puede prolongarse:

Extensión por discapacidad del período de 18 meses de la cobertura de continuación de COBRA

Si el Seguro Social determina que usted o alguien de su familia que esté cubierto por el Plan tiene una discapacidad y usted le avisa al respecto al administrador del Plan en el plazo correspondiente, usted y toda su familia pueden recibir una estensión adicional de hasta 11 meses de cobertura de continuación de COBRA, por un máximo de 29 meses. La discapacidad debe haber comenzado en algún momento antes de los 60 días de la cobertura de continuación de COBRA y debe durar al menos hasta el final del período de 18 meses de la cobertura de continuación de COBRA.

Extensión por un segundo evento especifico del período de 18 meses de la cobertura de continuación de COBRA

Si su familia sufre otro evento especifico durante los 18 meses de la cobertura de continuación de COBRA, su cónyuge y sus hijos dependientes pueden recibir hasta 18 meses adicionales de cobertura de continuación de COBRA, por un máximo de 36 meses, si se le avisa al Plan como corresponde acerca del segundo evento especifico. Esta extensión puede estar disponible para el cónyuge y cualquier hijo dependiente que reciba la cobertura de continuación de COBRA en el caso de que el empleado o exempleado muera, adquiera el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas), se divorcie o se separe legalmente, o si el hijo dependiente deja de ser elegible en el Plan como hijo dependiente. Esta extensión solo está disponible en el caso de que el segundo evento especifico hubiese hecho que el cónyuge o el hijo dependiente pierda la cobertura del Plan si no se hubiese producido el primer evento especifico.

¿Hay otras opciones de cobertura además de la cobertura de continuación de COBRA?

Sí. En lugar de inscribirse en la cobertura de continuación de COBRA, puede haber otras opciones de cobertura para usted y su familia a través del mercado de seguros médicos, Medicaid u otras opciones de un plan de salud grupal (por ejemplo, el plan de su cónyuge) mediante lo que se denomina un “período de inscripción especial”. Es posible que algunas de estas opciones cuesten menos que la cobertura de continuación de COBRA. Puede encontrar más información sobre muchas de estas opciones en **www.cuidadodesalud.gov**.

¿Puedo inscribirme en Medicare, en caso de ser elegible, después de que finalice la cobertura de mi plan de salud colectivo?

En general, después del período de inscripción inicial, hay un período de inscripción especial de 8 meses[1] para inscribirse en Medicare Parte A o B, que comienza cuando ocurre lo primero de lo siguiente:

- El mes posterior a la finalización del empleo.
- El mes posterior a la finalización de la cobertura del plan de salud colectivo basada en el empleo actual.

Si elige la Ley Ómnibus Consolidada de Reconciliación Presupuestaria (COBRA) y desea inscribirse en Medicare Parte B después de que finalice su cobertura de continuación, es posible que tenga que pagar una penalidad por inscripción tardía. Si se inscribe inicialmente en Medicare Parte A o B después de elegir la cobertura de continuación COBRA, el plan puede terminar su cobertura de continuación (sin embargo, si Medicare Parte A o B entra en vigencia en la fecha de la elección de COBRA o antes de esta fecha, la cobertura de COBRA no se puede descontinuar debido al derecho a Medicare, incluso si la persona se inscribe en la otra parte de Medicare después de la fecha de la elección de la cobertura de COBRA).

Si está inscrito tanto en COBRA como en Medicare, Medicare será generalmente el pagador principal. Es posible que algunos planes "disminuyan" el monto que Medicare pagaría en caso de ser el pagador principal, incluso si usted no está inscrito.

Para obtener más información, visite **www.medicare.gov/medicare-and-you**

Si tiene preguntas

Las preguntas acerca de su Plan o de sus derechos a recibir la cobertura de continuación de COBRA deben enviarse al contacto o los contactos identificados abajo. Para obtener más información sobre sus derechos según la Ley de Seguridad de los Ingresos de Jubilación de los Empleados (ERISA, por sus siglas en inglés), incluida la ley COBRA, la Ley de Atención Médica (de bajo costo) y la Protección al Paciente, y otras leyes que afectan a los planes de salud grupales, comuníquese con la oficina regional o de distrito más cercana de la Administración de Seguridad de Beneficios para Empleados (EBSA, por sus siglas en inglés) del Departamento de Trabajo de Estados Unidos en su área, o visite www.dol.gov/ebsa. (Las direcciones y los números de teléfono de las oficinas regionales y de distrito de EBSA están disponibles en el sitio web de EBSA). Para obtener más información acerca del mercado de seguros médicos, visite **www.cuidadodesalud.gov**.

Informe a su plan si cambia de dirección

Para proteger los derechos de su familia, informe al administrador del Plan sobre cualquier cambio en las direcciones de sus familiares. También debe conservar una copia, para su registro, de todos los avisos que le envíe al administrador del Plan.

Información de contacto del Plan

2026-2027 Plan Year
Tammy Nichols
143 Third Street, NW
Pulaski, Virginia 24301

General FMLA Notice

EMPLOYEE RIGHTS

UNDER THE FAMILY AND MEDICAL LEAVE ACT

The United States Department of Labor Wage and Hour Division

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this 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.

Health Insurance Exchange Notice

For Employers Who Offer a Health Plan to Some or All Employees

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact:

Tammy Nichols
143 Third Street, NW
Pulaski, Virginia 24301

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Pulaski County	4. Employer Identification Number (EIN) 54-6002979	
5. Employer address 143 Third Street NW	6. Employer phone number (540) 994-2406	
7. City Pulaski	8. State Virginia	9. ZIP code 24301
10. Who can we contact about employee health coverage at this job? Tammy Nichols		
11. Phone number (541) 994-2406	12. Email address tnichols@pulaskicounty.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☑ Some employees. Eligible employees are: FT Benefit Eligible Employees

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are: Spouse; dependent children under age 26

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Note: Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

Aviso de Intercambio de Seguros de Salud

Para los empleadores que ofrecen un plan de salud a algunos o a todos los empleados

Cobertura del Mercado de Seguros Médicos Opciones y su cobertura de salud

PARTE A: Información general

Incluso si le ofrecen cobertura de salud a través de su empleo, es posible que tenga otras opciones de cobertura a través del Mercado de Seguros Médicos ("Mercado"). Para ayudarlo a evaluar las opciones para usted y su familia, este aviso proporciona cierta información básica sobre el Mercado de Seguros Médicos y la cobertura de salud ofrecida a través de su empleo.

¿Qué es el Mercado de Seguros Médicos?

El Mercado está diseñado para ayudarle a encontrar un seguro médico que satisfaga sus necesidades y se ajuste a su presupuesto. El Mercado ofrece un "punto único de compra" para encontrar y comparar opciones de seguros médicos privados en su área geográfica.

¿Puedo ahorrar dinero en las primas de mi seguro médico en el Mercado?

Es posible que califique para ahorrar dinero y reducir su prima mensual y otros costos de bolsillo, pero solo si su empleador no ofrece cobertura o si ofrece cobertura que no se considera asequible para usted y no cumple con ciertas normas de valor mínimo (que se analizan a continuación). Los ahorros para los que es elegible dependen de los ingresos de su hogar. También puede ser elegible para un crédito fiscal que reduzca sus costos.

¿La cobertura de salud basada en el empleo afecta la elegibilidad para recibir ahorros en primas a través del Mercado?

Sí. Si tiene una oferta de cobertura de salud de su empleador que se considera asequible para usted y cumple con ciertas normas de valor mínimo, no será elegible para un crédito fiscal o pago por adelantado del crédito fiscal para su cobertura del Mercado y es posible que desee inscribirse en su plan de salud basado en el empleo. Sin embargo, usted puede ser elegible para un crédito fiscal y pagos por adelantado del crédito, que reducen su prima mensual, o una reducción en ciertos costos compartidos, si su empleador no le ofrece cobertura alguna o no le ofrece cobertura que se considera asequible para usted o cumple con las normas de valor mínimo. Si su participación del costo de la prima de todos los planes que se le ofrecen a través de su empleo es más del 9.12 %1 de su ingreso familiar anual, o si la cobertura a través de su empleo no cumple con la norma de "valor mínimo" establecida por la Ley de Cuidado de la Salud a Bajo Precio, puede ser elegible para un crédito fiscal y el pago por adelantado del crédito, si no se inscribe en la cobertura de salud basada en el empleo. Para los miembros de la familia del empleado, la cobertura se considera asequible si el costo de las primas del plan de menor costo que cubriría a todos los miembros de la familia no excede el 9.12 % de los ingresos del hogar del empleado..12

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[1] Indexado anualmente; consulte https://www.irs.gov/pub/irs-drop/rp-22-34.pdf para 2023.

[2] Un plan de salud patrocinado por el empleador o basado en el empleo cumple con la "norma de valor mínimo" si la participación del plan en los costos totales de beneficios permitidos cubiertos por el plan no es inferior al 60 por ciento de dichos costos. A los efectos de la elegibilidad para el crédito fiscal para la prima, para cumplir con la "norma de valor mínimo", el plan de salud también debe proporcionar una cobertura sustancial tanto de los servicios hospitalarios como de los servicios médicos para pacientes hospitalizados.

Nota: si compra un plan de salud a través del Mercado, en lugar de aceptar la cobertura de salud ofrecida a través de su empleo, entonces puede perder el acceso a todo lo que el empleador contribuya a la cobertura basada en el empleo. Además, esta contribución del empleador, así como la contribución de su empleado a la cobertura basada en el empleo, generalmente se excluye de los ingresos para efectos del impuesto sobre la renta federal y estatal. Sus pagos de cobertura a través del Mercado se realizan después de impuestos. Además, tenga en cuenta que, si la cobertura de salud ofrecida a través de su empleo no cumple con las normas de asequibilidad o valor mínimo, pero acepta esa cobertura de todos modos, no será elegible para un crédito fiscal. Debe considerar todos estos factores al determinar si debe comprar un plan de salud a través del Mercado.

¿Cuándo puedo inscribirme en una cobertura de seguro médico a través del Mercado?

Puede inscribirse en un plan de seguro médico del Mercado durante el Período de Inscripción Abierta anual del Mercado. La Inscripción Abierta varía según el estado, pero generalmente comienza el 1 de noviembre y continúa al menos hasta el 15 de diciembre.

Fuera del Período de Inscripción Abierta anual, puede inscribirse en un seguro médico si califica para un Período de Inscripción Especial. En general, usted califica para un Período de Inscripción Especial si ha tenido ciertos eventos de vida calificativos, como casarse, tener un bebé, adoptar un niño o perder la elegibilidad para otra cobertura de salud. Dependiendo de su tipo de Período de Inscripción Especial, es posible que tenga 60 días antes o 60 días después del evento de vida calificativo para inscribirse en un plan del Mercado.

También existe un Período de Inscripción Especial del Mercado para personas y sus familias que pierden la elegibilidad para la cobertura de Medicaid o del Programa de Seguro Médico para Niños (CHIP, por sus siglas en inglés) a partir del 31 de marzo de 2023 hasta el 31 de julio de 2024. Desde el inicio de la emergencia de salud pública del COVID-19 a nivel nacional, las agencias estatales de Medicaid y CHIP generalmente no han cancelado la inscripción de ningún beneficiario de Medicaid o CHIP que estuviera inscrito a partir del 18 de marzo de 2020 hasta el 31 de marzo de 2023. A medida que las agencias estatales de Medicaid y CHIP reanuden las prácticas habituales de elegibilidad e inscripción, es posible que muchas personas ya no sean elegibles para la cobertura de Medicaid o CHIP a partir del 31 de marzo de 2023. El Departamento de Salud y Servicios Humanos de EE. UU. **ofrece un período temporal de Inscripción Especial en el Mercado para permitir que estas personas se inscriban en la cobertura del Mercado.**

Las personas elegibles para el Mercado que viven en estados atendidos por HealthCare.gov y que envían una nueva solicitud o actualizan una solicitud existente en HealthCare.gov entre el 31 de marzo de 2023 y el 31 de julio de 2024, y dan fe de una fecha de terminación de la cobertura de Medicaid o CHIP dentro del mismo período, son elegibles para un Período de Inscripción Especial de 60 días. **Eso significa que, si pierde la cobertura de Medicaid o CHIP entre el 31 de marzo de 2023 y el 31 de julio de 2024, es posible que pueda inscribirse en la cobertura del Mercado dentro de los 60 días posteriores a la pérdida de la cobertura de Medicaid o CHIP.** Además, si usted o los miembros de su familia están inscritos en la cobertura de Medicaid o CHIP, es importante asegurarse de que su información de contacto esté actualizada para asegurarse de recibir cualquier información sobre los cambios en su elegibilidad. Para obtener más información, visite HealthCare.gov o llame al Centro de llamadas del Mercado al 1-800-318-2596. Los usuarios de TTY pueden llamar al 1-855-889-4325.

¿Qué pasa con las alternativas a la cobertura de seguro médico del Mercado?

Si usted o su familia son elegibles para la cobertura de un plan de salud basado en el empleo (como un plan de salud patrocinado por el empleador), usted o su familia también pueden ser elegibles para un Período de Inscripción Especial para inscribirse en ese plan de salud en ciertas circunstancias, incluso si usted o las

personas a su cargo estaban inscritos en la cobertura de Medicaid o CHIP y perdieron esa cobertura. Generalmente, tiene 60 días después de la pérdida de la cobertura de Medicaid o CHIP para inscribirse en un plan de salud basado en el empleo, pero si usted y su familia perdieron la elegibilidad para la cobertura de Medicaid o CHIP entre el 31 de marzo de 2023 y el 10 de julio de 2023, puede solicitar esta inscripción especial en el plan de salud basado en el empleo hasta el 8 de septiembre de 2023. Confirme la fecha límite con su empleador o con su plan de salud basado en el empleo.

Alternativamente, puede inscribirse en la cobertura de Medicaid o CHIP en cualquier momento completando una solicitud a través del Mercado o solicitando directamente a través de su agencia estatal de Medicaid. Visite https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ para obtener más detalles.

¿Cómo puedo obtener más información?
Para obtener más información sobre la cobertura que ofrece a través de su empleo, consulte el Resumen de la descripción del plan de salud o comuníquese con

Tammy Nichols
143 Third Street, NW
Pulaski, Virginia 24301

El Mercado puede ayudarlo a evaluar sus opciones de cobertura, incluida su elegibilidad para cobertura a través del Mercado y su costo. Visite HealthCare.gov para obtener más información, incluida una solicitud en línea para cobertura de seguro médico e información de contacto de un Mercado de Seguros Médicos en su área.

PARTE B: Información sobre la cobertura de salud ofrecida por su empleador

Esta sección contiene información sobre cualquier cobertura de salud ofrecida por su empleador. Si decide completar una solicitud de cobertura en el Mercado, se le pedirá que proporcione esta información. Esta información está numerada según la solicitud del Mercado.

3. Nombre del empleador Pulaski County	4. Número de identificación patronal (EIN) 54-6002979	
5. Dirección del empleador 143 Third Street NW	6. Número de teléfono del empleador (540) 994-2406	
7. Cuidad Pulaski	8. Estado Virginia	9. Código postal 24301
10. ¿A quién podemos contactar sobre la cobertura de salud de los empleados en este trabajo? Tammy Nichols		
11. Número de teléfono (si es diferente al anterior) (541) 994-2406	12. Dirección de correo electrónico tnichols@pulaskicounty.org	

A continuación, se ofrece información básica sobre la cobertura de salud que ofrece este empleador:

- Como su empleador, ofrecemos un plan de salud para:

☑ Some employees. Eligible employees are: FT Benefit Eligible Employees

- Respecto a los dependientes:

☑ We do offer coverage. Eligible dependents are: Spouse; dependent children under age 26

☑ Si se marca, esta cobertura cumple con la norma de valor mínimo y el costo de esta cobertura para usted debe ser asequible, según los salarios de los empleados.

Nota: Incluso si su empleador tiene la intención de que su cobertura sea asequible, aún puede ser elegible para un descuento en la prima a través del Mercado. El Mercado utilizará los ingresos de su hogar, junto con otros factores, para determinar si puede ser elegible para un descuento en la prima. Si, por ejemplo, sus salarios varían de una semana a otra (quizás es un empleado por horas o trabaja por comisión), si es nuevo empleado a mitad de año o si tiene otras pérdidas de ingresos, aún puede calificar para un descuento en la prima.

Medicare Part D Creditable Coverage Notice

Important Notice from Pulaski County 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 with Pulaski County 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. Pulaski County has determined that the prescription drug coverage offered by the Pulaski County Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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 Pulaski County coverage will be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current Pulaski County coverage, be aware that you and your dependents will be able to get this coverage back.

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

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

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

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

Contact the person listed below for further information call Tammy Nichols at (541) 994-2406. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Pulaski County changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (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).

Date: 4/27/2026

Name of Entity/Sender: Pulaski County

Contact--Position/Office: Tammy Nichols, Human Resources Director

Address: 143 Third Street, NW Pulaski, Virginia 24301

Phone Number: (541) 994-2406

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (541) 994-2406.

Newborns' and Mothers' Health Protection Act Notice

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).

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.

https://scc.virginia.gov/pages/Balance-Billing-Protection

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.

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's network.

https://scc.virginia.gov/pages/Balance-Billing-Protection

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 Help Desk, 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.

Notice of Patient Protections

The Pulaski County Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Pulaski County designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact:

Tammy Nichols

143 Third Street, NW

Pulaski, Virginia 24301

For children, you may designate a pediatrician as the primary care provider.

Notice of Privacy Practices

Pulaski County
143 Third Street NW
Pulaski, Virginia 24301

Privacy Official:
Tammy Nichols
143 Third Street, NW
Pulaski, Virginia 24301

Effective Date: 07/01/2026

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law

- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

To the extent we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no," for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at:
  Tammy Nichols
  143 Third Street, NW
  Pulaski, Virginia 24301
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **https://www.hhs.gov/hipaa/filing-a-complaint/index.html.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and share your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Other Information

Notice of Special Enrollment Rights

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).

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.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact:

Tammy Nichols

143 Third Street, NW

Pulaski, Virginia 24301

USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

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

B. Reemployment Rights

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

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

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

C. Right to Be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
    - Initial employment;
    - Reemployment;
    - Retention in employment;
    - Promotion; or
    - Any benefit of employment because of this status.

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

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you 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 (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at https://www.dol.gov/agencies/vets. An interactive online USERRA Advisor can be viewed at https://webapps.dol.gov/elaws/vets/userra/.

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

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *https://www.dol.gov/sites/dolgov/files/VETS/files/USERRA-Poster.pdf*. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

Women's Health and Cancer Rights Act (WHCRA) Notices

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. Therefore, the following deductibles and coinsurance apply: $See Benefit Summary deductible (in-network) and See Benefit Summary% coinsurance (in-network) and $See Benefit Summary deductible (out-of-network) and See Benefit Summary% coinsurance (out-of-network). If you would like more information on WHCRA benefits, call your plan administrator at (541) 994-2406.

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 (541) 994-2406 for more information.