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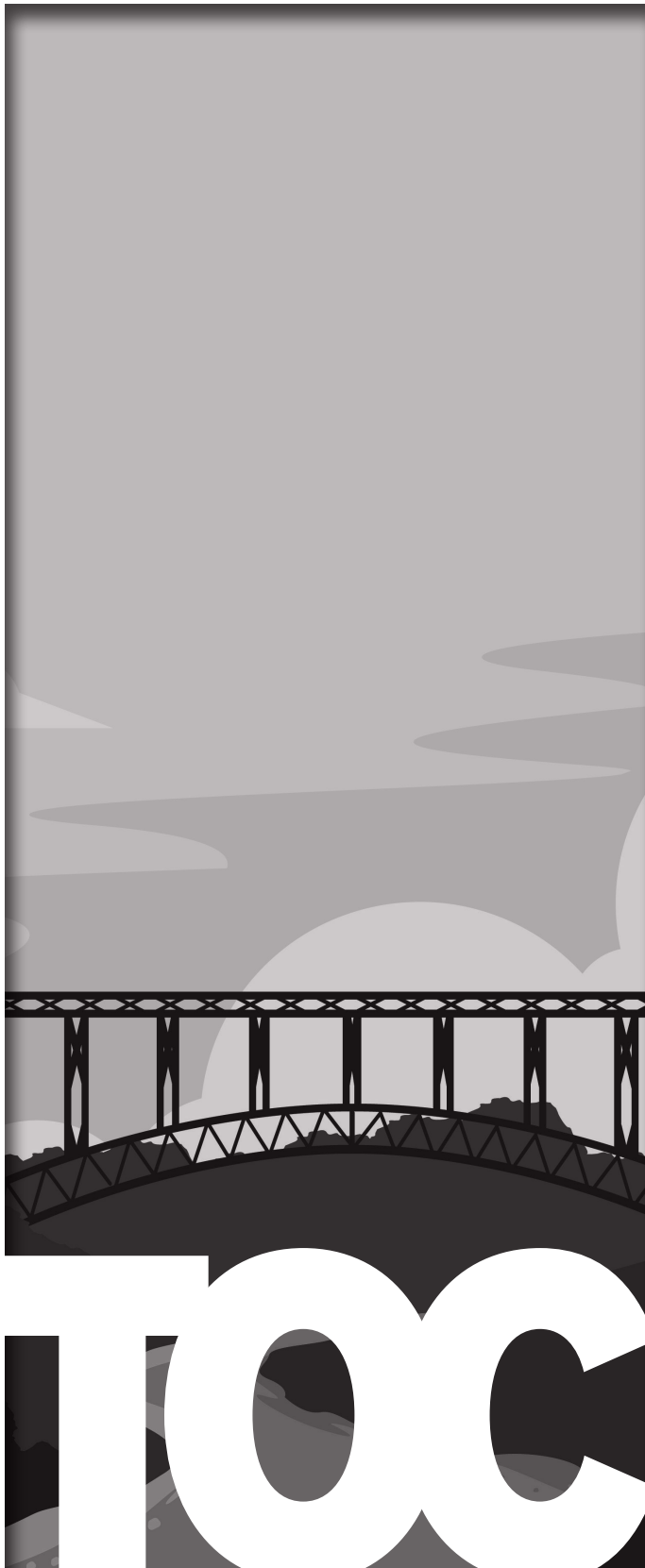
— EMPLOYEE FLEXIBLE BENEFITS GUIDE —



2024

Take Control Of Your Future

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LET'S GET STARTED



Important Dates to Remember

Your Open Enrollment dates are:

April 2, 2023 - May 15, 2023.

Your Period of Coverage dates are:

July 1, 2023 - June 30, 2024.

WHAT'S
CHANGING FOR
2024

Get ready for benefits Open Enrollment! Here's what's changing for your upcoming Mountaineer Flexible Benefits Plan Open Enrollment:

- **GREAT NEWS!** Sun Life is the new provider for your dental plans. Enhancements have been made to the plans. Rates have been lowered, and a **NEW** Premier Dental Plan has been added. See **page 7** for details.
- The legal plans have enhanced benefits and the rates for each plan have been reduced. See **page 21** for details.
- The rates for the hearing plan have been reduced and adult members may now receive a hearing exam once every year. See **page 15** for details.
- The 2023 annual Health Care FSA contribution limit will be \$3,050.
- The 2023 annual HSA contribution limit for individuals will be \$3,850. The limit for individuals with family HDHP will be \$7,750.

Important Enrollment Information

If you do not wish to make changes to your benefits for next year, you do not need to enroll. Your benefits selections will roll over to the following plan year. WV FSA's automatically roll over into the new plan year.

You can visit www.myFBMC.com and enroll online or complete and return your signed and dated enrollment form to your benefits coordinator by May 15, 2023, to enroll for or make changes to your benefits. **NOTE:** The Routine Dental Plan is being replaced. If you are currently enrolled in this plan and do not complete an enrollment, you will be automatically enrolled in the Assistance Dental Plan with no change in your current rates.

Log online at www.myFBMC.com to register or access your online account. For online technical support contact FBMC Tech Support at techsupport@fbmc.com.

Benefit Fairs

Plan Year 2023-2024 Benefit Fairs will be held **April 11 - April 25, 2023**. These fairs will allow you access to specific information on each of your benefits. You're invited to ask questions, share your concerns, and gain more knowledge about the coverages you select.

During these fairs, Mountaineer Flexible Benefits Representatives will be available to:

- Provide you with detailed benefit information
- Answer any benefit questions
- Help you complete your enrollment form

See the Benefit Fairs schedule on page 30 of this guide for dates and times.

HOW TO ENROLL

Enroll Online

Employees may choose to enroll at www.myFBMC.com. You must be registered to access the web enrollment. If you have not already, you will need to register following the first-time user link provided.



Registering Online

Your first step is to register, using your name, mailing ZIP code, email address and one of the following: FBMC ID or Social Security number (current users will continue to use your existing login credentials).

Fill out the registration form, enter the random image string into the text box, read the user acceptance agreement and then click the, "I agree. Complete my registration" button. You will receive an email shortly to finalize the registration. Follow the instructions within the email.

If you previously registered an email address and password on FBMC's website, you may continue using this information.

Accessing Your Online Benefits

Once registered, you may access the web enrollment instructions at the "Resources" tab.

- Click the "Web Enrollment" link.
- Verify your demographic information.
- Add or update any dependent or beneficiary information.
- Begin the enrollment process.
- For each benefit, choose your coverage level or election amounts and then go to the next benefit.
- Continue until your enrollment is complete.
- Print out your confirmation statement containing all your benefit elections for you and your family.

Keep Your Address Updated

In order to protect your family's rights, you should keep your employer and FBMC Benefits Management Inc., informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices you send to your employer and FBMC. Please see your benefits coordinator to complete the FBMC Demographic Change Form. The Demographic Change Form can also be found on the PEIA website (www.peia.wv.gov).

A New Way to Explore Your Benefits

A new Benefits Explorer website is now available to you at mountaineer.fbmcbenefits.com.

You can access it during and after enrollment to learn about your benefits through this digitally powered platform. Here you will find access to live benefits counselors via chat and have the ability to schedule an appointment if you would like to speak with a counselor over the phone, or by video. Extensive educational content, including videos, benefit highlighters, comparison tables, illustrative examples, helpful hints and FAQs are also available on the site.

Enroll by Paper

You must enroll by paper form, if you:

- Are a new hire after **March 1, 2023**.
- Currently do not participate.
- Work for a non-state agency or a County Board of Education.
- If FBMC does not have your annual salary amount.



Note: This is a changes-only enrollment. If you have no changes, you do not have to do anything and your benefits will remain the same.

For each benefit you are adding, changing or canceling, you must check the appropriate box next to the corresponding benefit. For the benefit selections you are not altering, check the "Keep Coverage" box. If you complete an enrollment form, but do not indicate your desire to cancel or change an existing benefit, that benefit will continue regardless of other benefits which may or may not be indicated on the enrollment form.

If you are selecting "Employee & Children," "Employee & Spouse" or "Employee & Family" coverage, you must complete the dependent information in Section 4 on the enrollment form. Use an additional sheet of paper as needed for additional dependents.

Your cost per pay period is based on your number of payrolls per plan year. Please check with your benefits coordinator if you have questions.

Sign and date the form at the bottom. Return your completed enrollment form to your benefits coordinator no later than **May 15, 2023**.

HOW TO ENROLL



Enrollment Q&A

- **Enrolling for the first time?** Enroll online or complete an enrollment form and make your benefit selections by checking the “Add Coverage” box.
- **Changing your benefits?** Make changes online or complete an enrollment form and change your selections by checking the “Change Coverage” box. Complete the line with the new coverage information.
- **Adding a new benefit?** Enroll online or complete an enrollment form and make your selections by checking the “Add Coverage” box. Complete the line with the new coverage information.
- **Keeping all of your current benefits?** All benefits will continue as currently enrolled, and any premium changes will be applied.
- **Canceling current benefits?** Make changes online or complete an enrollment form and check the “Cancel Coverage” box for the benefit you want to cancel; otherwise, it will automatically continue for the 2023-2024 plan year.
- **Transferring to a new agency?** If you transfer from one agency to another, your benefits must remain the same. Complete an enrollment form, check the “Transfer” box and turn the form in to your new benefits coordinator.

When an employee transfers, it is the employee’s responsibility to provide their current benefits to the new agency. In the event that the new employee is unsure of his or her current benefits, the employee needs to contact the old agency to confirm coverage.

If an employee transfers from an agency that did not participate to an agency that does participate, they will be treated as a “new hire.”

Filing an Enrollment Appeal

If your request for an enrollment change or a mid-plan year election change is denied, you have the right to appeal the decision by sending a written request for review within 30 days of the initial denial.

- Your appeal must include:
- The name of your employer
- Your contact information, including an email address so you may be contacted easily and in a timely manner
- Why you believe your request for a variance should be considered
- Any additional documents, information or comments you think may have a bearing on your appeal

Your appeal and supporting documentation will be reviewed upon receipt. You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

Important Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer’s, insurance provider’s and IRS regulations governing the plan.

For appeals involving your enrollment elections or mid-year changes, mail to:

FBMC Benefits Management
Attn: Enrollment Appeal; Mail Slot 51
PO Box 1878
Tallahassee, FL 32302-1878

ELIGIBILITY + COVERAGE

Who is Eligible?

All active, benefit-eligible employees of state agencies, colleges and universities and participating County Boards of Education are eligible to participate in this program.

This program is also offered to some non-state agencies. Please check with your benefits department to see if you are eligible.

Upon certain qualifying events, spouses, children and employees may be eligible to continue for group health plan coverage under COBRA law.

Please consult your benefit coordinator for more information.

A provision in the Patient Protection and Affordable Care Act (PPACA) allows for an employee's adult child to be covered under the employee's healthcare plan through the end of the month in which the adult child turns age 26. Coverage is in effect whether the adult child is/is not married or is/is not a student. For more information, please read the FAQs at www.myFBMC.com.

Period of Coverage

Your period of coverage begins on **July 1, 2023**, and continues until **June 30, 2024**, unless you:

- Terminate employment
- Go on an unpaid leave of absence or
- Change your benefit elections in limited circumstances as further discussed under "Changing Your Coverage"

Retiree Coverage

During the 90 days prior to your anticipated retirement date, contact FBMC for your retiree enrollment packet. When you retire, the benefits that are currently offered are dental, vision, hearing and legal. Flexible Spending Accounts and disability income protection are not offered to retirees and the coverage will end at the end of the month in which you end employment. If you are retiring, you have the option to meet with a benefits coordinator to discuss retiree benefits available and complete your enrollment form.

HIPAA Privacy

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy that was previously given to you. A copy of this notice is available upon request.

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 62 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, the request must be made within the month of and two months following the qualifying event.

To request special enrollment or obtain more information, consult your benefit coordinator.

Employees on Leave

Approved Medical Leave: If you go on medical leave because of your own disability (which includes pregnancy and disabilities resulting from pregnancy complications), your premium deductions will continue through the Mountaineer Flexible Benefits Plan as long as you receive a salary. The Family and Medical Leave Act may affect your rights concerning the continuation of your health benefits while on unpaid leave. Consult your benefit coordinator.

Approved Unpaid Leave: You can continue to receive coverage for certain benefits for the duration of your leave if you pay your premium to FBMC on an after-tax basis.

If you have not maintained a current premium status while on leave, you will be required to re-satisfy eligibility requirements when you return to active status, except as otherwise provided by law. Consult your benefit coordinator for further information on billing if you go on approved, unpaid leave.

If you are planning on a leave of absence, you will need to contact your benefits coordinator to advise. To remit payment while on leave, you will need to send your payment to your benefits coordinator. The benefits coordinator will submit the payment with the Mt. Flex personal pay summary form to FBMC.

New Insurance Provider



Sun Life

Insurance products are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA).

Group ID Number:

Group Plan Name:

Insured Member Name:

Effective Date:

www.sunlife.com/wvpeia

SUN LIFE DENTAL INSURANCE

Good health starts with your teeth. Annual preventive care alone can help prevent health problems such as heart disease and diabetes. Sun Life, your **NEW** dental insurance provider, helps protect your teeth for a lifetime. Enhancements have been made to the plans. Rates have been lowered, and a **NEW** Premier Dental Plan has been added.

FOUR PLANS ARE AVAILABLE

Assistance Plan: 100% coverage in-network for preventative services (cleanings, exams, and X-rays); 40% of cost for basic services (new fillings, simple extractions and biopsy); 25% for major services (dentures and bridges)

Basic Plan: 100% coverage in-network for preventative services (cleanings, exams, and X-rays); 75% of cost for basic services (new fillings, simple extractions and biopsy); 40% for major services (dentures and bridges)

Enhanced Plan: 100% coverage in-network for preventative services (cleanings, exams, and X-rays); 80% of cost for basic services (new fillings, simple extractions, and biopsy); 60% for major services (dentures, bridges, and TMJ treatment); 40% of the cost of ortho services (no age limit orthodontic treatment)

Premier Plan: 100% coverage in-network for preventative services (cleanings, exams, and X-rays); 90% of cost for basic services (new fillings, simple extractions, and biopsy); 75% for major services (dentures, bridges, and TMJ treatment); 50% of the cost of ortho services (no age limit orthodontic treatment)

VALUE OF USING AN IN-NETWORK PROVIDER

You are free to use the dentist or specialist of your choice. However, you have access to the Sunlife Dental Network® PPO dentists and to take advantage of their fee discounts. If you see an out-of-network dentist, their fee will be subject to an allowable amount. Sun Life determines the allowable amount for your area by looking at the fees other dentists

IMPORTANT INFORMATION ABOUT THE ROUTINE DENTAL PLAN

The Routine Dental Plan is being replaced. If you are currently enrolled in this plan and do not complete an enrollment, you will be automatically enrolled in Sun Life's Assistance Dental Plan with no change in your current rates.

charge and your plan type. The allowable amount will vary depending on the plan you choose.

Three of the plans are MAC (Maximum Allowable Charge) plans.

- The Assistance, Basic and Enhanced plans are MAC plans.
- You are responsible for fees above the allowable amount.

The new Premier plan is a 90th U&C (Usual and Customary) plan.

- The U&C plan provides a higher allowable amount than the MAC plans and is designed to lower your out-of-pocket costs.
- With this new plan, the likelihood of being balance billed is lower because the allowable amount is higher. Balance billing is when a dentist charges more than the allowable amount for a service.

FIND AN IN-NETWORK PROVIDER

Simply visit www.sunlife.com/findadentist. Follow the prompts to find a dentist in your area who participates in the PPO network. You do not need to select a dentist in advance. The PPO network for your plan is the Sun Life Dental Network® with 130,000+ unique dentists.

FILING A CLAIM

Many dentists will file claims for you. If a dentist will not file your claim, simply ask your dentist to complete a standard American Dental Association (ADA) claim form and mail it to Sun Life. The address will be provided on your dental ID card.

SUN LIFE	ASSISTANCE PLAN		BASIC PLAN		ENHANCED PLAN		PREMIER PLAN	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Plan Year Deductible (Per Person)	\$25 (applies Type II and III services only)		\$25 (applies Type II and III services only)		\$50 (applies Type II and III services only)		\$75 (applies Type II and III services only)	
Maximum Totals Per Family Deductible	\$75		\$75		\$150		\$225	
Plan Year Maximum Benefit (Per Person)	\$750	\$500	\$1,000	\$500	\$1,500	\$1,000	\$2,500	\$1,500
Other Maximums								
Ortho Lifetime Max (Paid over two plan years)	Not Covered	Not Covered	Not Covered	Not Covered	\$1,250	\$500	\$2,500	\$1,000
TMJ Disorder Lifetime Max	Not Covered	Not Covered	Not Covered	Not Covered	\$1,000	\$1,000	\$1,000	\$1,000
BENEFIT	In Network (Plan Pays)	Out of Network (Plan Pays)	In Network (Plan Pays)	Out of Network (Plan Pays)	In Network (Plan Pays)	Out of Network (Plan Pays)	In Network (Plan Pays)	Out of Network (Plan Pays)
Type I: Preventive Dental Services	100%	80%	100%	80%	100%	80%	100%	80%
Type II: Basic Dental Services	40%	25%	75%	50%	80%	60%	90%	70%
Type III: Major Dental Services	25%	10%	40%	25%	60%	40%	75%	50%
Type IV: Orthodontic Services								
• No orthodontic treatment age limitation	Not Covered	Not Covered	Not Covered	Not Covered	40%	25%	50%	50%
Treatment for TMJ Disorder								
• Non-Surgical TMJ treatment \$1,000 lifetime maximum	Not Covered	Not Covered	Not Covered	Not Covered	60%	40%	75%	50%

Waiting Periods

For a complete description of services and waiting periods, please review your certificate of insurance.

If you were covered under your employer's prior plan the wait will be waived for any type of service covered under the prior plan and this plan.

- No waiting period for preventive or basic services
- 6 months for major services
- 6 months for orthodontic services

DENTAL

Your Tax-Free Dental Rates

ASSISTANCE	10 PAY	12 PAY	18 PAY	20 PAY	21 PAY	22 PAY	24 PAY	26 PAY
Employee Only	\$13.14	\$10.95	\$7.30	\$6.57	\$6.26	\$5.97	\$5.48	\$5.05
Employee + Spouse	\$29.39	\$24.49	\$16.33	\$14.69	\$13.99	\$13.36	\$12.25	\$11.30
Employee + Child(ren)	\$26.34	\$21.95	\$14.63	\$13.17	\$12.54	\$11.97	\$10.98	\$10.13
Employee + Family	\$42.66	\$35.55	\$23.70	\$21.33	\$20.31	\$19.39	\$17.78	\$16.41

BASIC	10 PAY	12 PAY	18 PAY	20 PAY	21 PAY	22 PAY	24 PAY	26 PAY
Employee Only	\$19.90	\$16.58	\$11.05	\$9.95	\$9.47	\$9.04	\$8.29	\$7.65
Employee + Spouse	\$44.41	\$37.01	\$24.67	\$22.21	\$21.15	\$20.19	\$18.51	\$17.08
Employee + Child(ren)	\$39.85	\$33.21	\$22.14	\$19.93	\$18.98	\$18.11	\$16.61	\$15.33
Employee + Family	\$64.40	\$53.67	\$35.78	\$32.20	\$30.67	\$29.27	\$26.84	\$24.77

ENHANCED	10 PAY	12 PAY	18 PAY	20 PAY	21 PAY	22 PAY	24 PAY	26 PAY
Employee Only	\$33.58	\$27.98	\$18.65	\$16.79	\$15.99	\$15.26	\$13.99	\$12.91
Employee + Spouse	\$78.05	\$65.04	\$43.36	\$39.02	\$37.17	\$35.48	\$32.52	\$30.02
Employee + Child(ren)	\$67.21	\$56.01	\$37.34	\$33.61	\$32.01	\$30.55	\$28.01	\$25.85
Employee + Family	\$111.48	\$92.90	\$61.93	\$55.74	\$53.09	\$50.67	\$46.45	\$42.88

PREMIER	10 PAY	12 PAY	18 PAY	20 PAY	21 PAY	22 PAY	24 PAY	26 PAY
Employee	\$44.16	\$36.80	\$24.53	\$22.08	\$21.03	\$20.07	\$18.40	\$16.98
Employee + Spouse	\$103.42	\$86.18	\$57.45	\$51.71	\$49.25	\$47.01	\$43.09	\$39.78
Employee + Child(ren)	\$88.78	\$73.98	\$49.32	\$44.39	\$42.27	\$40.35	\$36.99	\$34.14
Employee + Family	\$147.85	\$123.21	\$82.14	\$73.93	\$70.41	\$67.21	\$61.61	\$56.87

Rates are effective as of July 1, 2023.



DENTAL FAST FACTS

- Treating the inflammation from periodontal disease can help manage other health problems such as heart disease and diabetes.¹
- 50% of adults over the age of 30 are suffering from periodontal disease.²
- Consider a dental treatment cost pre-determination. Sun Life can review your provider's treatment plan to let you know before treatment is started how much of the work should be covered by the plan, and how much you may need to cover. It is recommended for any dental treatment expected to exceed \$500.

1. American Academy of Periodontology <https://www.perio.org/consumer/gum-disease-and-other-diseases> (accessed 07/21).
 2. American Academy of Periodontology <https://www.perio.org/newsroom/periodontal-disease-fact-sheet> (accessed 07/21).

ASSISTANCE & BASIC DENTAL PLAN

Type I Preventive Dental Services, including:

- Oral evaluations – 2 in any benefit year
- Routine dental cleanings – 2 in any benefit year
- Fluoride treatment – 1 in any 6 month period. Only for children under age 19
- Sealants – no more than 1 per tooth in any 36 month period, only for permanent molar teeth. Only for children under age 14
- Space maintainers – only for children under age 19
- Bitewing x-rays – 2 in any 12 month period
- Intraoral complete series x-rays – 1 in any 36 month period
- Genetic test for susceptibility to oral diseases

Type II Basic Dental Services, including:

- New fillings
- Simple extractions, incision and drainage
- Surgical extractions of erupted teeth, impacted teeth, or exposed root
- Biopsy (including brush biopsy)
- Endodontics (includes root canal therapy) – 1 per tooth in any 24 month period
- General anesthesia/IV sedation – medically required
- Minor gum disease (non-surgical periodontics)

- Scaling and root planing – 1 in any 24 month period per area
- Periodontal maintenance – 2 in any benefit year
- Localized delivery of antimicrobial agents
- Major gum disease (surgical periodontics)

Type III Major Dental Services, including:

- Dentures and bridges – subject to 5 year replacement limit
- Stainless steel crowns – only for children under age 19
- Inlay, onlay, and crown restorations – 1 per tooth in any 5 year period

Waiting Periods

For a complete description of services and waiting periods, please review your certificate of insurance. If you were covered under your employer's prior plan the wait will be waived for any type of service covered under the prior plan and this plan.

- No waiting period for preventive or basic services
- 6 months for major services

ENHANCED & PREMIER SERVICES

Type I Preventive Dental Services, including:

- Oral evaluations – 2 in any benefit year
- Routine dental cleanings – 2 in any benefit year
- Fluoride treatment – 1 in any 6 month period. Only for children under age 19
- Sealants – no more than 1 per tooth in any 36 month period, only for permanent molar teeth. Only for children under age 14
- Space maintainers – only for children under age 19
- Bitewing x-rays – 2 in any 12 month period
- Intraoral complete series x-rays – 1 in any 36 month period
- Genetic test for susceptibility to oral diseases

Type II Basic Dental Services, including:

- New fillings
- Simple extractions, incision and drainage
- Surgical extractions of erupted teeth, impacted teeth, or exposed root
- Biopsy (including brush biopsy)
- Endodontics (includes root canal therapy) – 1 per tooth in any 24 month period
- General anesthesia/IV sedation – medically required
- Minor gum disease (non-surgical periodontics)
- Scaling and root planing – 1 in any 24 month period per area

- Periodontal maintenance – 2 in any benefit year
- Localized delivery of antimicrobial agents
- Major gum disease (surgical periodontics)

Type III Major Dental Services, including:

- Dentures and bridges – subject to 5 year replacement limit
- Stainless steel crowns – only for children under age 19
- Inlay, onlay, and crown restorations – 1 per tooth in any 5 year period
- Treatment for TMJ Disorder - *Non-Surgical TMJ treatment \$1,000 lifetime maximum*

Type IV Ortho Services, including:

- No orthodontic treatment age limitation

Waiting Periods

For a complete description of services and waiting periods, please review your certificate of insurance. If you were covered under your employer's prior plan the wait will be waived for any type of service covered under the prior plan and this plan.

- No waiting period for preventive or basic services
- 6 months for major services
- 6 months for orthodontic services

IMPORTANT INFORMATION

Benefit adjustments

Benefits will be coordinated with any other dental coverage. Under the Alternative Treatment provision, benefits will be payable for the most economical services or supplies meeting broadly accepted standards of dental care.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see your Certificate or ask your benefits administrator for details.

Dental

We will not pay a benefit for any Dental procedure, which is not listed as a covered dental expense. Any dental service incurred prior to the Effective date or after the termination date is not covered, unless specifically listed in the certificate. A member must be a covered dental member under the Plan to receive dental benefits. The Plan has frequency limitations on certain preventive and diagnostic services, restorations (fillings), periodontal services, endodontic services, and replacement of dentures, bridges and crowns. All services must be necessary and provided according to acceptable dental treatment standards. Treatment performed outside the United States is not covered, except for emergency dental treatment, subject to a maximum benefit.

This Overview is preliminary to the issuance of the Policy. Refer to your Certificate for details. Receipt of this Overview does not constitute approval of coverage under the Policy. In the event of a discrepancy between this Overview, the Certificate and the Policy, the terms of the Policy will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

VISION



Humana's Insight network includes top retail names in eye care, LensCrafters, Pearle Vision, Target Optical and most Wal-Mart locations.

Present your Humana Vision card and the Vision provider will do the rest!

Use the Mobile App

Manage your vision care — wherever you are with the MyHumana Mobile app.

- View your plans and coverage details
- View claims
- View, fax or save ID cards
- Find a doctor in your network

Download the Mobile App

Download the MyHumana Mobile app from your app store. Search "MyHumana" in the Google Play® or Apple Store®.

You may choose from the following vision plans:

- Exam Plus Plan
- Full Service Plan

Humana powered by EyeMed is your vision plan provider. You may choose to cover your family by selecting "Employee & Family" rates. You may cover your spouse and any children, stepchildren or foster children up to age 26.

Value-Added Benefits

- Diabetic Eyecare Coverage \$0 copay (available only on the Full Service Plan)
- Discounts at ContactsDirect.com
- Discounts at Glasses.com

How Your Vision Plans Work

- After enrolling in your vision plan, you will receive your new Humana vision ID card in the mail.
- Prior to scheduling your appointment, select a participating network provider.
- A list of providers can be found on the Humana website at www.humana.com by simply registering with your member ID number.
- You may contact Humana customer service at 1-877-398-2980, Monday-Saturday 7:30 a.m.-11 p.m. (EST) and 11 a.m. - 8 p.m. Sunday



Scan Me



To find a provider near you.

Your Tax-Free Vision Rates

EXAM PLUS PLAN	10-PAY	12-PAY	18-PAY	20-PAY	21-PAY	22-PAY	24-PAY	26-PAY
Employee Only	\$1.46	\$1.22	\$0.81	\$0.73	\$0.70	\$0.67	\$0.61	\$0.56
Employee + Family	\$3.31	\$2.76	\$1.84	\$1.66	\$1.58	\$1.51	\$1.38	\$1.27
FULL SERVICE PLAN	10-PAY	12-PAY	18-PAY	20-PAY	21-PAY	22-PAY	24-PAY	26-PAY
Employee Only	\$8.59	\$7.16	\$4.77	\$4.30	\$4.09	\$3.91	\$3.58	\$3.30
Employee + Family	\$22.20	\$18.50	\$12.33	\$11.10	\$10.57	\$10.09	\$9.25	\$8.54

Humana®



	EXAM PLUS PLAN		FULL SERVICE PLAN	
	IF YOU USE AN IN-NETWORK PROVIDER (MEMBER COST)	IF YOU USE AN OUT-OF-NETWORK PROVIDER (REIMBURSEMENT)	IF YOU USE AN IN-NETWORK PROVIDER (MEMBER COST)	IF YOU USE AN OUT-OF-NETWORK PROVIDER (REIMBURSEMENT)
Exam with dilation as necessary • Retinal imaging ¹	\$10 Up to \$39	Up to \$40 Not covered	\$20 Up to \$39	Up to \$40 Not covered
Contact lens exam options ² • Standard contact lens fit and follow-up • Premium contact lens fit and follow-up	Up to \$40 10% off retail	Not covered Not covered	Up to \$40 \$60 copay	Not covered Not covered
Frames ³	35% off retail	Not covered	\$150 allowance 20% off balance over \$150	\$75 allowance
Standard plastic lenses ⁴ • Single vision • Bifocal • Trifocal • Lenticular	\$50 \$70 \$105 20% off retail	Not covered Not covered Not covered Not covered	\$20 \$20 \$20 \$20	Up to \$30 Up to \$50 Up to \$70 Up to \$80
Covered lens options ⁴ • UV Coating • Tint (solid and gradient) • Standard scratch-resistance • Standard polycarbonate - adults • Standard polycarbonate - children <19 • Standard anti-reflective coating • Standard progressive • Polarized • Photochromatic / Plastic transitions • Premium anti-reflective coating Tier 1 Tier 2 Tier 3 • Premium progressive Tier 1 Tier 2 Tier 3 Tier 4	\$15 \$15 \$15 \$40 \$40 \$45 \$65 20% off retail Not applicable Not applicable	Not covered Not covered Not covered Not covered Not covered Not covered Not covered Not covered Not applicable Not applicable	\$0 \$15 \$15 \$40 \$0 \$45 \$20 20% off retail \$75 Premium anti-reflective coatings as follows: \$57 \$68 80% of charge Premium progressives as follows: \$20 \$20 \$20 \$20	Up to \$8 Not Covered Not Covered Not covered Up to \$20 Not covered Up to \$50 Not covered Not covered Premium anti-reflective coatings as follows: Not covered Premium progressives as follows: Up to \$50 Up to \$50 Up to \$50 Up to \$50
Contact lenses ⁵ (applies to materials only) • Conventional • Disposable • Medically necessary	15% off retail Not covered Not covered	Not covered Not covered Not covered	\$150 allowance, 15% off balance over \$150 \$150 allowance \$0	\$105 allowance \$105 allowance \$210 allowance

Humana



	EXAM PLUS PLAN		FULL SERVICE PLAN	
	IF YOU USE AN IN-NETWORK PROVIDER (MEMBER COST)	IF YOU USE AN OUT-OF-NETWORK PROVIDER (REIMBURSEMENT)	IF YOU USE AN IN-NETWORK PROVIDER (MEMBER COST)	IF YOU USE AN OUT-OF-NETWORK PROVIDER (REIMBURSEMENT)
Frequency • Examination • Lenses or contact lenses • Frame	Once every Plan Year Not applicable Not applicable	Once every Plan Year Not applicable Not applicable	Once every Plan Year Once every Plan Year Once every other Plan Year	Once every Plan Year Once every Plan Year Once every other Plan Year
Diabetic Eye Care: care and testing for diabetic members • Examination - Up to (2) services per year • Retinal Imaging - Up to (2) services per year • Extended Ophthalmoscopy - Up to (2) services per year • Gonioscopy - Up to (2) services per year • Scanning Laser - Up to (2) services per year	Not covered Not covered Not covered Not covered Not covered	Not covered Not covered Not covered Not covered Not covered	\$0 \$0 \$0 \$0 \$0	Up to \$77 Up to \$50 Up to \$15 Up to \$15 Up to \$33

Optional benefits

Polycarbonate Lenses for Children <19 Provides for standard polycarbonate lens with \$0 copay. Not available in AK, CT, ID, & OH.

1 Member costs may exceed \$39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.
 2 Standard contact premium contact lens exam and fit and follow-up cost may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.
 3 Discounts may be available on all frames except when prohibited by the manufacturer.
 4 Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
 5 Plan covers contact lenses, in lieu of frames, but not both.

HEARING



Why have a Hearing Plan?

Hearing is one of the five natural senses that allow us to enjoy life and the world around us. Music, radio, television, movies, and theater all become less accessible and enjoyable without the benefit of hearing. And the loss of sounds like sirens and alarms can actually endanger your life.

Hearing is a valued life asset that can be protected and treated through a program for hearing healthcare. With EPIC Hearing Healthcare (EPIC), you'll get the options, care and convenience to help make it easier to hear the sounds you've been missing.

With EPIC, you'll have access to:

- Choice of 2,000+ hearing aid models and styles from the industry's top brands, including Beltone™, Oticon, Phonak, ReSound, Signia, Starkey®, Unitron™ and Widex®
- Advanced hearing aid technology such as rechargeable battery options, Bluetooth streaming and more
- Charging case or extra batteries included with purchase
- 3 in-person follow-up visits included after hearing aid purchase
- 60-day trial period.
- 3-year extended warranty covers repair and 1-time loss/damage replacement*

Hearing Care Options

- Virtual visits with online appointments and remote hearing aid adjustments**
- In-person visits with the ability to choose from over 7,000 locations nationwide
-

Schedule Your In-Person Care

1. Visit [EPIChearing.com](https://www.epichearing.com) or call EPIC at 1-866-956-5400 to schedule an appointment
2. Have eligibility validated, discuss product and service options, receive provider consult letter
3. Visit an EPIC provider for hearing test and consultation
4. Discuss pricing, pay out-of-pocket costs (if any), order hearing aids
5. Receive hearing aids, fitting and follow-up care at in-person visits

Hearing Care from Home

EPIC's virtual care and direct delivery option lets you choose from hearing aids with the latest technology, including Bluetooth® streaming, rechargeable batteries and more. They're delivered right to your doorstep, complete with virtual follow-up care.

Hearing Aid Ordering Options

- Order Relate™ or Phonak hearing aids through virtual care and direct delivery, and they'll come right to your doorstep.
- Order through an in-person hearing provider, and choose from more than 2,000 name-brand hearing aids.

* One-time professional fee may apply.
**In-person visit to a local hearing provider may be required.

HEARING

When to Call EPIC

If you or a family member experience any of the following, you may have a hearing problem that could be helped by a hearing health professional:

- Difficulty understanding voices and words (especially those of women and children).
- Occasional ringing in one or both ears.
- Itching in the ear canals.
- Difficulty understanding in noisy situations.
- Turning up the television volume to understand the dialogue.

In addition, some more serious symptoms merit immediate attention by a physician:

- A sudden hearing loss.
- Spinning and dizziness with vomiting.
- Persistent ringing in one ear.
- Blood or fluid draining from one or both ears.
- Persistent pain in one or both ears.

Underwritten by Fidelity Security Life Insurance Company®, Kansas City, MO Policy Form #M-9091. Policy Number HC-111.

FEATURE	BENEFIT AMOUNT	FREQUENCY
Examination		
Adults	\$70	Adults: Once every year
Children	\$70	Children: Once every year
Hearing Aid Device		
Adults	\$500 per ear device benefit	Adults: Once every 5 years
Children	\$500 per ear device benefit	Children: Once every 2 years

For more information on EPIC or your hearing aid benefit, call 1-866-956-5400, 9 a.m. – 9 p.m. ET, Monday – Friday, or visit EPIChearing.com.

Fully Insured Exclusions: No benefits will be paid for services or materials: provided free of charge in the absence of insurance; payable under any Workers' Compensation law or similar statutory authority; payable under any governmental plan or program whether Federal, state or subdivisions thereof, except for medical assistance benefits under Title XIX of the Social Security Act (Medicaid); for the medical and/or surgical treatment of the internal or external structures of the ear(s); provided by a Hearing Aid Dispenser; required by an employer as a condition of employment; not prescribed by a Physician or Audiologist; for Hearing Aid batteries, cleaning supplies or accessories; for ear protection devices or plugs; for Assistive Listening Devices; or for replacement due to loss, theft of or damage to the Hearing Aid.

Termination of Coverage: The Insured's insurance coverage will cease on the earliest of the following dates: on the date the Policy ends; the end of the last period for which any required premium has been made; or the date the Insured is no longer eligible for insurance.

Your Hearing Rates

	10-PAY	12-PAY	18-PAY	20-PAY	21-PAY	22-PAY	24-PAY	26-PAY
Employee Only	\$2.18	\$1.82	\$1.21	\$1.09	\$1.04	\$0.99	\$0.91	\$0.84
Employee + Spouse	\$4.33	\$3.61	\$2.41	\$2.17	\$2.06	\$1.97	\$1.81	\$1.67
Employee + Children	\$3.20	\$2.67	\$1.78	\$1.60	\$1.53	\$1.46	\$1.34	\$1.23
Employee + Family	\$5.34	\$4.45	\$2.97	\$2.67	\$2.54	\$2.43	\$2.23	\$2.05

LONG-TERM DISABILITY

Employee Only, Pretax Benefit

Long-Term Disability (LTD) insurance can help safeguard your family's lifestyle and provide some peace of mind in the event you become disabled and are unable to work.

Because the State of West Virginia's retirement plan may not provide you adequate protection in the event you become disabled, you should consider enrolling in one of the two Long-Term Disability insurance plans offered by Standard Insurance Company.

When am I considered disabled?

During the benefit waiting period and the next 24 months you are considered disabled if, due to injury, physical disease, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of your own occupation, or you are unable to earn more than 80% of your pre-disability earnings while working in your own occupation.

Thereafter, you are considered disabled if, due to an injury, physical disease, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience, or you are unable to earn more than 60% of your pre-disability earnings while working in your own or any other occupation.

What is the LTD benefit?

The monthly LTD benefit is based on your earnings from your public employer. The group insurance policy refers to these earnings as pre-disability earnings. The group policy has an actively-at-work requirement you must meet before your insurance will become effective.

You may apply for coverage under either **Plan 1** or **Plan 2**. The monthly benefit under each plan is determined as follows:

- **Plan 1** - 50% of the first \$6,000 of your monthly pre-disability earnings, reduced by deductible income. The maximum monthly benefit is \$3,000.
- **Plan 2** - 70% of the first \$8,571 of your monthly pre-disability earnings, reduced by deductible income. The maximum monthly benefit is \$6,000.

Both plans have a minimum monthly LTD benefit of \$100.

What is deductible income?

Deductible Income is income you receive or are eligible to receive from other sources. It includes, but is not limited to: sick pay or other salary continuation, workers' compensation benefits, Social Security benefits, disability benefits from any other group insurance, 50% of earnings from work activity while you are disabled (after the first 12 months of your disability), and disability or retirement benefits you receive any amount you receive by compromise, settlement, or other method as a result of a claim for any of the above, whether disputed or undisputed.

When do LTD benefits become payable?

If your LTD claim is approved by The Standard Insurance Company, LTD benefits become payable at the end of the 180-day benefit waiting period. Refer to the Beyond Your Benefits section for information on taxes you may have to pay on insurance payments you receive.

How long can LTD benefits continue?

If you become continuously disabled before age 62, LTD benefits can continue during disability until age 65, or 3 years and six months if longer. If you become continuously disabled at age 62 or older, LTD benefits can continue during disability for a limited time. See the chart below.

How long are benefits payable?

Your benefits are payable according to the following schedule:

AGE	MAXIMUM BENEFIT PERIOD
age 61 or younger	to age 65 (or 3 years, 6 months, if longer)
age 62	3 years, 6 months
age 63	3 years
age 64	2 years, 6 months
age 65	2 years
age 66	1 year, 9 months
age 67	1 year, 6 months
age 68	1 year, 3 months
age 69 +	1 year

Benefits are limited to 24 months for each period of continuous disability caused or contributed by a mental disorder. This limitation will not apply if you are continuously confined in a hospital at the end of the 24 months.

This description is designed to answer some common questions about the Long-term Disability coverage. It is not intended to provide a detailed description of the plans. If you become insured, a more detailed description will be available in group insurance certificates provided to you. The controlling provisions are in the master group insurance policies. This description and the certificates do not modify the group policies or the insurance in any way. For rules governing the taxes on the insurance payments you may receive, please read the "Notices" section in the back of this guide.

LONG-TERM DISABILITY

Employee Only, Pretax Benefit

What are the exclusions and limitations?

You are not covered for a disability caused or contributed to by: 1) a pre-existing condition (except as provided in your Certificate), 2) an intentionally self-inflicted injury or 3) war or any act of war. Benefits are not payable for more than 24 months for each period of disability caused or contributed to by a mental disorder, or for any period when you are not under the ongoing care of a physician.

What is the definition of a pre-existing condition?

If your disability results, directly or indirectly, from a pre-existing sickness or injury for which you received medical treatment or services, took prescribed drugs or medicines, or consulted a Physician within three (3) months before the most recent effective date of your insurance, you will receive no monthly benefit for that condition. However, this exclusion does not apply to a period of Disability that begins after you have been insured under the plan for 12 consecutive months.

The Pre-existing Condition Exclusion will apply to any added benefits or increases in benefits.

What are some of the features of this coverage?

- Coverage for disabilities occurring 24 hours a day both on or off the job.
- Insurance continues without premium payments while LTD benefits are payable.
- A survivors' benefit may be applicable if you die while LTD benefits are payable.

Assisted Living Benefit

This benefit is available when LTD benefits are payable. It provides additional income replacement if you become disabled and cannot perform two of six activities of Daily Living or suffer a Severe Cognitive Impairment, and the condition is expected to last 90 days or more. It increases the income replacement to 80% of your pre-disability earnings. The additional benefits paid under the Assisted Living Benefit are not reduced by deductible income. The maximum benefit amount for the Assisted Living Benefit cannot exceed \$1,800 for **Plan 1** or \$857 for **Plan 2**. This benefit is available on both **Plan 1** and **Plan 2**.

Lifetime Security Benefit

This benefit provides a lifetime income to severely disabled employees, extending LTD benefits indefinitely by continuing to pay benefits, beyond the regular Maximum Benefit Period of age 65, until death at the original 70% level. Severely disabled means you cannot perform two of six activities of Daily Living or suffer a Severe Cognitive Impairment, and the condition is expected to last 90 days or more. Benefits paid under the Lifetime Security Benefit are reduced by deductible income. This benefit is available on **Plan 2**. If you have a lifetime security benefit and it continues after age 65, you will no longer be eligible for the survivor benefit.

Policy Provider

Standard Insurance Company underwrites this plan. The A.M. Best Company, an organization that rates the financial strength and performance of insurance companies, rates Standard Insurance Company "A" Excellent.

West Virginia Public Employees Insurance Agency

Policy #611506-A

Standard Insurance Company

Mon – Fri, 10 a.m. – 9 p.m. ET

1-800-368-2859

* Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.

LONG-TERM DISABILITY

Employee Only, Pretax Benefit

Pretax RATES FOR PLAN 1 (50% Coverage Level)

AGE*	MONTHLY PREMIUM RATE PER \$100 OF SALARY
to 29	\$0.15
30-34	\$0.18
35-39	\$0.22
40-44	\$0.32
45-49	\$0.46
50-54	\$0.67
55-59	\$0.95
60-64	\$1.07
65-69	\$1.35
70 and over	\$1.74

* Age as of July 1, 2021. Disability Income Plan premiums are adjusted on an annual basis according to the employee's age and salary.

Disability Income Protection Formula:

1. Enter your monthly salary (maximum \$6,000) _____
2. Divide by 100 _____
3. Find your age on the chart above and enter the figure from the "Rate" column _____
4. Multiply the amount in Line 2 by the amount in Line 3 to get your monthly premium (based on 12 months) _____
Monthly Premium

If you are paid more than 12 times a year, you can calculate the amount to be deducted from your paycheck by completing the following chart.

5. Enter the monthly premium amount from Line 4 _____
6. Multiply by 12 _____
7. This is your annual premium _____
8. Divide by the number of regular paychecks you receive annually _____
Per Paycheck Deduction

Pretax RATES FOR PLAN 2 (70% Coverage Level)

AGE*	MONTHLY PREMIUM RATE PER \$100 OF SALARY
to 29	\$0.24
30-34	\$0.29
35-39	\$0.37
40-44	\$0.52
45-49	\$0.76
50-54	\$1.12
55-59	\$1.47
60-64	\$1.57
65-69	\$1.76
70 and over	\$1.88

* Age as of July 1, 2021. Disability Income Plan premiums are adjusted on an annual basis according to the employee's age and salary.

Disability Income Protection Formula:

1. Enter your monthly salary (maximum \$8,571) _____
2. Divide by 100 _____
3. Find your age on the chart above and enter the figure from the "Rate" column _____
4. Multiply the amount in Line 2 by the amount in Line 3 to get your monthly premium (based on 12 months) _____
Monthly Premium

If you are paid more than 12 times a year, you can calculate the amount to be deducted from your paycheck by completing the following chart.

5. Enter the monthly premium amount from Line 4 _____
6. Multiply by 12 _____
7. This is your annual premium _____
8. Divide by the number of regular paychecks you receive annually _____
Per Paycheck Deduction

SHORT-TERM DISABILITY

Employee Only, Pretax Benefit

When am I considered disabled?

You are considered disabled if, due to sickness, injury or pregnancy, you are unable to perform with reasonable continuity the material duties of your own occupation or you are unable to earn more than 60% of your pre-disability earnings while working in your own occupation.

What is the STD benefit?

The weekly Short-Term Disability (STD) benefit is based on your earnings from your public employer. The group insurance policy refers to these earnings as pre-disability earnings.

The weekly benefit is 70% of your pre-disability earnings, reduced by deductible income. The maximum weekly benefit is \$750. The minimum weekly benefit is \$15.

What is deductible income?

Deductible income includes 50% of earnings from work activity while you are disabled, and disability benefits you receive or are eligible to receive because of your disability under any state disability benefit law or similar law. Any amount you receive by compromise, settlement, or other method as a result of a claim for any of the above, whether disputed or undisputed.

When do STD benefits become payable?

If your STD claim is approved by The Standard Insurance Company, STD benefits become payable at the end of the 30-day benefit waiting period. During this 30-day period, no STD benefits are payable.

The Group Policy has an actively-at-work requirement you must meet before your insurance will become effective.

How long can STD benefits continue?

STD benefits can continue during the disability until no longer disabled, but no longer than the 180th day of disability.

What are the exclusions and limitations?

You are not covered for a disability caused or contributed to by: 1) a work-related injury, 2) an intentionally self-inflicted injury or 3) war or any act of war. Benefits are not payable for any period when you 1) receive or are eligible to receive sick leave, 2) are working for any employer other than the State of West Virginia or your public employer, 3) are eligible for any benefits under a workers' compensation act or similar law or 4) are not under the ongoing care of

a physician.

This description is designed to answer some common questions about the Short-Term Disability coverage. It is not intended to provide a detailed description of the plan. If you become insured, a more detailed description will be available in group insurance certificates provided to you. The controlling provisions are in the master group insurance policies. This description and the certificates do not modify the group policies or the insurance in any way.

For rules governing the taxes on the insurance payments you may receive, please read the "Notices" section in the back of this benefits guide.

Policy Provider

Standard Insurance Company underwrites this plan. The A.M. Best Company, an organization that rates the financial strength and performance of insurance companies rates Standard Insurance Company "A" Excellent.

YOUR PRETAX RATES

Example: If your weekly salary is \$350, your monthly premium would be calculated:
 $\$350 \times \$0.0315 = \$11.02$ per month.

WORKSHEET:

1. Your weekly salary (maximum _____
\$1,071.00) X \$0.0315

2. This is your monthly premium _____

If you are paid more than 12 times a year, you can calculate the amount to be deducted from your paycheck by completing the following chart.

3. Enter the monthly premium amount from **Line 2** _____

4. Multiply by 12 _____

5. This is your annual premium _____

6. Divide by the number of regular paychecks you receive annually _____
Per Paycheck Deduction

West Virginia Public Employees Insurance Agency

Policy #611506-B

Standard Insurance Company

Mon – Fri, 10 a.m. – 9 p.m. ET

1-800-368-2859

ARAG LEGAL INSURANCE

A Payroll Deductible, Post-tax Benefit



Affordable Legal Protection with Access to Network Attorneys

We're excited to provide you with valuable legal protection from ARAG®. It's affordable legal counsel for everyday life matters – like a dispute with a contractor, buying or selling a home or the need for estate planning. The plan provides you with the peace of mind knowing that attorney fees for most covered legal matters are 100% paid in full when you work with a network attorney. That means you'll avoid paying high-cost attorney fees, which currently average \$368 an hour.*

Resolve Your Legal Issues with a Network Attorney by Your Side

When a life event turns into a legal issue, ARAG will be there for you, backed by a nationwide network of knowledgeable attorneys who average more than 20 years of experience. They can review or prepare documents, make follow-up calls or write letters on your behalf, provide legal advice and consultation, and represent you in court. Rely on legal help and protection with a wide range of covered services. For additional details regarding your plan's specifically-covered services, visit ARAGLegal.com/myinfo and enter **Access Code 18387wv** to learn more about what these plans offer, research specific legal topics and more.

Pre-existing Legal Matters

For any legal matters not covered and not excluded, you may be eligible to receive a minimum 25% reduced fee off a network attorney's normal hourly rate.

Call for Questions or Legal Assistance

You can also get assistance from our award-winning Customer Care Center with dedicated specialists who will help you navigate your legal issues. Call **800-247-4184** to speak with an ARAG Customer Care Specialist.

* Average attorney rates in the United States of \$368 per hour for attorneys with 11-15 years of experience, Survey of Law Firm Economics, The National Law Journal and ALM Legal Intelligence, November 2019.

Visit ARAGLegal.com/myinfo and enter Access Code 18387wv to learn more about your legal benefit!

See the plan options on the following page.

Your Post-Tax Group Legal Rates

UltimateAdvisor®	10-PAY	12-PAY	18-PAY	20-PAY	21-PAY	22-PAY	24-PAY	26-PAY
Employee & Family	\$11.40	\$9.50	\$6.33	\$5.70	\$5.43	\$5.18	\$4.75	\$4.38
UltimateAdvisor Plus™	10-PAY	12-PAY	18-PAY	20-PAY	21-PAY	22-PAY	24-PAY	26-PAY
Employee & Family	\$16.68	\$13.90	\$9.27	\$8.34	\$7.94	\$7.58	\$6.95	\$6.42

ARAG LEGAL INSURANCE

Compare Your Legal Insurance Plan Options from ARAG®

Plan Options	Ultimate Advisor®	Ultimate AdvisorPlus™
Consumer Protection		
Auto Repairs, Buy/Sell a Car, Consumer Fraud, Contractors and More	•	•
Insurance Disputes	•	•
Estate Planning		
Wills and Powers of Attorney	•	•
Revocable Living Trusts		•
Irrevocable Living Trusts		•
Estate Administration & Closing (9 Hours)	•	•
Family		
Adoption	•	•
Alimony/Child Custody/Visitation/Child Support (8 Hours)		•
Initial Child Custody/Child Support Agreements (8 Hours)		•
Contested Divorce (30 Hours)	•	•
Uncontested Divorce	•	•
Domestic Violence Protection	•	•
Restraining/Protective Order	•	•
Elder Law - Member Support	•	•
Guardianship/Conservatorship	•	•
Mental Incompetency or Infirmary	•	•
Name Change	•	•
Prenuptial Agreements	•	•
School Administrative Hearings	•	•
Real Estate — Primary and Secondary Residence		
Building Codes — Primary Residence	•	•
Building Codes — Secondary Residence		•
Buy/Sell — Primary Residence	•	•
Buy/Sell — Secondary Residence		•
Easements — Primary Residence	•	•
Easements — Secondary Residence		•
Foreclosure — Primary Residence	•	•
Foreclosure — Secondary Residence		•
Home Equity Loan — Primary Residence	•	•
Home Equity Loan — Secondary Residence		•
Neighbor Disputes — Primary Residence	•	•
Neighbor Disputes — Secondary Residence		•
Real Estate Disputes — Primary Residence	•	•
Real Estate Disputes — Secondary Residence		•
Refinance — Primary Residence	•	•
Refinance — Secondary Residence		•
Zoning and Variances — Primary Residence	•	•
Zoning and Variances — Secondary Residence		•
Traffic and Vehicle		
Driving Privilege Protection	•	•
Driving Privilege Restoration	•	•
Minor Traffic (Excluding DWI)	•	•

Plan Options	Ultimate Advisor®	Ultimate AdvisorPlus™
Services for Tenants		
Disputes with a Landlord — Contracts, Lease, Eviction, Deposits	•	•
Financial Services		
Financial Education and Counseling Services		•
Immigration		
Immigration Services	•	•
Government Benefits		
Social Security/Veterans/Medicare	•	•
Identity Theft		
Identity Theft Services	•	•
Full-Service Identity Restoration		•
\$1 Million Theft Insurance¹		•
Single-Bureau Credit Monitoring		•
Internet Surveillance		•
Change of Address Monitoring		•
Child Identity Monitoring		•
Lost Wallet Services		•
Taxes		
Tax Services		•
IRS Audit Protection	•	•
IRS Collection Defense	•	•
State and Local Tax Audit	•	•
State and Local Tax Collection Defense	•	•
Property Tax — Primary Residence	•	•
Property Tax — Secondary Residence		•
Debt		
Bankruptcy	•	•
Defense of Debt Collection	•	•
Defense of Garnishment	•	•
Mechanic's Lien	•	•
Student Loan Debt Collection	•	•
Services for Parents/Grandparents		
Annual Legal Checkup, Advice and Caregiving Services		•
Criminal		
Criminal Misdemeanor Defense	•	•
Habeas Corpus	•	•
Parental Responsibilities	•	•
Juvenile Court	•	•
Civil Damage Defense		
Libel/Slander, Pet-Related Matters and More	•	•
General Coverages		
Credit Record Correction	•	•
Small Claims Court	•	•
Miscellaneous Services (8 Hours per Year)		•
Document Preparation and Review	•	•
Personal Property Protection	•	•



800-247-4184

ARAGlegal.com/plans, access code 18387wv

You may be eligible to receive a minimum 25% reduced fee off a network attorney's normal hourly rate for any other non-covered and non-excluded issues.

¹The Identity Theft Insurance is underwritten and administered by American Bankers Insurance Company of Florida, an Assurant company. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions. Please see the plan summary document for details. Limitations and exclusions apply. Depending upon a state's regulations, ARAG's legal insurance plan may be considered an insurance product or a service product. Insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa. Service products are provided by ARAG Services, LLC. This material is for illustrative purposes only and is not a contract. For terms, benefits or exclusions, contact us.

FLEXIBLE SPENDING ACCOUNTS



Flexible Spending Accounts

A Flexible Spending Account (FSA) lets you pay for eligible expenses with tax-free money. You contribute to an FSA with pretax money from your paycheck. This, in turn, may help lower your taxable income. There are two types of FSAs – Healthcare FSA and Dependent Care FSA.

Healthcare FSA

A Healthcare FSA is used to pay for eligible medical expenses which are not covered by your insurance or other plan. These expenses can be incurred by you, your spouse, a qualifying child or relative. Your full annual contribution amount is available at the beginning of the plan year, so you don't have to wait for the money to accumulate.

Please note that:

- Healthcare FSA card transactions under \$150 **DO NOT** require supporting documentation to be approved.
- Healthcare FSA card transactions for Dental claims **DO NOT** require supporting documentation to be approved.

Dependent Care FSA

The Dependent Care FSA is a great way to pay for eligible dependent care expenses, such as: before and after school care, day time baby-sitting fees, elder care services, nursery and preschool costs. Eligible dependents include your qualifying child up to age 13, your spouse and/or relative unable to care for him or herself.

Once you pay for dependent care services for your eligible dependent(s), you can request reimbursement from your Dependent Care FSA. Please note that you are only able to submit a claim for the amount that is available in your account at the time of your reimbursement request. Unlike the Healthcare FSA, your full annual contribution is not available at the beginning of the plan year.

Annual Contribution Limits For Healthcare FSA:

- Minimum Annual Contribution: \$150
- Maximum Annual Contribution: \$3,050*

For Dependent Care FSA:

- Minimum Annual Contribution: \$150
- The maximum contribution depends on your tax filing status.
- If you are married and filing separately, your maximum annual contribution is \$2,500*.
- If you are single and head of household, your maximum annual contribution is \$2,500*.
- If you are married and filing jointly, your maximum annual contribution is \$5,000*.
- If either you or your spouse earn less than \$5,000* a year, your maximum annual contribution is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual contribution is \$3,000* a year for one dependent and \$5,000 a year for two or more dependents.

*Including administrative fees

Grace Period and Run Out Period

You have a 120-day run-out period (ending **October 31, 2024**) after your 2023 plan year ends to submit reimbursement requests for all eligible FSA expenses incurred DURING your plan year.

You may, however, continue using only your Healthcare FSA during the grace period (ending **September 15, 2024**), which is two months and 15 days after the end of your 2023 plan year. Be sure to submit your grace period claims before the end of your 120-day run-out period.

FLEXIBLE SPENDING ACCOUNTS

FSA Appeals and Managing Your FSA Online

Appeals Process

If you have an FSA reimbursement claim denied, in full or in part, you have the right to appeal the decision by sending a written request within 30 days of the denial for review by mail to:

PayFlex Systems USA, Inc.
Flex Department
PO Box 8396
Omaha, NE 68103-8369

or Fax to: **1-855-703-5305**

Your appeal must include:

- The name of your employer;
- The date of the services for which your request was denied;
- A copy of the denied request;
- The denial letter you received;
- Why you think your request should not have been denied; and
- Any additional documents, information or comments you think may have a bearing on your appeal.

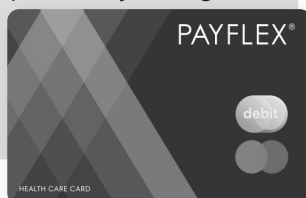
Your appeal and supporting documentation will be reviewed upon receipt. You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and the IRS regulations governing the plan.

Use your PayFlex Card®, your account debit card

The PayFlex debit card is a convenient way to pay for eligible Healthcare expenses. The card knows when the expense is eligible and whether you have funds available. When you use the card, save your Explanation of Benefits, itemized statements and detailed receipts. There may be times when PayFlex asks you to provide documentation to verify you used your card for an eligible expense. If you're a new Healthcare FSA member, you'll automatically receive one card in the mail before the beginning of the plan year. The card is not available for the dependent care FSA. Additional cards may be requested by calling the PayFlex customer service at

1-844-PAYFLEX (1-844-729-3539).



Filing a Claim with PayFlex

If you pay for an eligible expense with cash, check or personal credit card, you can file a claim online at payflex.com or through the PayFlex Mobile® app to pay yourself back for your out of pocket expenses. Or you can fill out a paper claim form and mail it to PayFlex at:

PayFlex Systems USA, Inc.
Flex Department
PO Box 8396
Omaha, NE 68103-8369

or Fax to: **1-855-703-5305**

This form can be found in the Resource Center at payflex.com or you may call PayFlex at **844-PAYFLEX** to request a form.

After you log in to payflex.com, click on the **Financial Center** tab and select your account from the drop down. Click on **File a Spending Account Claim** to get started.

When you submit a claim or validate a card swipe, you need to include supporting documentation that shows the following required items for approval.

Five Required Items for FSA Claim Approval:

- Merchant or service provider name
- Name of patient (if applicable)
- Date of service
- Amount you were required to pay
- Description of item or service

How to Register Online

- Go to payflex.com.
- Click on Create Your Profile and follow the online instructions.
- After successfully registering your account, My Dashboard will be displayed and you will be able to access your account information.
- To receive electronic account notifications, select My Settings at the top of the page

Step 1. Select the notifications link.

Step 2. Enter your email address and then re-enter to confirm.

Step 3. Then select the notifications you wish to receive and click "Submit."

Enroll in Direct Deposit

To receive your claim payments quickly, sign up for direct deposit through the PayFlex member website. Log in to payflex.com. Click on the "Financial Center" tab. Select your account from the drop down menu and click on "Enroll in Direct Deposit" to get started.

HEALTH SAVINGS ACCOUNT

For Members with High Deductible Health Plan Only (PEIA PPB Plan C)

What is a Health Savings Account?

Providing economical Healthcare while costs are rising is a major issue facing the nation. To deal with this issue and help you plan for future health expenses, you will have the choice of enrolling in a Health Savings Account (HSA). This option allows you and your family to take greater responsibility for your medical care to reduce your insurance premiums and save money for future health expenses.

A Health Savings Account (HSA) is a tax-free account that can be used to pay Healthcare expenses. Unlike money in a Flexible Spending Account, the funds do not have to be spent in the plan year they are deposited. Money in the account, including interest or investment earnings, accumulates tax-free, so the funds can be used to pay qualified medical expenses in the future¹. An important advantage of an HSA is that it is owned by the employee. If you leave your job, you can take the account with you and continue to use it for qualified medical expenses.

Who is eligible to contribute to an HSA?

- Employees must be covered by an eligible, high deductible health plan (PEIA PPB Plan C).
- Employees cannot be covered by any other health plan that is not a qualified high deductible health plan, including Medicare. However, they may be covered for specific injuries, accidents, disability, dental care, vision care and long-term care.
- Participants cannot be claimed as a dependent on another person's tax return.

How much can I contribute to my HSA?

If you enroll in an HSA and elect to make contributions, your contributions are deducted on a pretax basis. The 2023 annual HSA contribution limit for individuals with self-only HDHP coverage will be \$3,850 – a \$200 increase from 2022. The 2023 limit for individuals with family HDHP coverage will be \$7,750 – a \$450 increase from 2022.

These limits, established by the federal government and subject to change, are tied to the rate of inflation. An individual age 55 and older may make “catch-up” contributions of up to \$1,000 above the limits shown above in 2024.²

You may also make after-tax contributions, which apply toward the maximum annual limit(s). You will receive additional information when you enroll.

Can I transfer funds from my IRA to my HSA?

A one-time irrevocable trustee-to-trustee transfer of IRA funds to an HSA will be allowed as long as the transferred amount does not exceed the annual HSA contribution limits³. Any transfer from an IRA to an HSA will reduce the maximum amount that may be contributed to an HSA during a calendar year.

How do I access the funds in my HSA account?

After electing the HSA, your information and account is established. Please go to payflex.com to open your account. You will receive a MasterCard with instructions on how to go to payflex.com and create your profile. You can link your bank account and set up for alerts. You may order additional cards at no charge online or by calling customer service at **844-729-3539**. You may use your MasterCard to pay for eligible expenses. However, if you withdraw funds for ineligible expenses, you may have to pay taxes and penalties on those funds, unless you reimburse your HSA for the ineligible expense.

Will I be charged any banking or custodian fees?

The custodian will charge you \$2.50 per month for your HSA. This fee includes the MasterCard® debit card, all transaction fees associated with the card. To make an HSA payment, use the online payment tool to pay your provider directly from your HSA. A check will be mailed to your provider at no additional cost. Other fees may apply, including fees for insufficient funds and account closure fees. Refer to the PayFlex Fees and Charges for more information.

PRETAX BENEFITS SAVINGS EXAMPLE*

(With HSA)		(Without HSA)
\$31,000	Annual Gross Income	\$31,000
- 5,000	HSA Deposit for Recurring Expenses	- 0
\$26,000	Taxable Gross Income	\$31,000
- 5,369	Federal, Social Security Taxes*	- 6,401
\$20,631	Annual Net Income	\$24,599
- 0	Cost of Recurring Expenses	- 5,000
\$20,631	Spendable Income	\$19,599

By using an HSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of:

\$1,032!

* Based upon a 20.65% tax rate (15% federal and 7.65% Social Security) calculated on a calendar year.

Remember, Limited Healthcare FSAs are available to HSA participants. Dependent Care Spending Account eligibility is not affected by your HSA participation. Limited Healthcare FSAs are ONLY available to HSA participants.

¹ Please consult your tax advisor or IRS Publication 502 with questions regarding these expenses, qualified health plans, and tax information. Accounts opened prior to March 1, 2022 will continue their current fee structure of \$2 per month maintenance fee waived with an average daily balance of \$2,500 and a \$0.50 per check written fee. Other fees may apply, including fees for insufficient funds. Refer to the PayFlex Fees and Charges for more information.

² The “catch-up” contribution rule applies to employees who are or become age 55 prior to 12/31 of the election year.

³ Please consult a tax advisor. Certain restrictions apply.

LIMITED HEALTHCARE FSA

FSA Annual Contribution Limits:

- Minimum Annual Contribution: **\$150**
- Maximum Annual Contribution: **\$3,050**

Limited Healthcare FSA (LPFSA) is offered in conjunction with your Health Savings Account, should you elect. LPFSA funds can only be used for dental and vision. You are not allowed to contribute to both a health savings account as well as a standard (non-limited) healthcare FSA.

Whose expenses are eligible?

Your LPFSA may be used to reimburse eligible expenses incurred by yourself, your spouse, your qualifying child or your qualifying relative.

When are my funds available?

Funds are available on day one of the plan. Once you sign up for a LPFSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible expenses will be available throughout your period of coverage.

Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible expenses at the start of your plan year, which is **July 1, 2023**.

FSA Grace Period and Run-Out Period Dates

Your FSA grace period ends two months and 15 days after the end of your plan year. During the FSA grace period, you may incur expenses and submit claims for those expenses. The grace period does not apply to Dependent Care FSAs.

Your grace period ends September 15, 2024.

Your FSA run out period is a 120-day run-out period after your plan year ends to submit reimbursement requests for all eligible FSA expenses (for both Healthcare or Dependent Care FSAs) incurred DURING your plan year. Be sure to submit your grace period claims before the end of your 120-day run-out period.

Your run-out period ends October 31, 2024.

CHANGING YOUR COVERAGE

Changing Your Benefits During The Plan Year

You will have the month of and two months following a qualifying event to submit an election form and supporting documentation to your benefits coordinator. Upon the approval of your election change request, your existing benefit elections will be stopped or modified (as appropriate). However, if your benefit election change request is denied, you have the month of and two months following from the date of a qualifying event, to file an appeal with your employer. For more information, contact your employer's Benefit Coordinator. *All changes must be approved by your coordinator prior to submission to FBMC.*

CHANGES IN STATUS:

Marital Status	A change in marital status includes marriage, death of a spouse, divorce or annulment (legal separation is not recognized in all states).
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid Change In Status (CIS) event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital, employment or tax dependent status.
Change in Residence*	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.

SOME OTHER PERMITTED CHANGES:

Coverage and Cost Changes*	Your employer's plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Care FSA benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.
Open Enrollment Under Other Employer's Plan*	You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and: <ul style="list-style-type: none"> The other employer's plan has a different period of coverage (usually a plan year) or The other employer's plan permits mid-plan year election changes under this event.
Judgment/Decree/Order†	If a judgment, decree or order from a divorce, legal separation (if recognized by state law), annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Medicare/Medicaid†	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. Note that a Healthcare FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.
Family and Medical Leave Act (FMLA) Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.

* Does not apply to a Healthcare FSA plan.

† Does not apply to a Dependent Care FSA plan.

NOTICES

COBRA

Overview

The right to COBRA continuation coverage was created by a federal law, the **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**. COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event, also called a “qualifying event.” After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

- Your spouse dies; Your spouse’s hours of employment are reduced; Your spouse’s employment ends for any reason other than his or her gross misconduct; Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies; The parent-employee’s hours of employment are reduced; The parent-employee’s employment ends for any reason other than his or her gross misconduct; The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); The parents become divorced or legally separated; or The child stops being eligible for coverage under the Plan as a “dependent child.”

When is COBRA available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the State of West Virginia. However, due to COVID-19, certain COBRA deadlines have been extended, including the timeframe to elect COBRA coverage, the date for making COBRA premiums, and the date to notify the plan of a qualifying event or disability determination. Please ask your COBRA administrator for more information.

Options Besides COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [Healthcare.gov](https://www.healthcare.gov).

More Information

This COBRA Q&A section does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from your employer.

Keep Address Updated

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

This is not an exhaustive account of your right under, or the conditions of, COBRA. Complete information will be provided in separate notices as appropriate.

TAXABLE BENEFITS AND THE IRS

Certain benefits may be taxed if you become disabled, depending on how the premiums were paid during the year of the disabling event. Payments, such as disability, from coverages purchased with pretax premiums and/or nontaxable employer credits, will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pretax and after-tax dollars, then any payments received under the plan will be taxed on a pro-rata basis. If premiums were paid on a post-tax basis, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages. Consult your personal tax adviser for additional information.

In addition, FICA and Medicare taxes will be withheld from any disability payments paid through six calendar months following the last calendar month in which you worked prior to becoming disabled. Thereafter no FICA or Medicare tax will be withheld.

You will be required by the IRS to pay FICA, Medicare, and federal income taxes on certain other benefit payments, such as those from Hospital Indemnity Insurance, Personal Cancer Expense Insurance and Hospital Intensive Care Insurance, that exceed the actual Healthcare expenses you incur, if these premiums were paid with pretax dollars and/or nontaxable employer credits. If you have questions, consult your personal tax adviser.

SOCIAL SECURITY

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors’ and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.

However, the tax savings realized through a cafeteria plan may generally outweigh the Social Security reduction.

DISCLAIMER - HEALTH INSURANCE BENEFITS PROVIDED UNDER HEALTH INSURANCE PLAN(S)

Health Insurance benefits will be provided not by your employer’s flexible benefits plan, but by the health insurance plan(s). The types and amounts of health insurance benefits available under the health insurance plan(s), the requirements for participating in the health insurance plan(s) and the other terms and conditions of coverage and benefits of the health insurance plan(s) are set forth from time to time in the health insurance plan(s). All claims to receive benefits under the health insurance plan(s) shall be subject to and governed by the terms and conditions of the health insurance plan(s) and the rules, regulations, policies and procedures from time to time adopted.

NOTICE OF FBMC’s CAPACITY

FBMC Benefits Management, Inc. (FBMC) has been authorized by your employer to provide certain administrative services for some of the insurance plans offered within your employer’s benefit program. Importantly, FBMC is not the policyholder or an insurance company. The policyholder is the entity to whom the insurance policy has been issued; the employer is the policyholder for group insurance products and the employee is the policyholder for individual products. The policyholder is identified on either the face page or schedule page of the policy or certificate. The insurance companies noted in this guide have been selected by your employer and are liable for the funds to pay your insurance claims.

BENEFITS DIRECTORY

FBMC Benefits Management, Inc.

Contract Benefits Administrator

FBMC Online Technical Support
techsupport@fbmc.com

FBMC Service Center

Benefit Inquiries
svccenter@fbmc.com

Monday – Friday, 7 a.m. – 7 p.m. ET
1-844-55-WVA4U (1-844-559-8248)

EPIC Hearing Service Plan

Monday – Friday, 9 a.m. – 9 p.m. ET
1-866-956-5400
epichearing.com

Sun Life Dental

Plan number: 959860
Plan Year Customer Service Line:
Monday – Friday, 8 a.m. – 8 p.m. ET
1-844-583-5036
<http://www.sunlife.com/wvpeia>

Humana / EyeMed Vision

Customer Service
Monday – Saturday, 7:30 a.m. – 11 p.m. ET
Sunday, 11 a.m. – 8 p.m. ET
1-877-398-2980
www.humana.com

ARAG Legal

Customer Care Number:
Monday – Friday, 8 a.m. – 8 p.m. ET
1-800-247-4184
1-800-383-4184 for TTY
Access code: **18387wv**
ARAGlegal.com/myinfo

Standard Insurance Company

Short-Term / Long-Term Disability Claims
(STD) Policy #**611506-B**
(LTD) Policy #**611506-A**
Customer Service
Monday – Friday, 10 a.m. – 9 p.m. ET
1-800-368-2859
standard.com

Trustmark Insurance Company*

LifeEvents®
Customer Service
Monday – Thursday, 7 a.m. – 7 p.m.
Friday, 7 a.m. - 6 p.m.
1-800-918-8877
trustmarksolutions.com

PayFlex

Flexible Spending Accounts & Health Savings
Accounts
Customer Service
Monday – Friday, 8 a.m. – 8 p.m. ET
Saturday, 10 a.m. - 3 p.m. ET
1-844-PAYFLEX (1-844-729-3539) *
Toll-Free Claims Fax: **1-888-238-3539**
payflex.com *

* Can provide replacements for lost or stolen cards

PayFlex Systems USA, Inc.

COBRA
1-800-359-3921
payflex.com

*Trustmark no longer offers new LifeEvents® policies. Employees who currently have LifeEvents may continue coverage.

PY 2023-2024 BENEFIT FAIRS

Date	Location	Time
Tuesday, April 11	Holiday Inn Express – Charleston Civic Center 100 Civic Center Drive, Charleston, WV 25301	3 p.m. – 6 p.m.
Wednesday, April 12	Tamarack Conference Center 1 Tamarack Park Beckley, WV 25801	3 p.m. – 7 p.m.
Thursday, April 13	Delta Hotels Huntington Downtown Huntington, WV 25701	3 p.m. – 7 p.m.
Tuesday, April 18	West Virginia Northern Community College J. Michael Koon Auditorium (1st floor of the B&O Building), 1704 Market Street, Wheeling, WV 26003	3 p.m. – 7 p.m.
Wednesday, April 19	University Holiday Inn 1188 Pineview Drive Morgantown, WV 26508	3 p.m. – 7 p.m.
Thursday, April 20	Holiday Inn 301 Foxcroft Avenue Martinsburg, WV 25401	3 p.m. – 7 p.m.
Tuesday, April 25	167 Elizabeth Pike Mineral Wells, WV 26150	3 p.m. – 7 p.m.



Contract Administrator

FBMC Benefits Management, Inc.

PO Box 1878 • Tallahassee, Florida 32302-1878

Information contained herein does not constitute an insurance certificate or policy.
Certificates or policies will be provided to participants following the start of the plan year, if applicable.
The information in this guide constitutes a Summary of Material Modifications.