MOUNTAINEER
FLEXIBLE BENEFITS
FBMC BENEFITS MANAGEMENT, INC.

WEST VIRGINIA

2025 EMPLOYEE FLEXIBLE BENEFITS GUIDE

Connect with Your Benefits

mountaineer.fbmcbenefits.com

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If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

LET'S GET STARTED

MOUNTAINEER FLEXIBLE BENEFITS
FBMC BENEFITS MANAGEMENT

Who is Eligible?

- All active employees of state agencies, colleges and universities and participating County Boards of Education
- This program is also offered to some non-state agencies. Check with your benefits department.
- If you feel you are eligible for COBRA, see page 33

Important Dates to Remember

Your Open Enrollment dates are:

April 2, 2024 - May 15, 2024.

Benefit Education Schedule

See page 5

Your Period of Coverage dates are:

July 1, 2024 - June 30, 2025.

WHAT'S CHANGING FOR 2025

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

1. **New voluntary benefit education resources:** Scan the QR Code on page 4, or call 844-633-6797 to schedule your appointment and learn about your voluntary benefit options.
2. **Benefit expansion!** Three new voluntary benefits are available to you this year:
   - **Hospital Indemnity**
   - **Critical Illness**
   - **Accident**
3. **MetLife** will be the new provider for your disability plans, and some disability plan rates will be lower.
4. **New Name** - PayFlex is now **Inspira Financial**. Your PayFlex login username and password will still work. If you have a PayFlex-branded card associated with your account, it will work until the card expires.
5. FSA and HSA limits are changing, see page 13

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. **See page 4 for How to Enroll**

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**).

HOW TO ENROLL IN YOUR VOLUNTARY BENEFITS

Enroll With a Benefits Counselor

We have three methods to schedule

- **Telephonically**
- **Virtually**
- **On-site**

https://booknow.appointment-plus.com/dhvjny10/

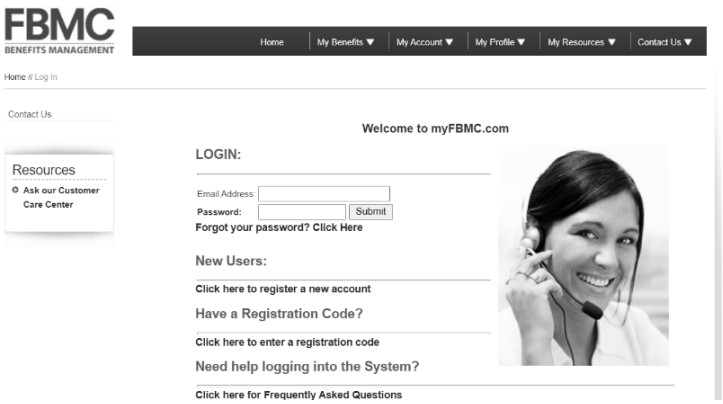
SCAN ME

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 Social Security number (current users will continue to use your existing login credentials). If you previously registered an email address and password on FBMC's website, you may continue using this information. For Online Tech Support, submit inquiry to techsupport@fbmc.com.



Enroll by Paper

You must enroll by paper form, if you:

- Are a new hire after **March 1, 2024**.
- Currently do not participate.
- Work for a non-state agency or a County Board of Education and are not currently enrolled in benefits through the Mountaineer Flexible Benefits Plan.

BENEFIT EDUCATION SCHEDULE

PEIA - MOUNTAINEER FLEX BENEFIT FAIRS		
Date	**Location**	**Time**
Tuesday, **April 16**	Holiday Inn Express – Charleston Civic Center 100 Civic Center Drive, Charleston, WV 25301	3 p.m. – 6 p.m.
Wednesday, **April 17**	Tamarack Conference Center 1 Tamarack Park Beckley, WV 25801	3 p.m. – 7 p.m.
Thursday, **April 18**	Cabell County Library 455 9th St, Huntington, WV 25701	3 p.m. – 6 p.m.
Tuesday, **April 23**	Holiday Inn – Martinsburg 301 Foxcroft Avenue Martinsburg, WV 25401	3 p.m. – 7 p.m.
Wednesday, **April 24**	Holiday Inn Morgantown – University Area 1188 Pineview Drive Morgantown, WV 26508	3 p.m. – 7 p.m.
Thursday, **April 25**	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.
Tuesday, **April 30**	167 Elizabeth Pike Mineral Wells, WV 26150	3 p.m. – 7 p.m.
VIRTUAL OPEN ENROLLMENT UPDATE SESSIONS		
Wednesday, **April 10**	**Meeting ID**: meet.google.com/qej-ovtx-yen **Phone Number**: 1-971-301-5590 **PIN**: 978 945 135#	3 p.m.
Thursday, **May 2**	**Meeting ID**: meet.google.com/vft-ztgo-ewb **Phone Number**: 1 413-561-7676 **PIN**: 705 669 821#	9 a.m.

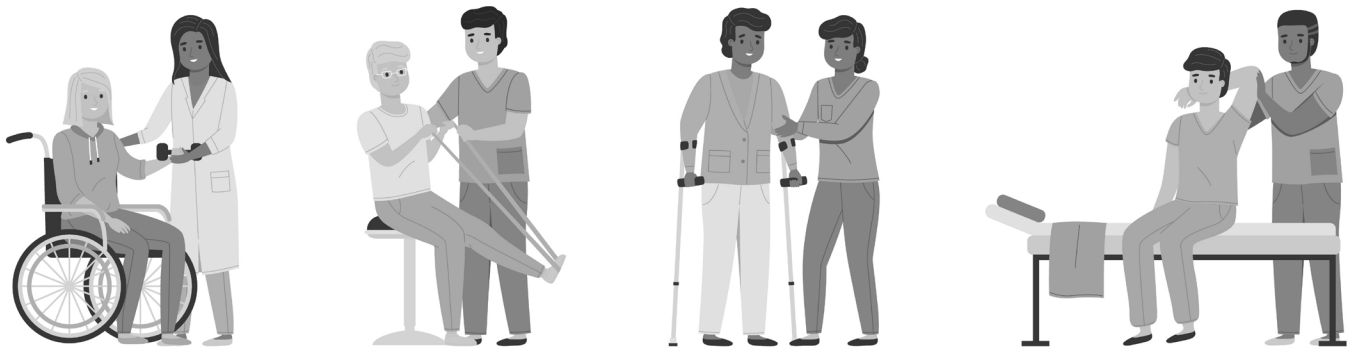
New voluntary benefit education opportunity allows you to meet with a benefit counselor one of three ways: telephonically, virtually or on-site.

SCAN ME

If there is any discrepancy between the plan details in this benefits guide and the official plan documents, the language in the official plan documents shall prevail as accurate.

ACCIDENT INSURANCE

NEW BENEFIT AVAILABLE FOR YOU THIS YEAR



HOW ACCIDENT INSURANCE CAN HELP A FAMILY

Your teenager breaks their leg while playing in a game for their high school basketball team.

COVERED BENEFITS	PAYMENT SCHEDULE	CONCLUSION
Ambulance ride to hospital	$400	You receive up to $3,700 to help you offset out-of-pocket expenses – without having to rely solely on your savings. You can use the $3,700 benefit to supplement out-of-pocket medical expenses like in this example, but you can also use the benefits for everyday expenses. Keep in mind that this is not tied to the medical plan; you could use it for cab fare to the hospital or for parking or taking a vacation.
Emergency room or urgent care visit	$200	
X-ray	$100	
Diagnosis of leg fracture	$1,500	
Medical device (crutches)	$400	
Follow-up visit (6 visits per accident @ $100/visit)	$600	
Physical therapy (10 visits per accident @ $50/visit)	$500	
Total payments received from Sun Life Accident policy	$3,700	

Accident Rates

	10-PAY	12-PAY	18-PAY	20-PAY	21-PAY	22-PAY	24-PAY	26-PAY
Employee Only	$7.80	$6.50	$4.33	$3.90	$3.71	$3.55	$3.25	$3.00
Employee + Spouse	$18.72	$15.60	$10.40	$9.36	$8.91	$8.51	$7.80	$7.20
Employee + Children	$18.08	$15.07	$10.04	$9.04	$8.61	$8.22	$7.54	$6.96
Employee + Family	$29.00	$24.17	$16.11	$14.50	$13.81	$13.19	$12.09	$11.16

ACCIDENT INSURANCE

Accident Insurance helps protect your finances after a mishap. When you, your spouse or child has a covered accident, like a fall from a bicycle that requires medical attention, you can receive cash benefits to help cover the unexpected costs.

While health plans may cover direct costs associated with an accident, you can use accident benefits to help cover related expenses like lost income, child care, deductibles and co-pays.

Benefits are payable directly to you. Accident Insurance can be used however you want, and it pays in addition to any other coverage you may already have. And get this – there are no health questions or pre-existing conditions limitations.

What's more, all enrolled family members on your plan are eligible for a wellness-screening benefit, also paid directly to you, once each year per covered person up to a maximum of $300 per family per year.

ACCIDENT INSURANCE

New Product

WHAT'S COVERED

Once your coverage goes into effect, you can file a claim for covered accidents that occur after your insurance plan's effective date. Unless otherwise specified, benefits are payable only once for each covered accident, as applicable. The full list of benefits is listed here.

DISLOCATIONS	SURGICAL PROCEDURE	NON-SURGICAL PROCEDURE
Hip, Knee, ankle, or bones of the foot, Elbow, wrist, Shoulder, Collarbone, bones of the hand or Lower jaw, Finger(s) or toe(s) (Cost varies depending on the procedure)	$400-$8,000	$200-$4,000
FRACTURES	**SURGICAL PROCEDURE**	**NON-SURGICAL PROCEDURE**
Hip or thigh, Skull-depressed, Skull-simple, Vertebral processes, Bones of the face, Nose, Upper jaw, upper arm, Lower jaw, Collarbone, Shoulder, Forearm, Hand, Wrist, Foot, Ankle, Kneecap, Elbow, Heel or Multiple ribs, Leg, Vertebrae, Sternum or Pelvis, Rib, Finger, Toe or Coccyx	$600 - $7,500	$300 - $3,750
ADDITIONAL INJURIES		
Eye Injury - surgical repair, Eye Injury - object remove, Brain injury, Paralysis—paraplegia, Paralysis—quadriplegia, Coma, Concussion		$200- $25,000
BURNS	**2ND DEGREE**	**3RD DEGREE**
21-40 square centimeters, 41-65 square centimeters, 66-160 square centimeters, 161-255 square centimeters, More than 225 square centimeters, Skin graft (50% of the applicable Burn Benefit)	$300 - $1,500	$750 - $15,000
LACERATIONS		
No sutures and treated by doctor, Single laceration under 5 cm with sutures, 5-15 cm with sutures (total of all lacerations), Greater than 15 cm with sutures (total of all lacerations)	$35 - $700	
MEDICAL SERVICES		
Diagnostic Exam - Arteriogram, Angiogram, CT, CAT, EKG, EEG, or MRI (1 time per benefit year)	$200	
Diagnostic Exam - X-ray (1 time per covered accident)	$100	
Accident Emergency Treatment, non-emergency room (once per covered accident)	$200	
Physician's Follow-up Treatment office visit (per visit, up to 6 times per covered accident)	$100	
Physical Therapy (per visit up to 10 visits per covered accident)	$50	
Medical Devices	$400	
Epidural Pain Management (up to 2 times per covered accident)	$100	
Prescription drug	$35	
Prosthesis (one)	$750	
Prosthesis (two)	$1,500	
Blood, Plasma, or Platelet Transfusion	$200	

ACCIDENT INSURANCE

New Product

HOSPITAL	
Hospital Admission (once per benefit year)	$1,500
Hospital Confinement (per day up to 365 days per covered accident)	$300
Intensive Care Unit Admission (once per Benefit Year; payable instead of Hospital Admission benefit if Confined immediately to ICU)	$2,000
Intensive Care Unit Confinement (per day up to 15 days, payable in addition to any Hospital Confinement benefit)	$300
Ambulance (Ground)	$400
Ambulance (Air)	$1,500
Emergency Room Admission	$200
Family Lodging (per day up to 30 days per benefit year)	$100
Transportation (100 or more miles up to 3 times per covered accident)	$500
Rehabilitation Unit (per day up to 30 days per covered accident)	$100
SURGERY	
Miscellaneous Surgery requiring general anesthesia (not covered by any other benefit)	$750
Open Surgery	$1,500
Exploratory Surgery or Debridement	$500
Tendon/Ligament/Rotator Cuff Tear	$750
Torn Knee Cartilage	$750
Ruptured/Herniated Disc	$750
EMERGENCY DENTAL	
Emergency Dental extraction, Emergency Dental crown	$100 - $200
WELLNESS	
Wellness Screening Benefit (once per benefit year)	$50

HOSPITAL INDEMNITY INSURANCE

NEW BENEFIT AVAILABLE FOR YOU THIS YEAR

Hospital Indemnity Insurance

Hospital Indemnity Insurance helps protect your finances if you, your spouse, or child experience a hospital stay. You can receive money to help pay unexpected expenses like lost income, child care, deductibles and copays.

Hospital Indemnity insurance payments are paid directly to you, and can be used however you want. It pays in addition to any other coverage you may already have, even if you are enrolled in the HSA.

Benefits are payable for hospital stays due to:

- Sickness
- Accidents, confinements due to an accident must be within 365 days of the accident
- Routine pregnancy
- Complications of pregnancy
- Newborn complications
- Mental and nervous disorders
- Substance abuse

What benefits will I receive for my newborn child?

If your newborn has to stay in the Neonatal Intensive Care unit (NICU), benefits are payable. Hospital stays for routine newborn care are not covered.

WHAT BENEFIT COULD YOU RECEIVE?

John was in a serious accident. He had to stay in the hospital's intensive care unit for 3 days and then spent 9 days in a regular room.

Assumed benefit = $10,000.

Benefit Schedule

The benefits shown in the schedule are payable for each person covered by the plan unless otherwise stated.

FIRST DAY BENEFITS **Payable per benefit year**	**CHOICE 1**
First day hospital confinement – This benefit pays the first day you stay in a regular hospital bed.	$1,000 per day 1 day
First day ICU confinement – This benefit pays the first day you stay in an ICU bed.	$1,000 per day 1 day
CONFINEMENT BENEFITS **Payable per benefit year**	**CHOICE 1**
Hospital confinement – This benefit pays for a hospital stay in a standard room. Payable with: • *First day hospital confinement benefit*	$100 per day Up to 30 days
Intensive Care Unit (ICU) confinement – This benefit pays for a hospital ICU stay. Payable with: • *First day hospital confinement benefit* • *Hospital confinement benefit*	$100 per day Up to 10 days
ADDITIONAL AND ENHANCED BENEFITS **Payable per benefit year**	**CHOICE 1**
Wellness screening benefit – This benefit pays for a covered wellness test or exam even without a hospital stay.	$50 per day 1 day per insured per benefit year

COVERED BENEFITS	ELIGIBLE DAYS	
STANDARD BENEFIT AMOUNT		
First day ICU confinement	Day 1	$1,000
ICU confinement	Days 1-3	$300
Hospital confinement	Days 1-12	$1,200
Total benefit paid for John		$2,500
These potential benefits are for illustrative purposes only and actual benefits may vary based on the terms of the policy and the claimant's specific circumstances.		
CONCLUSION		
Sun Life's Hospital Indemnity Insurance policy could pay John up to $2,500		

Your Hospital Indemnity Rates

	10-PAY	12-PAY	18-PAY	20-PAY	21-PAY	22-PAY	24-PAY	26-PAY
Employee Only	$16.38	$13.65	$9.10	$8.19	$7.80	$7.45	$6.83	$6.30
Employee + Spouse	$32.90	$27.42	$18.28	$16.45	$15.67	$14.96	$13.72	$12.66
Employee + Children	$25.28	$21.07	$14.05	$12.64	$12.04	$11.50	$10.54	$9.72
Employee + Family	$41.81	$34.84	$23.23	$20.90	$19.91	$19.01	$17.43	$16.08

CRITICAL ILLNESS INSURANCE

NEW BENEFIT AVAILABLE FOR YOU THIS YEAR

Critical Illness Insurance

This coverage helps protect your finances from an illness. When you, your spouse or child is diagnosed with a covered condition, you can receive a cash benefit to help pay unexpected costs not covered by your health plan.

It also helps cover related expenses like lost income, child care, travel to and from treatment, deductibles and co-pays.

It pays a cash benefit directly to you can be used however you want, and it pays in addition to any other coverage you may already have.

What's more, all family members on your plan are eligible for a wellness-screening benefit, also paid directly to you once each year per covered person.

BENEFITS

For you: You can choose between $10,000 and $50,000 of coverage, in increments of $10,000. No medical questions asked.

For your spouse: If you elect coverage for yourself, you can choose between $10,000 and $50,000 of coverage, in increments of $10,000 for your spouse. Not to exceed 100% of your coverage amount.

For your children: If you elect coverage for yourself, you can choose between $2,000 and $25,000 of coverage, in increments of $1,000 for your child. Not to exceed 50% of your coverage amount. An eligible child is defined as your child from birth to age 26.

Highlight

- Includes the Health Navigator Help Line for expert guidance with health needs and medical billing questions.

Critical Illness Rates

Employee Benefit

AGE	UNI-TOBACCO*** MONTHLY RATE*
Under age 30	$0.25
30-39	$0.45
40-49	$0.91
50-59	$1.82
60-69	$3.01
70 and over	$5.09

Rate basis: Per $1,000 of coverage
*Attained age rating applies – premiums will increase due to age increase.

Spouse Benefit

AGE**	UNI-TOBACCO MONTHLY RATE*
Under age 30	$0.25
30-39	$0.45
40-49	$0.91
50-59	$1.82
60-69	$3.01
70 and over	$5.09

Rate basis: Per $1,000 of coverage
*Attained age rating applies – premiums will increase due to age increase.
**The employee's age is used to determine rates.
***Rates are not affected based on tobacco use.

Child Benefit

COVERAGE	MONTHLY RATE*
All Age Bands	$0.04

Rate basis: Per $1,000 of coverage

CRITICAL ILLNESS INSURANCE

New Product

HOW CRITICAL INSURANCE CAN HELP

Denise suffered a heart attack due to a blocked artery. After she filed a claim, she received a check for her benefit amount. Unfortunately, Denise needed surgery 8 months later[2] and then suffered another heart attack 2 years later. Luckily, Denise had Sun Life Critical Illness insurance with a Recurrence Benefit[3].

Assumed benefit = $10,000.

COVERED BENEFITS	PAYMENT SCHEDULE	CONCLUSION
Wellness Benefit[1]: blood test for cholesterol	$50	Our critical illness insurance policy could pay Denise $22,550 to help pay for out-of-pocket medical expenses
Heart Attack (100%)	$10,000	
Coronary artery bypass graft (25%)	$2,500	
Recurrent Heart attack (100%)	$10,000	
Total payments	$22,550	

These potential benefits are for illustrative purposes only and actual benefits may vary based on the terms of the policy and the claimant's specific circumstances.

1. Wellness Benefit is payable once per covered person, per contract year. May not be available in all states.
2. Your plan may include a waiting period before a different condition may be payable under the same contract.
3. Your plan may include a waiting period before the same condition may be payable under recurrence.

COVERED CONDITIONS – ***The plan pays 100% of the benefit amount unless stated otherwise***		
Core Conditions	Heart Attack[R] End-Stage Kidney Disease[R] Occupational HIV/ Hepatitis B, C, or D Major Organ Failure[R]	Stroke[R] Coronary Artery Bypass Graft[R] (Pays 25%) Angioplasty[R] (Pays 5%)
Cancer Conditions	Invasive Cancer[R] Noninvasive Cancer[R] (Pays 25%) Skin Cancer[R] (Pays 5%)	
Other Conditions	Complete Blindness Complete Loss of Hearing Loss of Speech Benign Brain Tumor Coma	Severe Burns Advanced ALS/Lou Gehrig's Disease Advanced Parkinson's Disease (Pays 25%) Advanced Alzheimer's Disease (Pays 25%) Paralysis
Childhood Conditions Applies to dependent children only	Down Syndrome Cystic Fibrosis Type 1 Diabetes Mellitus Complex Congenital Heart Disease	Cerebral Palsy Cleft Lip/Palate Muscular Dystrophy Spina Bifida
Wellness screening benefit	Payable to any covered person on your plan one time each year, once you provide proof of an eligible health screening.	Employee $50 Spouse $50 Child $50

R = Recurrence Benefit available

When would I need the Recurrence Benefit?

Sometimes people are diagnosed with the same condition twice. If this happens to you, and 6 consecutive months have passed between the first and second diagnoses, we'll pay you an additional benefit (the amount of which is noted in your Certificate). Only the conditions marked (R) in the table above are eligible for the Recurrence Benefit. Once a Recurrence Benefit has been paid, no additional benefit will be paid for that critical illness.

IMPORTANT INFORMATION

The following coverage(s) do not constitute comprehensive health insurance (often referred to as “major medical coverage”). They do NOT provide basic hospital, basic medical, or major medical insurance.

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Similarly, dependent coverage, if offered, may be delayed if your dependents are in the hospital (except for newborns) on the date coverage would otherwise become effective. Refer to your Certificate for details.

Limitations and exclusions

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.

Critical Illness: We will not pay a benefit that is due to or results from services, treatment or complications not included in the Benefit Highlights; provided by an immediate family member; or unrelated to a Critical Illness/Specified Disease. These include an autologous bone marrow transplant, suicide, attempted suicide or intentionally self inflicted injuries, elective plastic or cosmetic surgery, active military duty, war, any act of war, or your active duty in any armed service during a time of war (excluding during acts of terrorism); your active participation in a riot, rebellion or insurrection; committing or attempting to commit an assault, felony or other criminal act; engaging in dangerous conduct or hazardous activity where there is a likelihood of death or serious injury; being incarcerated in a penal institution of any kind; being legally intoxicated or under the influence of any narcotic, unless taken on the advice of a physician and taken as prescribed.

Covered conditions have specific diagnostic criteria that must be met (along with supporting documentation) for a benefit to be paid. For additional information regarding covered conditions, please request an outline of coverage.

This product is inappropriate for individuals who are eligible for Medicaid coverage.

Hospital Indemnity: No benefits will be payable relating to or resulting from services or treatment rendered or confinement outside the United States or Canada. No benefits will be payable for any loss that is caused or contributed to by: war or any act of war or your active duty in any armed service during a time of war (this does not include acts of terrorism); active military duty; riding in or driving any motor-driven vehicle in a race, stunt show, speed test or driving while Intoxicated; committing of or attempting to commit an assault, felony or other criminal act; active participation in a riot, rebellion or insurrection; committing or attempting to commit suicide, whether sane or insane, or injuring oneself intentionally; incarceration in a penal institution of any kind; elective abortion or complications thereof; elective or cosmetic surgery or procedures, except for reconstructive surgery unless due to congenital anomaly or disease of a dependent child which has resulted in a defect; artificial insemination, in vitro fertilization, test tube fertilization; or sterilization, tubal ligation or vasectomy, and reversal thereof, unless recommended by a physician.

Accident: We will not pay a benefit that is due to or results from: suicide while sane or insane; intentionally self-inflicted injuries; committing or attempting to commit an assault, felony or other criminal act; war or an act of war; active participation in a riot, rebellion or insurrection; voluntary use of any controlled substance/ illegal drugs; operation of a motorized vehicle while intoxicated; if you do not submit proof of your loss as required by us (this covers medical examination, continuing care, death certificate, medical records, etc.); incarceration; engaging in hang-gliding, bungee jumping, parachuting, sail gliding, parasailing, parakiting or mountaineering; participating in or practicing for any semi-professional or professional competitive athletic contest in which any compensation is received, including coaching or officiating; injuries sustained from commercial air transportation other than riding as a fare paying passenger; work-related illness or injuries unless you are enrolled in 24-hour coverage.

Information about services offered

Value-added services are not insurance, are offered only on specific lines of coverage, and carry a separate charge, which is added to the cost of the insurance. The cost is included in the total amount billed.

Health Navigator Help Line is provided by PinnacleCare. PinnacleCare is a member of the Sun Life Financial Inc. (“Sun Life”) family of companies. PinnacleCare and its employees do not diagnose medical conditions, recommend treatment options or provide medical care, and any information or services provided should not be considered medical advice. Any medical decisions should be made only after consultation with and at the direction of the medical provider. Any person or entity who provides health care services following a referral or other service provided does so independently and not as an agent or representative of PinnacleCare.

Sun Life reserves the right to discontinue any of the Services at any time. Employers who provide group insurance coverage and make available value-added services within an I.R.C. Section 125 cafeteria plan should consult a tax professional to determine whether those services are Qualified Benefits for Section 125 plans. Value-added services are not available in New York and may not be available in all other states.

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.

FLEXIBLE SPENDING ACCOUNTS

New Name

- The company that administers your FSA/HSA accounts, PayFlex, is now **Inspira Financial**. Your PayFlex login username and password will still work. FSA/HSA cards are good for 5 years ,and will only be replaced if they are set to expire. Your current card will work until the card expires.

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: $3,200*

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, 2025**) after your 2024 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, 2025**), which is two months and 15 days after the end of your 2024 plan year. Be sure to submit your grace period claims before the end of your 120-day run-out period.

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:

Inspira Financial
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 Inspira Card®, your account debit card

The Inspira 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 Inspira 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 Inspiracustomer service at **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 **inspirafinancial.com** or through the Inspira 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 Inspira Financial at:

Inspira Financial
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 **inspirafinancial.com** or you may call Inspira Financial at **1-844-729-3539** to request a form.

After you log in to **inspirafinancial.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
- Date of service
- Amount you were required to pay
- Description of item or service

How to Register Online

- Go to **inspirafinancial.com.**
- Select login, then click Health & Benefits and 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 Inspira Financial member website. Log in to **inspirafinancial.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

Why Choose an HSA?

Here are some of the advantages a Health Savings Account provides you with:

- **Security** – Your HSA can provide a savings buffer for unexpected or high medical bills.
- **Affordability** – In most cases, you can lower your monthly health insurance premiums when you switch to health insurance coverage with a higher deductible, and these HDHPs can be paired with an HSA.
- **Ownership –** Your HSA and the money in it belongs to you - not your employer or insurance company.
- **Flexibility –** You can use your HSA to pay for current medical expenses, including your deductible and expenses that your insurance may not cover, or you can save your funds for future medical expenses, such as:
- Health insurance or medical expenses if unemployed
- Medical expenses after retirement (before Medicare)
- Out-of-pocket expenses when covered by Medicare
- Long-term care expenses and insurance

Also, you do not have to use your HSA to pay for medical expenses. You can withdraw money from your HSA at any time and for any reason. However, if your HSA money is not used for medical expenses, you will have to pay income tax on your withdrawal. You will also have to pay a 20% additional tax, unless the withdrawal is made after you attain age 65, become disabled or after your death.

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.

What is a Health Savings Account?

Health savings accounts (HSAs) are a great way to save money and efficiently pay for medical expenses. HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHPs).

There are certain advantages to putting money into these accounts, including investment earnings and favorable tax treatment. The rationale behind the HSA/HDHP combination is that people will have a clearer idea of their medical costs and more control over their spending, enabling them to reduce their medical costs.

HSA money can be used tax-free when paying for qualified medical expenses[1], helping you pay your HDHP's larger deductible. At the end of the year, you keep any unspent money in your HSA. This rolled over money can grow with tax-deferred investment earnings, and, if it is used to pay for qualified medical expenses, then the money will continue to be tax-free.

An HSA can be a tremendous asset as you save for and pay medical bills because it gives you tax advantages, more control over your own spending and the ability to save for future 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.

Is an HSA Right for You?

HSAs are a growing trend in health care and offer many advantages, but whether it's the right choice for you depends on several factors.

Comparing HSA/HDHPs to traditional health plans can be difficult, as each has pros and cons. For example, traditional health plans typically have higher monthly premiums, a smaller deductible and fixed copays. You pay less out-of-pocket costs due to the lower deductible, but you will pay more each month in premiums.

HDHPs with HSAs generally have lower monthly premiums and a higher deductible. You may pay more out-of-pocket medical expenses, but you can use your HSA to cover those costs, and you pay less each month for your premium.

The decision is different for each individual. If you are generally healthy and/or have a reasonable idea of your annual health care expenses, then you could save a lot of money from the lower premiums and valuable tax-advantaged account with an HSA/HDHP plan. For example, even someone with a chronic condition could take advantage of an HSA/HDHP plan if he or she has a good idea of his or her annual expenses and then budgets enough money to cover cost of care.

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 2024 annual HSA contribution limit for individuals with self-only HDHP coverage will be $4,150. The 2024 limit for individuals with family HDHP coverage will be $8,300.

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.

How do I access the funds in my HSA account?

After electing the HSA, your information and account is established. Please go to **inspirafinancial.com** to open your account. You will receive a MasterCard with instructions on how to go to **inspirafinancial.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 Inspira Financial Fees and Charges for more information.

LIMITED HEALTHCARE FSA

If you are enrolled in an HSA, you are still eligible to enroll in the Limited Healthcare FSA .

FSA Annual Contribution Limits:

- Minimum Annual Contribution: **$150**
- Maximum Annual Contribution: **$3,200**

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.

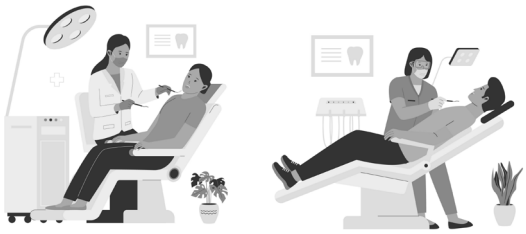
When are my funds available?

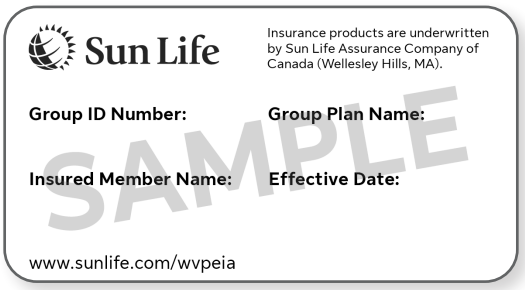
Funds are available on day one of the plan. Once you sign up for a LPFSA and decide how much to contribute,
the maximum annual amount of reimbursement for eligible expenses will be available throughout your period of coverage.

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, 2024**.

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.

DENTAL





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 dental insurance provider, helps protect your teeth for a lifetime.

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 charge and your plan type. The allowable amount will vary depending on the plan you choose. **To find an in-network provider visit www.sunlife.com/wvpeia.**

SUN LIFE DENTAL HAS A DEDICATED TEAM JUST FOR YOU

- Sun Life Dental, in an effort to provide PEIA members and providers the best experience, has established a dedicated team for support. Please be sure all claim and eligibility questions are submitted to the contact information on the back of your ID card.

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

Partial List of Covered Services

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%
reembursement type	Maxium Allowable Charge		Maxium Allowable Charge		Maxium Allowable Charge		Usual and Customary	

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

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 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
- 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

VISION

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

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®.

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

VISION

Partial List of Covered Services

Humana. eyeMed

	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	$15 $15 $15 $40 $40 $45 $65 20% off retail	Not covered Not covered Not covered Not covered Not covered Not covered Not covered Not covered	$0 $15 $15 $40 $0 $45 $20 20% off retail	Up to $8 Not Covered Not Covered Not covered Up to $20 Not covered Up to $50 Not covered
• Photochromatic / Plastic transitions • Premium anti-reflective coating Tier 1 | Tier 2 | Tier 3	Not applicable	Not applicable	$75 Premium anti-reflective coatings as follows: $57 | $68 | 80% of charge	Not covered Premium anti-reflective coatings as follows: Not covered
• Premium progressive Tier 1 | Tier 2 | Tier 3 | Tier 4	Not applicable	Not applicable	Premium progressives as follows: $20 | $20 | $20 | $20	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

VISION

Partial List of Covered Services

Humana. | eyeMed

	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	Not covered	Not covered	$0	Up to $77
• Retinal Imaging - Up to (2) services per year	Not covered	Not covered	$0	Up to $50
• Extended Ophthalmoscopy - Up to (2) services per year	Not covered	Not covered	$0	Up to $15
• Gonioscopy - Up to (2) services per year	Not covered	Not covered	$0	Up to $15
• Scanning Laser - Up to (2) services per year	Not covered	Not covered	$0	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.

SHORT-TERM DISABILITY

New Carrier

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 $1,000. 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 MetLife, 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

MetLife underwrites this plan.

YOUR PRETAX RATES

Example: If your weekly salary is $350, your monthly premium would be calculated:
$350 x $0.0257 = $8.99* per month.

*Actual premium may vary slightly due to rounding

WORKSHEET:

1.	Your weekly salary (maximum $1,000.00)	_____ X $0.0257
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
MetLife
Policy Number: #150596-3-G
Mon – Fri, 10 a.m. – 9 p.m. ET
1-888-466-8640

LONG-TERM DISABILITY

New Carrier

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 now being offered by MetLife.

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.
IMPORTANT NOTE - The 70% plan has been closed; however, you may keep this plan if you are already enrolled. Visit myFBMC.com to see your rates.

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** - 60% 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 MetLife, benefits become payable at the end of the 180-day benefit waiting period. Refer to your benefit coordinators 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.

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.

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

MetLife underwrites this plan.

West Virginia Public Employees Insurance Agency
MetLife
Policy Number: #150596-3-G
Mon – Fri, 10 a.m. – 9 p.m. ET
1-888-466-8640

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

LONG-TERM DISABILITY

New Carrier

Employee Only, Pretax Benefit

PRETAX RATES FOR PLAN 1
(50% Coverage Level)

AGE*	MONTHLY PREMIUM RATE PER $100 OF SALARY
to 29	$0.12
30-34	$0.15
35-39	$0.18
40-44	$0.26
45-49	$0.38
50-54	$0.54
55-59	$0.77
60-64	$0.87
65-69	$1.09
70 and over	$1.41

* Age as of July 1, 2023. 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
(60% Coverage Level)

AGE*	MONTHLY PREMIUM RATE PER $100 OF SALARY
to 29	$0.17
30-34	$0.20
35-39	$0.26
40-44	$0.37
45-49	$0.53
50-54	$0.78
55-59	$1.02
60-64	$1.09
65-69	$1.22
70 and over	$1.45

* Age as of July 1, 2023. 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 $10,000) _____
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**

ARAG LEGAL

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, even in court, if necessary. 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 rates.

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

Compare Your Legal 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 Infirmity	●	●
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 Insurance[1]		●
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	●	●

ARAG
Legal Insurance

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 rate for any other non-covered and non-excluded issues.

[1]The 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.

2023 Standard Plan Design Rev 2/24 200365wv

HEARING

Why Have a Hearing Plan?

Hearing loss is more common than you may think – in fact, 48 million Americans have some degree of hearing loss. Hearing is also an important part of your overall health and well-being. Not only does it keep you connected to the people and activities you love, it helps preserve important connections in your brain that can help keep you sharp as you age. A hearing aid may help.

If you've noticed a change in your hearing, you're not alone and there are ways to help regain many of the sounds you've been missing. Your coverage through EPIC Hearing Healthcare can help you save on hearing exams, hearing aids, and follow-up care.

With EPIC, You'll Have Access to:

- Expansive network with 7,000 hearing care professional locations nationwide.
- Thousands of name-brands and private-labeled hearing aids from the industry's top brands, including Relate®, Beltone™, Oticon, Phonak, ReSound, Signia, Starkey®, Unitron™ and Widex®.
- A wide selection of advanced technology, including recharging capabilities, remote adjustments, connection to 2 Bluetooth® devices, tap control and other advanced features.
- 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.**

How to Get Started

1. Visit EPICHearing.com/FBMC or call EPIC at 1-866-956-5400 to request an appointment. Reference hearing plan name: State of West Virginia (Active Employees).
2. Have eligibility validated, discuss product and service options, receive provider consult letter.
3. Visit an EPIC provider for hearing exam and consultation.
4. Your provider will help you choose from a broad array of hearing aids based on your unique hearing needs.
5. Receive hearing aids, fitting and follow-up care.

Hearing Aids are More Advanced Than Ever

Today's hearing aids are cutting edge, discreet and use advanced technology to mimic natural hearing. With a wide variety of styles that feature the latest technology such as recharging capabilities, connection to Bluetooth® devices, the ability to automatically adapt to new listening environments, and more, hearing aids can become a natural part of your daily life.

*Hearing aids purchased in the Silver technology level will receive 1 follow-up visit.
**One-time professional fee may apply.

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 Children	$70 $70	Adults: Once every year Children: Once every year
Hearing Aid Device		
Adults Children	$500 per ear device benefit $500 per ear device benefit	Adults: Once every 5 years 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 and reference hearing plan name: State of West Virginia (Active Employees), or visit EPICHearing.com/FBMC.

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

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: • 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.

FREQUENTLY ASKED QUESTIONS

Find Your Answers Here

Q: If I do not make changes during open enrollment, will my benefits continue?

A: This is a changes-only enrollment. If no changes are made, then all benefits will continue into the new plan year as they currently are.

Q: I am a New Hire, how can I get an enrollment form?

A: Forms are available on PEIA's website under "Forms and Downloads," or you may contact your Benefits Coordinator.

Q: How can I view my current benefits?

A: Login to your account at myFBMC.com to view current benefit elections and covered dependents.

Q: How do I register or reset my online account to change my benefits?

A: Contact FBMC Tech Support at: techsupport@fbmc.com.

Q: Where can I learn more about the new Sun Life voluntary products being offered?

A: Schedule an appointment with a Benefits Counselor.

Q: How do I schedule an appointment with a Benefits Counselor?

A: Log in online at: https://3mpwr-enroll.com/westvirginia-oe, or call the scheduling line at 844-633-6797.

Q: How do I find a provider?

A: Contact the carrier directly online or by phone. Refer to the Provider Directory on Page 35 of this guide.

Q: I have not received my ID Card. What should I do?

A: ID cards are not distributed; however, you can contact the carrier directly to request one.

Q: How do I use the EPIC Hearing plan?

A: Follow the instructions provided on Pages 29-30 of this guide.

Q: I am not able to register or log into the carrier's website. What do I need to do?

A: Contact the carrier's customer service. Refer to Page 35 of this guide.

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**.

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.

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.

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.

NOTICES

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.

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.

BENEFITS DIRECTORY

FBMC BENEFITS MANAGEMENT, INC. CONTRACT BENEFITS ADMINISTRATOR

FBMC Online Technical Support
techsupport@fbmc.com

Benefits 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 HEALTHCARE

Hearing Plan Name: State of West Virginia (Active Employees)

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

SUNLIFE INSURANCE

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

Accident

Plan number: #965932
800-309-8699/sunlife.com/us

Critical Illness

Plan number: #965932
800-309-8699/sunlife.com/us

Hospital Indemnity

Plan number: #965932
800-309-8699/sunlife.com/us

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

METLIFE INSURANCE COMPANY

Short-Term / Long-Term Disability Claims
Policy Number: #150596-3-G
Customer Service
Monday – Friday, 10 a.m. – 9 p.m. ET
1-888-466-8640
www.metlife.com

INSPIRA FINANCIAL

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
1-844-729-3539*
Toll-Free Claims Fax: 1-888-238-3539
inspirafinancial.com*
* Can provide replacements for lost or stolen cards

COBRA

1-800-359-3921
inspirafinancial.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

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

FBMC
BENEFITS MANAGEMENT

Contract Administrator

FBMC Benefits Management, Inc.
PO Box 1878 • Tallahassee, Florida 32302-1878