2024 Employee Benefit Guide

Commission On Economic Opportunity

Changing lives, improving our community.

20+ programs and services

Helping over 13,000 people each year

Over 92% of funds go directly to services

Making a lasting impact in our community

Employee Benefit Guide

Coverage Period : January 1, 2024 – December 31, 2024

Welcome

CEO takes pride in offering a comprehensive and valuable benefit package to its employees. CEO offers you a benefit program that allows choice and flexibility.

Through this program you can choose the benefits that are best suited for you and your family.

About this guide

This guide is a basic outline of your benefits and highlights the plans that are part of CEO's benefits program. This guide does not include all of the details or exclusions that are found in the insurance contracts or official plan documents. If there is a conflict between this guide or the information directly from the carriers contract, the official carrier's plan document will govern.

Benefits at a glance for 2024

Insurance Type	Carrier	Renewal Date	Plan
Medical	CDPHP	1/1	HMO Plan
Vision	Guardian	1/1	Davis Vision
Dental	Guardian	1/1	PPO
Voluntary Life Insurance	Guardian	1/1	Term Life
Telemedicine	United Concierge	1/1	Employer Paid
Flexible Spending Account	Flores	1/1	FSA- Employee Funded

Changes ahead: When switching Insurance carriers

- Make sure your provider(s) are participating
- Make sure that your medications are on the drug formulary
- Keep in mind that authorizations are not always carried over
- Make sure once the new plans are active, that you provide your new ID card to your doctors, pharmacy, dental office, and vision provider.

Eligibility

If you are a full-time or part - time employee you are eligible to enroll in the benefits outlined in this guide. The following family members are eligible for medical, dental, and vision coverage: spouse, domestic partner, and any eligible dependent children.

New Employee

New employees are eligible for coverage first of the following month after you complete 30 days of employment.

Open Enrollment

The annual open enrollment is the time for you to review your benefit offerings and update information if necessary. During Open Enrollment you can make the following benefit changes:

- Switch between plans
- Enroll yourself (and dependents) in the insurance(s)
- Cancel your coverage
- Remove dependents

Special Enrollment

Typically you are not permitted to make changes to or cancel your coverage during the plan year.

Changes and cancellations are permitted only during the annual Open Enrollment or if you experience a qualifying event during the plan year. The effective date of coverage would occur the date the change below took place. Qualifying events include:

- Marriage/ Divorce
- Birth of child; adoption or legal guardianship
- Death
- Loss or gain of alternative coverage
- Change in work status
- Medicare/ Medicaid eligible

2024 Open Enrollment - What do I need to know?

- **CDPHP medical**
- Renewing as is with the Hybrid plan.
- CEO has increased their total employer contribution to the plan.
- In the unfortunate event someone has a service that applies to the deductible, contact Gallagher's Benefit Advocacy Center (BAC) who can help guide you in applying for financial assistance with the hospital/facility (which is typically income based). We will make efforts to further negotiate the bill down.
- CDPHPs biggest change is that they are moving their pharmacy vendor from Caremark to CapitalRx. You should have received this information on this change. This will prompt a new ID card that needs to get to your pharmacy on 1/1/2024 or else your prescriptions will deny. There is a change in the mail order pharmacy, if you are currently using mail order contact BAC to help get a new profile set up.
  CVS is now a non-preferred pharmacy and members will be responsible for 50% of the prescription cost.

- **Guardian voluntary life** is remaining the same, if you are newly enrolling for open enrollment or are increasing the amount of life insurance, you will need to complete the EOI form (medical underwriting).
- Guardian will approve or deny your coverage request, you will receive a letter confirming this.
  - The only time you will see a change in rate is if you aged into the next bracket.
- **Guardian dental and vision-** no change to rate or plan design.
- **Guardian EAP** (Employee Assistance Program) is FREE to everyone!
- **Flexible Spending Account (FSA)** will be renewing with Flores and Associates.
- **UCM, virtual ER** is continuing as an employer paid benefit, it is free to you!
  - You are given the option to enroll or decline the benefit. Make sure your correct dependents are covered on this plan.
- **AFLAC**: Accident, Cancer/ Specified Disease, Disability Insurance, and Hospital coverage. All policies are standalone and you can mix and match coverage. Please contact CEO's AFLAC rep for more information or to set up/ change your policy:
  - Susan Todd-Bedell Phone: 518-269-1731 Email: susan_toddbedell@us.aflac.com
- **Navigator:** For **Open Enrollment** we will be using our new benefit platform, **Employee Navigator**. Every employee must sign-on to their account and elect or decline all benefits. It is important to make sure all of your personal information is correct in the system. You will receive an email with instructions on how to sign-on to your member account.
- **Benefit Advocacy Center (BAC)** is a new service offered by Gallagher. CEO employees will have a dedicated email and phone number to reach a licensed healthcare advocate. The advocates will assist with insurance cards replacements, claims or complex issues, prescription or pharmacy issues, and benefit questions or provider searches. Phone: 855-400-0792 Email: support@getebm.com
- **Fidelis:** For any questions on eligibility and coverages of Child Health Plus, Medicaid, Essential Plan, and all Marketplace coverages please reach out to CEO's Fidelis rep.

  - Josh DeMarsh Phone: 518-859-1974 Email: joshua.demarsh@fideliscare.org
    Call or Text

CDPHP HMO Plan

Carrier	CDPHP
Plan Type	Hybrid Plan
Network	HMO
Cost Share Information	
Individual/Family Deductible	$3,000/ $7,500
Out of Pocket Maximum	$9,450/ $18,000
Co-Insurance	20%
Office Visits	
Routine Preventive Care	$0
Primary Care	$30
Specialist	$50
Inpatient Services	
Inpatient Hospital	Deduct then 20%
Outpatient Services	
Outpatient Surgery	Deduct then 20%
Lab	$50*
Advanced Radiology	$50*
Emergency Care	
ER	Deduct then 20%
Urgent Care	$40
Prescription Drugs	
RX Deductible	None
Drug Card	$10/ $30/ $50

*Waives copay (FREE) at CDPHP Preferred Sites

CDPHP® HMO Plan Benefit Summary

Plan Code: HM7L24
Group ID: 20023624
Presented For: Commission on Economic Opportunity
Date Prepared: 9/13/2023
Effective Date: 1/1/2024

	In-Network
Cost Sharing Information	
Deductible	$3,000 Single / $7,500 Family (Embedded)
Out of Pocket Maximum	$9,450 Single / $18,900 Family (Embedded)
Office Visits	
PCP	$30 Copayment
*PCP Cost share waived for members that are under age of 19	
Specialist	$50 Copayment
Telemedicine	
Preferred Live Video Doctor Visits (aptihealth, Doctor on Demand, Foodsmart, MovN)	Covered in Full
Other Participating Telemedicine Providers (Valera)	$30 Copayment
Telehealth services from a CDPHP Network provider (PCP or Specialist)	PCP or Specialist cost share based on provider
Preventive and Well Care Services*	
Well Baby and Child Care including immunizations	Covered in full
Annual Adult Exam (One exam per plan year regardless if 365 days have passed)	Covered in full
Mammography	Covered in full
Annual Pap Test and Ob/Gyn Exam	Covered in full
Prostate Cancer Screening	Covered in full
Bone Density Tests	Covered in full
*Cost sharing may apply to diagnostic care	
Hospital Services	
Inpatient Hospital (semi-private room, anesthesia, X-Ray, lab tests, etc)	Deductible then 20% Coinsurance
Outpatient Surgery Facility	Deductible then 20% Coinsurance
Maternity Services*	
Maternity - Routine Prenatal Care and Postnatal Care	Covered in Full*
Maternity - Inpatient Hospital Services	20% Coinsurance
Newborn Nursery	Covered in full
*(Non-routine services may result in an additional cost share)	
Emergency Care	
Worldwide Emergency Room Care (waived if admitted inpatient)	Deductible then 20% Coinsurance
Ambulance	Deductible then 20% Coinsurance
Urgent Care	
When seeking care within CDPHP's Service Area, a participating Urgent Care Center must be used.	$40 Copayment
Diagnostic Testing*	
Outpatient Hospital or Office Based Laboratory Services: * Copayment waived if provider is a preferred laboratory.	$50 Copayment
Outpatient Hospital or Office Based Radiology Services: * Copayment waived if provider is a preferred center.	$50 Copayment
Behavioral Health Services	
Mental Health/Substance Use Inpatient Services	Deductible then 20% Coinsurance
Mental Health/Substance Use Outpatient Services	Covered in full
*(Up to 20 visits per plan year may be used for substance use family counseling.)	
Condition Support Services	
Outpatient Rehabilitation - Physical Therapy	$50 Copayment (30 visits per benefit period)

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	In-Network
Outpatient Rehabilitation - Speech Therapy	$50 Copayment (20 visits per benefit period)
Outpatient Rehabilitation - Occupational Therapy	$50 Copayment (30 visits per benefit period)
Home Health Care	Covered in full
Skilled Nursing Facility	Deductible then 20% Coinsurance (45 days per plan year)
Chemotherapy/Radiation Therapy visit	$30 Copayment
Prosthetic Devices and Durable Medical Equipment	50% Coinsurance
Diabetic Services	
Includes Insulin, oral medication, needles and syringes - up to a 30 day supply, Glucometers and Diabetic DME. Insulin is limited to $100 out of pocket per 30 day supply.	$30 Copayment
Vision Services	
Laser Eye Surgery	Up to a maximum of $750 reimbursement for eligible eye surgeries and consultations per lifetime
Wellness Care	
Weight Management	Up to a $100 reimbursement available for participation in a weight loss program
Fitness Reimbursement	Subscribers can be reimbursed up to $400 per plan year for qualified fitness activities. Of the $400, up to $200 can be applied for reimbursement of wearable fitness devices. Covered dependents can be reimbursed up to a combined $200 for qualified fitness activities and youth sports fees for members under age 18. Of the $200, up to $100 can be applied for reimbursement of wearable fitness devices.
Child Birthing Classes	Up to $75 reimbursement available for completion of child birthing class
Doula Reimbursement (A doula is a trained companion who supports another person through pregnancy and childbirth)	$1,500
Life Points Rewards	Participating (Up to $180 Life Points per contract per calendar year)
Acupuncture (10 visit limit per plan year for acupuncture services)	$50 Copayment
Nutritional Counseling	$50 Copayment
Chiropractic Benefits	$50 Copayment

This Summary of Benefits is intended to provide a general outline of coverage. In the event of any conflict between this document and the member's Certificate and any applicable Rider(s) issued by CDPHP, the Certificate and Rider(s) will be the controlling documents.

CDPHP gives you access to more than 12,000 participating practitioners and providers, including most of the local hospitals, and a variety of value-added services to help you and your family stay healthy. If you have a question or wish to receive additional information, please contact the CDPHP marketing department at (518) 641-5000 or 1-800-993-7299 or visit our Web site at www.cdphp.com.

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under the Certificate, You will be responsible for the full cost of the services.

CDPHP® HMO Plan Benefit Summary

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Your employer has chosen the following rider(s) to modify the Plan under which you would be covered as a CDPHP Member.

Domestic Partnership	
Rider Name	ELG12
Description	Provides coverage for an eligible same or opposite sex domestic partner and his or her eligible dependent children.
Pharmacy Coverage	
Rider Name	HMRXL4A24
Description	Preferred Retail Prescription Drugs (30 Day Supply) Tier 1 Drugs* $10 Tier 2 Drugs $30 Tier 3 Drugs $50 Non-Preferred Retail Pharmacy (30 Day Supply) Tier 1 Drugs 50% Tier 2 Drugs 50% Tier 3 Drugs 50% Specialty Drugs $50 *Copay/Coinsurance waived for members under age 19 Mail order, 2.0 Preferred Tier Copayments for a 90-day supply. Prescription drugs are subject to the plan deductible. Preventive prescription drugs are not subject to the plan deductible. Prescriptions must be written by a duly licensed health care provider and filled at a participating pharmacy, unless otherwise authorized in advance by CDPHP. Specialty drugs are not eligible for the mail order program.

HMO

Security of a plan you can trust

You select your doctor. We do the rest.

Our HMO plan is designed to offer you comprehensive coverage with care delivered by your choice of physicians from our extensive network. All for just a fixed copayment per visit.

The primary care physician (PCP) you select will handle most of your health care needs and refer you within the Capital District Physicians' Health Plan, Inc. (CDPHP) network for specialty care when necessary. Women may choose both a primary care physician and an OB/GYN to visit without a referral. For complete information on the CDPHP network, refer to the Directory of Participating Practitioners and Providers, or go to **findadoc.cdphp.com**.

With our HMO plan:

- No charge for certain preventive care visits, including well-baby care, immunizations, mammograms, routine annual physicals, Pap smears, prostate cancer screenings, and well-woman care.
- Predictable copayment per visit.
- Routine preventive care and medical treatments provided and coordinated by a PCP.
- No special referral paperwork required.
- Single-source referral phone line to direct you to the health or wellness program that best fits your needs.

You can take it with you.

Your coverage, that is. Travel out of the service area for work or pleasure, and CDPHP covers you worldwide for emergency care.

We're here if you need us.

If you have questions about your benefits, simply call one of our knowledgeable member representatives, any weekday between 8 a.m. and 8 p.m.

You also have access to your benefit information online, any time, by logging into **www.cdphp.com**.

HMO Tip Sheet

MEMBER BENEFIT QUESTIONS: 1-800-777-2273 **PRIOR AUTHORIZATION REQUESTS:** 1-800-274-2332

- As a member of the HMO, you must have a CDPHP-participating primary care physician (PCP). Female members may also select a network OB/GYN.
- To view your choice of physicians, please visit findadoc.cdphp.com. To select or change a PCP or OB/GYN, simply contact the member services department as listed above. You may also change your PCP online.
- When changing your PCP, you must contact member services within five days of visiting your new physician, so you do not get charged for the visit. Also, if your previous doctor has written prescriptions or given you an ongoing referral to a specialist, please consult with your new practitioner to coordinate your care.
- Out-of-network care is covered only in an emergency or if pre-approved by CDPHP.
- Please refer to your ID card or the benefit materials provided to you upon enrollment for details on your copayment and coinsurance levels. These vary according to the plan purchased by your employer group.

At the Time of Your Visit

Please remember to present your member ID card and copayment at the time of service.

Referrals

- To request a referral, please consult with your PCP.
- Your PCP should direct you to in-network specialists as needed.
- You do not need a referral number or any special paperwork. Just tell the specialist's office the name of the PCP who referred you.

Emergency Care

- Emergency services are covered for a condition that is of sufficient severity that the average person would believe that serious bodily harm, loss of function, or disfigurement could result unless care is received right away.
- If you require emergency medical care as described above, go to the nearest hospital emergency room or call 911 or your local emergency response number.

This tip sheet provides an overview of your coverage but does not detail all of the benefits, limitations, or exclusions. It is not a contract and is subject to change. For more detailed information, please refer to your membership certificate.

Discrimination is Against the Law
Capital District Physicians' Health Plan, Inc. (CDPHP®) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Multi-language Interpreter Services
ATENCIÓN: Si habla otro idioma que no es el inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación de miembro (TTY: 711).

注意：如果您使用的語言不是英語，您可以免費獲得語言援助服務。請致電您會員ID卡上的電話（聽力障礙電傳：711）。

Important Pharmacy Changes

CDPHP® understands the important role prescription drugs play in the health and safety of our members, which is why we have made strategic investments in the future of our pharmacy strategy.

Please read for important pharmacy updates:

- New pharmacy benefit manager
- New mail order pharmacy partner
- Free Rx delivery options for your patients
- Rx savings opportunities for your patients
- **CVS is a non-preferred pharmacy and you will be responsible for 50% of the cost of your prescriptions**

NEW PHARMACY BENEFIT MANAGER

A key piece of our pharmacy strategy is changing our pharmacy benefit manager (PBM) to Capital Rx. By partnering with Capital Rx, CDPHP aims to stem the tide of rising drug prices through greater transparency, as well as a new pricing model that more accurately and fairly sets the cost of drugs.

Capital Rx is more agile than any other PBM on the market. It can modify formularies in days rather than weeks or months, allowing CDPHP to seamlessly update our list of covered drugs. With Capital Rx, as new, more affordable drugs come to market, CDPHP will be able offer those products more quickly to your patients.

This change goes into effect January 1, 2024.

COMMERCIAL, MEDICARE, ESSENTIAL PLAN, AND CHILD HEALTH PLUS PHARMACY NETWORK

Members will continue to have access to national pharmacy chains and supermarkets (including, Walgreens, Walmart, Rite Aid, Price Chopper/Market 32, Hannaford, Kinney Drugs, Wegmans, etc.), as well as most other pharmacies they've had in the past. Although CVS is still in the CDPHP pharmacy network for these plans, we recommend members switching to a different pharmacy because CVS pharmacies typically have higher costs for prescription medications. This translates into higher out of pocket costs for your patients.

NEW MAIL ORDER PARTNER AND HOME DELIVERY OPTIONS

Members can skip the trip to the pharmacy and have prescriptions delivered right to their door – all at no extra cost!

Free Home Delivery with ConnectRx

Our very own pharmacies, ConnectRx, offer fast, free, and personalized home delivery services to patients in the broader Capital Region. With locations in Watervliet, Clifton Park, and Latham, patients can pick up their prescriptions in-person or have them delivered for free to their home. Visit **pharmacyconnectrx.com** to learn more.

Walmart Home Delivery is the new CDPHP mail order pharmacy starting January 1, 2024.

Our prescription mail-order service will now be administered by Walmart Home Delivery. This service is perfect for members who take medications to treat chronic conditions. Current and new users of this service will need to call Walmart after January 1, 2024 to setup a profile and provide payment information. Specific details on how to setup a profile and transfer prescriptions to Walmart Home Delivery will be shared directly with impacted members. The CDPHP mail order service through Walmart Home Delivery is available for commercial plans with prescription benefits.

RX SAVINGS OPPORTUNITIES

Starting in 2024, the popular **Rx for Less** program is nearly doubling in size with the addition of multiple chain pharmacies, plus independent pharmacies.

Rx for Less pharmacies include:

- ✓ ConnectRx
- ✓ Hannaford
- ✓ Market 32/Price Chopper
- ✓ ShopRite
- ✓ Walmart
- ✓ Food Lion – *Starting 1/1/24*
- ✓ Kinney Drugs – *Starting 1/1/24*
- ✓ Giant Foods – *Starting 1/1/24*
- ✓ Rite Aid – *Starting 1/1/24*
- ✓ Stop & Shop – *Starting 1/1/24*
- ✓ Walgreens – *Starting 1/1/24*
- ✓ Multipleindependent pharmacies – *Starting 1/1/24*

CVS has opted out of this popular program. CDPHP commercial and Medicare members are still able to fill prescriptions at CVS pharmacies after December 31, 2023, but the Rx for Less discount will no longer apply. If members are currently filling an Rx for Less medication at CVS and would like to continue receiving a discount on prescriptions through the Rx for Less program, they can transfer applicable prescriptions to a different Rx for Less retail pharmacy.

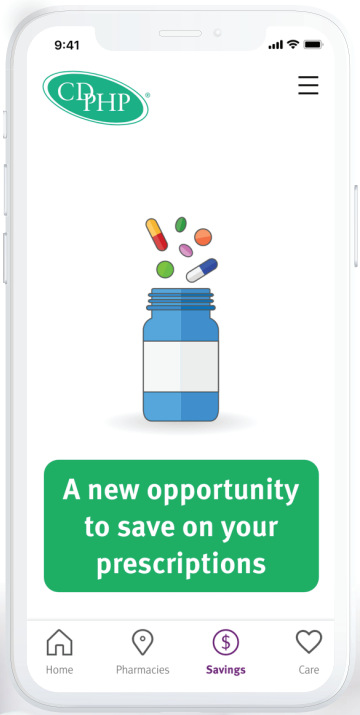
Members can switch to a different Rx for Less pharmacy by downloading the CDPHP ConnectRx, On the Go app. They can also call the pharmacy that they would like to switch to and let them know they want to transfer their prescriptions there. Rx for Less is available for commercial plans with prescription benefits (including self-funded plans) and Medicare advantage. For more details, go to **cdphp.com/save**.

Save money on your prescription drugs with CDPHP® ConnectRx, On the Go

You may be overpaying for your medications. We can help.

Our pharmacy app will enable you to:

- View your current medication list and alert you to savings opportunities
- See if you're eligible for additional savings using a CDPHP Rx for Less pharmacy
- Request a medication or pharmacy switch
- View how much a medication will cost*
- Get alerts about screenings or appointments you may need to keep you healthy
- And more!



Get Started

- Download **CDPHP ConnectRx, On the Go** from your app store
- Have your CDPHP member ID handy to fill in your personal information
- Check your email for an activation code
- Complete your registration and begin using the app to save money on your prescriptions!

Need help with the app? Call 1-800-266-6117 or email **appsupport@levrx.com**.

Download on the App Store

GET IT ON Google Play

Applies if CDPHP provides the pharmacy benefit for your plan.

** Pricing cannot be calculated for drugs requiring prior authorization.*

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Capital District Physicians' Health Plan, Inc. | CDPHP Universal Benefits,® Inc. | Capital District Physicians' Healthcare Network, Inc. 21-17204

Keeping your business and your employees healthy

CDPHP® brings value to your business with award-winning customer service, a robust national network, and innovative, cost-saving plans. In 2023, as always, you can count on CDPHP to provide high quality benefits and personalized service that saves you money and helps your employees live their healthiest lives.

FREE PREVENTIVE CARE
Checkups, cancer screenings, and more

HEARING AND VISION
Hardware, exams, LASIK surgery, and more

PREGNANCY RESOURCES
A $1,500 doula reimbursement and many other support tools

CDPHP PRICE CHECK
Get a cost estimate before choosing a provider

PREFERRED LABS AND RADIOLOGY
Free and low-cost services

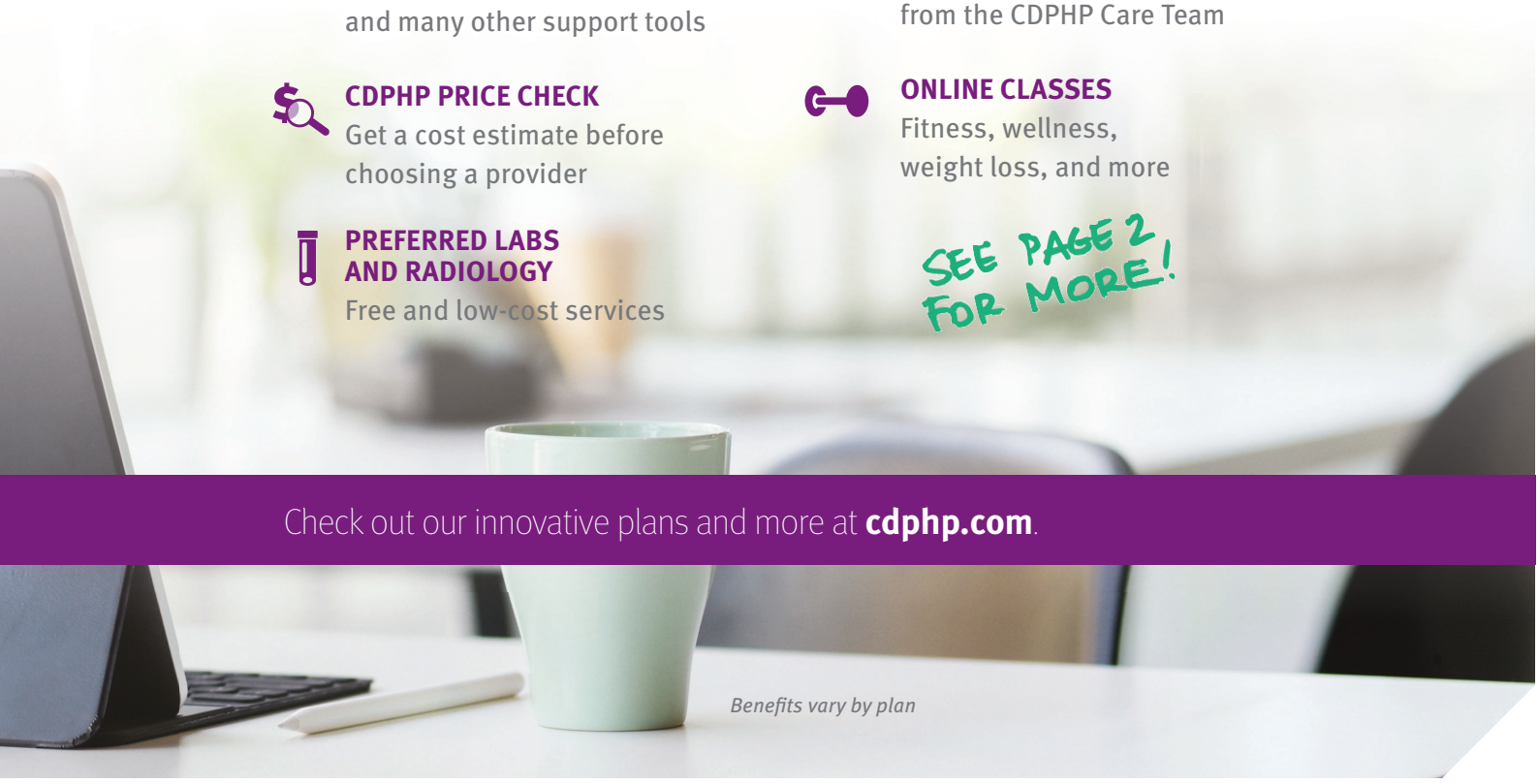
MENTAL HEALTH SERVICES
24/7 support including video doctor visits

RX FOR LESS
Generic medications for as little as a penny a pill

ONE-ON-ONE SUPPORT
Personalized assistance from the CDPHP Care Team

ONLINE CLASSES
Fitness, wellness, weight loss, and more

SEE PAGE 2 FOR MORE!



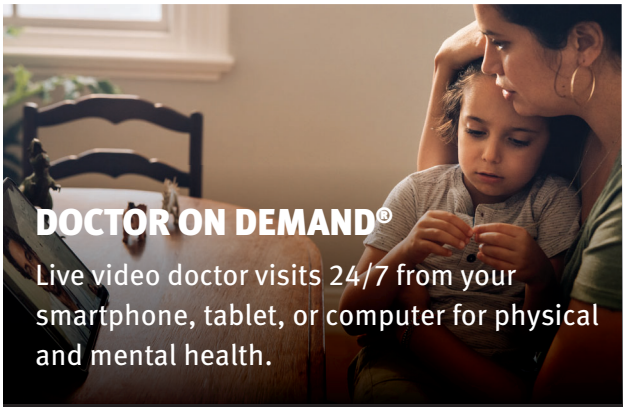
Check out our innovative plans and more at **cdphp.com**.

Benefits vary by plan

Employee favorites

FITNESS AND WEIGHT MANAGEMENT REIMBURSEMENTS

Earn up to $600 per year for going to the gym, youth sports fees, online classes, or wearable fitness devices; and $100 for completing a weight loss program.



DOCTOR ON DEMAND®

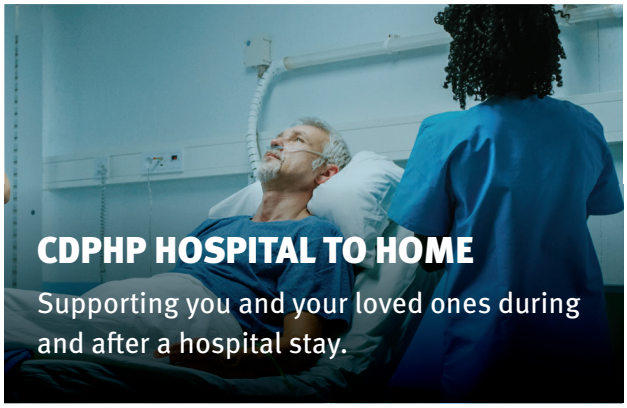
Live video doctor visits 24/7 from your smartphone, tablet, or computer for physical and mental health.

CDPHP CONNECTRx, ON THE GO

View medication costs, search for potential savings, request a medication or pharmacy change, and more.

$0 CHILD PRIMARY CARE VISITS

No member cost-share for children ages 18 and younger.*



CDPHP HOSPITAL TO HOME

Supporting you and your loved ones during and after a hospital stay.

CONNECTRx

CDPHP retail pharmacy locations, providing free home delivery to surrounding areas and more. Visit pharmacyconnectrx.com for details.

WANT TO KNOW MORE?

Check out **cdphp.com**/need

**Deductible will apply on HSA qualified high deductible plans for non-preventive care visits.*

Flexible Spending Account: Flores

- FSA is a stand alone product meaning you do not need to be enrolled in a medical plan at CEO to enroll.
- A funding arrangement through Flores, where you can put aside pre-tax dollars from your paycheck to help fund any copays, deductibles, or coinsurance.
- In addition to medical expenses, you can use your FSA for any section 213(d) qualified expense, which includes dental and vision expenses. FSA can be used to help fund dependent care for children under 12.
- Elections will be calculated on the number of pay periods from your effective date to 12/31/2024.
- $640 rollover feature– this allows to rollover a portion of your unused funds to the next plan year. Fund are 'released' after the claims run out, typically end of March.

Why should I consider enrolling in the FSA? If this past year you:

- Felt like you paid a lot of healthcare expenses out of pocket
- If you have high cost medications
- Planned medical or dental procedures
- Satisfied your deductible in 2023
- How much should I consider electing for my FSA?

Healthcare services incurred throughout the year can not always be expected. The best suggestion to decide how much to put in your FSA is based on last years medical history. Keep in mind if you see a specialist regularly, if you take medications every month, if you have a planned in patient hospitalization (ie. birth of a child), if you plan to get new glasses, if you wear contacts, if you need dental work.

	Health FSA	Dependent Care FSA
Minimum Election	$500	$500
Maximum Election	$3,200	$5,000
Allocation Available	Day 1	As money is accrued

FLORES BENEFITS CARD

1 ENROLL IN ELIGIBLE BENEFIT PLAN

Your employer offers the Flores Benefits Card to employees who enroll in an eligible benefit plan. The card will allow you to pay for eligible expenses at participating providers at the time services are rendered, thus eliminating or reducing your out-of-pocket cost at the time of the purchase or service.

2 RECEIVE YOUR FLORES BENEFITS CARD

Your Flores Benefits Card will be mailed upon your enrollment in an eligible benefit plan. No activation is required, but you should review the Cardholder Agreement included in this mailing, and then sign the back of your card.

3 PROPER USE & ACCOUNT MANAGEMENT

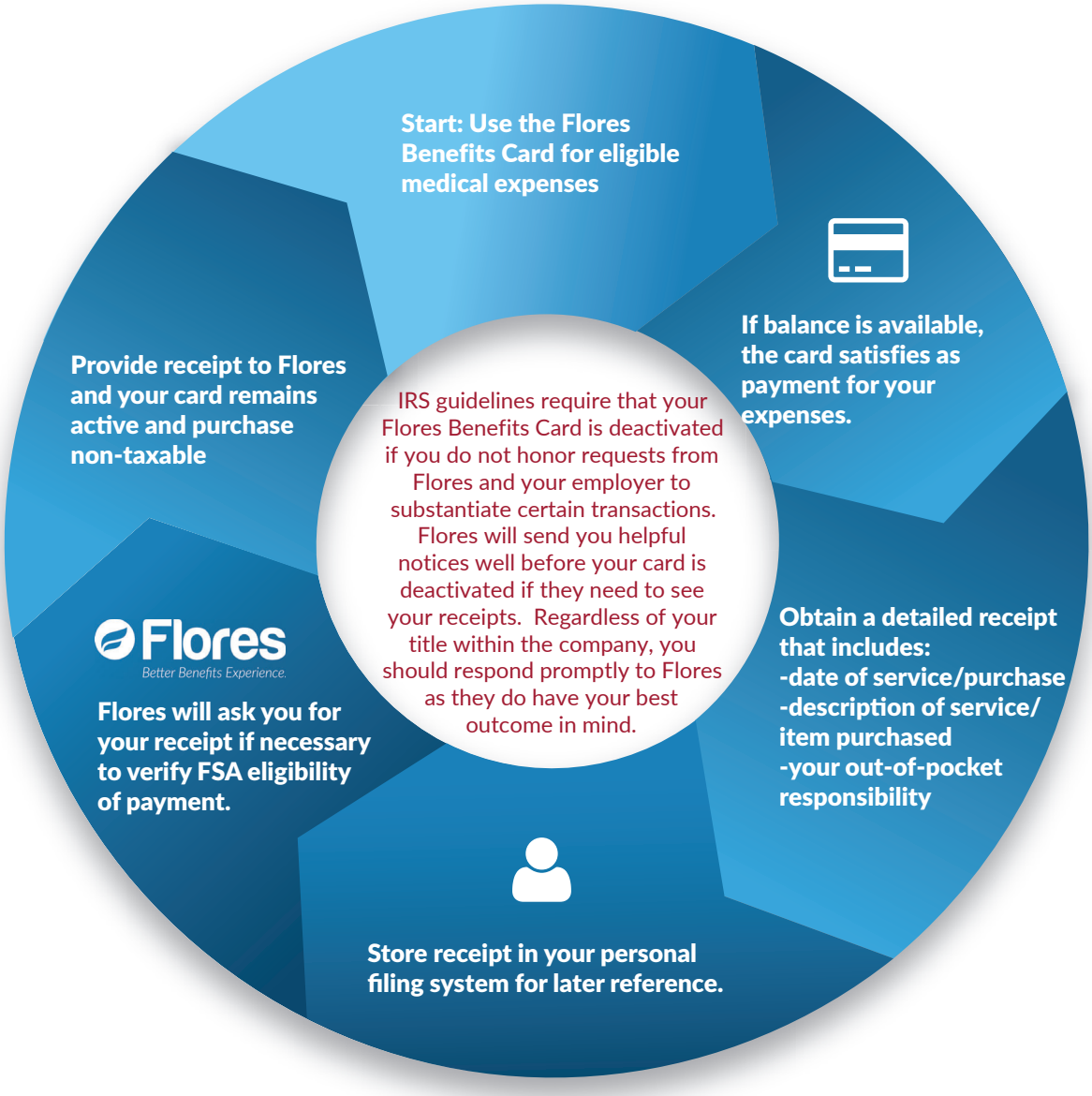
You will be able to view and manage your account on the Flores Web Portal, www.flores247.com.
You should keep your receipts and invoices for payments made with your Flores Benefits Card, as you may be required to provide documentation to Flores to verify the eligibility of certain transactions. If requested, you may submit your documentation to Flores by uploading it to your online account, uploading using the Flores Mobile App, or sending it by fax or mail.

Recordkeeping Tip:
Most payments will be automatically substantiated at the point of the transaction. Flores will only ask you to provide a copy of your receipts when substantiation is required per IRS guidelines. Establish a physical location where you will keep all receipts for your Flores Benefits Card purchases. Regardless of your position with your company, every employee will be treated the same in regard to IRS plan administration guidelines. No exceptions will be made.

If you are asked to provide a receipt, it must include:

- name of provider or merchant
- description of service or item purchased
- date of service
- your out-of-pocket responsibility

Items such as handwritten explanations, Card transaction receipts or previous balance receipts cannot be used to verify an expense. If you do not have the receipt, you can contact the provider who can usually supply the receipt from their files.



IS SUBSTANTIATION REQUIRED?

YES

Co-pay amounts that do not match your company sponsored health insurance plan

Charges applied against your plan year deductible

Charges applied against your plan year coinsurance

Dental charges

Vision charges

NO

Co-pay amounts that match your company sponsored health plan

Prescription charges purchased at a retailer utilizing a FSA inventory control system

Recurring charges that were previously approved and documented (i.e. orthodontia, chiropractic care)

FLORES BENEFITS CARD FAQs

FREQUENTLY ASKED QUESTIONS

What expenses are eligible for payment with my Flores Benefits Card?
You can use your Flores Benefits Card to pay for expenses incurred during your active enrollment period in the current plan year. If a provider or merchant does not accept cards, you do have the option to file a manual request for reimbursement of your eligible out-of-pocket cost. Please visit www.flores247.com for a guide to allowable expenses. If you terminate employment during the plan year, the card will be turned off at that time. Only expenses incurred while you are an active participant will be considered reimbursable.

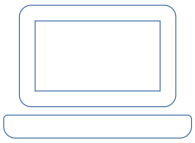
How can I use my Flores Benefits Card to pay for my eligible out-of-pocket expenses? Although the Flores Benefits Card is a debit card with a cash balance loaded onto it, you should select "credit" as the transaction type, and sign for purchases at authorized merchants. Please keep in mind that the Flores Benefits Card will decline if you try to swipe it for an amount greater than your available balance.

How should I send my documentation to Flores?
Many transactions will be auto-approved at the point of sale and will not require further documentation. Flores will notify you by email or a mailed letter if additional information is needed to verify the eligibility of a particular transaction. You may submit your documentation by upload on the participant website, www.flores247.com, using the Flores Mobile App, or by fax or mail.

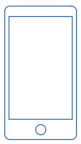
I used my card for an ineligible expense. What do I need to do to correct this?
You may send a refund check to Flores for the ineligible amount, which will be credited back to your Flores Benefits Card to be used toward other eligible expenses you incur later in the year. You may also submit documentation that verifies you have paid out-of-pocket for an eligible expense, which Flores will use to offset the ineligible amount paid with your Flores Benefits Card.

Will I receive a new card each plan year?
Your card is valid for five years from its issue date. Do not discard your card prior to its expiration date. At the start of each new plan year, your card will be reloaded with your new election amount. A new card will be mailed to you when your expiration date is approaching.

HOW DO I OBTAIN MY ACCOUNT DETAILS?



WEBSITE
Visit www.flores247.com and log-in using Participant ID or UserName and password



MOBILE WEBSITE
Visit our mobile website at m.flores247.com

PID & PASSWORD
ASSISTANCE
Dial 800.840.7684

HOW DO I SUBMIT DOCUMENTS TO FLORES?

ONLINE
Visit www.flores247.com and upload scanned documents securely

MOBILE
Download Flores Mobile smartphone App Available for Apple or Android devices

MAIL
Flores
PO Box 31397
Charlotte, NC 28231

FAX
800.726.9982 or 704.335.0818

CUSTOMER SERVICE 1.800.532.3327

How to Submit a Claim

Flores

1 **FLORES WEB PORTAL:**
You may scan your claim and upload it to our secure website or complete your claim detail online at www.flores247.com.

2 **FLORES MOBILE SMARTPHONE APP:**
Use your phone's camera to take a picture of your documentation and upload. Download Flores Mobile through Apple Store or Google Play.

Available on the App Store | GET IT ON Google play

3 **MAIL CLAIMS:**
Claims Processing
PO Box 31397
Charlotte, NC 28231
*Please keep in mind, certified mail will need to be sent to our physical address at 1218 South Church St Charlotte, NC 28203.

4 **FAX CLAIMS:**
704.335.0818 or 800.726.9982

How to upload a claim on www.flores247.com

Step One: Log in to www.flores247.com using your Participant ID or Username and password. Tip: Your Participant ID will be on any correspondence you have received from Flores.

Step Two: Click "File a new Health Care or Dependent Care Flexible Spending Account Claim". Hit Next.

Step Three: If you have completed a hard copy claim form and scanned it into your computer, click "Already Completed" to up-load your document. If you have not already completed a claim form, fill in your claim detail and hit "Next".

Step Four: Click "Choose File" and choose the file on your computer that contains your scanned documentation that is required to process your claim. Repeat until all docu-ments are attached. Click "Submit" to final-ize your claim.

Tip: Update your email or subscribe to SMS notifi-cations in the Settings tab to receive email or text updates on your claim!

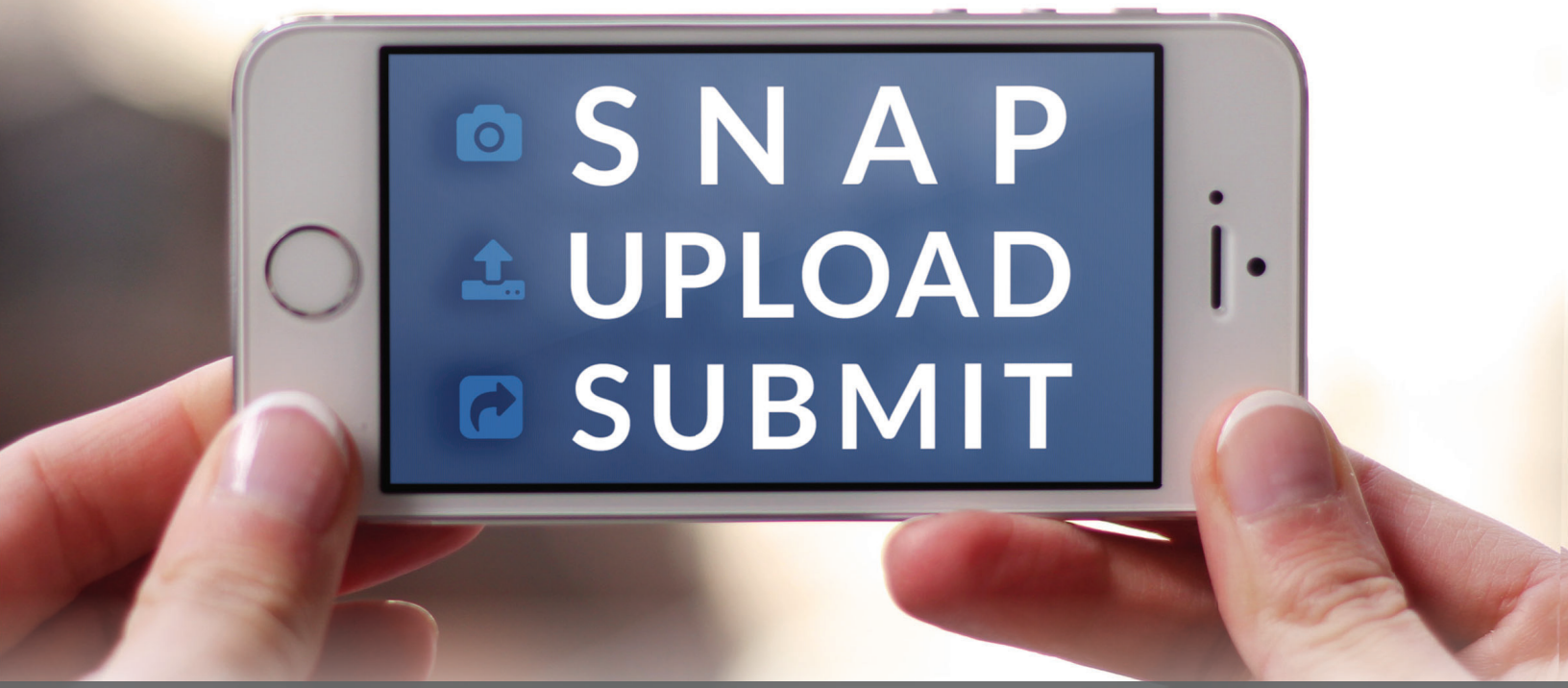
All receipts for reimbursement must include the following:

- Date of Service
- Description of Service
- Out-of-Pocket Cost
- Provider Name
- Patient Name

Reimbursement for Orthodontia Expenses

Only proof of payment will be required for future claim submissions. Orthodontia will be reimbursable as you pay it, meaning that the payment can only be reimbursed from the plan year in which the payment was made. If you have any questions about reimbursement for Orthodontia you can call an account manager at 800.532.3327.

Flores

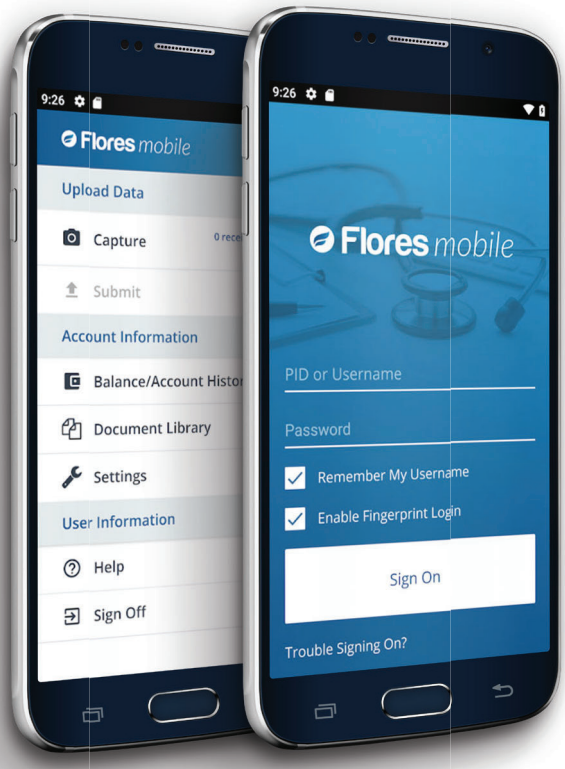


WHENEVER...WHEREVER...WITH FLORES MOBILE

Download Flores Mobile today

Available on the App Store

GET IT ON Google play



USING THE FLORES MOBILE MOBILE APP IS EASY!

SUBMIT RECEIPTS IMMEDIATELY AFTER YOU USE YOUR FLORES DEBIT CARD OR INCUR AN ELIGIBLE OUT-OF-POCKET EXPENSE

- Logon with your PID or username and password
- Click Capture to take a photo of your documents
- Return to main screen and click Submit Document
- Once your upload transmits you will receive confirmation via email or text message
- Additional confirmation will be sent once your document is processed

- SNAP PICTURE
- SELECT DOCUMENT
- UPLOAD RECEIPT
- SUBMIT CLAIM
- VIEW ACCOUNT
- CHECK BALANCE
- EMAIL ACCOUNT MANAGER

800.532.3327 Fax: 800.726.9982 www.flores247.com P.O. Box 31397 Charlotte, NC 28231-1397

Dental Insurance

Participating Dentist vs. Non-Participating Dentist

Under this plan you have the freedom to see any provider you chose. However, if your dentist is participating, it will reduce or eliminate out of pocket expenses. When seeing an out of network provider, they may balance bill you, which increases your out of pocket expense.

Guardian Network

To take advantage of in network (participating) dentists, you want to make sure they participate with the Guardian DentalGuard Preferred Network.

Pre-Determination or Pre-Treatment Plan

When you are going for dental services other than a routine cleaning or exam, you should have your dental office submit a pre-determination or pre-treatment plan on your behalf. The dental office submits a form to the insurance carrier outlining all of the anticipated services and Guardian in turn tells the dental office at what percentage the services are covered, how much of the annual maximum has been used, and most importantly what your expected out of pocket cost is.

Please note the Guardian ID Cards are generic and are available on the Guardian website: www.guardiananytime.com we also attached a PDF copy of the generic card on HR connection.

Dental Insurance: Guardian

The Guardian Dental Plans		
Benefit	**In Network**	**Out of Network**
Annual Deductible *Amount you must pay before the plan begins to pay*	$50; max 3 per (waived for Diagnostic & Preventive services)	
Annual Benefit Maximum *Maximum amount the plan will pay per person enrolled, in a year. Once this money is exhausted you are responsible for your dental expenses in full.*	$2,000	
Preventive & Diagnostic Services *(eligible once per 6 months) Oral exams, cleanings, sealants*	90%	90%
Basic Services *X-rays, fillings, Root canals, periodontal services, simple extractions*	80%	80%
Major Services *Bridges, dentures, crowns, inlays, onlays*	50%	50%
Orthodontia	$1,250 Lifetime maximum	
Roll Over	Yes	

Limitations or exclusions may apply.

*** Keep in mind that if you exhaust your annual maximum, you are responsible for the full cost of the dental service, regardless of the percentage that is listed above.* ***Note**: This includes routine cleanings.*

Dependent age limits: 19 unless proof of full time student status, then to age 23

Dental Maximum Rollover®

Save Your Unused Claims Dollars For When You Need Them Most

Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). If you reach your Plan Annual Maximum in future years, you can use money from your MRA. To qualify for an MRA, you must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. Your MRA may not exceed the MRA limit. You can view your annual MRA statement detailing your account and those of your dependents on www.GuardianAnytime.com.

Please note that actual maximum limitations and thresholds vary by plan. Your plan may vary from the one used below as an example to illustrate how the Maximum Rollover functions.

Plan Annual Maximum*	Threshold	Maximum Rollover Amount	In-Network Only Rollover Amount	Maximum Rollover Account Limit
$2000	$800	$400	$600	$1500
Maximum claims reimbursement	Claims amount that determines rollover eligibility	Additional dollars added to Plan Annual Maximum for future years	Additional dollars added to Plan Annual Maximum for future years if only in-network providers were used during the benefit year	Plan Annual Maximum plus Maximum Rollover cannot exceed $3,500 in total

* If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, ($1500 PPO/$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan.

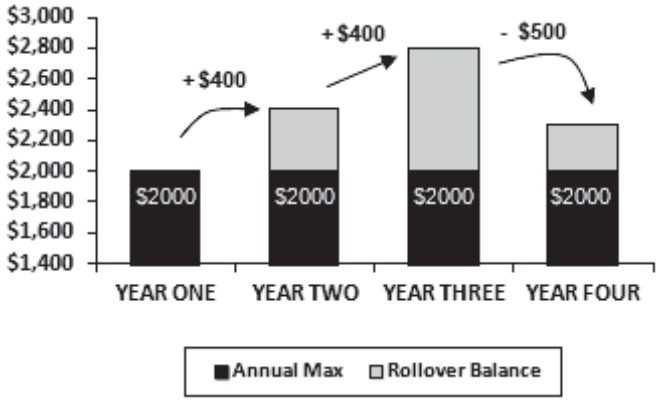
Here's how the benefits work:

YEAR ONE: Jane starts with a $2000 Plan Annual Maximum. She submits $150 in dental claims. Since she did not reach the $800 Threshold, she receives a $400 rollover that will be applied to Year Two.

YEAR TWO: Jane now has an increased Plan Annual Maximum of $2,400. This year, she submits $50 in claims and receives an additional $400 rollover added to her Plan Annual Maximum.

YEAR THREE: Jane now has an increased Plan Annual Maximum of $2,800. This year, she submits $2,500 in claims. All claims are paid due to the amount accumulated in her Maximum Rollover Account.

YEAR FOUR: Jane's Plan Annual Maximum is $2,300 ($2,000 Plan Annual Maximum + $300 remaining in her Maximum Rollover Account).



For Overview of your Dental Benefits, please see About Your Benefit Section of this Enrollment Booklet.

NOTES:

You and your insured dependents maintain separate MRAs based on your own claim activity. Each MRA may not exceed the MRA limit.

Cases on either a calendar year or policy year accumulation basis qualify for the Maximum Rollover feature. For calendar year cases with an effective date in October, November or December, the Maximum Rollover feature starts as of the first full benefit year. For example, if a plan starts in November of 2013, the claim activity in 2014 will be used and applied to MRAs for use in 2015.

Under either benefit year set up (calendar year or policy year), Maximum Rollover for new entrants joining with 3 months or less remaining in the benefit year, will not begin until the start of the next full benefit year. Maximum Rollover is deferred for members who have coverage of Major services deferred. For these members, Maximum Rollover starts when coverage of Major services starts, or the start of the next benefit year if 3 months or less remain until the next benefit year. (Actual eligibility timeframe may vary. See your Plan Details for the most accurate information.)

Policy Form #GP-1-DG2000, et al.

College Tuition Benefit Self Registration

Note this program has been discontinued. Anyone who has accrued funds, will keep what has been earned but you will not receive additional rewards. here are no longer new participants available for this program.

Welcome to the College Tuition Benefit Rewards program! You can now create your Rewards account and start accumulating your Tuition Rewards that can be used to pay up to one year's tuition at SAGE Scholars Consortium colleges.

How does it work?

You can use your College Tuition Benefits Rewards at over 340+ private colleges and universities across the nation. 80% of SAGE colleges have received an "America's Best" ranking by US News & World Reports. This benefit is being provided to you by your employer and Guardian at no addition cost to you.

- Each Tuition Rewards point equals a $1 guaranteed minimum reduction off of published full price tuition, spread evenly over four years of undergraduate education, starting with freshman year.
- You will receive rewards each year you have Guardian Dental Plan benefits.
- Tuition Rewards can be given to your relatives including children, nephews, nieces, and grandchildren. Don't forget to enroll them!
- See how quickly your account can grow!

Policy Year	Subscriber Reward*	Subscriber's Reward Balance (balance does not accrue interest)
Initial Registration Subscriber & Student Rewards		2,500 (2,000 + 500)
2	2,000	4,500
3	2,000	6,500
4	**4,500 (Bonus Year)**	11,000
5	2,000	13,000
6	2,000	15,000
7	2,000	17,000

*After initial registration, future points created 30 days after plan anniversary.

To learn more about the program and how to get started, go to: http://www.Guardian.CollegeTuitionBenefit.com to set up your account. If you have any questions, please feel free to visit the website or contact College Tuition Benefit directly 215-839-0119.

Register Today!

(Print and cut out ID Card)

College Tuition Benefits Rewards – ID Card

Register @
http://www.Guardian.CollegeTuitionBenefit.com

User ID: 443854

Password: Guardian

fold

COLLEGE TUITION BENEFIT.com

The College Tuition Benefit
150 E. Swedesford Road, Suite 100
Wayne, PA 19087
Phone: (215) 839-0119
Fax: (215) 392-3255

Guardian Vision

Your vision coverage provides a full range of vision care services provided through Guardian. You may receive care from any provider you choose, but your benefits are greater when you see a participating, in-network provider. If you choose to receive services from an out-of-network provider, you will be required to pay that provider at the time of service and submit a manual claim for reimbursement.

Guardian Network

To take advantage of in network (participating) vision providers, you want to make sure they participate with the Davis Network.

Please note the Guardian ID Cards are generic and are available on the Guardian website: www.guardiananytime.com we also attached a PDF copy of the generic card on HR connection.

Davis Full Feature		
Benefits	**In Network**	**Out of Network**
Vision Exam *Once every 12 months*	$10	$46 Allowance
Eyeglass Frames *Once every 24 months*	$135 Allowance + 20% off remaining balance	$47 Allowance
Eyeglass Lenses Once every 12 months		
Single	$10	$47 Allowance
Bifocal	$10	$66 Allowance
Trifocal	$10	$85 Allowance
Lenticular	$10	$125 Allowance
*Lens upgrades apply additional copays		
Contact Lenses *Once every 12 months*		
Medically Necessary	Covered in full	$210 Allowance
Elective	$135 Allowance +15% off	$105 Allowance

* Additional discounts may not be available at Sam's Club or Walmart Dependent age limits: 19 unless proof of full time student status, then to age 23

UNITED CONCIERGE MEDICINE

We are excited to continue to offer this benefit to all employees at no cost. Employees have a $0 co-pay and a true concierge service they can use 24/7. Employees can use the benefits by a phone call or video chat with an emergency- trained physician anywhere at any time.

UCM is a group of ER physicians who formed a practice without the brick and mortar. They go above and beyond the traditional carrier provided telemedicine with a personal touch. The same doctor that treats you, calls you back to see how you are feeling. ***UCM is expanding our services to include a broader range of healthcare services including primary care, chronic care management, and mental healthcare*.**

No Deductibles. No Co-Pays. No Waiting Rooms. No Problem!

- All employees enrolled in medical will receivethis benefit at **no cost**
- Premier provider of telemedicine
- Accredited emergency medicine physicians and PAs
- Access 24/7/365 by encrypted phone or video, including international access for travelers; HIPAAcompliant
- One-click call to request consults with a provider
- Schedule Consults from your App or Online
- Prescriptions sent directly to your pharmacy
- Can treat wide range of conditions and order labs, x-ray, write prescriptions
- Share pictures and/or video with a provider
- Follow up to track your recovery
- Primary Care Visits
- Chronic Pain Management
- Mental Health Visits

We offer:

Diagnosis and treatment of many common disorders such as:

- Cold/ flu
- Allergies
- Poison ivy
- Sore throat
- Insect bites
- Vomiting
- Pink eye
- Urinary tract infections
- Yeast infections
- Diarrhea
- Rashes
- Bronchitis
- Ear infections
- Mild asthma
- Pediatric conditions
- Sports injuries

and much more.

844-4-VIP DOC
(844-484-7362)

Board-certified providers ready to care for you.

Sam℠

Primary Care

Ongoing care to address a range of primary care needs to help you **get well and stay well.**

- Wellness visits
- **Routine Screenings for H**ypertension, Diabetes, & more
- Age-appropriate screenings, e.g. mammograms, colonoscopies, and more
- **Labs** for cholesterol, blood sugar, & more
- Smoking cessation
- Chronic disease management

Urgent & Emergency Care

A convenient, cost-effective alternative to going to urgent care or to the emergency room. Get treated within minutes, not hours.

UCM does not turn any patients away. We are proud to treat a wide range of complex conditions and injuries, including, but not limited to:

- Upper respiratory infection
- Urinary tract infection
- Cough, sore throat, or flu
- Abdominal pain
- Rashes or Pink eye
- Nausea, vomiting, or diarrhea
- Headaches
- COVID-19
- Ear problems

Mental Health Care

Unlimited, confidential consults with Masters and Ph.D. level trained counselors.

- Anxiety and Depression
- Alcohol or drug abuse
- Child or family issues
- Caring for the Caregiver
- Marital or relationship issues
- Parenting
- Grief
- Sexual, physical, or mental abuse

Our Benefits

- Easy to access via phone, mobile app, or online.
- Cost-effective and convenient.
- Concierge service from a care coordinator to handle follow-ups like prescriptions, labs, and referrals when needed. We even follow up with each patient after a consult to see how they are doing!
- Access to "Up to Date", evidence-based clinical information to learn more about health topics directly on the app.

www.sambyucm.com
1-844-4-VIP-DOC

Sam

Download the "Sam by UCM" Mobile App

Thank you for trusting us with your health!

UCM DIGITAL HEALTH

MAKE UCM DIGITAL HEALTH YOUR FIRST STOP FOR *ALL* OF YOUR HEALTHCARE NEEDS.

PRIMARY CARE

- Wellness visits
- Routine preventive screenings
- Labs and imaging
- Smoking cessation
- Weight management
- Nutrition counseling
- Chronic disease management

AND MORE!

- Emergencies, injuries, and illnesses*
- Urinary tract infections
- COVID-19, the flu, and upper respiratory infections
- Dermatology
- School or work notes
- Prescription refills and referrals

**Treatment provided for any emergencies deemed as non-life threatening.*

1-844-4-VIP-DOC

WWW.GOSEESAM.COM

We hope that you continue to see us for your ongoing primary care needs, and more!

Benefits of virtual primary care with UCM Digital Health:

- **Fast:** Appointments available within days, not weeks
- **High quality:** Dedicated time with a board-certified provider
- **Saves time:** Connect with a provider within minutes from the comfort of your home
- **Saves money:** Lower cost than an in-person office visit
- **Simplifies follow-up:** Care coordinators handle follow-ups for you, including referrals and more

DOWNLOAD THE "SAM BY UCM" MOBILE APP!

GET IT ON Google Play

Download on the App Store

TELEHEALTH FOR YOU.

Physical and mental health go hand in hand. Sam is here to help.

Access to mental health counseling is in the palm of your hand with Sam, the telehealth app from UCM Digital Health.

You now have access to confidential mental health counseling and care coordination through UCM's telehealth service.

This service is to help you manage your overall well-being and is available to you and your immediate family members for help with:

- Alcohol and drug abuse
- Anxiety and depression
- Child and family issues
- Dealing with change
- Parenting and elder care
- Healthy living practices
- PTSD
- And more.

Available 24/7 via phone, mobile app or website

Confidential, treated by mental health clinicians

Paid for by employer, no co-pay or out-of-pocket cost.*

Ongoing care, direct referrals for further levels of care

Convenient access on mobile device via mobile app

Remember, mental health is part of overall well-being. Download the Sam app today, and have access to mental health counseling in the palm of your hand, anytime you need it.

A

SAM BY UCM MOBILE APP

GET IT ON Google Play

Download on the App Store

B

VISIT WWW.GOSEESAM.COM

SCAN CODE

C

CALL US BY PHONE

844-4-VIP-DOC

(844-484-7362)

* HDHP/HSA qualified plans have a $10 consult fee

For life-threatening situations, or if you believe you or another individual is suffering a mental health crisis or other medical emergency, call 9-1-1

Life Insurance: Guardian

Group Life Insurance

Life Insurance helps protect your family from financial risk and sudden loss of income in the event of your death.

Guarantee Issue means that the insurance company will insure you regardless of your health, provided you apply during your initial eligibility period or open enrollment. This program provides a maximum of $50,000 of Guarantee Issue and if your spouse will be guaranteed a maximum of $20,000 of group term life insurance.

$250,000 is the maximum amount of insurance available to an employee through this program (in $10,000 increments). Amounts in excess of $50,000 require Evidence of Insurability.

Your child(ren) may be insured for either $2,500, $5,000 or $10,000. The monthly cost for this amount of insurance is $.50 for $2,500, $1.00 for $5,000, or $10,000 for $2.00 per family.

Basic Group Life Insurance	
Employee Benefit *Guarantee Issue*	$50,000
Maximum Life Benefit Amount	$250,000 with approved Evidence of Insurability
Benefit Reduction	Yes: Age 65 = Reduction 65% Age 70 = Reduction 40%
Portable	Yes
Evidence of Insurability *Medical Underwriting*	Yes, if you elect over $50k

Guardian®

Your life coverage

	VOLUNTARY TERM LIFE
Employee Benefit	$10,000 increments to a maximum of $250,000. See Cost Illustration page for details.
Spouse/Domestic Partner Benefit	$5,000 increments to a maximum of $100,000. See Cost Illustration page for details.‡
Child Benefit	Your dependent children age 14 days to 26 years. $2,500 increments to a maximum of $10,000. Subject to state limits. See Cost Illustration page for details.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period**.**	We Guarantee Issue coverage up to: Employee Less than age 65 $50,000, $0, 70+ $10,000. Spouse Less than age 65 $20,000, 65-69 $10,000, $0. Dependent children $10,000.
Premiums	Increase on plan anniversary after you enter next five-year age group
Portability: Allows you to take coverage with you if you terminate employment.	Yes, with age and other restrictions
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	Yes

COMMISSION ON ECONOMIC OPPORTUNITY FOR THE GREATER CAPITAL REGION INC

ALL OTHER ELIGIBLE EMPLOYEES

Guardian®

Your life coverage

	VOLUNTARY TERM LIFE
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 65, if conditions met
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80

Subject to coverage limits

‡ **Spouse/DP coverage terminates at age 70.**

Annual Election Option allows employees to increase the amount of their life coverage without a medical exam when they re-enroll in their company's Voluntary Life plan. This option allows employees to step up to an amount of up to $50,000, up to the Guarantee Issue amount.

COMMISSION ON ECONOMIC OPPORTUNITY FOR THE GREATER CAPITAL REGION INC

ALL OTHER ELIGIBLE EMPLOYEES

Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style.

Monthly premiums displayed.

Policy Election Amount	Policy Election Cost Per Age Bracket								
Employee	**< 30**	**30–34**	**35–39**	**40–44**	**45–49**	**50–54**	**55–59**	**60–64**	**65–69†**
$10,000	$.70	$.90	$1.20	$1.90	$3.20	$5.40	$8.50	$13.10	$23.60
$20,000	$1.40	$1.80	$2.40	$3.80	$6.40	$10.80	$17.00	$26.20	$47.20
$30,000	$2.10	$2.70	$3.60	$5.70	$9.60	$16.20	$25.50	$39.30	$70.80
$40,000	$2.80	$3.60	$4.80	$7.60	$12.80	$21.60	$34.00	$52.40	$94.40
$50,000	$3.50	$4.50	$6.00	$9.50	$16.00	$27.00	$42.50	$65.50	$118.00
$60,000	$4.20	$5.40	$7.20	$11.40	$19.20	$32.40	$51.00	$78.60	$141.60
$70,000	$4.90	$6.30	$8.40	$13.30	$22.40	$37.80	$59.50	$91.70	$165.20
$80,000	$5.60	$7.20	$9.60	$15.20	$25.60	$43.20	$68.00	$104.80	$188.80
$90,000	$6.30	$8.10	$10.80	$17.10	$28.80	$48.60	$76.50	$117.90	$212.40
$100,000	$7.00	$9.00	$12.00	$19.00	$32.00	$54.00	$85.00	$131.00	$236.00
$110,000	$7.70	$9.90	$13.20	$20.90	$35.20	$59.40	$93.50	$144.10	$259.60
$120,000	$8.40	$10.80	$14.40	$22.80	$38.40	$64.80	$102.00	$157.20	$283.20
$130,000	$9.10	$11.70	$15.60	$24.70	$41.60	$70.20	$110.50	$170.30	$306.80
$140,000	$9.80	$12.60	$16.80	$26.60	$44.80	$75.60	$119.00	$183.40	$330.40
$150,000	$10.50	$13.50	$18.00	$28.50	$48.00	$81.00	$127.50	$196.50	$354.00
$160,000	$11.20	$14.40	$19.20	$30.40	$51.20	$86.40	$136.00	$209.60	$377.60
$170,000	$11.90	$15.30	$20.40	$32.30	$54.40	$91.80	$144.50	$222.70	$401.20
$180,000	$12.60	$16.20	$21.60	$34.20	$57.60	$97.20	$153.00	$235.80	$424.80
$190,000	$13.30	$17.10	$22.80	$36.10	$60.80	$102.60	$161.50	$248.90	$448.40
$200,000	$14.00	$18.00	$24.00	$38.00	$64.00	$108.00	$170.00	$262.00	$472.00
$210,000	$14.70	$18.90	$25.20	$39.90	$67.20	$113.40	$178.50	$275.10	$495.60
$220,000	$15.40	$19.80	$26.40	$41.80	$70.40	$118.80	$187.00	$288.20	$519.20
$230,000	$16.10	$20.70	$27.60	$43.70	$73.60	$124.20	$195.50	$301.30	$542.80
$240,000	$16.80	$21.60	$28.80	$45.60	$76.80	$129.60	$204.00	$314.40	$566.40
$250,000	$17.50	$22.50	$30.00	$47.50	$80.00	$135.00	$212.50	$327.50	$590.00
Policy Election Amount									
Spouse/DP									
$5,000	$.35	$.45	$.60	$.95	$1.60	$2.70	$4.25	$6.55	$11.80
$10,000	$.70	$.90	$1.20	$1.90	$3.20	$5.40	$8.50	$13.10	$23.60

COMMISSION ON ECONOMIC OPPORTUNITY FOR THE GREATER CAPITAL REGION INC

ALL OTHER ELIGIBLE EMPLOYEES

Voluntary Life Cost Illustration *continued*

	< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$15,000	$1.05	$1.35	$1.80	$2.85	$4.80	$8.10	$12.75	$19.65	$35.40
$20,000	$1.40	$1.80	$2.40	$3.80	$6.40	$10.80	$17.00	$26.20	$47.20
$25,000	$1.75	$2.25	$3.00	$4.75	$8.00	$13.50	$21.25	$32.75	$59.00
$30,000	$2.10	$2.70	$3.60	$5.70	$9.60	$16.20	$25.50	$39.30	$70.80
$35,000	$2.45	$3.15	$4.20	$6.65	$11.20	$18.90	$29.75	$45.85	$82.60
$40,000	$2.80	$3.60	$4.80	$7.60	$12.80	$21.60	$34.00	$52.40	$94.40
$45,000	$3.15	$4.05	$5.40	$8.55	$14.40	$24.30	$38.25	$58.95	$106.20
$50,000	$3.50	$4.50	$6.00	$9.50	$16.00	$27.00	$42.50	$65.50	$118.00
$55,000	$3.85	$4.95	$6.60	$10.45	$17.60	$29.70	$46.75	$72.05	$129.80
$60,000	$4.20	$5.40	$7.20	$11.40	$19.20	$32.40	$51.00	$78.60	$141.60
$65,000	$4.55	$5.85	$7.80	$12.35	$20.80	$35.10	$55.25	$85.15	$153.40
$70,000	$4.90	$6.30	$8.40	$13.30	$22.40	$37.80	$59.50	$91.70	$165.20
$75,000	$5.25	$6.75	$9.00	$14.25	$24.00	$40.50	$63.75	$98.25	$177.00
$80,000	$5.60	$7.20	$9.60	$15.20	$25.60	$43.20	$68.00	$104.80	$188.80
$85,000	$5.95	$7.65	$10.20	$16.15	$27.20	$45.90	$72.25	$111.35	$200.60
$90,000	$6.30	$8.10	$10.80	$17.10	$28.80	$48.60	$76.50	$117.90	$212.40
$95,000	$6.65	$8.55	$11.40	$18.05	$30.40	$51.30	$80.75	$124.45	$224.20
$100,000	$7.00	$9.00	$12.00	$19.00	$32.00	$54.00	$85.00	$131.00	$236.00
Policy Election Amount									
Child(ren)									
$2,500	$0.50	$0.50	$0.50	$0.50	$0.50	$0.50	$0.50	$0.50	$0.50
$5,000	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
$7,500	$1.50	$1.50	$1.50	$1.50	$1.50	$1.50	$1.50	$1.50	$1.50
$10,000	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00	$2.00

Refer to Guarantee Issue row on page above for Voluntary Life GI amounts.
Premiums for Voluntary Life Increase in five-year increments
Spouse/DP coverage premium is based on Employee age.
†Benefit reductions apply.

All Employees are eligible for the Guardian EAP program even if you do not enroll in a Guardian product

Employee Assistance Program Overview

Our comprehensive WorkLifeMatters Employee Assistance Program[1], available through Integrated Behavioral Health, provides you and your family members with confidential, personal and web-based support on a wide variety of important and relevant topics — such as stress management, dependent/elder care, nutrition, fitness, and legal and financial issues.

Employee assistance program (EAP) consultative services

- **Telephonic Counseling** — Unlimited, 24/7 consultations with master's and doctoral-level counselors
- **Face-to-face Counseling** — Up to 3 visits per employee/household member per year
- **Bereavement** — Support available through telephonic or face-to-face sessions; online resources available on EAP website
- **Tobacco Cessation Coaching** — Unlimited telephonic support and resources to assist with tobacco cessation; refers members directly to the American Lung Association's Quit program
- **EAP Website Resources** — Comprehensive website that includes articles, videos, FAQs, etc.; additionally, individuals can chat online with an EAP Consultant or email an EAP Counselor through the website
- **College Planning Resources** — Expert assistance in finding the right college that fits your child academically, socially and financially, provided by College Planning USA

Work/life assistance & resources

- **WorkLife Services** — Unlimited 24/7 access to WorkLife Specialists (subject matter experts) in the areas of: family and care giving, health and wellness, emotional well-being, daily living, and balancing work/life responsibilities
- **Child and Elder Care Referral** — Unlimited telephonic consultation with a WorkLife Specialist (part of WorkLife Services)
- **Employee Discounts** — Access to discounts on a large number of products and services, from gym memberships to dental, vision and pharmacy items, entertainment, restaurants, computers, cars, and much more
- **Webinars, Podcasts, Articles and FAQs** — Various topics available on the EAP website

Legal/financial assistance & resources

- **Legal Consultation** — Unlimited telephonic support and free initial 30 minute face-to-face consultation with an attorney, includes a 25% discount on attorney services thereafter; online legal forms; extensive online law library
- **Financial Consultation** — Unlimited telephonic support for financial problems or planning needs; 30 days of financial coaching; extensive online financial library and calculators
- **ID Theft** — Free consultation with a trained Fraud Resolution Specialist that will assist with ID theft resolution and education; ID theft educational materials available online
- **Will Prep** — Online self-service documents available on EAP website; 30 minute consultation (part of Legal Consultation offering) can be used for estate planning/will preparation
- **Legal Document Preparation** — Online self-service documents available on the EAP website
- **Tax Consultation** — Tax questions only can be answered as part of the Financial Consultation offering
- **Online Self-Service Documents** — Examples include, but are not limited to: Living Trust, Will, Power of Attorney, Deeds

Ibhworklife.com

User Name: Matters
Password: wlm70101
Phone: 1 800 386 7055
Available 24 hours a day, 7 days a week[2]

The Guardian Life Insurance Company of America

guardianantytime.com

New York, NY

2018-58488 (04-20)

[1] WorkLifeMatters Program services are provided by Integrated Behavioral Health, Inc., and its contractors. Guardian does not provide any part of WorkLifeMatters program services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the WorkLifeMatters program at any time without notice. Legal services provided through WorkLifeMatters will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer. WorkLifeMatters Program is not an insurance benefit and may not be available in all states.
[2] Office hours: Monday-Friday 6 a.m.–5 p.m. PST.

We're in Your Community.

To learn more about health insurance for your child or any family member, visit one of our convenient community offices. Here, you can:

- **Meet with a friendly and knowledgeable Representative about your health insurance options**
- **Get help applying for enrollment (for eligible individuals)**
- **Receive assistance in finding a provider**

(For more information about Fidelis Care's provider network, including available providers in your area, review our provider directory at **fideliscare.org.**)

Visit **fideliscare.org/offices** to find the community office closest to you!

Joshua DeMarsh | Health Benefit Representative/Fidelis Care
Cellphone: 518-859-1974 call or text
Email: joshua.demarsh@fideliscare.org

FIDELIS CARE®

Fidelis Care offers quality, affordable health insurance for qualifying children and adults of all ages through Qualified Health Plans and the New York State-sponsored Child Health Plus, Essential Plan, and Medicaid programs.

nystateofhealth™
The Official Health Plan Marketplace

To learn more about applying for health insurance, including Medicaid, Child Health Plus, Essential Plan, and Qualified Health Plans through NY State of Health, The Official Health Plan Marketplace, visit www.nystateofhealth.ny.gov or call 1-855-355-5777.

To learn more about specific benefits inclusions and exclusions, please request a Summary of Benefits from Fidelis Care Member Services at **1-888-FIDELIS (1-888-343-3547)** or visit our website at **www.fideliscare.org**. To learn about utilization management procedures and more detailed plan information, please request a copy of our Member Contract(s) and/or Member Handbook. Our Member Service Representatives are also available to answer any questions or walk you through the suggested documents.

Privacy: Maintaining our members' privacy is paramount to the Fidelis Care mission. If you would like to know more about how Fidelis Care keeps health information private and secure, please visit our website at **https://www.fideliscare.org/PrivacyPolicy.aspx** to review our Privacy Policy and Member Rights and Responsibilities Statement. Fidelis Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Fidelis Care cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.
Fidelis Care 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-343-3547 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-343-3547 (TTY: 711)。

1-888-FIDELIS • fideliscare.org
(1-888-343-3547) TTY: 711
@fideliscare

Let's get every child covered.

FIDELIS CARE®

Child Health Plus
New York State's Health Plan for Kids

There are more than 100,000 uninsured children in New York State.

We want everyone to know that learning about quality, free or low-cost health insurance is just a call, click, or visit away.

More than

80,000

quality providers in Fidelis Care's Statewide network!

Quality, free or low-cost health insurance for children under 19.

No copays or deductibles!

Children in New York State may be eligible for Child Health Plus, regardless of immigration status or income.*

*Children who are Medicaid eligible, have health insurance, or access to NYSHIP are not eligible for Child Health Plus.

Child Health Plus with Fidelis Care.

Through the New York State-sponsored Child Health Plus (CHPlus) program, Fidelis Care provides quality, free or low-cost health insurance coverage for children under 19.

Covered Benefits include:

- **Checkups and well child visits**
- **Immunizations**
- **X-rays and lab tests**
- **Hospital and emergency care**
- **Prescription drug coverage**
- **Vision and dental care**
- **Hearing services**
- **Occupational, speech, and physical therapy****

** Some limits may apply.

Coverage is FREE or Low Cost!

Your child may be eligible for coverage no matter how much income you make.

Apply for Enrollment All Year Long.

For eligible individuals, apply through NY State of Health at **www.nystateofhealth.ny.gov**

FIDELIS CARE®

Let's get every child covered.

CHILD HEALTH PLUS

www.health.ny.gov website is still reflecting 2023 rates. Contact Gallagher to be put in contact with our Fidelis rep who can assist with Medicaid, CHP, and Fidelis plans and verifying eligibility/help with enrollment.

To be eligible for either Children's Medicaid or Child Health Plus, children must be under the age of 19 and be residents of New York State. Whether a child qualifies for Children's Medicaid or Child Health Plus depends on gross family income. Children who are not eligible for Medicaid can enroll in Child Health Plus if they don't already have health insurance and are not eligible for coverage under the public employees' state health benefits plan. Check the following income charts to see whether your child qualifies for Child Health Plus or Children's Medicaid.

There is no monthly premium for families whose income is less than 2.2 times the poverty level. That's about $1150 a week for a three-person family, about $1387 a week for a family of four. Families with somewhat higher incomes pay a monthly premium of $15, $30, $45, or $60 per child per month, depending on their income and family size. For larger families, the monthly fee is capped at three children. If the family's income is more than 4 times the poverty level, they pay the full monthly premium charged by the health plan. There are no co-payments for services under Child Health Plus, so you don't have to pay anything when your child receives care through these plans.

To see whether you would have to pay a premium for coverage, consult the Child Health Plus eligibility tables below.

Child Health Plus
2023 Federal Poverty Levels

Family Contributions	MONTHLY INCOME FOR FAMILY SIZE*								
	1	2	3	4	5	6	7	8	Each Additional Person, Add:
Free Insurance	$2,698	$3,649	$4,600	$5,550	$6,501	$7,452	$8,403	$9,354	$951
$15 Per Child Per Month (Max of $45 per family)	$3,038	$4,109	$5,180	$6,250	$7,321	$8,392	$9,463	$10,534	$1,071
$30 Per Child Per Month (Max of $90 per family)	$3,645	$4,930	$6,215	$7,500	$8,785	$10,070	$11,355	$12,640	$1,285
$45 Per Child Per Month (Max of $135 per family)	$4,253	$5,752	$7,251	$8,750	$10,250	$11,749	$13,248	$14,747	$1,500
$60 Per Child Per Month (Max of $180 per family)	$4,860	$6,574	$8,287	$10,000	$11,714	$13,427	$15,140	$16,854	$1,714
Full Premium Per Child Per Month	Over $4,860	Over $6,574	Over $8,287	Over $10,000	Over $11,714	Over $13,427	Over $15,140	Over $16,854	Over $1,714

* Pregnant Women: Household size calculation includes all expected children.

* Pregnant Women: Household size calculation includes all expected children.

Children's Medicaid
2023 Federal Poverty Levels

Age Categories for Children	Monthly Income for Family Size								
	1	2	3	4	5	6	7	8	Each Additional Person, Add:
Children under 1 Year; Pregnant Woman*	$2,710	$3,665	$4,620	$5,575	$6,531	$7,486	$8,441	$9,396	$956
Children 1 - 18 Years	$1,872	$2,531	$3,191	$3,850	$4,510	$5,170	$5,829	$6,489	$660

AFLAC CHOICE

FIXED INDEMNITY HOSPITAL CONFINEMENT INDEMNITY INSURANCE – OPTION 1

Policy NYB40100; Riders NYB40050 and NYRB40051

HC

Life is full of tough choices, but this isn't one of them.

Aflac Choice makes selecting the right coverage easier and less stressful. With your trusted Aflac agent you can tailor Aflac Choice to meet your specific needs and enhance your existing coverage. Choose the options you want and ignore the rest.

Here's how we can help

Aflac Choice offers our best selection of hospital-related benefits to help with the expenses not covered by major medical, which can help prevent high deductibles and out-of-pocket expenses from derailing your life plans.

If choosing the right coverage has given you one giant headache in the past, don't worry. We're here to help.

Why Aflac Choice may be the right policy for you

- It's customizable. You choose the plan that's right for you based on your specific needs. It also works well with our other products.
- Guaranteed-issue options available—that means there is no medical questionnaire required.*
- We pay cash directly to you (unless otherwise assigned)—not the doctor or hospital.

*Payment of claims is subject to all policy limitations and exclusions and pre-existing condition limitations.

Aflac herein means American Family Life Assurance Company of New York.

Understand the difference Aflac makes in your financial security.

Aflac pays cash benefits directly to you, unless otherwise assigned, for covered hospital expenses. We provide you with financial resources to help you overcome some of the unexpected expenses associated with a visit to the hospital, giving you less to worry about so you can focus your energy on getting better.

How it works

AFLAC CHOICE FIXED INDEMNITY HOSPITAL CONFINEMENT INDEMNITY INSURANCE - OPTION 1

POLICYHOLDER FEELS A SHARP PAIN IN HIS RIGHT SIDE AND DECIDES TO VISIT HIS URGENT CARE CLINIC FOR CARE.

DOCTOR DIAGNOSES APPENDICITIS, SENDS PATIENT TO HOSPITAL BY AMBULANCE.

PATIENT HAS LAB TEST AND DIAGNOSTIC EXAM IN HOSPITAL ER. UNDERGOES SURGERY AND RELEASED AFTER 3 DAYS.

Choice 1	Choice 2	Choice 3	Choice 4
$1,750	**$2,250**	**$2,160**	**$2,660**
Aflac Choice Policy	**Policy + Hospital Stay and Surgical Care Rider**	**Policy + Extended Benefits Rider**	**Policy + Both Riders**

The above example is based on four scenarios. **Choice 1 Scenario:** Policyholder has the Aflac Choice policy only; includes a Hospital Emergency Room Benefit of $150 (1 day), a Daily Hospital Confinement Benefit of $100 (2 days), and an Annual Hospital Admission Benefit of $1,500. **Choice 2 Scenario:** Policyholder has the Aflac Choice policy plus the Hospital Stay and Surgical Care Rider; includes the benefit amounts from Choice 1 Scenario (shown above), plus a Surgery Benefit (appendectomy) of $200 and a Daily Hospital Confinement Benefit of $300 (hospitalized for 3 days). **Choice 3 Scenario:** Policyholder has the Aflac Choice policy plus the Extended Benefits Rider; includes the benefit amounts from Choice 1 Scenario (shown above), plus a Physician Visit Benefit of $25, a Laboratory Test and X-Ray Benefit of $35, a Medical Diagnostic and Imaging Exams Benefit of $150, and an Ambulance Benefit of $200 (ground). **Choice 4 Scenario:** Policyholder has the Aflac Choice policy plus both the Extended Benefits Rider and the Hospital Stay and Surgical Care Rider; includes the benefit amounts from Choice 1 Scenario (shown above), plus a Physician Visit Benefit of $25, a Laboratory Test and X-Ray Benefit of $35, a Medical Diagnostic and Imaging Exams Benefit of $150, an Ambulance Benefit of $200 (ground), a Surgery Benefit (appendectomy) of $200, and a Daily Hospital Confinement Benefit of $300 (hospitalized for 3 days).

Benefits and/or premiums may vary based on state and benefit option selected. The policy has limitations, exclusions, and pre-existing condition limitations that may affect benefits payable. Riders are available for an additional cost. The policy may contain a waiting period. This brochure is for illustrative purposes only. Refer to the policy for benefit details, definitions, limitations and exclusions.

For more information, ask your insurance agent/producer, call 1.800.992.3522, or visit aflac.com.

Benefits overview Choose the Policy and Riders that Fit Your Needs

BENEFIT:	DESCRIPTION:
DAILY HOSPITAL CONFINEMENT	Pays $50 per day, per covered person, for up to 365 days.
ANNUAL HOSPITAL ADMISSION	Pays $500; $1,000; $1,500; or $2,000. You choose the benefit amount at the time of application. Payable once per period of hospital confinement, per calendar year, per covered person.
REHABILITATION FACILITY	Pays $100 per day; limited to 15 days per confinement. Limited to 30 days per calendar year, per covered person.
HOSPITAL EMERGENCY ROOM	Pays $150 per day for treatment in a hospital emergency room. Limited to 2 payments per calendar year, per covered person.
HOSPITAL SHORT-STAY	Pays $100 for hospital stays of less than 23 hours. Limited to 2 payments per calendar year, per policy.
WAIVER OF PREMIUM	Yes
CONTINUATION OF COVERAGE	Yes
OPTIONAL RIDERS:	**DESCRIPTION:**
EXTENDED BENEFITS RIDER	**Physician Visit Benefit:** Pays $25 per day for visits to a physician, psychologist or urgent care center. **Individual Coverage:** Limited to 3 visits per calendar year, per policy. / **Insured/Spouse & Family Coverage:** Limited to 6 visits per calendar year, per policy. **Laboratory Test and X-Ray Benefit:** Pays $35 per day; limited to 2 payments per covered person, per calendar year. **Medical Diagnostic and Imaging Exams Benefit:** Pays $150 per day for a covered exam, limited to 2 exams per covered person, per calendar year. Benefits payable for a variety of medical diagnostic and imaging exams, including sleep studies. **Ambulance Benefit:** Pays $200 per day (ground) or $2,000 per day (air) for transportation to or from a hospital. The benefit is limited to two trips, per calendar year, per covered person.
HOSPITAL STAY AND SURGICAL CARE RIDER	**Surgery Benefit:** Pays $50-$1,000 for a covered surgery. Limited to one payment per 24-hour period, per covered person. **Invasive Diagnostic Exams Benefit:** Pays $100 per day for one covered exam, per covered person, per 24-hour period. **Hospital Intensive Care Unit Confinement Benefit:** Pays $500 per confinement, per covered person. **Daily Hospital Confinement Benefit:** Pays $100 per day, per covered person, for up to 365 days. **Second Surgical Opinion Benefit:** Pays $50 once per covered person, per calendar year.

Refer to the disclosure statement and policy for complete benefit details, definitions, limitations and exclusions.

Understand the difference Aflac can make in your financial security.

Aflac pays cash benefits for covered accidental injuries directly to you, unless assigned. Your own peace of mind and the assurance that your family will have help financially are powerful reasons to consider Aflac.

The financial impact of an accident is often surprising. Most people have expenses after an accident they never thought of before. From out-of-pocket medical costs to a temporary loss of income, your finances may be strained. If you or a family member suffered an accidental injury, can your finances handle it?

What does the Aflac Accident Advantage policy include?

- Benefits payable for fractures, dislocations, lacerations, concussions, burns, emergency dental work, eye injuries, and surgical procedures.
- Benefits payable for initial treatment, X-rays, major diagnostic exams, and follow-up treatments.
- Benefits payable for physical, speech, and occupational therapy.
- Daily hospitalization benefits payable for hospital stays, and additional daily benefits paid for stays in a hospital intensive care unit.

Why Aflac Accident Advantage may be the right choice for you:

- No underwriting questions to answer[1]
- No coordination of benefits—we pay regardless of any other insurance you may have
- No network restrictions—you choose your own health care provider
- Portable—take the plan with you if you change jobs or retire
- 24-hour accident insurance

How it works

AFLAC ACCIDENT ADVANTAGE

AFLAC ACCIDENT ADVANTAGE – OPTION 3 COVERAGE IS SELECTED

WHILE PLAYING IN THE STATE HOCKEY PLAYOFFS, YOUR CHILD WAS INJURED AND WAS TAKEN TO THE ER BY AMBULANCE.

HIS LEG IS BROKEN AND SURGERY IS PERFORMED.

AFLAC ACCIDENT ADVANTAGE – OPTION 3 COVERAGE PROVIDES THE FOLLOWING:

$4,710

TOTAL BENEFITS

The above example is based on a scenario for the Aflac Accident Advantage – Option 3 that includes the following benefit conditions: Ambulance Benefit of $200 (ground ambulance transportation); Accident Treatment Benefit of $220 (hospital emergency room treatment with X-rays); Accident Specific-Sum Injuries Benefit of $1,750 (fractured leg {femur}–open reduction under anesthesia); Initial Accident Hospitalization Benefit of $1,000; Accident Hospital Confinement Benefit of $165 (hospitalized for 1 day); Major Diagnostic and Imaging Exams Benefit of $200 (CT scan); Appliances Benefit of $300 (wheelchair); Therapy Benefit of $450 (9 physical therapy treatments); Accident Follow-Up Treatment Benefit of $300 (6 follow-up treatments); and Family Lodging Benefit of $125 (hospital and motel/hotel more than 50 miles from residence).

Benefits and/or premium may vary based on state and benefit option selected. The policy has limitations and exclusions that may affect benefits payable. Riders are available for an additional cost. For costs and complete details of the coverage, contact your Aflac insurance agent/producer. This brochure is for illustrative purposes only. Refer to the disclosure statement and policy for complete benefit details, definitions, limitations and exclusions.

[1]Association and associate-only accounts have one underwriting question. Payment of claims is subject to all policy limitations and exclusions and pre-existing condition limitations.

AFLAC ACCIDENT ADVANTAGE – OPTION 3 BENEFIT OVERVIEW

BENEFIT NAME	BENEFIT AMOUNT
INITIAL ACCIDENT HOSPITALIZATION BENEFIT	$1,000 when admitted for a hospital confinement of at least 18 hours or $2,000 when admitted directly to an intensive care unit of a hospital for a covered accident, per calendar year, per covered person
ACCIDENT HOSPITAL CONFINEMENT BENEFIT	$165 per day, up to 365 days per covered accident, per covered person
INTENSIVE CARE UNIT CONFINEMENT BENEFIT	$640 per day for up to 15 days, per covered accident, per covered person
ACCIDENT TREATMENT BENEFIT	Payable once per 24-hour period and only once per covered accident, per covered person Hospital emergency room with X-ray: $220 Hospital emergency room without X-ray: $170 Office or facility (other than a hospital emergency room) with X-ray: $170 Office or facility (other than a hospital emergency room) without X-ray: $120
AMBULANCE BENEFIT	$200 ground ambulance transportation or $1,500 air ambulance transportation
BLOOD/PLASMA/PLATELETS BENEFIT	$250 once per covered accident, per covered person
MAJOR DIAGNOSTIC AND IMAGING EXAMS BENEFIT	$200 per calendar year, per covered person
ACCIDENT FOLLOW-UP TREATMENT BENEFIT	$50 for one treatment per day (up to a max of 6 treatments), per covered accident, per covered person
THERAPY BENEFIT	$50 for one treatment per day (up to a max of 10 treatments), per covered accident, per covered person
APPLIANCES BENEFIT	Benefits are payable for the medical appliances listed below: Back brace: $300 · Body jacket: $300 · Knee scooter: $300 · Wheelchair: $300 · Leg brace: $125 · Crutches: $100 · Walker: $100 · Walking boot: $100 · Cane: $25 Payable once per covered accident, per covered person
PROSTHESIS BENEFIT	$800 once per covered accident, per covered person
PROSTHESIS REPAIR OR REPLACEMENT BENEFIT	$800 once per covered person, per lifetime
REHABILITATION FACILITY BENEFIT	$150 per day
HOME MODIFICATION BENEFIT	$3,000 once per covered accident, per covered person
ACCIDENT SPECIFIC-SUM INJURIES BENEFITS	Pays benefits for the treatments listed below: DISLOCATIONS.....$100–$3,750 BURNS.....$125–$12,500 SKIN GRAFTS..... 50% of the burns benefit amount paid for the burn involved EYE INJURIES Surgical repair.....$300 Removal of foreign body by a physician.....$65 LACERATIONS Not requiring sutures.....$35 Less than 5 centimeters.....$65 At least 5 cm but not more than 15 cm.....$250 Over 15 centimeters.....$500 FRACTURES.....$125–$3,500 CONCUSSION (BRAIN).....$150 EMERGENCY DENTAL WORK Broken tooth repaired with crown.....$400 Broken tooth resulting in extraction.....$130 PARALYSIS Quadriplegia.....$12,500 Paraplegia.....$6,250 Hemiplegia.....$4,750 SURGICAL PROCEDURES.....$200–$1,250 MISCELLANEOUS SURGICAL PROCEDURES.....$120–$300 PAIN MANAGEMENT (NON-SURGICAL) Epidural.....$100

ACCIDENTAL-DEATH BENEFIT	Common-Carrier Accident	Other Accident
INSURED	$150,000	$40,000
SPOUSE	$150,000	$40,000
CHILD	$25,000	$10,000

ACCIDENTAL-DISMEMBERMENT BENEFIT	$300–$40,000
CONTINUATION OF COVERAGE BENEFIT	Waives all monthly premiums for up to two months, if conditions are met
WAIVER OF PREMIUM BENEFIT	Yes
TRANSPORTATION BENEFIT	$600 per round trip, up to 3 round trips per calendar year, per covered person
FAMILY LODGING BENEFIT	$125 per night, up to 30 days per covered accident

REFER TO THE DISCLOSURE STATEMENT AND POLICY FOR COMPLETE BENEFIT DETAILS, DEFINITIONS, LIMITATIONS AND EXCLUSIONS.

AFLAC CANCER CARE

SPECIFIED-DISEASE INSURANCE

Policy NY78300

CC CLASSIC

Added Protection for You and Your Family

Chances are you know someone who's been affected, directly or indirectly, by cancer. You also know the toll it's taken on them—physically, emotionally, and financially. That's why we've developed the Aflac Cancer Care insurance policy. The plan pays a cash benefit upon initial diagnosis of a covered cancer, with a variety of other benefits payable throughout cancer treatment. You can use these cash benefits to help pay out-of-pocket medical expenses, the rent or mortgage, groceries, or utility bills—the choice is yours.

And while you can't always predict the future, here at Aflac we believe it's good to be prepared. The Aflac Cancer Care plan is here to help you and your family better cope financially—and emotionally—if a positive diagnosis of cancer ever occurs. That way you can worry less about what may be ahead.

HOW IT WORKS

AFLAC CANCER CARE - CLASSIC coverage is selected.

Policyholder suffers from frequent infections & high fevers.

Physician visit & bone marrow biopsy reveals diagnosis of leukemia.

AFLAC CANCER CARE - CLASSIC insurance policy provides the following:

$27,175
TOTAL BENEFITS

The above example is based on a scenario for Aflac Cancer Care – Classic that includes the following benefit conditions: Physician visit (Cancer Wellness Benefit) of $75, bone marrow biopsy (Surgical/Anesthesia Benefit) of $125, National Cancer Institute Evaluation/Consultation Benefit of $500, Initial Diagnosis Benefit of $4,000, venous port (Surgical/Anesthesia Benefit) of $125, Injected Chemotherapy Benefit (10 weeks) of $6,000, Immunotherapy Benefit (3 months) of $1,050, Antinausea Benefit (3 months) of $300, Hospital Confinement Benefit (10-week hospitalization) of $14,000, Blood/Plasma Benefit (10 transfusions) of $1,000.

THE FACTS SAY YOU NEED THE PROTECTION OF AFLAC'S CANCER CARE PLAN:

FACT NO. 01

IN THE UNITED STATES, MEN HAVE SLIGHTLY LESS THAN A

1-in-2

LIFETIME RISK OF DEVELOPING CANCER.[1]

FACT NO. 02

IN THE UNITED STATES, WOMEN HAVE SLIGHTLY MORE THAN A

1-in-3

LIFETIME RISK OF DEVELOPING CANCER.[1]

[1] *Cancer Facts & Figures 2012,* American Cancer Society.

The policy has limitations and exclusions that may affect benefits payable. For costs and complete details of the coverage, contact your Aflac insurance agent/producer. This brochure is for illustrative purposes only. Refer to the policy for benefit details, definitions, limitations, and exclusions.

Aflac herein means American Family Life Assurance Company of New York.

Classic Cancer Care Benefit Overview

BENEFIT NAME	BENEFIT AMOUNT
Cancer Wellness Benefit	$75 per year, per Covered Person
Cancer Diagnosis Benefits:	
Initial Diagnosis Benefit	Insured/Spouse: $4,000; Dependent Child: $8,000; payable once per Covered Person
Medical Imaging With Diagnosis Benefit	$135; two payments per year, per Covered Person; no lifetime max
NCI Evaluation/Consultation Benefit	$500 payable only once per Covered Person
Cancer Treatment Benefits:	
Injected Chemotherapy Benefit	$600 per day; limited to one payment per week; no lifetime max
Oral Chemotherapy Benefit	$250 per day up to $750 max per month for Oral/Topical Benefit[2]
Topical Chemotherapy Benefit	$150 per prescription, per month up to $750 max per month for Oral/Topical Benefit[2]
Radiation Therapy Benefit	$350 per day; limited to one payment per week; no lifetime max
Experimental Treatment Benefit	$350 per week outside of a clinical trial; $100 per week as part of a clinical trial; no lifetime max
Immunotherapy Benefit	$350 once per month; $1,750 lifetime max per Covered Person
Antinausea Benefit	$100 per month; no lifetime max
Stem Cell Transplantation Benefit	$7,000; lifetime max $7,000 per Covered Person
Bone Marrow Transplantation Benefit	$7,000; $7,000 lifetime max per Covered Person; $750 to donor
Blood and Plasma Benefit	Inpatient: $100 times the number of days paid under the Hospital Confinement Benefit; Outpatient: $175 per day; no lifetime max
Surgical/Anesthesia Benefit	$100–$3,400 (Anesthesia: additional 25% of Surgical Benefit); maximum daily benefit not to exceed $4,250; no lifetime max on number of operations
Skin Cancer Surgery Benefit	$35–$400; no lifetime max on number of operations
Additional Surgical Opinion Benefit	$200 per day; no lifetime max
Hospitalization Benefits:	
Hospital Confinement Benefit	$200 per day; no lifetime max
Outpatient Hospital Surgical Room Benefit	$200 (payable in addition to Surgical/Anesthesia Benefit); no lifetime max on number of operations
Continuing Care Benefits:	
Extended-Care Facility Benefit	$100 a day, limited to 30 days per year, per Covered Person
Home Health Care Benefit	$50 per day; lifetime max of 100 days per Covered Person
Hospice Care Benefit	$1,000 for the 1st day; $50 per day thereafter; $12,000 lifetime max per Covered Person
Nursing Services Benefit	$100 per day; no lifetime max
Surgical Prosthesis Benefit	$2,000; lifetime max $4,000 per Covered Person
Nonsurgical Prosthesis Benefit	$175 per occurrence; lifetime max $350 per Covered Person
Reconstructive Surgery Benefit	$220–$2,000 (Anesthesia: 25% of Reconstructive Surgery Benefit); no lifetime max on number of operations
Egg Harvesting and Storage (Cryopreservation) Benefit	$1,000 to have oocytes extracted; $350 for storage; $1,350 lifetime max per Covered Person
Ambulance, Transportation, Lodging, and Other Benefits:	
Ambulance Benefit	$250 ground or $2,000 air; no lifetime max
Transportation Benefit	$.40 per mile; max $1,200 per round trip; no lifetime max
Lodging Benefit	$65 per day; limited to 90 days per year
Bone Marrow Donor Screening Benefit	$40; limited to one benefit per Covered Person, per lifetime

[2]Up to three different oral/topical chemotherapy medicines per calendar month.

REFER TO THE FOLLOWING DISCLOSURE STATEMENT FOR BENEFIT DETAILS, DEFINITIONS, LIMITATIONS, AND EXCLUSIONS.

AFLAC SHORT-TERM DISABILITY INCOME INSURANCE

Policy NY57600; Riders NY57650 and NY57651

SD

Helping Pay Your Bills, While You Pay Attention to You

What if one day, not very far in the future, you become disabled and you can't go to work. How would you pay for the expenses of daily life such as monthly mortgage or rent, groceries and your utilities? The bills keep on coming even if you're unable to work. That's where Aflac's short-term disability insurance policy can help make the difference. It's a source of monthly income you may need to help take care of your bills while you take care of yourself.

Why Aflac Short-Term Disability may be the best choice for you:

- It's sold on an individual basis. You choose the plan that's right for you based on your financial needs and income.
- We offer the option of guaranteed-issue,[1] short-term disability coverage. That means no medical questionnaire is required.
- We pay you a cash benefit for each day you are disabled.[2]

Here's how we can help

When disabled, you may not only lose the ability to earn a living, but you may also lose savings or retirement funds. The financial obligations can be overwhelming. Disability insurance plays an integral and important role in your financial planning.

Aflac provides benefits for both total and partial disability. Even if you're able to work, partial disability benefits may be available to help compensate for lost income.

Aflac does not coordinate benefits. Regardless of any other disability insurance you may have, including Social Security, we will pay you directly.

The facts say you need the protection of the Aflac Short-Term Disability plan:

FACT NO. 1

BEFORE THEY RETIRE, **1-in-4** AMERICANS ENTERING THE WORKFORCE WILL BECOME DISABLED.[3]

FACT NO. 2

NEARLY **90%** OF DISABILITIES ARE NOT WORK RELATED.[3]

[1]Subject to certain conditions.
[2]Subject to your benefit period and elimination period.
[3]2015 Disability Insurance Awareness Month, Facts from LIMRA.

Understand the difference Aflac makes in your financial security.

Aflac pays cash benefits directly to you, unless you choose otherwise. This means that you will have added financial resources to help with expenses incurred due to medical treatment, ongoing living expenses or any purpose you choose.

Coverage Options

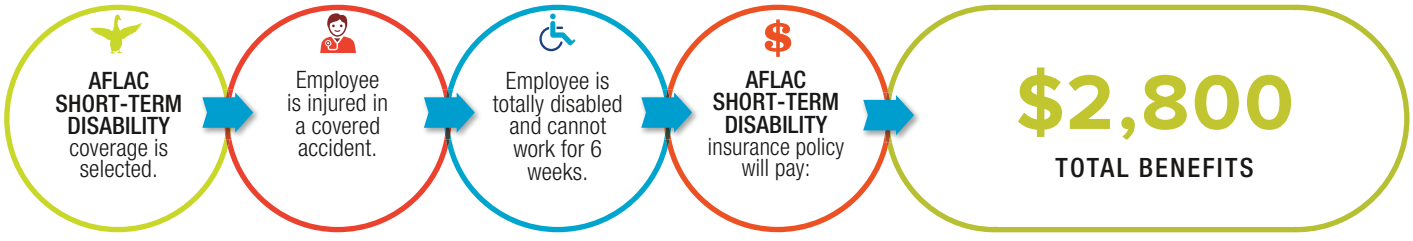
Choose the Policy You Need

BENEFIT	DESCRIPTION
MONTHLY BENEFIT PAYMENT	$400 to $6,000 (subject to income requirements)
TOTAL DISABILITY BENEFIT PERIODS	3, 6, 12, 18 or 24 months
PARTIAL DISABILITY BENEFIT PERIOD	3 months
ELIMINATION PERIODS (INJURY/SICKNESS)	0/7, 0/14, 7/7, 7/14, 14/14, 0/30, 30/30, 60/60, 90/90, 180/180
WAIVER OF PREMIUM	Premium waived, month to month, for policy and any applicable rider(s) for as long as you remain disabled, up to the applicable benefit period shown in the Policy Schedule. Not available with a 3-month total disability benefit period.
OPTIONAL RIDERS	
DISABILITY BENEFIT FOR ON-THE-JOB INJURY RIDER	Provides benefits if a disability is caused by a covered on-the-job injury while coverage is in force. Available even with Workers' Compensation.* Benefits payable up to the total disability benefit period selected. Benefit subject to elimination period shown in the Policy Schedule and income requirements.
ADDITIONAL UNITS OF DISABILITY BENEFIT RIDER	Allows you to purchase additional units of disability coverage to add to your existing short-term disability policy. Subject to income requirements.

All benefits are subject to the Limitations and Exclusions, Pre-existing Condition Limitations and other policy terms.

*Subject to certain conditions/maximum.

How it works



The above example is based on a scenario for Aflac Short-Term Disability that includes the following benefit conditions: ages 18–49, employed full-time at the time disability began, $2,000** monthly disability benefit amount, $40,000 annual salary, not covered by a state disability plan, elimination period 0/7 days, 3 month benefit period, benefits based on policy premiums being paid with after-tax dollars.

The policy has limitations and exclusions that may affect benefits payable. For costs and complete details of the coverage, contact your Aflac insurance agent/producer. This brochure is for illustrative purposes only. Refer to the disclosure statement and policy for complete benefit details, definitions, limitations, and exclusions.

**The monthly disability benefit may be limited if covered by a state disability plan.

Gallagher

Insurance | Risk Management | Consulting

Ask Your Advocate Team

Maximize your healthcare benefits with a team of licensed healthcare advocates.

Gallagher is ready to help you get the most from your benefits program by providing support from an advocate at no cost to you. Get assistance with:

1. **Insurance cards**
   Are you missing your insurance cards, need replacement cards or need to get in touch with an insurance carrier?
2. **Benefits questions**
   Do you need help with specific benefits questions relating to how plans work, coverage questions or in-network benefits?
3. **Eligibility rules**
   Who can be covered under the plan and when?
4. **Provider search**
   Do you need help finding an in-network or specialty provider?
5. **Prescription/pharmacy issues**
   Is the pharmacy telling you that your medication is not covered or charging you full price? Do you need help getting a pre-authorization on your medication?
6. **Claim/complex issues**
   Are you unsure if your insurance will pay for a certain procedure? Do you have a complex situation and need assistance with an appeal, billing coding issue, or out-of-network claim?
7. **Nurse advocacy**
   Do you need assistance with a medical diagnosis, treatment options, pre-authorization issue, specific benefits or drug denial?

Hours of Operation

Monday – Friday
5 a.m.–6 p.m. PT

Connect With Us

Commission On Economic Opportunity

(888) 819-3011
bac.ceo@ajg.com

AJG.com **The Gallagher Way.** Since 1927.

All employees should be utilizing the Benefit Advocacy Center (BAC) for all ID requests, claims issues, help finding a provider, and benefit questions. If there is a time sensitive or escalated issue please reach out to your **dedicated Account Manager** for additional assistance.

Benefit Advocacy Center (BAC)
Phone: (888) 819-3011
Email: bac.ceo@ajg.com

Lindsay Hill
Phone: (518)556-3105
Email: lindsay_hill@ajg.com

Please reach out to Josh for all questions on eligibility and coverages of Child Health Plus, Medicaid, Essential Plan, and all Marketplace coverages.

Josh DeMarsh
Call or Text: (518) **859-1974**
Email: joshua.demarsh@fideliscare.org

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

Legal Notices

Patient Protections Disclosure

The CEO Health Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, CDPHP designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact CDPHP at 800-777-2273 or www.cdphp.com.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from CDPHP or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact CDPHP at 800-777-2273 or www.cdphp.com.

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

HMO : HM7L23 (Individual: 20% coinsurance and $3,000 deductible; Family: 20% coinsurance and $7,500 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 518-272-6012 or agarner@ceoempowers.org.

Newborns' and Mothers' Health Protection Act

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

Legal Notices

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

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

Legal Notices

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

Legal Notices

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs- services/medicaid/health -insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/ clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health- care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium- assistance/ famis-select https://coverva.dmas.virginia.gov/learn/premium- assistance/ health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

Legal Notices

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Legal Notices

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

CEO is committed to the privacy of your health information. The administrators of the CEO Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Alyssa Garner - HR assistant 518-272-6012 or agarner@ceoempowers.org.

HIPAA Special Enrollment Rights

CEO Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the CEO Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Alyssa Garner - HR assistant 518-272-6012 or agarner@ceoempowers.org.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Legal Notices

Notice of Creditable Coverage

Important Notice from CEO

About Your Prescription Drug Coverage and Medicare

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

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **CEO has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

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

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current CEO coverage will not be affected. You can keep the coverage if you elect Medicare Part D and this plan will coordinate with Medicare Part D coverage. You CEO coverage will be primary and your Medicare plan, secondary. If you do decide to join a Medicare drug plan and drop your current CEO coverage, be aware that you and your dependents will be able to get this coverage back, you may enroll during CEO's annual open enrollment period or due to a major life event (birth, death, marriage, divorce). If you enroll in a Medigap plan you will not be able to re-enroll.

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

You should also know that if you drop or lose your current coverage with CEO 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.

Legal Notices

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 CEO changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	**January 01, 2024**
Name of Entity/Sender:	**CEO**
Contact—Position/Office:	**Alyssa Garner - HR assistant**
Office Address:	**2331 5th Ave** **Troy, New York 12180-2221** **United States**
Phone Number:	**518-272-6012**

Notes