



2026 | All Employees

Benefits Guide

Your Benefits, Your Choice



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Disclaimer: The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Human Resources Department.

Welcome

We understand that your life extends beyond the workplace. That's why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

How to Enroll

- **Current Employees:** Open Enrollment, **which will run from November 2 – November 15, 2025**, is your once-a-year opportunity to adjust benefit coverages and update any dependents and beneficiaries.
- **New Hires:** Once eligible, you must complete your enrollment within **60** days. Some benefits have “guarantee issue” at your first opportunity only, so please carefully consider this before you decline any coverage.



Enroll through PlanSource:

Scan QR code or visit
<https://bit.ly/PTL-PS-G>

How to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within **30** days of the qualifying event. Examples include:

- Marriage, divorce, legal separation, or death of a spouse
- Birth, adoption, or death of a child
- Change in child's dependent status
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

New this Year!

Benefit Highlights

Benefit changes take effect on **01/01/2026**.



Pet
Insurance

- **Pet Insurance reimburses you for the eligible costs of accidents and illness for your pets.**
- Coverages include emergency treatments, surgeries, medications, laboratory services and more!

How to Enroll

**Enroll Online through
PlanSource:**



- 1.) Scan QR code or visit <https://bit.ly/PTL-PS-G>

Username: first letter of your first name, first six letters of your last name, and the last four digits of your SSN. (ex: Mary Thompson, SSN 123-45-6789, Username: mthomps6789)

Password: Use your birthdate in YYYYMMDD as the initial password. (ex: 19891027)

- 2.) Click "Get Started" on the Homepage.
- 3.) Review and update your profile, ensuring accuracy for yourself and family members.
- 4.) Select a plan by editing covered family members and choosing the desired plan cards. Click "Update Cart."
- 5.) Finalize choices by clicking "Review and Checkout."

Need Help?

Contact Human Resources
humanresources@ipsmgt.com



Contacts

Interstate Personnel Services Benefits Contact

HR Department 270-753-1717 humanresources@ipsmgt.com

Coverage	Carrier	Phone Number	Website/Email
Leading Edge Concierge	Leading Edge	844-335-2808	
Leading Edge MESA Portal	Leading Edge		Accessing claims information https://mesa.leadingedgeadmin.com
Medical Insurance	Anthem		Find a provider anthem.com/register
	Anthem Telemedicine	888-548-3432	Livehealthonline.com
Gap Plan	MEDlink	800-256-8606	www.ampublic.com
Pharmacy Benefit Manager	Carelon	833-267-2133	https://carelonrx.com
	Payer Matrix	877-305-6202	https://payermatrix.com
Dental Insurance	MetLife	1-800-GET-MET8	www.metlife.com
Vision Insurance			
Company-Paid Life/AD&D			
Voluntary Term Life/AD&D			
Voluntary Short-Term Disability			
Accident			
Critical Illness			
Hospital Indemnity			
Pet Insurance	One Pack Plan	1-866-774-1113	Salesupport@petpartners.com

Eligibility

Employee Eligibility

All full-time employees working 30 or more hours per week will be eligible for benefits. As a new employee, you have **60** days from your initial start date to enroll in benefits.

- **Medical, Dental, Vision:** These coverages will take effect on the **90th** day of full-time employment.
- **Life/AD&D, Voluntary Life/AD&D:** * These coverages will take effect 1st of the month following **6** months of full-time employment.
- **Other Coverages:** * All other coverages will take effect on the **90th** day of full-time employment.

* **IMPORTANT:** These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

Dependent Eligibility

If you are enrolled in coverage, you may also have the option to enroll your dependents in coverage.

Definition of “Eligible Dependents”

Medical, Dental, and Vision Coverage dependents include:

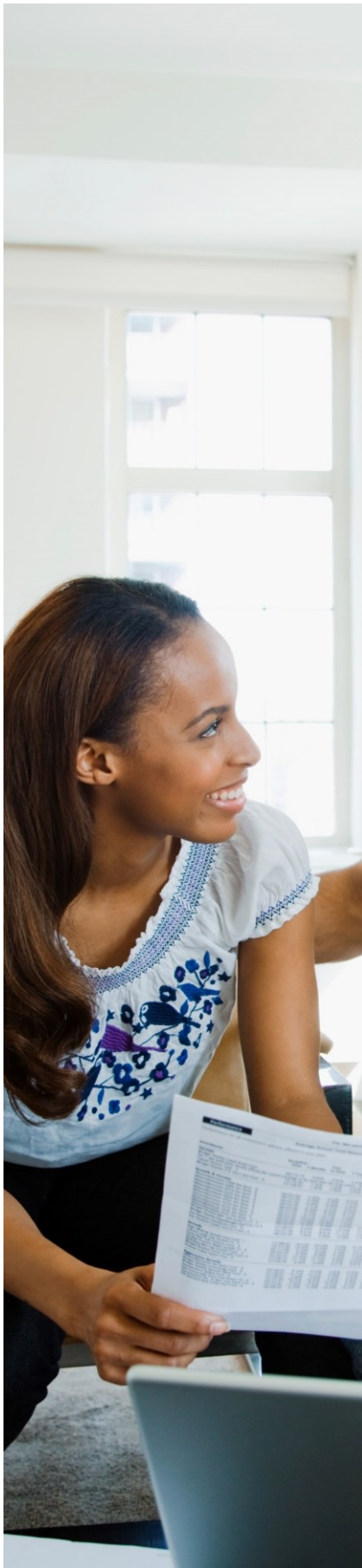
- **Your legally married spouse.** Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, “spouse” shall not mean a common law spouse or domestic partner. (If your legal spouse has medical insurance offered through his or her employer, they are not eligible for the Medical plan.)
- **Your dependent children under age 26.** This includes natural, step, foster, adopted, or other children under your legal guardianship.
- For additional eligibility details, please refer to the policy contract or summary plan documents.

Other Coverages: See page **13** for definitions of an “eligible dependent” under the Voluntary Life/AD&D Policy. Please note that benefit-eligible employees cannot be enrolled as a “spouse”, and dependent children cannot be covered more than once. Please refer to the policy certificate or HR for more information.

Working Spouse Provision

This applies only to those electing to have their spouse covered on the medical plan. If you have a spouse that has affordable coverage offered through his/her employer, they are not eligible to be covered on the Paschall medical plan.





Employee Contributions

If you elect coverage, your premiums will be conveniently deducted from your **weekly payroll deductions (52 per year)**. Please contact Human Resources regarding any questions or concerns.

Medical	PPO	HDHP HSA
Employee Only	\$65.00	\$30.00
Employee + Spouse	\$157.50	\$115.50
Employee + Child(ren)	\$115.50	\$87.15
Family	\$189.00	\$126.00

Dental	
Employee Only	\$4.55
Employee + Spouse	\$10.83
Employee + Child(ren)	\$10.83
Family	\$10.83

Vision	
Employee Only	\$1.51
Employee + Spouse	\$4.07
Employee + Child(ren)	\$4.07
Family	\$4.07

Basic Life/AD&D	Employer-provided

Gap Plan Voluntary Life/AD&D Voluntary Short-Term Disability Accident Critical Illness Hospital Indemnity	To view your personalized rates, log in to PlanSource or contact HR for details.

Medical

Leading Edge/Anthem



Locate an in-network provider near you at www.anthem.com/find-care or call 1-800-826-9781.

This coverage allows you to visit any in-network doctor or facility you choose.

Medical	PPO		HDHP HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible				
Individual	\$3,750	Not covered	\$5,000	Not covered
Family	\$7,500		\$10,000	
Coinsurance (Plan Pays/You Pay)	70%/30%	Not covered	70%/30%	Not covered
Annual Out-of-Pocket Max.				
Individual	\$8,000	Not covered	\$7,900	Not covered
Family	\$16,000		\$15,800	
Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Care	Covered 100%	Not covered	Covered 100%	Not covered
Telemedicine Visit	Covered 100% (Sydney Health services only)		Covered 100% (Sydney Health services only)	
Primary Care Office Visit	\$40		30% after deductible	
Specialist Office Visit	\$60			
Urgent Care	30% after deductible			
Emergency Room	Subject to deductible + \$250 copay (copay is waived if admitted)		30% after deductible	
Hospitalization	30% after deductible	Not covered	30% after deductible	Not covered
Prescription Drugs	In-Network	Out-of-Network	In-Network	Out-of-Network
Tier 1	\$10	Not Covered	30% after deductible	Not Covered
Tier 2	\$40			
Tier 3	\$60			
Tier 4	<i>Specialty medications are managed through Payer Matrix. Members can reach a Patient Care Coordinator at 877-305-6202 or email sales@payermatrix.com for assistance with acquiring specialty medications.</i>			

Medical Weekly Cost	PPO	HDHP HSA
Employee Only	\$65.00	\$30.00
Employee + Spouse	\$157.50	\$115.50
Employee + Child(ren)	\$115.50	\$87.15
Family	\$189.00	\$126.00

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Leading Edge

Explanation of Benefits Overview

An Explanation of Benefits (EOB) is a statement from your health insurance company providing details on payment for a medical service you received. It is not a bill, but a breakdown of the services provided and how the costs are processed according to your Healthcare insurance plans.

This illustration describes sections of an SPP EOB such as member information, service dates, member responsibility, coverage and billing amounts, and procedure codes and descriptions.

Claim Summary											
Claim Number		Patient Name		Total Charge	Ineligible Amount	Provider Discount	Covered By Plan	Deductible Amount	Patient Responsibility	Payment Amount	
224-0000XXXXXX-00		Jane Doe		\$378.00	\$156.22	\$31.50	\$346.50	\$190.28	\$346.50	\$0.00	
Totals				\$378.00	\$156.22	\$31.50	\$346.50	\$190.28	\$346.50	\$0.00	

Claim #:	224-0000XXXXXX-00	Provider:		Provider Name:		Enrollee ID:	Member ID														
Patient:	Jane Doe	Enrollee:	Employer Name																		
Dates of Service	01/11-01/11/2024	Procedure	99479	Charged Amount	\$378.00	Not Covered	\$156.22	Reason Code	SPP, 05	Provider Discount	\$31.50	Allowable Amount	\$346.50	Deductible Amount	\$190.28	Co-Pay Amount	\$0.00	Co-Insurance	\$0.00	Payment Amount	\$0.00
Column Totals				\$378.00	\$156.22	\$31.50	\$346.50	\$190.28	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		

Patient's Responsibility:		\$346.50	Other Carrier Adjustment		\$0.00	Total Payment Amount	\$0.00
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Procedures		Remarks	
Code	Description	Code	Description
99479	SUBSEQUENT INTENSIVE CARE	SPP	This service is subject to and has exceeded the maximum benefit allowable. If you have a balance billing issue, please contact Customer Service and they will work directly with providers on your behalf.
		05	PPO Discount has been applied.

Section 1
Provides the dates of service and the specific procedure code used for billing.

Section 2
These figures outline the original amount charged for the service, what part is not covered by insurance, any discounts provided by the provider and the amount that is eligible for insurance coverage.

Section 3
This section outlines what you, as the member, are responsible for based on the terms of your insurance coverage.
*If the Patient Responsibility figure exceeds the totals shown in section 3, and you receive a bill from your provider showing the same amount due as the patient responsibility, it may be due to balance billing. If this occurs, please contact your Concierge Customer Service at the number on the back of your ID Card.

Section 4
This section provides a brief description for each reason code listed.

Section 1
Provides the dates of service and the specific procedure codes used for billing.

Section 2
Outlines the original amount charged for the service, what part is not covered by insurance, and discounts provided by the providers, and the amount eligible for insurance coverage.

Section 3
Outlines what you, as the member, are responsible for based on the terms of your insurance coverage.
* If the **Patient's Responsibility** figure exceeds the totals shown in Section 3, it may include additional charges due to balance billing. If this occurs, please contact your Concierge Customer Service using the telephone number on the back of your ID card.

Section 4
Provides a brief description for each reason code listed. If there's a reference to Savings Plus Plan (SPP) on your EOB, and you are billed for the total amount in the **Patient's Responsibility** section, this is indicative of a balance bill. You are responsible for the cost share noted in Section 3. If balance bill, contact your Concierge Customer Service using the telephone number on the back of your ID card.

Leading Edge/Anthem



SPP Explanation of Benefits Overview and FAQs

Frequently Asked Questions

How do I read the *Dates of Service* on my EOB?

The *Dates of Service* column shows the range of dates during which medical services were provided to you. For instance, in the illustration provided, the services were rendered on 08/29/2023.

What does the *Procedure* column mean?

The *Procedure* column lists standardized medical codes for the services you received. Each code corresponds to a specific medical procedure or service, which helps the insurance company determine coverage and payment.

What is a *Billed Amount*?

A *Billed Amount* is the total cost billed by your healthcare provider for the services you received.

Why are some amounts listed in the *Not Covered* column?

The *Not Covered* column indicates expenses not eligible for payment under your insurance plan. This could be due to various reasons, such as services not covered by your policy or charges exceeding the usual rates.

What is a *Reason Code*?

A *Reason Code* provides an explanation for reductions or denials in coverage.

What's the significance of the *Provider Discount* column?

The *Provider Discount* column shows the amount discounted from the original charged amount, which is a result of the healthcare provider's agreement with the insurance company.

What does *Allowable Amount* mean?

The *Allowable Amount* is the amount your network has contracted, reflecting any negotiated discounts between your provider and the insurance.

Why am I being charged a *Deductible Amount*?

A *Deductible Amount* is what you owe as part of your insurance plan before your insurer starts to pay. This amount contributes to your annual deductible.

What is a *Co-Payment*?

A *Co-Payment* is a fixed amount you pay for a covered healthcare service, typically paid at the time of the service.

Leading Edge/Anthem Cont.



SPP Explanation of Benefits Overview and FAQs

What is a *Co-Insurance*?

A *Co-Insurance* is the percentage of covered health care costs you are responsible for paying after you have met your deductible.

What does *Patient's Responsibility* signify on the EOB?

Patient's Responsibility on your EOB reflects the total amount you may be billed for which may include any applicable deductible, copay, and coinsurance as determined by your health plan.

For these balance bill amounts under SPP, it is essential to contact Concierge Customer Service using the telephone number listed on the back of your ID Card.

What if there is an *Other Carrier Adjustment*?

If you have secondary insurance, any payments or adjustments made by this carrier would appear in the *Other Carrier Adjustment* column.

What is the *Plan Payment Amount*?

The *Plan Payment Amount* column shows how much your insurance company has paid towards the claim.

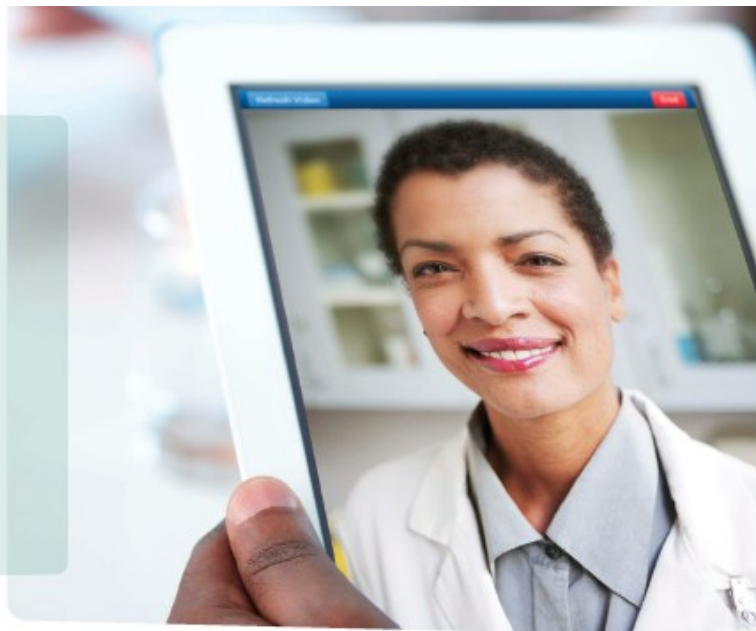
How do I obtain additional information?

For more detailed questions about your EOB, please contact Concierge Customer Service or your insurance provider directly.

Leading Edge/LiveHealth Online Telemedicine

LiveHealth Online

Quick and easy access to a doctor 24/7



Have you ever been at work and didn't feel well? Maybe you had a fever or a sore throat but you didn't have time to leave and see your doctor or go to urgent care. Now, with LiveHealth Online, you can see a board-certified doctor in minutes.

Just use your smartphone, tablet or computer with a webcam. It's so convenient, almost 90% of people who've used it feel they saved two hours or more and would use it again in the future.¹ Plus, online visits using LiveHealth Online are already part of your Anthem Blue Cross and Blue Shield benefits. To start using LiveHealth Online, all you need to do is sign up at livehealthonline.com or download the app.

Sign up for free today and get:

- 24/7 access to doctors.** They can assess your condition, provide treatment options and even send a prescription to the pharmacy of your choice, if needed.² It's a great way to get care when your doctor isn't available.
- Medical care when you need it.** For things like the flu, a cold, sinus infection, pink eye, rashes, fever and more.
- Convenience.** Since there are no appointments or long waits. In fact, most people are connected to a doctor in about 10 minutes or less.

Doctors using LiveHealth Online typically charge \$49 or less per visit, depending on your health plan.

LiveHealth Online Psychology

An easy, convenient way to see a therapist or psychologist in just a few days

If you're feeling stressed, worried, or having a tough time, you can talk to a licensed psychologist or therapist through video using LiveHealth Online Psychology. It's easy to use, private and, in most cases, you can see a therapist within four days or less.³ All you have to do is sign up at livehealthonline.com or download the app to get started. The cost is similar to what you'd pay for an office therapy visit.

Make your first appointment – when it's easy for you

- Use the app or go to livehealthonline.com and log in. Select **LiveHealth Online Psychology** and choose the therapist you'd like to see.
- Or, call LiveHealth Online at **1-844-784-8409** from 7 a.m. to 11 p.m.
- You'll get an email confirming your appointment.



Payer Matrix



Company Snapshot

About Us

Payer Matrix was founded in 2016 as we saw a critical need for a solution to address the rising specialty drug costs and their impact on plan budgets. Our founder and the senior management team have significant experience in the healthcare industry, focused on specialty pharmacy, life sciences, and employee benefits. This experience gives us the unique ability to provide specialized patient advocacy services and ultimately reduce the drug spend to the plan in a meaningful way.



Specialty Medication Trends



The Payer Matrix Difference

 <p>Human Capital Passionate and dedicated in-house services team including several clinicians</p>	 <p>Channel Partnerships Over the past six years, we have cultivated numerous channel partner relationships with PBMs, TPAs, and stop-loss providers.</p>
 <p>Infrastructure and Resources Invested in physical infrastructure and resources to support national coverage and expansion.</p>	 <p>Technology and Business Processes Proprietary technology platform tailored to specialty medication management and high-touch patient engagement</p>

Who We Help

<p>Patients We take the hassle out of coordinating your refills, researching insurance benefits, and make sure every member has a dedicated advocate at your service.</p>	<p>Partners Your lifeline to valuable resources, capabilities, and high-touch services to prevent client churn and provide a meaningful ROI.</p>	<p>Employers Leverage our human capital, infrastructure, technology, and partnerships to make 300+ medications available to a wide range of employees and patients.</p>
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Client Testimonials

"My disease brings stress and uncertainty, but having Payer Matrix has been a life-line."

"My client was impressed by the service he received from Payer Matrix. He spoke to separate individuals and both were excellent, and they really went above and beyond for him and his members."

"I had the pleasure of speaking to one of your care coordinators today. This was the first time working with Payer Matrix for one of our patients. I really am really impressed with what your company is doing to help patients."

"Payer Matrix has already been wonderful and proactive with setting everything up for the new year. They've been great so far and seem like good advocates for us."


877-305-6202

www.payermatrix.com

sales@payermatrix.com

Last updated 02/23

Payer Matrix- Cont.



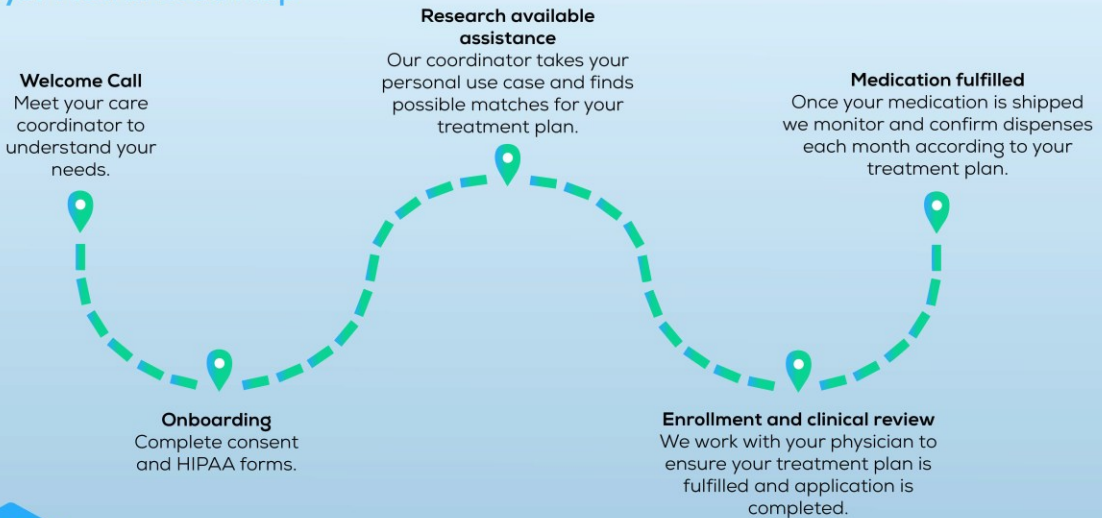
We are here to be your trusted patient advocate!

Payer Matrix is a patient advocacy group that wants to help you save money on your specialty medications. Your personalized care coordinator will guide you through every step and will be there if you have any questions along the way!

What your Care Coordinator does for you

-  Patient assistance program guidance
-  Keep everything on-time
-  Hands-on paperwork
-  Dispense notifications
-  Scheduling assistance
-  Program research
-  Personalized custom care
-  Your own dedicated care coordinator

Payer Matrix Road Map




Learn more about us today.
Visit our website at www.payermatrix.com.

\$0 Copay Brand Name Prescriptions

CANARX

Available to those enrolled in any of the *medical plans*.

Brand name medications FREE to your door!

Order brand name maintenance medications, in the original factory-sealed manufactures packaging directly to your door from certified pharmacies in Canada, the United Kingdom and Australia. **YOU PAY NOTHING (\$0 copay)** thanks to the savings this program brings to the medical plan!

Getting started is easy!

1. **Check to see if your medication is offered.** Call or go online to view the complete formulary and enroll in the program.
2. **Ask your doctor for a prescription for a 3-month supply, with 3 refills** – so long as you have been taking the prescription for at least 30 days.
3. **Submit documentation** (completed enrollment form, prescription, and a copy of your photo ID).
4. **Sit back and relax.** Medication will be mailed direct to your home within 4 weeks!



Check to see if your brand name medication is offered!

1-866-893-6337

www.canarx.com



Gap Plan

MEDlink®

A medical gap plan is a benefit that helps pay extra medical costs your regular insurance doesn't cover.

In-Hospital Benefit

In-Hospital Benefit Maximum	Maximum of \$4,000 per covered person per calendar year. Maximum of \$12,000 per calendar year for all covered persons combined.
In-Hospital Benefit	Benefits include in-hospital confinement, ambulance, and in-hospital treatment for mental or emotional disorders. All benefits are subject to the in-hospital benefit maximum.

Outpatient Rider

Outpatient Benefit Maximum	Maximum of \$2,400 per covered person per calendar year for covered outpatient services. Maximum of \$7,200 per calendar year for all covered persons combined.
Outpatient Benefits	<p>Covered outpatient services include:</p> <ul style="list-style-type: none"> • Hospital emergency room • Physical therapy facility • Urgent care facility • Ambulance • Surgery in a hospital outpatient facility or freestanding outpatient surgery center • Outpatient treatment for a mental or emotional disorder in a hospital outpatient facility • Diagnostic testing in a hospital outpatient facility or MRI facility <p>All benefits are subject to the outpatient benefit maximum and outpatient deductible.</p>
Outpatient Deductible	\$100 per covered person per calendar year

Additional Outpatient Riders

Office Treatment Rider	All benefits are subject to the outpatient benefit maximum and outpatient deductible
Cancer Outpatient Treatment Rider	All benefits are subject to the outpatient benefit maximum and outpatient deductible
Independent Lab Facility Rider	All benefits are subject to the outpatient benefit maximum and outpatient deductible
Durable Medical Equipment Rider	All benefits are subject to the outpatient benefit maximum and outpatient deductible
Home Health Care Rider	All benefits are subject to the outpatient benefit maximum and outpatient deductible

Benefit Cost

Total Weekly Premiums*

Ages	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
18-54	\$9.44	\$22.08	\$18.24	\$30.72
55+	\$17.27	\$39.72	\$32.82	\$55.26

*Total premium includes the Plan selected and any applicable rider premium. The premium and amount of benefits very dependent upon the Plan selected at the time of application.

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Telemedicine

LiveHealth Online

Available to employees enrolled in the **IPS health plan**.

Telemedicine can be a great alternative to visiting your normal doctor or urgent care, when you are suffering from one of many common, non-emergency medical conditions.

Using your computer, tablet, or smartphone device, you can conveniently access to U.S. board-certified doctors and licensed professionals from the comfort of your home or wherever you happen to be.

In some cases, doctors can write a prescription to a local pharmacy near you.¹

Telemedicine	
Medical Visit	\$49 or less if enrolled in the health plan
Commonly Treated Medical Conditions	Allergies Colds, respiratory problems, flu Ear infections Sore throat Pink eye Urinary tract infections
Benefit Cost	Included with Medical coverage

When can I use telemedicine?

- When you need care now.
- If you're considering the ER or urgent care center for a non-emergency issue.
- On vacation, on a business trip, or away from home.
- For short-term prescription refills.

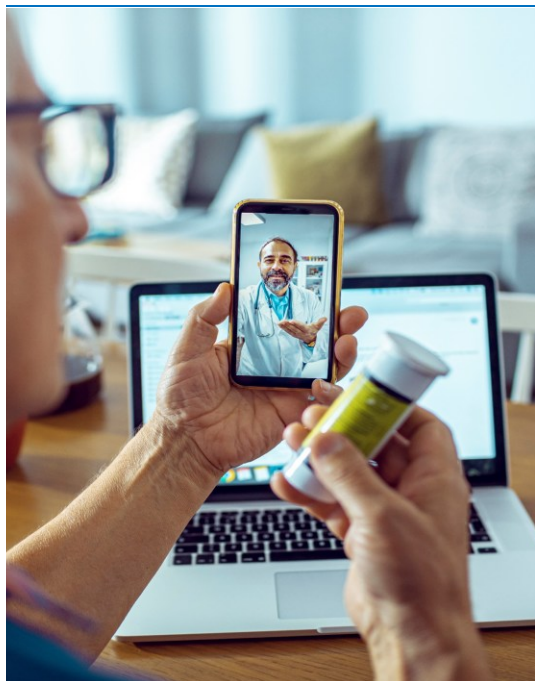
¹ Prescription services may not be available in all states.

Make your first appointment — when it's easy for you

- Use the app or go to **livehealthonline.com** and log in. Select
- **LiveHealth Online Psychology** and choose the therapist
- you'd like to see.
- Or call LiveHealth Online at **1-844-784-8409** from 7 a.m. to 11 p.m.
- You'll get an email confirming your appointment.

Get started today

It's quick and easy to sign up for LiveHealth Online. Just go to livehealthonline.com or download the mobile app at [Google Play™](https://play.google.com/store/apps/details?id=com.livehealthonline) or the [App StoreSM](https://apps.apple.com/us/app/livehealth-online/id1488888888).



Save time and money with telemedicine.


Telemedicine can provide significant savings over urgent care and emergency room visits. On top of that, you can connect with a doctor from the convenience of home or work, allowing you to avoid the hassle of traveling or sitting in a waiting room.

Health Savings Account

Health Equity

Available to employees enrolled in the **HDHP HSA medical plan**.

If you are enrolled in an HSA-qualified plan, you may be eligible to open a tax-free health savings account. The money in your HSA is carried over from year to year so you can budget for current and future expenses. Plus, you own the account so it's yours to keep even if you change jobs or retire.



Is an HSA Right for You?
cbmicrosite.com/video/movingtohdhp



Visit www.irs.gov and search for IRS Publication 502 to learn more about eligible expenses.

HSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

- Deductibles
- Other health-related expenses
- Coinsurance

Annual contribution limit	Individual	\$4,400
	Family	\$8,750
	Catch-up contribution (Age 55 or older)	\$1,000
Rollover		Full Amount

Your eligibility for an HSA may be misrepresented if you and/or your spouse currently utilize an FSA. Check with the plan administrator or Human Resources to learn more.

HSA Case Study

Justin is a healthy 28-year-old single man who contributes \$1,000 each year to his HSA. His plan's annual deductible is \$1,600 for individual coverage. Here is a look at the first two years of Justin's HSA plan, assuming the use of in-network providers. This example only includes HSA contribution amounts and does not reflect any investment earnings.

Year 1		➔	Year 2	
HSA Balance	\$1,000		HSA Balance	\$1,850
Total Expenses:			Total Expenses:	
Prescription drugs: \$150			Office visit: \$100	
			Prescription drugs: \$200	
			Preventive care services: \$0 (covered by insurance)	
				- \$300
	- \$150			
HSA Rollover to Year 2	\$850		HSA Rollover to Year 3	\$1,550

Since Justin did not spend all his HSA dollars in year 1, the remaining funds roll over.

Once again Justin did not spend all his HSA dollars, so they roll over to the next year.

Dental

MetLife

Dental	In-Network
Annual Deductible	\$25 per individual \$50 per family
Annual Benefit Maximum	\$1,250
Plan Pays	
Preventive Care (Deductible waived)	100% Covered
Basic	80%
Major	50%
Orthodontia	Not Covered



Locate an in-network provider near you at www.metlife.com or call 1-800-GET-MET8.

Dental Weekly Cost

Employee Only	\$4.55
Employee + Spouse	\$10.83
Employee + Child(ren)	\$10.83
Family	\$10.83

Vision

MetLife – VSP Choice Network

Vision	In-Network	Out-of-Network
Exam	\$10 copay	\$45 copay
Lenses (per pair)		
Single		\$30 copay
Bifocal	\$25 copay	\$50 copay
Trifocal		\$65 copay
Lenticular		\$100 copay
Frames	\$130 allowance	\$70 allowance
Contact Lenses		
Elective	\$130 allowance	\$105 allowance
Medically Necessary	Covered in full	\$210 allowance
Frequencies		
Exams	1 per 12 months	
Lenses or Contacts	1 per 12 months	
Frames	1 per 12 months	



Locate an in-network provider near you at www.metlife.com or call 1-800-GET-MET8.

Vision Weekly Cost

Employee Only	\$1.51
Employee + Spouse	\$4.07
Employee + Child(ren)	\$4.07
Family	\$4.07

Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Life/AD&D

MetLife

Life insurance protects your loved ones financially in the event of your death. Accidental death and dismemberment (AD&D) provides an additional benefit if you die or experience other covered catastrophic loss due to a covered accident.

Basic Life/AD&D

Benefit Amount	Employee: Please refer to PlanSource or contact HR for details. *
Benefit Cost	Employer-provided

Voluntary Term Life/AD&D

Benefit Amount	<p>Employee: Up to \$500,000</p> <p>Spouse: Up to \$250,000; not to exceed 50% of employee election[^]</p> <p>Child(ren): Up to \$10,000[^]</p>
Benefit Cost	To view your personalized rates, log in to PlanSource or contact HR for details

Benefits may be reduced for employees over age 65 per ADEA.

Actively-At-Work Requirement:

New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Dependent Delayed Effective Date:

Dependents may have a delayed effective date based on his/her health status at time of enrollment. Please refer to the policy certificate or HR for more details.

Definition of “Eligible Dependents”

It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies.

- **Spouse:** Eligibility may terminate at Spouse age 70.
- **Child:** Eligibility terminates earliest of age 26, married, or employed full time, or no longer a Full Time Student. Terms may vary for children with special needs. Benefits may be limited for children under age 6 months.

Please refer to the policy certificate or HR for more information.



Remember to update your beneficiaries.

It is important to update your beneficiaries and make sure they are accurate periodically. Having out of date beneficiaries listed will make it difficult to pay the benefit to the correct person in case it is ever needed.

* The value of employer-funded life insurance benefits in excess of \$50,000 is taxable to you.

[^] Dependent elections require employee enrollment and may be limited by employee volume.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Disability

MetLife

If you become disabled due to a covered injury or illness, disability income benefits may provide a partial replacement.

Voluntary Short-Term Disability

Benefit Amount	Replaces 60% of earnings, up to \$2,000 per week
Benefit Begins	Injury: after 14 days Illness: after 14 days
Benefit Duration	Up to 11 weeks
Pre-Existing Condition Limitations	3-month look back period 12-month exclusion period
Benefit Cost	To view your personalized rates, log in to PlanSource or contact HR for details.

Voluntary Long-Term Disability

Benefit Amount	Replaces 60% of pre-disability earnings, up to \$5,000 per month
Benefit Begins	After a period of 90 days
Benefit Duration	2 Years
Benefit Cost	Employee-paid

Disability excludes work-related injury or illness.



Pre-Existing Condition Limitations:

If you file a claim within the exclusion period following your plan effective date, the carrier will review to determine if the condition existed during the look back period. If so, benefits may be denied.

Actively-At-Work Requirement:

New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Supplemental Health

MetLife

The following benefits may protect your financial security in the event of an unexpected medical expense.

Accident

Helps cover the cost of expenses if you are injured in a non-work-related, covered accident.

Benefit Amount	Benefit amounts vary by severity. See schedule of benefits for details.	
Wellness Benefit	\$100	
Common Covered Injuries	Dislocations Fractures	Concussions Lacerations
Common Medical Services	Ambulance Emergency room visits Hospital admission	Surgical benefits Follow-up treatments
Other Benefits	Travel Lodging	Accidental death and dismemberment

Critical Illness

Helps cover the cost of expenses if you are diagnosed with a covered condition.

Benefit Amount	Employee: Up to \$50,000 Spouse: Up to 50% of employee election Child: Up to 50% of employee election	
Wellness Benefit	\$100	
Pre-Existing Condition Limitations	None	
Common Covered Conditions	Cancer Heart attack Stroke	Major organ failure Degenerative neurological disorders



Get paid for taking care of your health!

If you are enrolled in coverage, you can receive a wellness benefit payment each year when you have a qualifying screening or test.

Hospital Indemnity

Helps cover the cost of hospital stays—including pregnancy and childbirth.

Benefit Amount	\$1,000 hospital admission benefit \$100 daily confinement
Wellness Benefit	\$100
Pre-Existing Condition Limitations	None

Supplemental Health Cost

To view your personalized rates, log in to **PlanSource** or **contact HR for details**

Actively-at-Work Requirement: New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-at-Work/eligible status.

Dependent Delayed Effective Date: Dependents may have a delayed effective date based on his/her health status at time of enrollment. Please refer to the policy certificate or HR for more details.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Discount Program

PerkSpot through our partnership with Cottingham & Butler

This program provides you access to an online marketplace that delivers thousands of discounts for everyday business and personal purchases, leveraging the purchasing power of some of the largest employers in the United States.



Create your account and start saving today.

Visit: <https://cottinghambutler.perkspot.com>

Discount Program			
Shop for a Variety of Coupons & Deals from these Categories:	Apparel	Home & Garden	
	Auto Buying	Home Services	
	Automotive	Insurance & Protection Services	
	Beauty & Fragrance	Jewelry & Watches	
	Books, Movies, & Music	Movie Tickets	
	Business Perks	Office & Business	
	Cell Phones	Pets	
	Education	Real Estate & Moving Services	
	Electronics	Sports & Outdoors	
	Financial Wellness	Tickets & Entertainment	
	Flowers & Gifts	Toys, Kids & Babies	
	Food	Travel	
	Health & Wellness		
	Hobbies & Creative Arts		
Popular Discounted Brands*	Avis	Dell	Home Chef
	Canon	Enterprise	HP
	Casper	Holiday Inn	Ray-Ban
	Columbia		
Benefit Cost	Included in our partnership with Cottingham & Butler		

Who is PerkSpot?

- Online savings resources for employees
- Headquartered in Chicago, IL – Founded in 2006
- 750+ clients nationwide, 15 million members
- 30,000+ discount offers.

Website Features

- Recommended for You: chosen based on your top interests.
- Featured Offers: hand-selected to help you stretch your dollars.
- Today's Perk Alters: today's best limited time sales.
- Popular Savings: trending offers.
- Categories: shop by category
- Local Discounts: shop by location

* All brands and discounts available are subject to change. For a current listing of discounts and brands offered visit the website at <https://cottinghambutler.perkspot.com>.

Info for Those Eligible for Medicare

Next Level Planning

What Are My Options Once I Turn 65?

If you continue to work full-time, you may remain on the company medical plan as long as you meet the eligibility requirements. However, you may also be eligible for Medicare A & B, a Medicare Supplement and Medicare D. Please read the summary below and explore your options to determine what is best in your situation.

Working Beyond Age 65

If you are purchasing medical insurance through your employer, a Medicare plan could help you save money on your health care expenses. It may make sense for you to sign up for Medicare in addition to OR instead of the coverage you have today. If you enroll in Medicare and remain on the company health plan, be sure to check the coordination rules to determine which coverage is primary.

Medicare Options:

Many people who choose to work past age 65 enroll in Part A (Hospital Insurance) because there is no monthly premium. You may choose to enroll in Medicare Part B, a Medicare Supplement, and/or Medicare Part D (these options will be subject to a monthly premium cost).

- Medicare Part B - Physician Insurance
- Medicare Part D – Drug Coverage.
- Supplemental Coverage – This can include Medigap coverages, employer plans or Medicaid.

It is recommended that you explore all options to determine what is best for you. You may also shop for, and change plans each year based on your needs.

Understanding Your Options

Employees who choose to remain on the group health plan can sign up for premium-free Part A (if eligible) during or after their Initial Enrollment Period begins. You can only sign up for Part B (or Part A if you have to buy it) during certain enrollment periods as dictated by Medicare. For additional info on Medicare enrollment opportunities visit www.medicare.gov or reach out to your local SHIP office (see Medicare Resources for contact information).

Making Changes to Your Medicare Plans:

Health care needs can change from year to year. Be sure to review your needs annually (upcoming surgeries, current prescription drugs, new wellness goals) so you can find a plan to best meet them.

Medicare Open Enrollment Period

You can enroll in or change your plan once a year during the Open Enrollment Period (OEP) even if you do not have a qualifying event. The OEP is a seven-week period from October 15 - December 7.

Retiring At or After Age 65

Whether you retire or decide to work part-time, once you turn age 65 you will be eligible for Medicare (Parts A and B) and other Medicare Supplement Plans. If you don't have employer-sponsored coverage, you should consider enrolling during your Initial Enrollment Period. You can enroll any time within the 3 months before your 65th birthday month, your birthday month or 3 months after.

Multiple Medicare Resources Available

Next Level Planning and Wealth Management

- Get advice from Licensed insurance agents at no cost or obligation to enroll.
- Explore plans from numerous health insurance companies.
- Learn more about Medicare and be guided through the process.
- 1 on 1 assistance with benefit and financial planning
- Call (414) 369-6628 or visit www.NLPWMM.com

Our Medicare library is available 24/7 online. Here you can browse videos, download guides/presentations, listen to an agent and access information at your convenience.

Visit:

www.employeenavigator.com/benefits/Account/Login

Login using the following credentials:

- USERNAME: Medicare
- PASSWORD: Benefits65

You may also complete the [Permission to Contact Form](#) to speak to agent and receive assistance with questions related to Medicare as well as explore affordable options available based on your specific needs.

It is important to note that **Medicare resources and options vary by state**. Each state has a SHIP (Senior Health Insurance Information Program) that offers free education and assistance specific to their state. To find your state resource and get the number to speak to a licensed counselor, you may either **visit:** www.shiptacenter.org, call 877-839-2675 or email: info@shiptacenter.org.

Healthcare Tips


Get the Most Out of Your Care

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

- **In-Network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Out-of-Network Provider**—A provider who is not contracted with your health insurance company.

Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network. If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even though the primary physician is in-network.

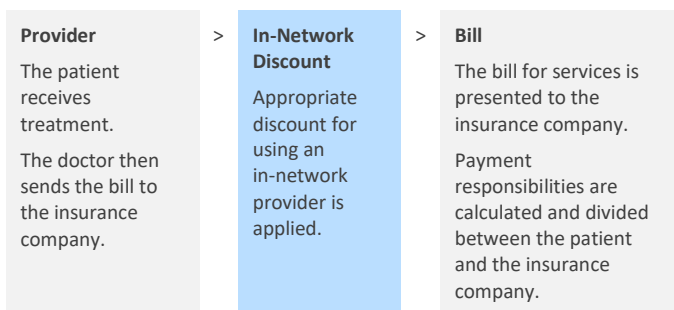




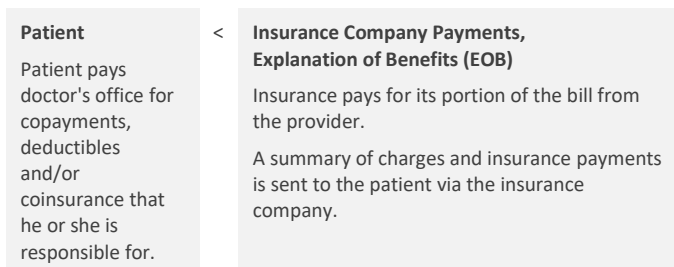
Where Should I Go for Care?
cbmicrosite.com/video/knowwheretogo

Billing & Claim Differences

Because in-network and out-of-network providers are treated differently by your insurance company, you will be billed differently depending on the type of provider you use for your care.



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Take advantage of preventive care.

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. This includes a variety of health care services, such as a physical examination, screenings, laboratory tests, and immunizations.

Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.



Know Where to Go for Care

Keeping your health care costs in check could be as simple as making the right choice when you need medical care. When you have an illness or suffer an injury, you understandably want to feel better fast but making the wrong choice about where to receive care can cost you.

The average outpatient emergency room (ER) visit costs \$1,917, according to the Health Care Cost Institute. This means that if you head to the ER when you don't really need emergency care, your wallet is going to feel the pain.

Where Should I Go?

Sometimes, it can be difficult to know where to draw the line when it comes to choosing if you should go to the ER, urgent care, or your primary doctor. Here are a few guidelines to help you know where to go next time you're sick or injured.

Emergency Room (\$\$\$\$)

A visit to the ER is the most expensive type of outpatient care and should only occur if there is a true emergency, or a life-threatening illness or injury. Examples of conditions that should be addressed in the ER include, but aren't limited to:

- Chest pain
- Uncontrollable bleeding
- Shortness of breath
- Poisoning



Where Should I Go for Care?

cbmicrosite.com/video/knowwheretog
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Urgent Care (\$\$\$)

Urgent care centers handle non-emergency conditions that require immediate attention—those for which delaying treatment could cause serious problems or discomfort. Urgent care visits are less expensive than ER visits but are typically more expensive than a visit to your primary care doctor. These conditions can usually be treated in urgent care centers:

- Sprains
- Ear infections
- High fevers

Doctor's Office (\$\$)

For most non-emergency illnesses or injuries, the best choice for medical care may be a visit to your primary care physician. Your regular doctor knows you best, has your medical history, and has the expertise to diagnose and treat most conditions. In addition, going to the doctor's office is usually the most cost-effective option.

Pet Insurance *New for 2026!*



2026 PetPartners Group Pet Insurance

Help take the stress out of unexpected vet bills. Pet insurance reimburses you for the eligible costs of accidents and illnesses. Coverage includes: emergency treatments, surgeries, medications, laboratory services, and more. Plus, you can visit any licensed veterinarian or specialist.

Accident & Illness	
Annual Deductible	\$300
Coinsurance	80%
Annual Limit	\$5,000
Age (Min/Max/Expiration)	8 weeks /10 years / None
Benefit Waiting Periods:	
Injuries & Illnesses	Both Waived
Orthopedics	6 Months
Pre-Existing Conditions	6 month look back/ Covered after 12 months
Prior Coverage Credits	Included

Optional Wellness	Annual Reimbursement
Rabies Vaccine	\$30
Flea & Tick Prevention	\$50
Heartworm Prevention	\$50
Blood, Fecal, Parasite Test	\$30
Preventative Vaccines	\$45
Urinalysis or ERD	\$30
Heartworm or Feline Leukemia Test (FeLV)	\$30
Spay/Neuter	\$50
Microchip	\$50
Office Visit/Exam	\$35

Additional benefits		
Rehabilitation and Physical Therapy	Covers physical therapy, hydrotherapy, thermotherapy and therapeutic massage	Subject to Deductible and Coinsurance
Inherited and Congenital Care	Covers diabetes, IVDD, luxating patella, osteoarthritis, spondylosis, hip dysplasia and birth defects	Subject to Deductible and Coinsurance and 30-day Benefit Waiting Period
Alternative and Behavioral Care	Covers acupuncture, chiropractic, homeopathy, herbal therapy, naturopathy, and vitamins/supplements	Subject to Deductible and Coinsurance Behavioral Care subject to \$1,000 Annual Limit and 14-day Benefit Waiting Period
Final Respects	Covers cremation and burial expenses	\$300 Limit Paid in excess of Annual Limit (Not subject to Deductible and Coinsurance)

Accident & Illness Plan

Weekly (per covered pet)	Cat: \$5.35	Dog: \$10.52
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Accident & Illness with Wellness Plan

Weekly (per covered pet)	Cat: \$8.76	Dog: \$14.90
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All pet insurance plans have limitations and exclusions. Specific products, features, rates, and discounts may vary by province, eligibility, and are subject to change. For all terms and conditions visit: <http://www.petpartners.com/sample-policies>. Insurance products are underwritten by (independent) American Insurance Company (NAIC #26981), 11333 N. Scottsdale Rd., Suite 100, Scottsdale, AZ 85254, and produced by PetPartners Inc. (NPN #7612549; CA license #0F27261 PPI Pet Insurance Agency, Inc.) 8661 Arco Corporate Drive, Suite 360, Raleigh, NC 27617.

Benefit Terms

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a \$1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is \$800. Because John hasn't paid anything toward his deductible yet this year, and because the \$800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.

- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care.
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.
- **HDHP**—High-deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

Interstate Personnel Services Group Health Plan: Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage. ❖

Benefits during a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs, but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

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

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

Employees living in one of the following States may be eligible for assistance paying employer health plan premiums. The following list of States is current as of July 31, 2025. V 0.6.0. The most recent CHIP notice can be found at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra>. Contact the respective State for more information on eligibility –

ALABAMA – Medicaid

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

ALASKA – Medicaid

AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
<https://dhss.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid

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

CALIFORNIA – Medicaid

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+)

Health First Colorado Website:
<https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+ Website: <https://hcpf.colorado.gov/child-health-plan-plus>
CHP+ Customer Service:
1-800-359-1991/State Relay 771
Health Insurance Buy-In Program (HIBI) Website:
<https://www.mycohibi.com/>
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

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

GEORGIA – 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

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: <https://www.in.gov/medicaid/http://www.in.gov/fssa/dfr/>
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: [lowa.gov/health & Human Services](http://lowa.gov/health-human-services)
Medicaid Phone: 1-800-338-8366
Hawki Website: [Hawki - Healthy and Well Kids in Iowa | Health & Human Services](http://lowa.gov/health-human-services)
Hawki Phone: 1-800-257-8563
HIPP Website: [Health Insurance Premium Payment \(HIPP\) | Health & Human Services \(iowa.gov\)](http://lowa.gov/health-human-services)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
 Phone: 1-855-459-6328
 Email: KIHIPPPROGRAM@ky.gov
 KCHIP Website: <https://kynect.ky.gov>
 Phone: 1-877-524-4718
 Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
 Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.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

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>
 Phone: 1-800-862-4840
 TTY: 711
 Email: masspreassistance@accenture.com

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/health-care-coverage/>
 Phone: 1-800-657-3672

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
 Phone: 1-800-694-3084
 Email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

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

NEVADA – Medicaid

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

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
 Phone: 603-271-5218
 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
 Phone: 1-800-356-1561
 CHIP Premium Assistance Phone: 609-631-2392
 CHIP Website: <http://www.nifamilycare.org/index.html>
 CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

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

NORTH CAROLINA – Medicaid

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

NORTH DAKOTA – Medicaid

Website: <https://www.hhs.nd.gov/healthcare>
 Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

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

OREGON – Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
 Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>
 Phone: 1-800-692-7462
 CHIP Website: [Children's Health Insurance Program \(CHIP\) \(pa.gov\)](http://www.dhs.pa.gov/childrens-health-insurance-program-chip)
 CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

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

SOUTH CAROLINA – Medicaid

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

SOUTH DAKOTA – Medicaid

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

TEXAS – Medicaid

Website: <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>
 Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: <https://medicaid.utah.gov/upp/>
 Email: upp@utah.gov
 Phone: 1-888-222-2542
 Adult Expansion Website: <https://medicaid.utah.gov/expansion/>
 Utah Medicaid Buyout Program Website: <https://medicaid.utah.gov/buyout-program/>
 CHIP Website: <https://chip.utah.gov/>

VERMONT – Medicaid

Website: <https://dvha.vermont.gov/members/medicaid/hipp-program>
 Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

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

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

WEST VIRGINIA – Medicaid and CHIP

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

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

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
 Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since July 31, 2025, 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 ❖

Patient Protection Notice

If the Interstate Personnel Services Group 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. If the plan or health insurance coverage designates a primary care provider automatically, you will be able to designate a new provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources. ❖

Women's Health and Cancer Rights Act of 1998

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.
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. ❖

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers offering group health insurance coverage 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 normal 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 or 96 hours, as applicable. Additionally, no group health plan or issuer may 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). ❖

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an

amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge. ❖

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?

Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depend on household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.96% of household income for the plan year beginning in 2026, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit.*

Note: If a health plan is purchased through the Marketplace instead of accepting health coverage

offered by an employer, then the Employee may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as the employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Any Employee payments for coverage through the Marketplace are made on an after-tax basis.

How Can Individuals Get More Information?

For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

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

- * An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. ❖

Special Enrollment Rights

If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan no later than the first day of the first month, beginning after the date the plan receives a timely request for enrollment.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month, beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP)

If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this

Plan will apply.

The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP. ❖

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INDIVIDUAL MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices

The Interstate Personnel Services Group Medical Plan (the “Plan”), which may include other health and welfare benefit offerings, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA’s privacy rule) to take reasonable steps to ensure the privacy of personally identifiable health information. This Notice is being provided to inform employees (and any of their dependents) of the policies and procedures Interstate Personnel Services has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of individually identifiable Health Information by the Plan that Does Not Require the Individual’s Authorization: The plan may use or disclose health information (that is protected health information (PHI)), as defined by HIPAA’s privacy rule) for:

1. Payment and Health Care

Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an

individual’s coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may also be used or disclosed to carry out Plan operations, such as the administration of the Plan and to provide coverage and services to the Plan’s participants. For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor:

As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law:

When required to do so by any federal, state or local law.

4. Health Oversight Activities:

To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety:

As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual’s health or safety or to the health and safety of the public.

6. Judicial and Administrative

Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a

good faith attempt to provide written notice to the individual to allow them to raise an objection.

7. Law Enforcement Purposes:

To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or

Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation:

If the person is an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions:

For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers’ Compensation:

As necessary to comply with workers’ compensation or other similar programs.

12. Distribution of Health-Related

Benefits and Services: To provide information to the individual on health-related benefits and services that may be of interest to them.

Notice in Case of Breach

Interstate Personnel Services is required to maintain the privacy of PHI; to provide individuals with this notice of the Plan’s legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

Use and Disclosure of Individual Health Information by the Plan that Does

Require Individual Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made

in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Individual Rights with Respect to

Personal Health Information: Each individual has the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses and Disclosures:

An individual may request the Plan to restrict uses and disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at Interstate Personnel Services, 3443 Highway 641 South, Murray, KY 42071, (270) 753-1717.

Right to Inspect and Copy Individual Health Information:

An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at Interstate Personnel Services, 3443 Highway 641 South, Murray, KY 42071, (270) 753-1717. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

Right to Amend Your Health

Information: You may request the Plan

to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at Interstate Personnel Services, 3443 Highway 641 South, Murray, KY 42071, (270) 753-1717. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

Right to an Accounting of Disclosures:

An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which the individual provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at Interstate Personnel Services, 3443 Highway 641 South, Murray, KY 42071, (270) 753-1717. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential

Communications: An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at Interstate Personnel Services, 3443 Highway 641 South, Murray, KY 42071, (270) 753-1717. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice:

Individuals may request a paper copy of

this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at Interstate Personnel Services, 3443 Highway 641 South, Murray, KY 42071, (270) 753-1717 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person:

If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, they must contact the HIPAA Contact Person, at Interstate Personnel Services, 3443 Highway 641 South, Murray, KY 42071, (270) 753-1717. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated. ❖

Important Notice from Interstate Personnel Services Health Plan about Your Prescription Drug Coverage and Medicare (Non-Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Interstate Personnel Services 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. Interstate Personnel Services High-Deductible Health Plan has determined that the prescription drug coverage offered by Interstate Personnel Services is, on average for all plan

participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Interstate Personnel Services high-deductible health plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from Interstate Personnel Services. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the

plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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 decide to drop your current coverage with Interstate Personnel Services, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the Interstate Personnel Services high deductible health plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under the Interstate Personnel Services high-deductible health plan is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 Interstate Personnel Services coverage will not be affected.

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

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 Interstate Personnel Services 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).

Date: November 7, 2025

Name of Entity/Sender: Interstate Personnel Services, 3443 Highway 641 South, Murray, KY 42071, (270) 753-1717❖

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.**
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact 1-844-335-2808. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-844-335-2808 to request a copy. **For assistance with claims and medical benefits contact LEA Member Services Concierge at 1-844-335-2808.**

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>Network providers: \$5,000 Individual / \$10,000 Family Out-of-network providers: Not Covered Benefit Period: Calendar Year</p>	<p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible (Embedded).</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Preventive care services are covered before you meet your deductible.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>Network providers: \$7,900 Individual / \$15,800 Family Out-of-network providers: Not Covered</p>	<p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met (Embedded).</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billing charges, penalties for failure to obtain Preauthorization for services, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. This plan uses the National PPO (BlueCard PPO) Network. A list of network providers can be found at www.anthem.com or call 1-800-810-2583</p>	<p>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No</p>	<p>You can see a specialist you choose without a referral</p>



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Professional Non-Facility based services: 30% coinsurance after deductible	Not Covered	Telemedicine with no cost share is available via Live Health Online at www.livehealthonline.com or 1-888-548-3432 Coverage includes Primary Care, Specialist Care, and Mental Health & Substance Use.
		Facility based services: 30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>		
	Specialist visit to treat an injury or illness	Professional Non-Facility based services: 30% coinsurance after deductible	Not Covered	
	Preventive care/screening/immunization	No Charge (deductible waived)	Not Covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Office Setting: 30% coinsurance after deductible	Not Covered	Sleep Studies are covered in the home.
		Independent Lab & Facility based services: 30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>		
	Imaging (CT/PET scans, MRIs)	All Settings: 30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	Genetic Testing beyond PPACA mandate is covered. Preauthorization is required or benefit reduces by \$250.



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.carelonrx.com or call 1-833-267-2133.	Generic drugs (Tier 1)	NO cost for PPACA mandated medications. Retail or Mail Order 30% coinsurance after deductible	Not Covered	Plan Deductible Does not apply. Rx Cost Shares apply to Plan Out of Pocket Maximum. Covers up to a 30-day supply (retail subscription); 1-90-day supply (mail order prescription). If a prescription is filled with a non-generic drug when a generic equivalent exists, member will be responsible for the cost difference between the non-generic drug and the generic equivalent. Interstate Personnel Services has arranged for Payer Matrix to assist you in obtaining financial assistance for select specialty drugs. You need to enroll with Payer Matrix to obtain such assistance. If you are eligible for financial assistance but refuse to enroll in Payer Matrix, you will have to pay the full cost of the drug.
	Preferred brand drugs (Tier 2)	NO cost for PPACA mandated medications. Retail or Mail Order 30% coinsurance after deductible	Not Covered	
	Non-preferred brand drugs (Tier 3)	Retail or Mail Order 30% coinsurance after deductible	Not Covered	
	Specialty drugs (Tier 4)	Contact Payer Matrix for assistance at 1-877-305-6202 9am - 8pm EST M-F.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	Preauthorization is required for services. If Preauthorization required but not obtained benefit reduces by \$250.
	Physician/surgeon fees	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	
If you need immediate medical attention	Emergency room care	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>		All facilities are covered as in-network subject to meeting "emergency" criteria.
	Emergency medical transportation	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>		All facilities are covered as in-network subject to meeting "emergency" criteria.
	Urgent care	30% coinsurance after deductible	Not Covered	None.

For more information about limitations and exceptions, call 1-844-335-2808



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	Preauthorization is required or benefit reduces by \$250.
	Physician/surgeon fees	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Professional Non-Facility based services: 30% coinsurance after deductible Facility based services: 30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	Intensive Outpatient therapy and Partial Hospitalization require Preauthorization or benefit reduces by \$250.
	Inpatient services	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	Preauthorization is required or benefit reduces by \$250.
If you are pregnant	Office visits	Professional Non-Facility based services: 30% coinsurance after deductible Facility based services: 30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	Maternity for Dependent Child is covered. Newborn well/sick nursery, facility, and professional services for a newborn of a dependent child (grandchild) are excluded. Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is required for stays longer than 48 hours for vaginal birth or 96 hours for cesarean birth if Preauthorization is not obtained benefit reduces by \$250.
	Childbirth/delivery professional services	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	
	Childbirth/delivery facility services	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	Maximum 100 visits per benefit period. Combined visit limit with Private Duty Nursing and Professional Home Visits. Preauthorization is required or benefit reduces by \$250.

For more information about limitations and exceptions, call 1-844-335-2808



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information	
		Preferred Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)		
	Rehabilitation services	Professional Non-Facility based services: 30% coinsurance after deductible	Not Covered	<p>Maximum 20 visits per benefit period. Combined limit with habilitative services.</p> <ul style="list-style-type: none"> - Combined limit with Occupational, Physical, Speech, Cognitive, Pulmonary / Respiratory, and Cardiac Rehabilitation Therapies. Services provided in the home count towards the home health care limit <p>Preauthorization is required or benefit reduces by \$250.</p>	
		Facility based services: 30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>			
	Habilitation services	Professional Non-Facility based services: 30% coinsurance after deductible	Not Covered		
		Facility based services: 30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>			
	Skilled nursing care	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered		<p>Maximum 100 days per benefit period. Combined Limit with Inpatient Physical Medical Rehabilitation. Preauthorization is required or benefit reduces by \$250.</p>
	Durable medical equipment	30% coinsurance after deductible	Not Covered		Preauthorization is required for all items over \$1000. If Preauthorization required but not obtained benefit reduces by \$250.
Hospice services	Home Setting: 30% coinsurance after deductible	Not Covered	Preauthorization is required or benefit reduces by \$250.		
	Facility Setting: 30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>				

For more information about limitations and exceptions, call 1-844-335-2808



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered Except for ACA mandated services	Not covered	One vision screening for children 3-5 years is covered as a preventive service. Cost sharing does not apply for preventive services.
	Children's glasses	Not Covered Except for ACA mandated services	Not covered	No coverage for glasses.
	Children's dental check-up	Not Covered Except for ACA mandated services	Not covered	Dental caries fluoride application for infants and children up to 5 years are covered as preventive services. Cost sharing does not apply for preventive services.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> Abortion - elective Acupuncture Bariatric Surgery Cosmetic Surgery Dental Care (Adult) Gene/Cellular Therapy Growth Hormone Therapy 	<ul style="list-style-type: none"> Hearing aids Infertility Treatment Long-term Care Newborn well/sick nursery, facility, and professional services for a newborn of a dependent child (grandchild) 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. Provider Buy & Bill of identified specialty/high cost drugs on J code list. Respite Care Routine eye care (Adult) Routine Foot Care (nondiabetic/circulatory disease) Weight Loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Chiropractic Care - Limited to 20 visits per benefit period 	<ul style="list-style-type: none"> Hearing aids (to age 18 only) 	<ul style="list-style-type: none"> Private-duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. For more information on your rights to continue coverage, contact the plan at 1-844-335-2808. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: 1-844-335-2808.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual mark policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-844-335-2808

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-335-2808

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-335-2808

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-335-2808

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist coinsurance](#) 30%
- [Hospital \(facility\) coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$7,360

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist coinsurance](#) 30%
- [Hospital \(facility\) coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$5,000
Copayments	\$0
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$5,120

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$5,000
- [Specialist coinsurance](#) 30%
- [Hospital \(facility\) coinsurance](#) 30%
- Other [coinsurance](#) 30%


This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.**
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact 1-844-335-2808. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-844-335-2808 to request a copy. **For assistance with claims and medical benefits contact LEA Member Services Concierge at 1-844-335-2808.**

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>Network providers: \$3,750 Individual / \$7,500 Family Out-of-network providers: Not Covered Benefit Period: Calendar Year</p>	<p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible (Embedded).</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Prescription drugs, Preventive care and primary care services are covered before you meet your deductible.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>Network providers: \$8,000 Individual / \$16,000 Family Out-of-network providers: Not Covered</p>	<p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met (Embedded).</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billing charges, penalties for failure to obtain Preauthorization for services, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. This plan uses the National PPO (BlueCard PPO) Network. A list of network providers can be found at www.anthem.com or call 1-800-810-2583</p>	<p>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No</p>	<p>You can see a specialist you choose without a referral</p>



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Professional Non-Facility based services: \$40 copay /per visit (deductible waived) Lab/Pathology/Xray in Office Setting has no additional cost share.	Not Covered	Telemedicine with no cost share is available via Live Health Online at www.livehealthonline.com or 1-888-548-3432 Coverage includes Primary Care, Specialist Care, and Mental Health & Substance Use.
		Facility based services: \$40 copay /per visit Lab/Pathology/Xray in a Facility Setting subject to plan deductible and coinsurance <i>Savings Plus Plan Benefit</i>		
	Specialist visit to treat an injury or illness	Professional Non-Facility based services: \$60 copay /per visit (deductible waived) Lab/Pathology/Xray in Office Setting has no additional cost share.	Not Covered	
	Preventive care/screening/immunization	No Charge (deductible waived)	Not Covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Office Setting: \$40 copay /per visit (deductible waived) Copay applies if submitted without Office Visit. Independent Lab & Facility based services: 30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	Sleep Studies are covered in the home.

For more information about limitations and exceptions, call 1-844-335-2808



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	All Settings: 30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	Genetic Testing beyond PPACA mandate is covered. Preauthorization is required or benefit reduces by \$250.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.carelonrx.com or call 1-833-267-2133.	Generic drugs (Tier 1)	\$10 copay Retail \$20 copay Mail Order	Not Covered	Plan Deductible Does not apply. Rx Cost Shares apply to Plan Out of Pocket Maximum. Covers up to a 30-day supply (retail subscription); 1-90-day supply (mail order prescription). If a prescription is filled with a non-generic drug when a generic equivalent exists, member will be responsible for the cost difference between the non-generic drug and the generic equivalent. Interstate Personnel Services has arranged for Payer Matrix to assist you in obtaining financial assistance for select specialty drugs. If you are eligible for financial assistance but refuse to enroll in Payer Matrix, you will have to pay the full cost of the drug.
	Preferred brand drugs (Tier 2)	\$40 copay Retail \$80 copay Mail Order	Not Covered	
	Non-preferred brand drugs (Tier 3)	\$60 copay Retail \$120 copay Mail Order	Not Covered	
	Specialty drugs (Tier 4)	Contact Payer Matrix for assistance at 1-877-305-6202 9am - 8pm EST M-F.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	Preauthorization is required for services. If Preauthorization required but not obtained benefit reduces by \$250.
	Physician/surgeon fees	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	None

For more information about limitations and exceptions, call 1-844-335-2808



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	\$250 copay /per visit then 30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>		ER copay is waived if admitted as inpatient. All facilities are covered as in-network subject to meeting “emergency” criteria.
	Emergency medical transportation	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>		All facilities are covered as in-network subject to meeting “emergency” criteria.
	Urgent care	30% coinsurance after deductible	Not Covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	Preauthorization is required or benefit reduces by \$250.
	Physician/surgeon fees	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Professional Non-Facility based services: \$40 copay /per visit (deductible waived) Additional Office services: 30% coinsurance after deductible	Not Covered	Intensive Outpatient therapy and Partial Hospitalization require Preauthorization or benefit reduces by \$250.
		Facility based services: \$40 copay /per visit (deductible waived) PHP/IOP Services: 30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>		
	Inpatient services	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	Preauthorization is required or benefit reduces by \$250.
If you are pregnant	Office visits	Professional Non-Facility based services: No Charge (deductible waived)	Not Covered	Maternity for Dependent Child is covered. Newborn well/sick nursery, facility, and professional services for a newborn of a dependent child (grandchild) are excluded. Cost sharing does not apply to certain preventive services . Depending
		Facility based services: No Charge (deductible waived) <i>Savings Plus Plan Benefit</i>		

For more information about limitations and exceptions, call 1-844-335-2808



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is required for stays longer than 48 hours for vaginal birth or 96 hours for cesarean birth if Preauthorization is not obtained benefit reduces by \$250.
	Childbirth/delivery facility services	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	Maximum 100 visits per benefit period. Combined visit limit with Private Duty Nursing and Professional Home Visits. Preauthorization is required or benefit reduces by \$250.
	Rehabilitation services	Professional Non-Facility based services: \$60 copay /per visit (deductible waived)	Not Covered	Maximum 20 visits per benefit period. Combined limit with habilitative services. - Combined limit with Occupational, Physical, Speech, Cognitive, Pulmonary / Respiratory, and Cardiac Rehabilitation Therapies. Services provided in the home count towards the home health care limit Preauthorization is required or benefit reduces by \$250.
		Facility based services: \$60 copay /per visit (deductible waived) <i>Savings Plus Plan Benefit</i>		
	Habilitation services	Professional Non-Facility based services: \$60 copay /per visit (deductible waived)	Not Covered	Maximum 20 visits per benefit period. Combined limit with habilitative services. - Combined limit with Occupational, Physical, Speech, Cognitive, Pulmonary / Respiratory, and Cardiac Rehabilitation Therapies. Services provided in the home count towards the home health care limit Preauthorization is required or benefit reduces by \$250.
		Facility based services: \$60 copay /per visit (deductible waived) <i>Savings Plus Plan Benefit</i>		

For more information about limitations and exceptions, call 1-844-335-2808



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	Maximum 100 days per benefit period. Combined Limit with Inpatient Physical Medical Rehabilitation. Preauthorization is required or benefit reduces by \$250.
	Durable medical equipment	30% coinsurance after deductible	Not Covered	Preauthorization is required for all items over \$1000. If Preauthorization required but not obtained benefit reduces by \$250.
	Hospice services	Home Setting: 30% coinsurance after deductible Facility Setting: 30% coinsurance after deductible <i>Savings Plus Plan Benefit</i>	Not Covered	Preauthorization is required or benefit reduces by \$250.
If your child needs dental or eye care	Children's eye exam	Not Covered Except for ACA mandated services	Not covered	One vision screening for children 3-5 years is covered as a preventive service. Cost sharing does not apply for preventive services.
	Children's glasses	Not Covered Except for ACA mandated services	Not covered	No coverage for glasses.
	Children's dental check-up	Not Covered Except for ACA mandated services	Not covered	Dental caries fluoride application for infants and children up to 5 years are covered as preventive services. Cost sharing does not apply for preventive services.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none">• Abortion - elective• Acupuncture• Bariatric Surgery• Cosmetic Surgery• Dental Care (Adult)• Gene/Cellular Therapy• Growth Hormone Therapy	<ul style="list-style-type: none">• Hearing aids• Infertility Treatment• Long-term Care• Newborn well/sick nursery, facility, and professional services for a newborn of a dependent child (grandchild)	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.• Provider Buy & Bill of identified specialty/high cost drugs on J code list.• Respite Care• Routine eye care (Adult)• Routine Foot Care (nondiabetic/circulatory disease)• Weight Loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">• Chiropractic Care - Limited to 20 visits per benefit period	<ul style="list-style-type: none">• Hearing aids (to age 18 only)	<ul style="list-style-type: none">• Private-duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. For more information on your rights to continue coverage, contact the plan at 1-844-335-2808. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: 1-844-335-2808.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual mark policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-844-335-2808

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-335-2808

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-335-2808

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-335-2808

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

For more information about limitations and exceptions, call 1-844-335-2808

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$3,750
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,750
Copayments	\$10
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,720

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$3,750
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$900
Copayments	\$700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,620

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$3,750
- [Specialist copayment](#) \$60
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$2,100
Copayments	\$700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800