2022 Benefits Guide

Benefits You Can Count on for You and Your Family

ARH®
Appalachian Regional Healthcare

THE HEALTHCARE SYSTEM OF APPALACHIA

ARH Mission

To improve health and promote well-being of all people in Central Appalachia in partnership with our communities.

ARH Vision

To provide an unparalleled experience as the most trusted home for healthcare.

ARH Values

Patient and family experience is our number one priority.

WELCOME TO ARH

We are pleased to provide you with the 2022 ARH Benefits Guide. Please take the time to review the various benefit options available to you as a valued ARH employee, and decide which option(s) best fit your needs for the 2022 plan year.

Our benefit program in 2022 includes a Medical and Pharmacy plan, three Dental plans to choose from, Cancer, Accident, and Critical Illness with Cancer coverage, Vision insurance, Voluntary Basic Life insurance, Dependent Life insurance, Supplemental Life insurance on yourself, your spouse or dependents, Legal Shield Identity Theft, Universal Life insurance with Long Term Care plan, and Medical Transport protection. Our Disability insurance offers most employees the choice of Voluntary Short Term and Long Term Disability coverage. Employees will continue to have the option of enrolling in the Flexible Spending Accounts.

SHOULD YOU WISH TO MAKE ANY CHANGES TO CURRENT BENEFITS OR TO ENROLL IN THE FSA BENEFIT FOR 2022, YOU MUST GO ONLINE OR CONTACT BENEFITFIRST TO DO SO DURING OPEN ENROLLMENT FOR 2022 (SEE PAGE 4).

INFORMATION IN THIS GUIDE

BENEFITS OVERVIEW

What's Changing

- Life & Disability: The Hartford is the new carrier.
- Ambulance Insurance: MASA is still the carrier, but enrollment must occur in Benefitfirst this year.
- Dental Implant coverage has been added to the MID and HIGH plans.
- Wellness Plan: New requirement added.
- Employee Assistance Programs: Two new programs available for employees.

2022 ARH Open Enrollment Notes

- 2022 open enrollment is **mandatory**.
- Benefitfirst is the benefits platform used by ARH.
- It is required that your name and your dependents' names in Benefitfirst reflect your legal names on your social security cards, per IRS Guidelines.

HOW TO ENROLL

Note: If you wish to make any changes to current benefits or to enroll in FSA for 2022, you must do so during open enrollment for 2022. Review your Employee Benefits Guide and use one of the options below:

1. **Enroll online**
   - Obtain your Personal Benefit Summary with temporary password from local Human Resources Department.
   - Go to https://www.Benefitfirst.com or scan the QR Code above.
   - Login using your current login information and **Company ID 631**, and create a new password.
   - At the homepage choose **Enroll Now**.
   - Select the Annual Enrollment option (new hires will select Enroll In or Decline Benefits).
   - When you get to the last enrollment screen you will be asked to review your elections and certify them by re-entering your password.
   - The final step is to click **Submit** to complete your transaction. **That's it... the entire process can take as little as 4 minutes to complete.** NOTE: Please print your enrollment document for your records.
2. **Call the Benefitfirst Call Center -** If you have technical questions or would like to enroll by phone, obtain your Personal Benefit Summary with temporary password from local Human Resources Department and then call **888-322-9374 and use Company ID 631** to speak with an Enrollment Specialist. The Benefitfirst Call Center is available Monday-Friday, 8:30 a.m. until 5:00 p.m. EST.

No benefit changes can be made after Open Enrollment for 2022 unless you experience a qualifying life event.

What Do You Need to Enroll?

When you enroll in Benefitfirst for 2022, you will need to have the following items in hand:

- **New hires** will receive a Benefitfirst Personal Benefits Summary with the ARH company ID and temporary password. You will be given an enrollment window during orientation and MUST enroll within that timeframe to be eligible for benefits.
- **Current employees** will receive a Benefitfirst Personal Benefits Summary with ARH company ID and temporary password from local HR.
- This guide as a reference.
- The names (as it is reflected on your Social Security Card), Social Security numbers, date of birth and addresses of any/all eligible dependents you may wish to enroll in one or more of the plans.
- Life Insurance beneficiary information.
- If you are adding a new dependent to the Medical, Dental or Vision Insurance plans, you must provide proof of dependent status (i.e. marriage certificate, verfication of birth from hospital and birth certificate when available, court order). Eligible dependents are considered legal spouse or dependent children. **You must present this documentation to your local HR Manager.**

2022 ARH Health Plan
Frequently Asked Questions

> What will I pay if I go outside ARH?

If there is a service available at ARH within your state, the service will not be covered. If the service is not available at an ARH facility within your state, then Tier 2 or Tier 3 level of benefits will be applied which incurs coinsurance and deductible, as applicable. Refer to Medical Coverage Information in this booklet.

> How do I know what facilities I can go to outside of ARH?

If there is a service not available at ARH, then you should refer to the Medical Coverage Information in this booklet, and/or visit the Anthem website.

> What services are available at ARH?

Check with local Human Resources.

> What is the difference between ARH Owned, ARH Approved and Anthem?

ARH Owned providers pay the highest level of coverage. Office Visits for ARH Approved are paid at 100%. Services provided at ARH Approved do apply to coinsurance and deductible. Coinsurance and Deductibles apply to office visits and services provided by Tier 3 ARH Preferred Provider (Anthem local network).

QUALIFYING LIFE EVENTS AND TIMELINE FOR WHICH EMPLOYEES MAY MAKE CHANGES TO THEIR BENEFITS

The choices you make during Open Enrollment or as a new employee remain in place from January 1, 2022 through December 31, 2022. You cannot add or drop coverage until the next Open Enrollment (for the plan year beginning January 1, 2023) unless you experience a true qualifying event with benefit changes related to the specific event.

These qualifying life events and examples of required documentation include:

- Marriage (copy of marriage certificate and birth certificate for covered step-children)
- Birth/Adoption (copy of proof of birth from hospital or copy of adoption papers)
- Death of spouse or dependent (copy of obituary or death certificate)
- Dependent child reaches limiting age (if applicable by plan) or is no longer considered a dependent
- Loss of spouse/dependent coverage (copy of termination letter)
- Divorce/Annulment (copy of final court decree)
- Legal Separation (if applicable in your state) (copy of final court decree)
- FMLA related leave
- Change of eligibility status (i.e., fulltime to part-time, union to non-union, etc.)
- Retirement

Changes to benefits for any event listed above must be made within 30 days of the qualifying event date. However, for the loss/gain of Medicaid or State Children's Health program, benefit changes may be made within 60 days.

Should you wait longer than the timeline stipulated above, you will not be able to make benefit changes until Open Enrollment for the next plan year.

Please be advised that your benefits terminate at the end of the month in which you are placed on any type of leave-without-pay (LWOP), and you are COBRA eligible the first of the following month. **Upon return to Active work status from LWOP, you must re-enroll in benefits within 30 days of returning to work**. Should you fail to re-enroll within 30 days of your return to work from LWOP, you must wait until Open Enrollment for the next plan year to re-enroll in the ARH offered benefit plans.

2022 ARH Health Plan Criteria

ARH provides employees and their families with 2 affordable options for health care.

Review the criteria below to choose the plan that is best for you.

ARH STANDARD HEALTH INSURANCE

The ARH Standard Health Insurance plan is a low premium plan available to all eligible employees. Employees are encouraged to take advantage of the health plan to complete an annual physical as part of a healthy lifestyle.

ARH WELLNESS HEALTH INSURANCE PLAN

The ARH Wellness Health Insurance Plan is available at a lower premium to all eligible employees who meet specific criteria demonstrating a commitment to a healthy lifestyle. The criteria below must be met to qualify for the Wellness Plan rate.

- Employee must watch the 2022 Health Plan video assigned to all employees in SEED.
- Employee and Spouse must be tobacco free.
- Employee and Spouse must complete a lab panel; lab orders may be found on the ARH Benefits website, in local Human Resources departments, or at any ARH lab (*Labs should be completed BEFORE a routine physical exam).
- Employee and Spouse must complete a physical exam with an ARH approved provider to review lab results and discuss preventive health measures, and have the "ARH Wellness Plan Documentation" form completed and signed.
- Employee and Spouse must receive the 2021-2022 flu shot; these may be provided by employee health, at your provider's office, or at any ARH retail pharmacy.

HOW TO DOCUMENT THAT ALL CRITERIA HAVE BEEN MET

During Open Enrollment, verify in ***BenefitFirst*** that all criteria have been met for the plan you choose (subject to verification based on review of insurance claims, employee health documentation, etc.)

Additionally, NEW FOR 2022 PLAN YEAR, Complete the ARH Wellness Plan Documentation Portal

Once all criteria are met and documentation is available, employee **must request** the ARH Wellness Health Insurance Plan in the ARH Wellness Plan Documentation Portal PRIOR TO December 31, 2021. Documents required (for both employee and spouse, if covered):

- Proof of flu shot (if received anywhere other than Employee Health)
- Completed and Signed Wellness Plan Documentation Form

*If you or your spouse are unable to participate in any of the health-related activities required to earn the reduced rate, you may request a reasonable alternative standard by contacting Tiffany Herald at tiherald@arh.org.

Medical Coverage Information

Appalachian Regional Healthcare provides medical coverage at affordable rates to its employees.

There are three tiers of coverage to help you manage your health:

Tier 1
ARH-owned providers; greatest level of coverage:

- Most services are covered in full.
- Co-pays for services including advanced imaging, outpatient surgeries/procedures, and emergency room visits.
- For services not available at an ARH facility you must use an ARH approved provider or an Anthem local network provider.

Tier 2
ARH approved providers (credentialed at ARH)

- Office visit pays at 100%
- Covered services not available at ARH and basic services apply to deductible/coinsurance.

Tier 3
Anthem local network providers

- Office visits and covered services not available at ARH apply to deductible/coinsurance.

ARH does not provide coverage if the Anthem network is not utilized.

Medical Coverage Information

Coverage	Tier 1 ARH Owned	Tier 2 ARH Approved	Tier 3 Anthem Local Network *(When service is not available at ARH)*
Networks Available	All ARH owned facilities including: • Hospitals • ER • Clinics • Home Health • DME • Pharmacy • Specialty Pharmacy • Rehab	ARH Credentialed Providers	KY and WV Preferred Network Providers • Anthem local (KY and WV) network providers • University of Cincinnati Children's Hospital Excludes • Pikeville Medical Center • Raleigh General (OB/GYN allowed only) • Greenbrier Valley (OB/GYN allowed only)
Annual Deductible	$0	$ 250 single/ $ 500 family	$ 500 single/ $ 1,000 family
Medical/Pharmacy Out-of-Pocket Maximum	$ 8,700 single/ $17,400 family	$ 8,700 single/ $17,400 family	$ 8,700 single/ $17,400 family
Medical Out of Pocket Maximum includes all In-Network member responsibility for Essential Health Benefits such as Plan Deductible, Plan Medical Out of Pocket, Coinsurance, Medical Copays and also includes Out of Network Emergency Services. Once this is met, the member is responsible for no additional expenses, including copays.			
	PLAN PAYS	**PLAN PAYS**	**PLAN PAYS**
Primary Care Physician Office Visit	100%	100%	80% after deductible
Specialist Office Visit	100%	100%	80% after deductible
Preventive Service (Mammograms, Pap Smears, Prostate and Colon Screening, Well baby and Well Child Screening)			
Preventive Services	100%	100%	100%

Medical Coverage Information

Coverage	Tier 1 ARH Owned	Tier 2 ARH Approved	Tier 3 Anthem Local Network *(When service is not available at ARH)*
Physician Office Services /Surgery	100%	80% after deductible	80% after deductible
Chiropractors (12 Annual Visits)	N/A	N/A	80% after deductible
Immediate/Urgent Care Center	100%	N/A	80% after deductible
Emergency Room Services (True Emergencies)	100% after $100 copay	N/A	100% after $100 copay
X-ray, Laboratory (Basic Lab/X-ray performed in Physician's Office)	100%	80% after deductible	80% after deductible
Advanced Imaging (MRI, CT Scan, PET Scan)	100% after $75 copay	Not covered unless performed at ARH - owned facility	Not covered unless performed at ARH-owned facility. Lexington plan may vary.
Inpatient Room/Board	100%	N/A	80% after deductible
Outpatient Surgery (Hospital and Ancillary services)	100% after $50 copay	N/A	80% after deductible
Inpatient Physician Services / Surgery	100%	N/A	80% after deductible
Inpatient Alcohol/Chemical Dependency	N/A	N/A	80% after deductible
Inpatient Behavioral - Mental Health	100%	N/A	80% after deductible
Durable Medical Equipment	100%	80% after deductible	80% after deductible
Diabetic Pumps and Supplies	100%	90% after deductible	90% after deductible
Rehabilitation (Physical Therapy, Occupational Therapy, Speech Therapy)	100%	Not covered unless performed at ARH - owned facility	Not covered unless performed at ARH-owned facility. Lexington plan may vary.
Bariatric Services available at ARH Only; copay applies: Sleeve/Gastric banding: $4,200; Gastric Bypass/RNY: $5,500			
Bariatric Services Available only at ARH Hazard	100% after copay	Only covered at ARH facility	Only covered at ARH facility

Prescription Benefits

Pharmacy Benefits	At an ARH Pharmacy	At an Anthem Approved Non-ARH Pharmacy
Level 1 Drugs		
0-30 day supply	15% with $4 minimum	20% with $15 minimum
>30 day supply	10% with $10 minimum	N/A
Level 2 Drugs		
0-30 day supply	20% with $15 minimum	30% with $30 minimum
>30 day supply	15% with $30 minimum	N/A
Level 3 Drugs		
0-30 day supply	30% with $30 minimum	40% with $45 minimum
>30 day supply	25% with $50 minimum	N/A
Level 4 Drugs		
0-30 day supply	40% with $400 maximum	50% with $600 maximum
>30 day supply	N/A	N/A

- The prescription benefit allows the member to pay a percentage of the drug cost or a minimum copay determined by the level of the drug:
  - Level 1: Low cost generic drugs
  - Level 2: Higher cost generic and brand name drugs
  - Level 3: Mostly high cost, brand name drugs (may have a lower cost generic or brand name alternative in Level 1 or 2)
  - Level 4: Highest cost drugs (includes most specialty drugs)

- To see a list of covered medications, visit the Anthem website or check with your local ARH pharmacy.

- An ARH pharmacy should be used except in cases where a drug is needed urgently and no ARH pharmacy is available.
  - Medications taken chronically: May be filled at a non-ARH pharmacy 1 time for a higher copay and then must be transferred to ARH
  - Medications taken for an acute illness (such as an antibiotic or pain medications): May be filled at a non-ARH pharmacy for a higher copay; use ARH pharmacies for the lowest copays
  - Specialty medications: May only be filled at ARH (on rare occasions, a non-ARH specialty pharmacy may be approved only if the drug is not available at ARH.)

- For questions about your prescription benefit, you may call the number on the back of your card labeled “Pharmacy Member Services.”

Employee Assistance Program
Service Summary
Appalachian Regional Healthcare

Effective date: 01/01/2022

Anthem

Available 24/7, 365 days a year

Everything you share is confidential*

Life can be full of challenges. Your Anthem Employee Assistance Program (EAP) is here to help you and your household members. EAP offers a wide range of **no-cost** support services and resources, including:

Counseling
- Up to 3 visits per issue
- In-person or online visits
- Call EAP or use the online Member Center to initiate services

Legal consultation
- 30-minute phone or in-person meeting
- Discounted fees to retain a lawyer
- Free legal resources, forms, and seminars online

Financial consultation
- Phone meeting with financial professionals
- Regular business hours; no appointment required
- Free financial resources and budgeting tools online

ID recovery
- Help reporting to consumer credit agencies
- Assistance with paperwork and creditor negotiations

Dependent care and daily living resources
- Online information about child care, adoption, elder care, and assisted living
- Phone consultation with a work-life specialist
- Help with pet sitting, moving, and other common needs

Other anthemEAP.com resources
- Well-being articles, podcasts, and monthly webinars
- Self-assessment tools for emotional health issues

Crisis consultation
- Toll-free emergency number; 24/7 support
- Online critical event support during crises

We are ready to support you

You can call us at **800-999-7222**, or go to **anthemEAP.com** and enter your company code: ARH

When something unexpected happens, EAP can help you figure out your next steps. Contact us today.

* In accordance with federal and state law, and professional ethical standards.
This document is for general informational purposes. Check with your employer for specific information on the services available to you.

Language Access Services – (TTY/TDD: 711)
Spanish – Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda.
Chinese – 您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。

Anthem complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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Dental Coverage

Employees have three voluntary dental plans to choose from for their oral health.

USW employees have the option of choosing union dental benefits or you may apply for one of the ARH dental options. It is important to note that you can enroll in one or the other, but not have both coverages. Once enrolled in a benefit with ARH, it cannot be cancelled unless there is a qualifying event.

ARH Dental Coverage	PPO Plus Premier Low Plan	PPO Plus Premier Mid Plan	PPO Plus High Plan
Annual Deductible	$50 individual / $150 family	$50 individual / $150 family	$50 individual / $150 family
Preventive Service Cleanings/Fluoride	100% coverage	100% coverage	100% coverage
Basic Services	50% coverage (Fillings and crown repair)	50% coverage (Fillings and crown repair, Extractions, denture repair)	80% coverage (Fillings and crown repair, root canals, Extractions)
Major Services	Not covered	30% coverage (Root canals, crowns, bridges, implants, implant maintenance and repair)	50% coverage (Crowns, bridges, implants, implant maintenance and repair)
Annual Maximum Benefit	$1,000	$1,000	$2,000
Orthodontics Dependents Only to age 19	Not covered	50% / $1,000 maximum lifetime benefit	50% / $1,500 maximum lifetime benefit

12 month wait period may apply for Orthodontic and Major Dental Services Refer to your certificate for details.

DELTA DENTAL®

Blue View Vision℠ Insight
Appalachian Regional Healthcare
January 1, 2022

Anthem. BlueCross BlueShield

Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, Sears Optical®, JCPenney® Optical and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at anthem.com, or from the home page menu under Care, select Find a Doctor. You may also call member services for assistance at 1-**877-635-6403**.

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	$10 copay	Up to $42 reimbursement	Once every calendar year
Eyeglass Frames			
One pair of eyeglass frames	$130 allowance, then 20% off any remaining balance	Up to $110 reimbursement	Once every two calendar years
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses: • Single vision lenses • Bifocal lenses • Trifocal lenses • Lenticular lenses	 $15 copay $15 copay $15 copay $15 copay	 Up to $40 reimbursement Up to $60 reimbursement Up to $80 reimbursement Up to $100 reimbursement	Once every calendar year
Eyeglass Lens Enhancements When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.			
• Transitions Lenses (for a child under age 19) • Standard polycarbonate (for a child under age 19) • Factory scratch coating	$0 copay $0 copay $0 copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
Contact Lenses *(instead of eyeglass lenses)* Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.			
• Elective conventional (non-disposable) OR • Elective disposable OR • Non-elective (medically necessary)	$130 allowance, then 15% off any remaining balance $130 allowance *(no additional discount)* Covered in full	Up to $110 reimbursement Up to $110 reimbursement Up to $210 reimbursement	Once every calendar year

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.
Excess Amounts. Amounts in excess of covered vision expense.
Sunglasses. Plano sunglasses and accompanying frames.
Safety Glasses. Safety glasses and accompanying frames.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.
Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
Orthoptics. Orthoptics or vision training and any associated supplemental testing.

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		In-network Member Cost (after any applicable copay)
Retinal Imaging - at member's option can be performed at time of eye exam		Not more than $39

Eyeglass lens upgrades
When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.
	• Transitions lenses (Adults)
	• Standard Polycarbonate (Adults)
	• Tint (Solid and Gradient)
	• UV Coating
	• Progressive Lenses[1]
	  ○ Standard
	  ○ Premium Tier 1
	  ○ Premium Tier 2
	  ○ Premium Tier 3
	• Anti-Reflective Coating[2]
	  ○ Standard
	  ○ Premium Tier 1
	  ○ Premium Tier 2
	• Other Add-ons
		$75
		$40
		$15
		$15
		
		$0
		$85
		$95
		$110
		
		$45
		$57
		$68
		20% off retail price

Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider.	• Complete Pair • Eyeglass materials purchased separately	40% off retail price 20% off retail price
Eyewear Accessories	• Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail price
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	• Standard contact lens fitting[3] • Premium contact lens fitting[4]	Up to $55 10% off retail price
Conventional Contact Lenses	• Discount applies to materials only	15% off retail price

[1] Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

[2] Please ask your provider for his/her recommendation as well as the available coating brands by tier.

[3] Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

[4] Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Discounts are subject to change without notice. Discounts are not 'covered benefits' under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where state law prevents discounting of products and services that are not covered benefits under the plan. Discounts on frames will not apply if the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Some of our in-network providers include:

GLASSES.COM · contactsdirect · LensCrafters · Pearle Vision · Target Optical · Sears Optical · JCPenney | optical

ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM *

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just log in at anthem.com, select discounts, then Vision, Hearing & Dental.

* Discounts cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at anthem.com, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at 1-866-723-0515 to request a claim form.

To Fax: 866-293-7373
To Email: oonclaims@eyewearspecialoffers.com
To Mail: Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

FSA - Flexible Spending Accounts

Today, we need every dollar we get to help with family budgets. Flexible Spending Accounts are one way of providing additional cash flow. They are designed to allow you to take part of your taxable “wage” dollars and turn them into nontaxable “benefit” dollars, which eliminates the tax on income.

Two major areas that qualify for FSAs are out-of-pocket medical expenses and dependent care expenses. Medical expenses include deductibles, co-payments, dental care, eye care, etc. Dependent care expenses can be reimbursed for care of a child under age 13, or a disabled dependent in your care, while you and your spouse work.

ARH provides both of these accounts to our employees. If you incur medical or child care/dependent expenses, you should consider taking advantage of this IRS benefit. The FSA allows you to save state, federal, and FICA taxes on out-of-pocket medical expenses.

The FSA program provides a Debit Card to all enrollees. Once activated, the Debit Card is loaded with the amount you elect to contribute to your Health Care FSA. Every time you use your Debit Card to pay for eligible health care expenses, corresponding deductions will be made from your card balance. BMS may ask for copies of your receipts so be sure to save them! BMS may need to verify that your expenses are eligible for reimbursement under IRS guidelines.

HEALTH CARE FSA

Health Care FSA can set aside up to $2,750 per year to pay for qualified, out-of-pocket medical expenses. Examples of qualified expenses include, but are not limited to: Prescription drugs, doctor’s office co-pays, co-insurance, deductibles, orthodontist & dental fees, prescription glasses & contacts, etc...

DEPENDENT CARE FSA

Dependent Care FSA can set aside up to $5,000 per calendar year to pay for qualified dependent care expenses. Examples of qualified expenses include, but are not limited to: Babysitter, before/after school programs, licensed nursery care, day care, elderly care, summer day camp, etc...

You continue to have a $550 carryover option for 2022. Under this rule, you are able to carryover up to $550.00 of your unused Health FSA balance remaining at the end of a plan year.

What should you do next?

- For the Current Plan Year: Please review your current balance and your planned expenses for the remainder of this year. Any balance over $550 must be spent by December 31st and claimed by the end of the 90 day run out period (March 31) or it will be forfeited. You will have the $550 carryover feature available for Current Plan Year funds remaining after March 31st.

- IMPORTANT: During the 90 day run out period, January 1 - March 31, claims for the prior Plan Year must be submitted for reimbursement and NOT paid using the FSA Debit Card.

- It will not affect your election limit for next year. You can carry a total balance of the full election amount for the new Plan Year, plus any carryover from the Current Plan Year (up to $550).

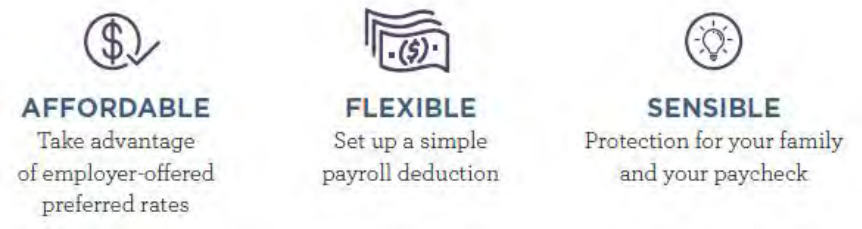
Voluntary Short-term Disability Insurance

- Help protect your income in the event of a disabling illness or injury such as a heart attack, pregnancy or back injury.
- Offers the financial support you need so you can focus on your recovery.

THE HARTFORD

ILLNESS OR INJURY CAN STRIKE ANY TIME. HELP PROTECT YOUR FAMILY FROM BOTH.

You don't have the time for a serious illness or injury. And your budget can't afford it either. But that doesn't mean it can't happen. Short-term Disability insurance can make both easier to manage. Of course your health insurance will help cover medical expenses. But what about the lost income from being out of work? Your family may need that money to keep your household going. Short-term Disability insurance can help.



Benefits Include:

- 60% of your weekly earnings up to a weekly maximum of $1,500.
- Benefits begin on the 31st day of disability due to an illness.
- Benefits being on the 1st day of disability due to an accident (off the job).
- Duration of benefits is 13 weeks, if disabled.

Need to Know:

- No Evidence of Insurability is required to obtain coverage if you previously declined coverage.
- Includes Pre-Existing Condition limitations; look-back period of 12 months; once continuously insured for 12 months, pre-existing condition limitations no longer apply.
- Pregnancy is covered the same as any other illness.

To learn more, visit: TheHartford.com/resources/STD

Voluntary Long-term Disability Insurance

• Help protect your income in the event of a disabling illness or injury such as a heart attack, pregnancy or back injury.

• Offers professional help for disability-related challenges such as legal specialists, financial and therapeutic counselors.

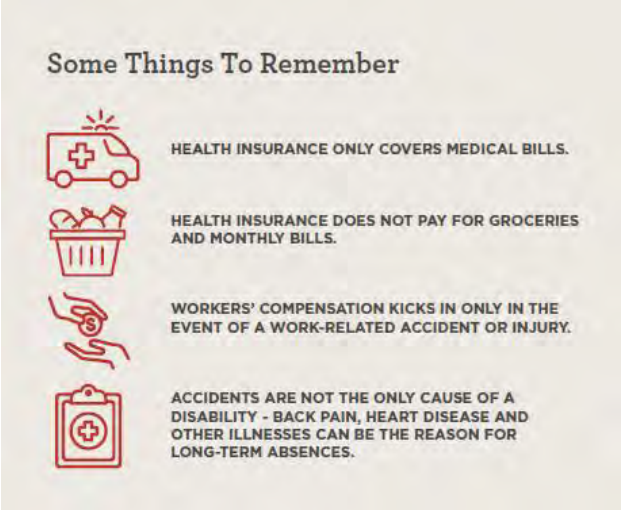
PLANNING AHEAD COULDN'T BE EASIER

An illness or injury can happen at any time. Long-term Disability insurance helps protect your family from the financial crunch of these unexpected health crises. Long-term Disability insurance gives you a percentage of your paycheck each month – depending on how much protection you have – should you become disabled.

Benefits Include:

- 60% of covered earnings to a monthly maximum of $5,000*.
- Benefits begin after 90 days of being disabled disability.

*Benefits may vary due to eligibility, please review your benefits online.



Need to Know:

- No Evidence of Insurability is required to obtain coverage if you previously declined coverage.
- Includes Pre-Existing Condition limitations; look-back period of 12 months; once continuously insured for 12 months, pre-existing condition limitations no longer apply.

To learn more, visit: TheHartford.com/resources/LTD

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

As families care for their lives after a loss or an accident, Life and AD&D insurance can help to care for the rest.

PREPARE FOR THE UNEXPECTED

A sudden death or accident can change everything for your family. Life insurance together with Accidental Death and Dismemberment insurance helps keep you covered in case of an untimely death or accident. With a lump sum payout, Life and AD&D insurance can help provide income and financial support to help your family.

Benefits Include:

Employee:	One time your salary to a maximum of $100,000 (rounded to the next higher $1,000).
Spouse:	$5,000 or $10,000
Child(ren):	14 days to 6 months; $500 6 months to age 26; $5,000

Need to Know:

- Living Benefit Option (Accelerated Death Benefit). If you are diagnosed with a life expectancy of 12 months or less, you can receive up to 80% of your benefit prior to your death.
- AD&D – If employee elects Basic Lie Insurance, ARH will pay for the AD&D Benefit.
- Benefits reduce by 35% at age 65 and 60% at age 70 of the original amount.

To learn more, visit:
TheHartford.com/resources/lifeadd

Voluntary Supplemental Life with Accidental Death & Dismemberment (AD&D)

As families care for their lives after a loss or an accident, Life and AD&D insurance can help to care for the rest.

PREPARE FOR THE UNEXPECTED

A sudden death or accident can change everything for your family. Life insurance together with Accidental Death and Dismemberment (AD&D) insurance helps keep you covered in case of an untimely death or accident. With a lump sum payout, Life and AD&D insurance can help provide income and financial support to help your family with:

Immediate Costs:	Funeral or Burial Expenses
Ongoing Bills:	Rent, Mortgage, Loans or Debt
Future Expenses:	College Tuition, Retirement Savings or Elderly Care

Benefits Include:

Employee:	Increments of $10,000 to a maximum of the lesser of 5 times your earnings or $500,000.
Spouse:	Increments of $5,000 to a maximum of the lesser of 50% of your supplemental coverage or $250,000.
Child(ren):	$10,000

Guarantee Issue Amount -If you elect a coverage amount over the guarantee issue, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective:

Employee: $250,000 Spouse: $25,000 Child(ren): N/A

Need to Know:

- Living Benefit Option (Accelerated Death Benefit). If you are diagnosed with a life expectancy of 12 months or less, you can receive up to 80% of your benefit prior to your death.
- Benefits reduce by 35% at age 65 and 60% at age 70 of the original amount.
- Value Added Services listed on the prior are also included.
- Employees must be enrolled into the Voluntary Basic Life and AD&D to qualify to enroll in the Voluntary Supplemental Life and AD&D plan.

To learn more, visit: TheHartford.com/resources/lifeadd

MASA Medical Transport Solutions™

You can decide which MASA MTS plan will provide you with the ultimate peace of mind at an affordable rate, when protecting your family from massive out-of-pocket ambulance charges.

MEMBERSHIP BENEFITS COMPARISON

DID YOU KNOW?

25 MILLION PEOPLE

are sent to the emergency room through ground or air ambulance every year.

Insurance companies may not cover all air and ground ambulance expenses, which can result in excessive bills.

$5,000 **$60,000**

MASA Medical Transport Solutions™

MEMBERSHIP BENEFITS COMPARISON

A MASA MTS Membership provides the ultimate peace of mind at an affordable rate for emergency ground and air transportation service within the United States and Canada, regardless of whether the provider is in or out of a given group healthcare benefits network.

After the group health plan pays its portion, MASA MTS works with providers to deliver our members' $0 in out-of-pocket costs for emergency transport.

	EMERGENT PLUS MEMBERSHIP	PLATINUM MEMBERSHIP
Emergent Air Transportation	●	●
Emergent Ground Transportation	●	●
Non-Emergency Inter-Facility Transportation	●	●
Repatriation/ Recuperation	●	●
Escort Transportation		●
Visitor Transportation		●
Return Transportation		●
Mortal Remains Transportation		●
Minor Return		●
Organ Retrieval/ Organ Recipient Transportation		●
Vehicle Return		●
Pet Return		●
Worldwide Coverage		●
	$12 /MONTH	$39 /MONTH

Exclusive pricing for Appalachian Regional Healthcare members.

SOURCE: Welch, Shari. "Emergency Department Usage Trend Data Can Help Physicians Prepare for Patients." ACEP Now http://bit.ly/3qBvNrc

VER: MCPSCBLAVS1.050521

ARH® Appalachian Regional Healthcare

PURCHASING POWER

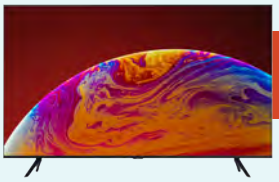
ARH
Appalachian Regional Healthcare

Get what you need **when it matters most**

Pay over time–right from your paycheck

Purchasing Power is a reliable way to buy computers, appliances, electronics and more when paying with cash or credit is challenging. Get your product upfront and pay over 6 or 12 months directly from your paycheck. **While not a discount program, you'll always know the total cost when you order–no surprises.**

No credit check. Fixed payments. No hidden fees.



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Use phone to scan the link

How it works

1. Sign up for free online.
2. Shop thousands of brand-name products.
3. Receive your order upfront.
4. Pay over time, directly from your paycheck.

*Pricing is based upon 26 pay periods per year which may vary by customer. Products and pricing are available while supplies last and are subject to change without notice, so go online for the latest offering. Individual eligibility requirements and spending limits may apply.

**Offer valid for 20% off your first order. Offer valid for new customers only and excludes Allstate Protection Plans, Automotive, and Vacations. Go online to purchasingpower.com/exclusions for full details.

Aflac
Group Critical Illness Advantage

Here's why the Aflac Group Critical Illness plan may be right for you.

For more than 60 years, Aflac has been dedicated to helping provide individuals and families peace of mind and financial security when they've needed it most. The Aflac Group Critical Illness plan is just another innovative way to help make sure you're well protected under our wing.

But it doesn't stop there. Having group critical illness insurance from Aflac means that you may have added financial resources to help with medical costs or ongoing living expenses.

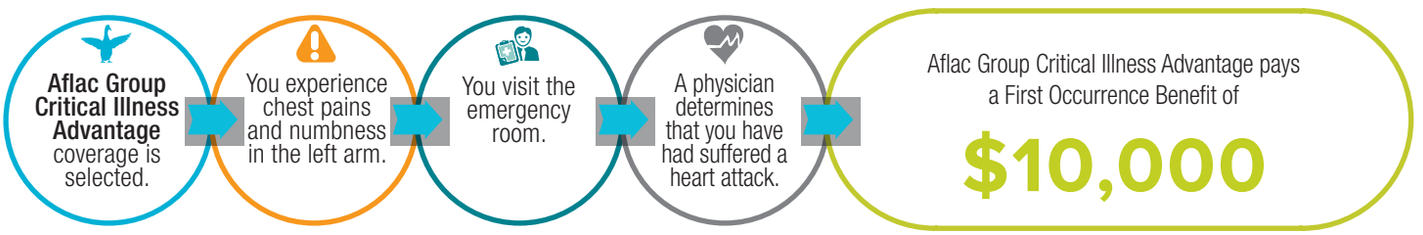
The Aflac Group Critical Illness plan benefits include:

- Critical Illness Benefit payable for:
  - Cancer
  - Heart Attack (Myocardial Infarction)
  - Stroke
  - Kidney Failure (End-Stage Renal Failure)
  - Major Organ Transplant
  - Bone Marrow Transplant (Stem Cell Transplant)
  - Sudden Cardiac Arrest
  - Coronary Artery Bypass Surgery
  - Non-Invasive Cancer
  - Skin Cancer
- Health Screening Benefit

Features:

- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is available for you, your spouse, and dependent children.
- Coverage may be continued (with certain stipulations). That means you can take it with you if you change jobs or retire.
- Fast claims payment. Most claims are processed in about four days.

How it works



Amount payable based on $10,000 First Occurrence Benefit.

To learn more about your Aflac benefits, call 1.800.433.3036 or visit aflacgroupinsurance.com.

Benefits Overview

COVERED CRITICAL ILLNESSES:

CANCER (Internal or Invasive)	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE (Ischemic or Hemorrhagic)	100%
MAJOR ORGAN TRANSPLANT	100%
KIDNEY FAILURE (End-Stage Renal Failure)	100%
BONE MARROW TRANSPLANT (Stem Cell Transplant)	100%
SUDDEN CARDIAC ARREST	100%
NON-INVASIVE CANCER	25%
CORONARY ARTERY BYPASS SURGERY	25%

INITIAL DIAGNOSIS
We will pay a lump sum benefit upon initial diagnosis of a covered critical illness when such diagnoses is caused by or solely attributed to an underlying disease. Cancer diagnoses are subject to the cancer diagnosis limitation. Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

ADDITIONAL DIAGNOSIS
We will pay benefits for each different critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.

REOCCURRENCE
We will pay benefits for the same critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months. Cancer diagnoses are subject to the cancer diagnosis limitation.

CHILD COVERAGE AT NO ADDITIONAL COST
Each dependent child is covered at 50 percent of the primary insured's benefit amount at no additional charge. Children-only coverage is not available.

SKIN CANCER BENEFIT
We will pay $250 for the diagnosis of skin cancer. We will pay this benefit once per calendar year.

WAIVER OF PREMIUM
If you become totally disabled due to a covered critical illness prior to age 65, after 90 continuous days of total disability, we will waive premiums for you and any of your covered dependents. As long as you remain totally disabled, premiums will be waived up to 24 months, subject to the terms of the plan.

The plan has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to your certificate for complete details, definitions, limitations, and exclusions.

Benefits Overview

COVERED CRITICAL ILLNESSES:

SUCCESSOR INSURED BENEFIT

If spouse coverage is in force at the time of the primary insured's death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amount and would also include any dependent child coverage in force at the time.

HEALTH SCREENING BENEFIT

We will pay $150 for health screening tests performed while an insured's coverage is in force. We will pay this benefit once per calendar year.

This benefit is only payable for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit is payable for the covered employee and spouse. This benefit is not paid for dependent children.

COVERED HEALTH SCREENING TESTS INCLUDE:

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- DNA stool analysis
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine level of HDL and LDL
- Serum protein electrophoresis (blood test for myeloma)
- Spiral CT screening for lung cancer
- Stress test on a bicycle or treadmill
- Thermography

OPTIONAL BENEFITS RIDER

BENIGN BRAIN TUMOR	100%
ADVANCED ALZHEIMER'S DISEASE	25%
ADVANCED PARKINSON'S DISEASE	25%

These benefits will be paid based on the face amount in effect on the critical illness date of diagnosis. We will pay the optional benefit if the insured is diagnosed with one of the conditions listed in the rider schedule if the date of diagnosis is while the rider is in force.

Aflac

Aflac
Group Accident Insurance

Just because an accident can change your health, doesn't mean it should change your lifestyle too.

Accidents can happen in an instant affecting you or a loved one. Aflac is designed to help families plan for the health care bumps ahead and take some of the uncertainty and financial insecurity out of getting better.

Protection for the unexpected, that's the benefit of the Aflac Group Accident Plan.

After an accident, you may have expenses you've never thought about. Can your finances handle them? It's reassuring to know that an accident insurance plan can be there for you in your time of need to help cover expenses such as:

- Ambulance rides
- Emergency room visits
- Surgery and anesthesia
- Prescriptions
- Major Diagnostic Testing
- Burns

Plan Features

- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Benefits are paid regardless of any other medical insurance.

How could an accident impact **your lifestyle**? The average cost of a broken leg is up to **$7,500**.*

What could a broken leg cost you?

6	7	83
MORTGAGE PAYMENTS (BASED ON THE AVG COST OF $1,375)[1]	**DAYCARE PAYMENTS** (BASED ON THE AVG COST OF $972 PER MONTH)[2]	**MOBILE PHONE BILLS** (BASED ON THE AVG COST OF $83.33 MONTHLY)[3]



GROUP ACCIDENT INSURANCE INITIAL ACCIDENT TREATMENT BENEFIT – HIGH

	BENEFIT AMOUNT
INITIAL TREATMENT (once per accident, within 7 days after the accident, not payable for telemedicine services) Payable when an insured receives initial treatment for a covered accidental injury. This benefit is payable for initial treatment received under the care of a doctor when an insured visits the following:	
Hospital emergency room with X-Ray / without X-Ray	$250/$200
Urgent care facility with X-Ray / without X-Ray	$250/$200
Doctor's office or facility (other than a hospital emergency room or urgent care) with X-Ray / without X-Ray	$150/$100
AMBULANCE (once per day, within 90 days after the accident) Payable when an insured receives transportation by a professional ambulance service due to a covered accidental injury.	$400 Ground $1,200 Air
MAJOR DIAGNOSTIC TESTING (once per accident, within 6 months after the accident) Payable when an insured requires one of the following exams: Computerized Tomography (CT/CAT scan), Magnetic Resonance Imaging (MRI), or Electroencephalography (EEG) due to a covered accidental injury. These exams must be performed in a hospital, a doctor's office, a medical diagnostic imaging center or an ambulatory surgical center.	$200
EMERGENCY ROOM OBSERVATION (within 7 days after the accident) Payable when an insured receives treatment in a hospital emergency room, and is held in a hospital for observation without being admitted as an inpatient because of a covered accidental injury.	$100 Each 24 hour period $50 Less than 24 hours, but at least 4 hours
PRESCRIPTIONS (2 times per accident, within 6 months after the accident) Payable for a prescription filled that - due to a covered accidental injury - is ordered by a doctor, dispensed by a licensed pharmacist and medically necessary for the care and treatment of the insured (in Alaska, Massachusetts and Montana prescriptions do not have to be medically necessary). This benefit is not payable for therapeutic devices or appliances; experimental drugs; drugs, medicines or insulin used by or administered to a person while he is confined to a hospital, rest home, extended-care facility, convalescent home, nursing home or similar institution; or immunization agents, biological sera, blood or blood plasma. This benefit is not payable for pain management techniques for which a benefit is paid under the Pain Management Benefit (if available).	$5
BLOOD/PLASMA/PLATELETS (3 times per accident, within 6 months after the accident) Payable for each day that an insured receives blood, plasma or platelets due to a covered accidental injury.	$200
PAIN MANAGEMENT (once per accident, within 6 months after the accident) Payable when an insured, due to a covered accidental injury, is prescribed and receives a nerve ablation and/or block, or an epidural injection administered into the spine. This benefit is only payable for pain management techniques (as shown above) that are administered in a hospital or doctor's office. This benefit is not payable for an epidural administered during a surgical procedure.	$100
CONCUSSION (once per accident, within 6 months after the accident) Payable when an insured is diagnosed by a doctor with a concussion due to a covered accident.	$500

TRAUMATIC BRAIN INJURY (once per accident, within 6 months after the accident) Payable when an insured is diagnosed by a neurologist with Traumatic Brain Injury (TBI) due to a covered accident. To qualify as TBI, the neurological deficit must require treatment by a neurologist and a prescribed course of physical, speech and/or occupational therapy under the direction of a neurologist.	$5,000
COMA (once per accident) Payable when an insured is in a coma lasting 30 days or more as the result of a covered accident. For the purposes of this benefit, Coma means a profound state of unconsciousness caused by a covered accident.	$10,000
EMERGENCY DENTAL WORK (once per accident, within 6 months after the accident) Payable when an insured's natural teeth are injured as a result of a covered accident.	$50 Extraction $200 Repair with a crown
BURNS (once per accident, within 6 months after the accident) Payable when an insured is burned in a covered accident and is treated by a doctor. We will pay according to the percentage of body surface burned. First degree burns are not covered.	
Second Degree	
Less than 10%	$100
At least 10% but less than 25%	$200
At least 25% but less than 35%	$500
35% or more	$1,000
Third Degree	
Less than 10%	$1,000
At least 10% but less than 25%	$5,000
At least 25% but less than 35%	$10,000
35% or more	$20,000
EYE INJURIES Payable for eye injuries if, because of a covered accident, a doctor removes a foreign body from the eye, with or without anesthesia.	$250
FRACTURES (once per accident, within 90 days after the accident) Payable when an insured fractures a bone because of a covered accident and is treated by a doctor. If the fracture requires open reduction, 200% of the benefit is payable for that bone. For multiple fractures (more than one bone fractured in one accident), we will pay a maximum of 200% of the benefit amount for the bone fractured that has the highest dollar amount. For a chip fracture (a piece of bone that is completely broken off near a joint), we will pay 25% of the amount for the affected bone. This benefit is not payable for stress fractures.	Up to $4,000 based on a schedule
DISLOCATIONS (once per accident, within 90 days after the accident) Payable when an insured dislocates a joint because of a covered accident and is treated by a doctor. If the dislocation requires open reduction, 200% of the benefit for that joint is payable. We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If the insured dislocated a joint before the effective date of his certificate and then dislocates the same joint again, it will not be covered by the plan. For multiple dislocations (more than one dislocated joint in one accident), we will pay a maximum of 200% of the benefit amount for the joint dislocated that has the highest dollar amount. For a partial dislocation (joint is not completely separated, including subluxation), we will pay 25% of the amount for the affected joint.	Up to $3,000 based on a schedule
LACERATIONS (once per accident, within 7 days after the accident) Payable when an insured receives a laceration in a covered accident and the laceration is repaired by a doctor. For multiple lacerations, we will pay a maximum of 200% of the benefit for the largest single laceration requiring stitches. Lacerations requiring stitches (including liquid skin adhesive):	
Over 15 centimeters	$800
5-15 centimeters	$400
Under 5 centimeters	$100
Lacerations not requiring stitches	$50

OUTPATIENT SURGERY AND ANESTHESIA (per day / performed in hospital or ambulatory surgical center, within one year after the accident) Payable for each day that, due to a covered accidental injury, an insured has an outpatient surgical procedure performed by a doctor in a hospital or ambulatory surgical center. Surgical procedure does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in the plan, we will pay the higher benefit amount.	$400
FACILITIES FEE FOR OUTPATIENT SURGERY (surgery performed in hospital or ambulatory surgical center, within one year after the accident) Payable once per each eligible Outpatient Surgery and Anesthesia Benefit (in a hospital or ambulatory surgical center).	$100
OUTPATIENT SURGERY AND ANESTHESIA (per day / performed in a doctor's office, urgent care facility, or emergency room; maximum of two procedures per accident, within one year of the accident) Payable for each day that, due to a covered accidental injury, an insured has an outpatient surgical procedure performed by a doctor in a doctor's office, urgent care facility or emergency room. Surgical procedure does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in this plan, we will pay the higher benefit amount.	$50
INPATIENT SURGERY AND ANESTHESIA (per day / within one year after the accident) Payable for each day that, due to a covered accidental injury, an insured has an inpatient surgical procedure performed by a doctor. The surgery must be performed while the insured is confined to a hospital as an inpatient. If an inpatient surgical procedure is covered under another benefit in the plan, we will pay the higher benefit amount.	$1,000
TRANSPORTATION (greater than 100 miles from the insured's residence, 3 times per accident, within 6 months after the accident) Payable for transportation if, because of a covered accident, an insured is injured and requires doctor-recommended hospital treatment or diagnostic study that is not available in the insured's resident city.	$500 Plane $200 Any ground transportation

Surgical Procedures may include, but are not limited to, surgical repair of: ruptured disc, tendons/ligaments, hernia, rotator cuff, torn knee cartilage, skin grafts, joint replacement, internal injuries requiring open abdominal or thoracic surgery, exploratory surgery (with or without repair), etc., unless otherwise noted due to an accidental injury. Review the plan document for Exclusions.

GROUP ACCIDENT INSURANCE HOSPITALIZATION BENEFIT – HIGH

	BENEFIT AMOUNT
HOSPITAL ADMISSION (once per accident, within 6 months after the accident) Payable when an insured is admitted to a hospital and confined as an inpatient because of a covered accidental injury. This benefit is not payable for confinement to an observation unit, for emergency room treatment or for outpatient treatment.	$1,250 per confinement
HOSPITAL CONFINEMENT (maximum of 365 days per accident, within 6 months after the accident) Payable for each day that an insured is confined to a hospital as an inpatient because of a covered accidental injury. If we pay benefits for confinement and the insured is confined again within 6 months because of the same accidental injury, we will treat this confinement as the same period of confinement. This benefit is payable for only one hospital confinement at a time even if caused by more than one covered accidental injury. This benefit is not payable for confinement to an observation unit or a rehabilitation facility.	$300 per day
HOSPITAL INTENSIVE CARE (maximum of 30 days per accident, within 6 months after the accident) Payable for each day an insured is confined in a hospital intensive care unit because of a covered accidental injury. We will pay benefits for only one confinement in a hospital intensive care unit at a time, even if it is caused by more than one covered accidental injury. If we pay benefits for confinement in a hospital intensive care unit and an insured becomes confined to a hospital intensive care unit again within 6 months because of the same accidental injury, we will treat this confinement as the same period of confinement. This benefit is payable in addition to the Hospital Confinement Benefit.	$400 per day
INTERMEDIATE INTENSIVE CARE STEP-DOWN UNIT (maximum of 30 days per accident, within 6 months after the accident) Payable for each day an insured is confined in an intermediate intensive care step-down unit because of a covered accidental injury. We will pay benefits for only one confinement in an intermediate intensive care step-down unit at a time, even if it is caused by more than one covered accidental injury. If we pay benefits for confinement in an intermediate intensive care step-down unit and an insured becomes confined to an intermediate intensive care step-down unit again within 6 months because of the same condition, we will treat this confinement as the same period of confinement. This benefit is payable in addition to the Hospital Confinement Benefit.	$200 per day
FAMILY MEMBER LODGING (greater than 100 miles from the insured's residence, maximum of 30 days per accident, within 6 months after the accident) Payable for each night's lodging in a motel/hotel/rental property for an adult member of the insured's immediate family. For this benefit to be payable: • The insured must be confined to a hospital for treatment of a covered accidental injury; • The hospital and motel/hotel must be more than 100 miles from the insured's residence; and • The treatment must be prescribed by the insured's treating doctor.	$200 per day

Aflac®

GROUP ACCIDENT INSURANCE AFTER CARE BENEFITS – HIGH

	BENEFIT AMOUNT
APPLIANCES (within 6 months after the accident) Payable if, as a result of an injury received in a covered accident, a doctor advises the insured to use a listed medical appliance as an aid in personal locomotion.	
Cane, Ankle Brace	$40
Walking Boot, Walker, Crutches, Leg Brace, Cervical Collar	$100
Wheelchair, Knee Scooter, Body Jacket, Back Brace	$400
ACCIDENT FOLLOW-UP TREATMENT (maximum of 6 per accident, within 6 months after the accident provided initial treatment is within 7 days of the accident) Payable for doctor-prescribed follow-up treatment for injuries received in a covered accident. Follow-up treatments do not include physical, occupational or speech therapy. Chiropractic or acupuncture procedures are also not considered follow-up treatment.	$50
POST-TRAUMATIC STRESS DISORDER (PTSD) (once per accident, within 6 months after the accident) Payable if the insured is diagnosed with PTSD, a mental health condition triggered by a covered accident. An insured must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV-TR), and be under the active care of either a psychiatrist or Ph.D.-level psychologist.	$200
REHABILITATION UNIT (maximum of 31 days per confinement, no more than 62 days total per calendar year for each insured) Payable for each day that, due to a covered accidental injury, an insured receives treatment as an inpatient at a rehabilitation facility. For this benefit to be payable, the insured must be transferred to the rehabilitation facility for treatment following an inpatient hospital confinement. We will not pay the rehabilitation facility benefit for the same days that the hospital confinement benefit is paid. We will pay the highest eligible benefit.	$100 per day
THERAPY (maximum of 10 per accident, beginning within 90 days after the accident provided initial treatment is within 7 days after the accident) Payable if because of injuries received in a covered accident, an insured has doctor-prescribed therapy treatment in one of the following categories: physical therapy provided by a licensed physical therapist, occupational therapy provided by a licensed occupational therapist, or speech therapy provided by a licensed speech therapist.	$50
CHIROPRACTIC OR ALTERNATIVE THERAPY (maximum of 6 per accident, beginning within 90 days after the accident provided initial treatment is within 7 days after the accident) Payable if because of injuries received in a covered accident, an insured receives acupuncture or chiropractic treatment.	$30

GROUP ACCIDENT INSURANCE LIFE CHANGING EVENTS BENEFITS – HIGH

DISMEMBERMENT (once per accident, within 6 months after the accident)
Payable if an insured loses a hand or foot or experiences loss of sight as the result of a covered accident.

Dismemberment means:

- Loss of a hand -The hand is removed at or above the wrist joint;
- Loss of a foot -The foot is removed at or above the ankle;
- Loss of a finger/toe - The finger or toe is removed at or above the joint where it is attached to the hand or foot; or
- Loss of sight - At least 80% of the vision in one eye is lost (such loss of sight must be permanent and irrecoverable).

If the Dismemberment Benefit is paid and the insured later dies as a result of the same covered accident, we will pay the appropriate death benefit (if available), less any amounts paid under this benefit.

SINGLE LOSS (the loss of one hand, one foot, or the sight of one eye)	**BENEFIT AMOUNT**
Employee	$12,500
Spouse	$5,000
Child(ren)	$2,500
DOUBLE LOSS (the loss of both hands, both feet, the sight of both eyes, or a combination of any two)	
Employee	$25,000
Spouse	$10,000
Child(ren)	$5,000
LOSS OF ONE OR MORE FINGERS OR TOES	
Employee	$1,250
Spouse	$500
Child(ren)	$250
PARTIAL DISMEMBERMENT (INCLUDES AT LEAST ONE JOINT OF A FINGER OR A TOE)	
Employee	$125
Spouse	$125
Child(ren)	$125

PARALYSIS (once per accident, diagnosed by a doctor within six months after the accident)
Payable if an insured has permanent loss of movement of two or more limbs for more than 90 days (in Utah, 30 days) as the result of a covered accidental injury.

Paraplegia	$5,000
Quadriplegia	$10,000

Aflac

GROUP ACCIDENT INSURANCE WELLNESS RIDER – HIGH

WELLNESS BENEFIT (once per calendar year)
Payable for the following wellness tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

- Annual physical exams
- Flexible Sigmoidoscopy
- Mammograms
- PSA Tests
- Pap Smears
- Ultrasounds
- Eye Examinations
- Blood Screening
- Immunizations

THE AMOUNT PAID WILL BE BASED ON WHEN THE WELLNESS TEST WAS PERFORMED:	BENEFIT AMOUNT
First year of certificate	$25
Second, third and fourth year of certificate	$50
Fifth year of certificate and thereafter	$75

EXCLUSIONS
For a complete list of exclusions and definitions applicable to this coverage, please refer to the Initial Accident Treatment insert.

GROUP ACCIDENT INSURANCE ACCIDENTAL DEATH RIDER

	BENEFIT AMOUNT
ACCIDENTAL DEATH BENEFIT (within 90 days after the accident*) Payable if a covered accidental injury causes the insured to die. The spouse benefit is 50% of the employee benefit shown. The child benefit is 20% of the employee benefit shown. We will pay 200% of the amount payable if the insured: • Is a fare-paying passenger on a common carrier; • Is injured in a covered accident; and • Dies within 90 days* after the covered accident.	$50,000

EXCLUSIONS
Please refer to the the Initial Accident Treatment insert for exclusions applicable to this coverage.

DEFINITIONS
Common Carrier means:

- An airline carrier that is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports;
- A railroad train that is licensed and operated for passenger service only; or
- A boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

Please refer to the Initial Accident Treatment insert for other definitions applicable to this coverage.

*In Oregon and Utah, within 180 days after the accident; in Pennsylvania, there is no limitation on the number of days.

Aflac

Group Cancer and Specified Disease Insurance

Underwritten by MetLife

Plan Features

- **Donor Benefits**
- **Wellness Benefits**
- **Many Benefits have No Lifetime Maximum**
- **Covers Certain Lodging and Transportation**
- **Portable (take it with You)**
- **In and Out of Hospital benefits**
- **Pays regardless of other coverage**

Benefit	Amount
Wellness Benefit. For Cancer screening tests such as mammogram, flexible sigmoidoscopy, pap smear, chest X-ray, hemocult stool specimen, or prostate screen. No Lifetime Maximum	$100 per calendar year
Positive Diagnosis Test. Payable for a test that leads to positive diagnosis of Cancer or Specified Disease within 90 days. This benefit is not payable if the same Cancer or Specified Disease recurs.	Up to $300 per calendar year
First Diagnosis Benefit. One-time benefit payable when a Covered Person is first diagnosed with Cancer (other than Skin Cancer) or a Specified Disease. Must occur after the Certificate Effective Date.	Low Option: $2,500 Mid Option: $5,000 High Option: $5,000
Second and Third Surgical Opinions. Covers written opinions received after a Positive Diagnosis and before surgery. No Lifetime Maximum	Incurred Expenses
Non-Local Transportation. Payable for transportation to a Hospital, clinic or treatment center which is more than 60 miles and less than 700 miles from a Covered Person's home. No Lifetime Maximum	Actual billed charges by a common carrier or 50 cents per mile if a personal vehicle is used.
Adult Companion Lodging and Transportation. Payable for one adult companion to stay with a Covered Person who is confined in a Hospital that is more than 60 miles and less than 700 miles from his or her home. Covered expenses include a single room in a motel or hotel up to 60 days per confinement; and the actual billed charges of round trip coach fare by a common carrier or a mileage allowance for the use of a personal vehicle. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment nor for lodging expense incurred more than 24 hours following treatment. No Lifetime Maximum	Up to $75 per day for lodging. 50 cents per mile if a personal vehicle is used.
Ambulance. For ambulance service if the Covered Person is taken to a Hospital and admitted as an inpatient. No Lifetime Maximum	Incurred Expenses
Surgery. Covers actual surgeon's fee for an operation up to the amount listed on the schedule. Benefits for surgery performed on an outpatient basis will be 150% of the schedule benefit amount, not to exceed the actual surgeon's fees. No Lifetime Maximum	Low Option: $1,500 Mid Option: $4,500 High Option: $6,000
Donor Benefit Bone Marrow and Stem Cell Transplant. We will pay the following benefit for the Covered Person and his or her live donor: (a) Medical expense allowance of two times the selected Hospital Confinement benefit. (b) Actual billed charges for round trip coach fare on a Common Carrier to the city where the transplant is performed; or personal automobile expense allowance of 50 cents per mile. Mileage is measured from the home of the Donor or Covered Person to the Hospital in which the Covered Person is staying. We will pay for up to 700 miles per Hospital stay. (c) Actual billed charges up to $50 per day for lodging and meals expense for donor to remain near Hospital.	Low Option: (a) $200 per day Mid Option: (a) $400 per day High Option: (a) $400 per day (b) Actual billed charges for round trip coach fare; or personal automobile expense of 50 cents per mile. (c) Actual billed charges up to $50 per day

Marketed by:

Benefitfirst™
The leader in benefits management.

Administered by:

BAY BRIDGE ADMINISTRATORS

"Your solutions begin at the Bridge"®

Benefit	Amount
Bone Marrow and Stem Cell Transplant. We will pay incurred expenses per Covered Person for surgical and anesthetic charges associated with bone marrow transplant and/or peripheral stem cell transplant	Incurred Expenses to a combined lifetime maximum of $15,000
Anesthesia. For services of an anesthesiologist during a Covered Person's surgery.	Up to 25% of surgical benefit paid.
For anesthesia in connection with the treatment of skin Cancer that is not invasive melanoma. No Lifetime Maximum	$100 maximum per Covered Person for skin Cancer
Ambulatory Surgical Center. We will pay the actual billed charges at an Ambulatory Surgical Center. No Lifetime Maximum	$250 Per Day
Drugs and Medicines. Payable for drugs and medicine received while the Covered Person is Hospital confined. No Lifetime Maximum	Up to $25 per day, $600 per calendar year
Outpatient Anti-Nausea Drugs. Payable for drugs prescribed by a Physician to suppress nausea due to Cancer or Specified Disease. No Lifetime Maximum	Up to $250 per calendar year
Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy. Covers treatment administered by a Radiologist, Chemotherapist or Oncologist on an inpatient or outpatient basis. No Lifetime Maximum	Low Option: Incurred Expenses up to $2,500 per month Mid Option: Incurred Expenses up to $2,500 per month High Option: Incurred Expenses up to $5,000 per month
Miscellaneous Diagnostic Services. Covers charges for lab work or x-rays in connection with radiation and chemotherapy treatment. Service must be performed while receiving treatment(s) in Radiation, Radioactive Isotopes Therapy, Chemotherapy, or Immunotherapy, or within 30 days following a covered treatment.	Incurred Expenses up to a lifetime maximum of $10,000
Self-Administered Drugs. We will pay the incurred expenses for self-administered chemotherapy, including hormone therapy, or immunotherapy agents. This benefit is not payable for planning, monitoring, or other agents used to treat or prevent side effects, or other procedures related to this therapy treatment. No Lifetime Maximum	Incurred Expenses up to $4,000 per month
Colony Stimulating Factors. We will pay incurred expenses incurred for: [a] cost of the chemical substances and [b] their administration to stimulate the production of blood cells. Treatment must be administered by an Oncologist or Chemotherapist. No Lifetime Maximum	Low Option: Incurred Expenses up to $1,000 per month Mid Option: Incurred Expenses up to $2,000 per month High Option: Incurred Expenses up to $3,000 per month
Blood, Plasma and Platelets. For blood, plasma and platelets, and transfusions: including administration. No Lifetime Maximum	Incurred Expenses up to $200 per day
Physician's Attendance. For one visit per day while Hospital confined. No Lifetime Maximum	Up to $35 per day
Private Duty Nursing Service. For private nursing services ordered by the Physician while Hospital confined. No Lifetime Maximum	Up to $100 per day
National Cancer Institute Designated Comprehensive Cancer Treatment Center Evaluation/Consultation Benefit. We will pay the actual billed charges if a Covered Person is diagnosed with Internal Cancer and seeks evaluation or consultation from a National Cancer Institute designated Comprehensive Cancer Treatment Center. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Covered Person's place of residence, We will also pay the transportation and lodging actual billed charges. This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable and is in lieu of the Non-Local Transportation Benefits of the policy.	Actual billed charges limited to a lifetime maximum up to $750 for evaluation. Actual billed charges limited to a lifetime maximum up to $350 for transportation and lodging.
Breast Prosthesis. Covers the prosthesis and its implantation if it is required due to breast cancer. No Lifetime Maximum	Incurred Expenses
Artificial Limb or Prosthesis. Covers implantation of an artificial limb or prosthesis when an amputation is performed.	Up to $1,500 lifetime maximum per amputation.
Physical or Speech Therapy. Payable when therapy is needed to restore normal bodily function. No Lifetime Maximum	$35 per session
Extended Benefits. If a Covered Person is confined in a Hospital for 60 continuous days We will pay three times the selected Hospital Confinement Benefit beginning on the 61st day for Hospital Confinement. This benefit is payable in place of the Hospital Confinement Benefit. No Lifetime Maximum	Low Option: $300 per day Mid Option: $600 per day High Option: $600 per day
Extended Care Facility. Limited to number of days of prior Hospital confinement. Must begin within 14 days after Hospital confinement, and be at the direction of the attending Physician. No Lifetime Maximum	$50 per day
At Home Nursing. Limited to number of days of prior Hospital confinement. Must begin immediately following a Hospital confinement, and be authorized by the attending Physician. No Lifetime Maximum	$100 per day
New or Experimental Treatment. We will pay the actual billed charges by a Covered Person for New or Experimental Treatment judged necessary by the attending Physician and received in the United States or in its territories. No Lifetime Maximum	Up to $7,500 per calendar year
Hospice Care. If a Covered Person elects to receive hospice care, We will pay the actual billed charges for care received in a Free Standing Hospice Care Center. No Lifetime Maximum	$50 per day

Benefit	Amount
Government or Charity Hospital. Payable if the Covered Person is confined in a U. S. Government Hospital or a Hospital that does not charge for its services. Paid in place of all other benefits under the Policy. No Lifetime Maximum	$200 per day
Hairpiece. We will pay the incurred expenses per Covered Person for a hairpiece when hair loss is a result of Cancer Treatment.	Incurred Expenses up to a lifetime maximum of $150
Rental or Purchase of Durable Goods. We will pay the incurred expenses for the rental or purchase of the following pieces of durable medical equipment: a respirator or similar mechanical device, brace, crutches, Hospital bed, or wheelchair. No Lifetime Maximum	Incurred Expenses up to $1,500 per calendar year
Waiver of Premium. After 60 continuous days of disability due to Cancer or Specified Disease, We will waive premiums starting on the first day of policy renewal.	After 60 days
Hospital Confinement. Payable for each day a Covered Person is charged the daily room rate by a Hospital, for up to 60 days of continuous stay. The benefit for covered children under age 21 is two times the Covered Person's daily benefit. No Lifetime Maximum	Low Option: $100 per day Mid Option: $200 per day High Option: $200 per day

Other Specified Diseases Covered:

- Addison's Disease
- Amyotrophic Lateral Sclerosis
- Cystic Fibrosis
- Diphtheria
- Encephalitis
- Epilepsy
- Hansen's Disease
- Legionnaire's Disease
- Lupus Erythematosus
- Lyme Disease
- Malaria
- Meningitis (epidemic cerebrospinal)
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Niemann-Pick Disease
- Osteomyelitis
- Poliomyelitis
- Rabies
- Reye's Syndrome
- Rheumatic Fever
- Rocky Mountain Spotted Fever
- Scarlet Fever
- Sickle Cell Anemia
- Tay-Sachs Disease
- Tetanus
- Toxic Epidermal Necrolysis
- Tuberculosis
- Tularemia
- Typhoid Fever
- Undulant Fever
- Whipple's Disease

Payment of Benefits

Benefits are payable for a Covered Person's Positive Diagnosis of a Cancer or Specified Disease that begins after the Certificate Effective Date and while this Certificate has remained in force.

Pre-Existing Condition Limitation

During the first 12 months of a Covered Person's insurance, losses incurred for Pre-Existing Conditions are not covered. During the first 12 months following the date a Covered Person makes a change in coverage that increases his or her benefits, the increase will not be paid for Pre-Existing Conditions. After this 12 month period, however, benefits for such conditions will be payable unless specifically excluded from coverage. This 12 month period is measured from the Certificate Effective Date for each Covered Person.

Pre-Existing Condition means Cancer or a Specified Disease, for which a Covered Person has received medical consultation, treatment, care, services, or for which diagnostic test(s) have been recommended or for which medication has been prescribed during the 12 months immediately preceding the Certificate Effective Date of coverage for each Covered Person.

Exceptions and Other Limitations

The Policy pays benefits only for diagnoses resulting from Cancer or Specified Diseases, as defined in the Policy. It does not cover:

1. any other disease or sickness;
2. injuries;
3. any disease, condition, or incapacity that has been caused, complicated, worsened, or affected by:
   a. Specified Disease or Specified Disease treatment; or
   b. Cancer or Cancer treatment, or unless otherwise defined in the Policy
4. care and treatment received outside the United States or its territories;
5. treatment not approved by a Physician as medically necessary;
6. Experimental Treatment by any program that does not qualify as Experimental Treatment as defined in the Policy.

Termination of Coverage

A Covered Person's insurance under the Policy will automatically terminate on the earliest of the following dates:

1. the date that the Policy terminates.
2. the date of termination of any section or part of the Policy with respect to insurance under such section or part.
3. the date the Policy is amended to terminate the eligibility of the Employee class.
4. any premium due date, if premium remains unpaid by the end of the grace period.
5. the premium due date coinciding with or next following the date the Covered Person ceases to be a member of an eligible class.
6. the date the Policyholder no longer meets participation requirements.

Portability

On the date the Policy terminates or the date the Named Insured ceases to be a member of an eligible class, Named Insureds and their covered dependents will be eligible to exercise the portability privilege. Portability coverage may continue beyond the termination date of the Policy, subject to the timely payment of premiums. Portability coverage will be effective on the day after insurance under the Policy terminates.

The benefits, terms and conditions of the portability coverage will be the same as those provided under the Policy when the insurance terminated. The initial portability premium rate is the rate in effect under the Policy for active employees who have the same coverage. The premium rate for portability coverage may change for the class of Covered Persons on portability on any premium due date.

Covered Persons

Covered Person means any of the following:

a. the Named Insured; or
b. any eligible Spouse or Child, as defined and as indicated on the Certificate Schedule whose coverage has become effective;
c. any eligible Spouse or Child, as defined and added to this Certificate by endorsement after the Certificate Effective Date whose coverage has become effective; or
d. a newborn child (as described in the Eligibility Section).

Child (Children)

means the Named Insured's unmarried child, including a natural child from the moment of birth, stepchild, foster or legally adopted child, or child in the process of adoption (including a child while the Named Insured is a party to a proceeding in which the adoption of such child by the Named Insured is sought); a child for whom the Named Insured is required by a court order to provide medical support, and grandchildren who are dependent on the Named Insured for federal income tax purposes at the time of application, who is not yet age 26.

Option to Add Additional Benefits Hospital Intensive Care Insurance Rider

In consideration of additional premium, this coverage will provide you with benefits if you go into a Hospital Intensive Care Unit (ICU).

Benefits

Your benefits start the first day you go into ICU. The benefit is payable for up to 45 days per ICU stay.

Hospital Intensive Care Confinement Benefit

You may choose a benefit of $325 or $425 per day. It is reduced by one-half at age 75.

Double Benefits

We will double the daily benefits for each day you are in an ICU as a result of Cancer or a Specified Disease. We will also double the benefit for an injury that results from: being struck by an automobile, bus, truck, motorcycle, train, or airplane; or being involved in an accident in which the named insured was the operator or was a passenger in such vehicle. ICU confinement must occur within 48 hours of the accident.

Emergency Hospitalization and Subsequent Transfer to an ICU

We will pay the benefit selected by you for the highest level of care in a hospital that does not have an ICU, if you are admitted on an emergency basis, and you are transferred within 48 hours to the ICU of another Hospital.

Step Down Unit

We will pay a benefit equal to one half the chosen daily benefit for confinement in a Step Down Unit.

Exceptions and Other Limitations

Except as provided in Step Down Unit and Emergency Hospitalization and Subsequent Transfer to an ICU, coverage does not provide benefits for: surgical recovery rooms; progressive care; intermediate care; private monitored rooms; observation units; telemetry units; or other facilities which do not meet the standards for a Hospital Intensive Care Unit. Benefits are not payable: if you go into an ICU before the Certificate Effective Date; if you go into an ICU for intentionally self-inflicted bodily injury or suicide attempts; if you go into an ICU due to being intoxicated or under the influence of alcohol, drugs or any narcotics, unless administered on the advice of a Physician and taken according to the Physician's instructions. The term "intoxicated" refers to that condition as defined by law in the jurisdiction where the accident or cause of loss occurred.

This is not a Medicare Supplement Policy. If you are eligible for Medicare, see the Medicare Supplement Buyer's Guide available from the Company.
This policy only covers cancer and the diseases specified above, unless the hospital intensive care rider is selected.
Upon receipt of your policy, please review it and your application.
If any information is incorrect, please contact us.
Administered by:
Bay Bridge Administrators
P.O. Box 161690 | Austin, Texas 78716 | 1-800-845-7519

IDShield

Affordable identity theft protection AT YOUR FINGERTIPS

RESTORING NEARLY 15,000 IDENTITIES, IDShield provides the identity theft protection and identity restoration services you not only need but deserve.

THE IDSHIELD PLAN INCLUDES THE FOLLOWING COVERED SERVICES:

MONITORED INFORMATION

- Bank Accounts
- Credit/Debit/Retail Cards
- Date of Birth
- Drivers License
- Email Addresses
- Home Address
- Medical ID
- Name
- Passport Number
- Phone Numbers
- Social Security Number

COMPREHENSIVE SOURCE MONITORING

- Global Black Market Websites
- Internet Relay Chat (IRC)
- Local, State and Federal Databases
- Online Chat Rooms
- Peer-to-Peer Sharing Networks
- Social Feeds

COMPREHENSIVE IDENTITY RESTORATION

- $5 Million Service Guarantee
- Full Service Restoration by Licensed Private Investigators
- Pre-Existing Identity Theft Restoration

PRIVACY AND SECURITY MONITORING

- Court Record Monitoring
- Child Monitoring
- Credit Monitoring
- Criminal Record Monitoring
- Internet Monitoring
- Pay Day Loan Monitoring
- Social Media Monitoring
- And More

UNLIMITED CONSULTATION

- Assistance in Analyzing and Interpreting Credit Reports
- Consultation on Common Trends and Scams
- Data Breach Safeguards
- Identity Theft Consultation
- Lost/Stolen Wallet Assistance

GENERAL

- 24/7 Emergency Assistance
- Direct Access to Licensed Private Investigators
- Live Member Support
- Mobile App
- Monthly Credit Score Tracker
- Password Manager
- Real-Time Alerts

Affordable identity theft protection

Employee: $4.23
Family: $6.48

SEMI-MONTHLY

For more information visit:

Coverage Questions Contact: Stephanie Boley at: sboley@legalshieldassociate.com OR 859-248-4332

See plan details for specific terms, coverage, conditions and exclusions. IDShield is a product of LegalShield, and provides access to identity theft protection and restoration services through an exclusive relationship with Kroll Inc. Neither LegalShield nor its officers, employees, or sales associates directly or indirectly provide identity theft protection, restoration services, or advice.

Universal Life with Long Term Care Rider
How to Enroll

IF YOU ARE INTERESTED IN ENROLLING IN THE UNIVERSAL LIFE W/LTC RIDER, PLEASE CONTACT A MEMBER OF STAR ROBBINS & COMPANY AT 800-486-7721, OPTION 2.

How does Guaranteed Universal Life work? Universal Life is permanent life insurance that provides affordable guaranteed protection for your family. It gives you death benefits that you can depend on and policy payments that remain the same throughout the life of your policy. Most policies also endow at age 100, which means benefits are payable to you in full if you live to be 100. Universal Life also comes with an extra level of protection for long-term care services, combining two important benefits into one affordable product. Your benefits can be paid as a Death Benefit, as Living Benefits for long-term care, or as a combination of both.

>>How are your benefits paid?
Your benefits can be paid as a Death Benefit, as Living Benefits for long-term care, or as a combination of both.

>>Death Benefit - Most people buy life insurance for the financial security of the death benefit. A death benefit puts money in your family's hands quickly when they need it most. It's money they can use any way they want to help cover short- and long-term expenses.

>>Living Benefits - Long-term care can be expensive. Living Benefits make it easy to accelerate the death benefit to help pay for home healthcare, assisted living, adult day care or nursing home services, should you or your covered spouse ever need them.

Features you will appreciate

>>Lifelong protection – Provides coverage that will last your lifetime.

>>Family coverage – Apply for your spouse even if you choose not to participate.

>>Terminal Illness Benefit – Accelerates up to 75 percent of your death benefit if your doctor determines your life expectancy is 24 months or less.

>>Guaranteed renewable – Guaranteed coverage, as long as your premiums are paid. Your premium may change if the premium for all policies in your class changes.

Separately priced benefits:

>>Waiver of premium – Waives policy payments if your doctor determines you are totally disabled.

>>EZ Value – Automatically raises your benefits to keep pace with your increasing needs, without additional underwriting.

How Living Benefits Add Up

Example: $100,000 Death Benefit	Maximum Benefit Amount
Long Term Care Benefit (LTC) Pays a monthly benefit equal to 4 percent of your death benefit for up to 25 months. The LTC benefit accelerates the death benefit and proportionately reduces it.	$100,000
Benefit Restoration Restores the death benefit that is reduced to pay for LTC, so your family receives the full death benefit amount when they need it most.	$100,000
Total Maximum Benefit Living Benefits can double the value of your life insurance	$200,000

The LTC Benefit is an acceleration of the death benefit and is not Long-Term Care Insurance. It begins to pay after 90 days of confinement or services and to qualify you must meet conditions of eligibility for benefits. Pre-existing condition limitation may apply. Living Benefits may not be available in all states or may be named differently. Please consult your policy for complete details.

MANDATORY NOTICE TO ALL ARH EMPLOYEES

IRS 1094C REPORTING INFORMATION: Per the IRS reporting guidelines, all employment records and benefit enrollment records must be listed under the employee's legal name (as it appears in the U.S. Social Security Administration Data Base, as listed on your Social Security card). It is each employee's responsibility to ensure their employment and benefit enrollment records are accurately listed. Employees must immediately contact their HR personnel to ensure their name is correct on their employment record if their paycheck does not list their name as it appears on their Social Security Card. Also, per the IRS reporting guidelines, any eligible dependent enrolled in an employee's benefits must be listed under their legal name (as their name appears in the U.S. Social Security Administration Data Base, as listed on their Social Security card). It is each employee's responsibility to ensure their dependents are accurately listed on their benefit records under the dependent's legal name.

BENEFIT ENROLLMENT INFORMATION: Upon benefit enrollment, all employees will be required to provide a valid contact phone number and a valid email address before being allowed to enroll in benefits. The benefit enrollment system will NOT allow any employee to move forward with making their benefit enrollment elections without providing their valid phone number and valid email address information.

All benefited employees who do not wish to enroll in benefits or who wish to drop any of their current benefits during this year's Open Enrollment MUST log onto the enrollment system and "decline" the benefits they do not wish to keep and/or do not wish to enroll in for 2022. The timeline for this year's Open Enrollment will be provided as soon as it is determined, along with other pertinent benefit enrollment information.

Required Notices

NOTICES TO EMPLOYEES OF **APPALACHIAN REGIONAL HEALTHCARE**
REGARDING ARH Wellness Program

NOTICE REGARDING ARH WELLNESS PROGRAM

The ARH Wellness Plan is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you and your spouse choose to participate in the wellness program you will be asked to complete a Health Provider Screening and a lab panel with an ARH approved provider. You and your spouse must be tobacco free. You and your spouse must receive the annual flu vaccine for the current flu season. Additionally, the employee must watch the 2022 Health Plan video assigned to all employees in SEED. Employees who choose to participate in the wellness program and complete the request in the wellness program will receive a reduction in their medical premium for completing the plan requirements.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting **Tiffany Herald at tiherald@arh.org.**

The information from your provider screening visit and lab panel testing will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as smoking cessation program, diabetes management programs, weight management classes. You also are encouraged to share your results or concerns with your own doctor.

Required Notices *(continued...)*

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Appalachian Regional Healthcare may use aggregate information it collects to design a program based on identified health risks in the workplace, **ARH Wellness Plan** will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is your physician and the ARH designated PHI personnel.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact **Tiffany Herald at tiherald@arh.org.**

Required Notices

Notices to Employees of ARH Regarding Health & Welfare Plans

I. NOTICES GENERALLY APPLICABLE TO GROUP HEALTH PLANS

A. Special enrollment notice

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

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

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

To request special enrollment or obtain more information, contact the plan administrator identified at the end of these notices.

II. NOTICES APPLICABLE TO GROUP HEALTH PLANS WITH CERTAIN BENEFIT DESIGNS

A. Wellness program disclosure

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call the plan administrator identified at the end of these notices and we will work with you to develop another way to qualify for the reward.

B. Newborns' act disclosure

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

C. WHCRA enrollment/annual notice

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

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

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

> **For purposes of this notice, the plan administrator is:**
>
> Tiffany Herald, PharmD, VP of Benefits & Wellness
> tiherald@arh.org

Medicare Part D Creditable Coverage Notice

Important Notice About Your Prescription Drug Coverage & Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage offered by the group health plan through Appalachian Regional Healthcare 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:

- 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.

- Appalachian Regional Healthcare has determined that the prescription drug coverage offered by the group Health and Welfare 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 through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Appalachian Regional Healthcare coverage will not be affected. You can keep this coverage if you elect Part D and this plan may coordinate with Part D coverage. See pages 7-9 of the CMS Disclosure of Creditable Coverage to Medicare part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current group health coverage through Appalachian Regional Healthcare be aware that you and your dependents will be able to get this coverage back subject to the terms and requirements of such group medical plan.

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

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

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

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

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Appalachian Regional Healthcare 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.

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

> **For purposes of this notice, the plan administrator is:**
> Tiffany Herald, PharmD, VP of Benefits & Wellness
> tiherald@arh.org

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: http://myalhipp.com/

Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program

Website: http://myakhipp.com/

Phone: 1-866-251-4861

Email:
CustomerService@MyAKHIPP.com

Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/

Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Website: http://dhcs.ca.gov/hipp **Phone:** 916-445-8322

Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) **& Child Health Plan Plus** (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/

Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711

CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus

CHP+ Customer Service: 1-800-359-1991/State Relay 711

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovrey.com/ flmedicaidtplrecovry.com/hipp/index.html

Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64

Website: http://www.in.gov/fssa/hip/

Phone: 1-877-438-4479

All other Medicaid

Website: https://www.in.gov/medicaid/

Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members

Medicaid Phone: 1-800-338-8366

Hawki Website: http://dhs.iowa.gov/Hawki

Hawki Phone: 1-800-257-8563

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/

Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

Phone: 1-855-459-6328

Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx

Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la. gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Website: https://www.maine.gov/dhhs/ofi/applicatoins-forms

Phone: 1-800-442-6003

TTY: Maine relay 711

MASSACHUSETTS- Medicaid and CHIP
Website:
https://www.mass.gov/info-details/masshealth-premium-assistance-pa

Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp

Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov MontanaHealthcarePrograms/HIPP

Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov **Phone:** 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm **Phone:** 603-271-5218

Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/

Medicaid Phone: 609-631-2392

CHIP Website: http://www.njfamilycare.org/index. html

CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/

Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/

Phone: 1-844-854-4825

OKLAHOMA - Medicaid and CHIP

Website: http://www.insureoklahoma.org

Phone: 1-888-365-3742

OREGON - MEDICAID

Website: http://healthcare.oregon.gov/Pages/index. aspx http://www.oregonhealthcare.gov/index-es.html

Phone: 1-800-699-9075

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

RHODE ISLAND - Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347 or 401-462-0311

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

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

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

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

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_ premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_ premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-healthcare/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext.15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

CARRIER CONTACT INFORMATION

Benefit First
Helpline: 888-322-9374
Company ID: 631
Website www.benefitfirst.com

Anthem
Medical Plan (Kentucky & West Virginia)
Customer Service: 833-832-2455
Website www.Anthem.com

Anthem
Vision Section Network Plan
Customer Service: 877-635-6403
Website www.Anthem.com

Anthem - EAP
1-800-999-7222 or
AnthemEAP.com, enter code ARH

Delta Dental of Kentucky
Customer Service: 800-955-2030
Website www.deltadentalky.com

Purchasing Power
Customer Service: 888-923-6236
Website: www.purchasingpower.com

AFLAC
Critical Illness & Accident
Customer Service: 800-433-3036
Website www.aflacgroupinsurance.com

MetLife/Baybridge
Cancer
Customer Service: 800-845-7519
Website www.baybridgeadministrators.com

BMS
Flexible Spending Accounts
Customer Service: 800-919-2674
Website www.bmsllc.net

Hartford
Voluntary Basic Life and AD&D and Voluntary Dependent Life
Supplemental Voluntary Life Insurance Voluntary
Customer Service: 888-563-1124
Short Term and Long Term Disability Insurance
Customer Service: 888-301-5615
Claims Website: www.thehartford.com/employee-benefits/claims

Travel Assistant Services (On Call)
USA 1-800-456-3893
Worldwide, collect 603-328-1966

Legal Shield
Identity Theft
Customer Service Stephanie Boley
859-248-4332
Website www.legalshield.com

Trustmark
Universal Life with LTC
For Enrollment call Star Robbins 800-486-7721
Customer Service 800-918-8877
Website www.trustmarksolutions.com

MASA Medical Transport Solutions
Matt Ellis - Regional Manager
304-792-9401
mellis@masamts.com

This Guide is only intended to offer an outline of benefits. All details and contract obligations of plans are stated in the group contract/insurance documents, including any disclosures (whether regarding "grandfathering" of plans or others) required by the new health reform law, the Patient Protection and Affordable Care Act (PPACA). In the event of conflict between this guide and the group contract/insurance documents, the group contract/ insurance documents will prevail. Please contact your Human Resources Department for further information.