HCC Network

2025

YOUR BENEFITS

A guide to understanding your
2025 employee benefits program

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If you and/or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 20 for more details.

Important Contacts

Medical/Dental
Auxiant
800-245-0533
www.auxiant.com

Vision
Principal/VSP
800-877-7195
www.vsp.com

Life/AD&D/Disability/Accident/Critical Illness
Principal
800-247-4695
www.principal.com

Flexible Spending Accounts
WEX
866-451-3399
www.wexhealth.com

Employee Assistance Program
Principal/Magellan
800-450-1327
https://member.magellanhealthcare.com

Human Resources
Charlene Hunter
660-202-6949
charlene.hunter@hccnetwork.org

Employee Response Center

Employee benefits can be complicated. The **Higginbotham Employee Response Center** can assist you with the following:

- Enrollment
- Benefit information
- Claims or billing questions
- Eligibility issues

Call or text **833-657-4226** to connect with a representative Monday through Friday from 7:00 a.m. to 6:00 p.m. CT. If you leave a message after 3:00 p.m. CT, your call or text will be returned the next business day. You can also email questions or requests to **hccnetwork@higginbotham.net**. Bilingual representatives are available.

Welcome

We are pleased to offer a full benefits package to help protect your well-being and financial health. Read this guide to learn about the benefits available to you and your eligible dependents starting January 1.

Each year during Open Enrollment, you may make changes to your benefit plans. The benefit choices you make this year will remain in effect through **December 31**. Take time to review these benefit options and select the plans that best meet your needs. After Open Enrollment, you may only make changes to your benefit elections if you have a Qualifying Life Event.

AVAILABILITY OF SUMMARY HEALTH INFORMATION

Your benefits program offers four medical plan coverage options. To help you make an informed choice and compare your options, a Summary of Benefits and Coverage (SBC) for each plan is available online via **Employee Navigator**.

How to Enroll

You will enroll online through **Employee Navigator**.

Eligibility

You are eligible for benefits if you are a regular, full-time employee working an average of 30 hours per week. Your coverage is effective the first of the month following 30 days of employment. You may also enroll eligible dependents for benefits coverage. When covering dependents, you must select and be on the same plans.

ELIGIBLE DEPENDENTS

- Your legal spouse
- Children under the age of 26 regardless of student, dependency, or marital status
- Children over the age of 26 who are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return

QUALIFYING LIFE EVENTS

Once you elect your benefit options, they remain in effect for the entire plan year until the following Open Enrollment. You may only change coverage during the plan year if you have a Qualifying Life Event, some of which include:

- Marriage, divorce, legal separation, or annulment
- Birth, adoption, or placement for adoption of an eligible child
- Death of your spouse or child
- Change in your spouse's employment status that affects benefits eligibility
- Change in your child's eligibility for benefits
- Significant change in benefit plan coverage for you, your spouse, or your child
- FMLA leave, COBRA event, court judgment, or decree
- Becoming eligible for Medicare, Medicaid, or TRICARE
- Receiving a Qualified Medical Child Support Order

If you have a Qualifying Life Event and want to change your elections, you must notify Human Resources and complete your changes **within 30 days of the event**. You may be asked to provide documentation to support the change. Contact Human Resources for details.

Medical Coverage

The medical plan options through **Auxiant** protect you and your family from major financial hardship in the event of illness or injury.

You have a choice of four plans using the **Freedom Network Select** and/or **HealthLink** provider networks:

- **HDHP/HSA $6,350 Plan** – This plan is an HDHP, with a $6,350 individual and $12,700 family in-network deductible.
- **HDHP/HSA $3,500 Plan** – This plan is an HDHP, with a $3,500 individual and $7,000 family in-network deductible.
- **PPO $3,000 Plan** – This plan is a PPO, with a $3,000 individual and $6,000 family in-network deductible.
- **PPO $5,000 Plan** – This plan is a PPO, with a $5,000 individual and $10,000 family in-network deductible.

High Deductible Health Plan (HDHP)

An HDHP also allows you to see any provider when you need care, but you will pay less for care when you go to in-network providers. In exchange for a lower per-paycheck cost for medical benefits, you must satisfy a higher plan deductible that applies to almost all health care expenses, including prescription drugs. If you enroll in the HDHP, you may be eligible to open a Health Savings Account (see page 9).

Preferred Provider Organization (PPO)

A PPO plan allows you to see any provider when you need care. When you see in-network providers for care, you will pay less and get the highest level of benefits. You will pay more for care if you use out-of-network providers. When you see in-network providers, your office visits, urgent care visits, and prescription drugs are covered with a copay, and most other in-network services are covered at the coinsurance level.

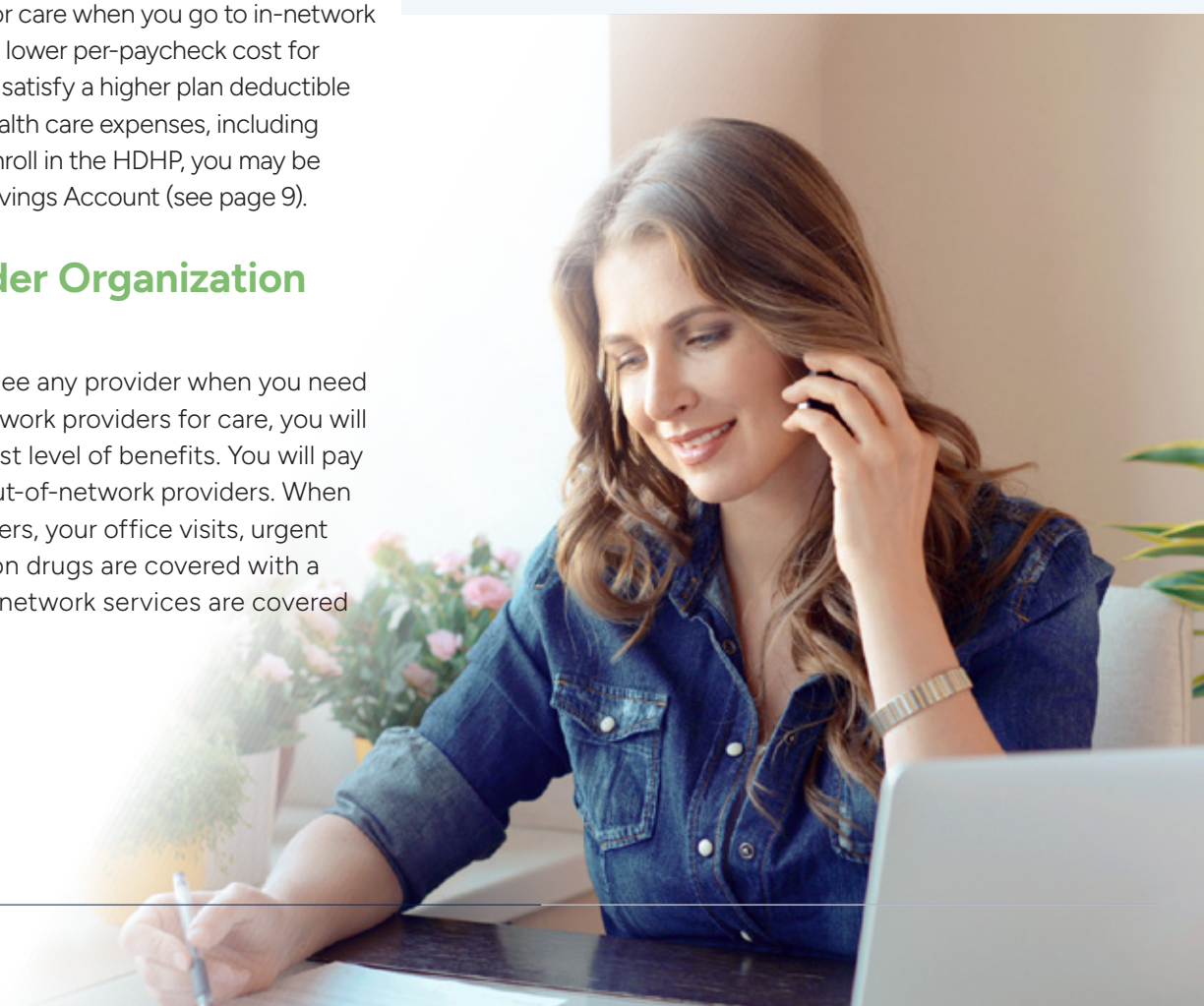
Auxiant

Auxiant is the third-party administrator who sets up and administers our health plans. With AuxiantHealth you can:

- Link to network providers
- Use Auxiant Live Chat to contact Customer Service
- View enrollment and claim information, print EOBs, and track claims
- View deductibles and out-of-pocket amounts
- Access plan documents
- Link to pharmacy benefit manager
- Get information on the go via the mobile app

At **www.auxiant.com**, you have 24/7 access to your personal health care account information. Contact Auxiant at **800-279-6772**.

Go to **www.auxiant.com** to access your Auxiant ID cards. Click *Register* and enter your user information. From the Home screen, click on *Enrollment Information*, then click on *View ID Card*. You can view your ID card on any electronic device or print the card to take with you.



Medical Coverage

Find a Provider

- Visit **www.phpkc.com**.
- Choose a network:
  - Select *Freedom Network Select* for KC Metro providers.
  - Select *HealthLink* for providers in St. Louis, Springfield, or Columbia.
- Call **800-544-3014** if you need assistance navigating the site.

FREEDOM NETWORK SELECT

Choose to search by ZIP code, city, or state, and specify a distance from location. Enter your provider details by selecting a provider type from the drop-down menu and entering additional known details. Click on the *Search* button to review your provider options.

HEALTHLINK

Select either *People, Places, Test/Imaging,* or *All Providers* to begin your search. Next select the type of health care provider you are looking for, such as primary care, hospital, or lab tests.

Select *HealthLink* as your health plan and *Healthlink Open Access III* as the network. Pick the location you want to search by entering a ZIP code and search radius (in miles) or a city and state. Choose a provider type from the drop-down menu, and enter additional known details. Click *Submit* to review your provider options.

Additional Medical Resources

CANCERCARE+

CancerCARE+ is included in your medical plan coverage to help navigate your cancer journey. To gain access, register online at **www.CancerCAREprogram.com** or call **877-640-9610**. Once you are registered, a nurse will be assigned to your case to help you with the rest of your cancer journey.

You can join CancerCARE at any point during your treatment. The CancerCARE team will collaborate with your oncologist and provide access to resources which may not be available at its facility. Your nurse will also review your treatment plan to ensure evidence-based quality care. You can also register covered dependents. If you have questions or need assistance, call **877-640-9610**.

HUSK MARKETPLACE

Access exclusive pricing with some of the best-known brands in fitness, nutrition, and wellness with **HUSK Marketplace**. Receive exclusive discounts on:

- **Gyms and fitness centers** – Get exclusive savings and flexible membership options.
- **HUSK Nutrition** – Meet with a registered dietitian for a personalized nutrition program.
- **Home equipment and tech** – Access equipment and wearable technology to support your wellness journey.
- **On-demand fitness** – Stream exercise classes in the comfort of your home.
- **Mental health** – Connect with licensed therapists for guidance and support.

SMARTCONNECT

SmartConnect is an exclusive program specifically for working or retiring adults (and family members) who are Medicare-eligible and may not have fully explored the benefits of Medicare coverage. Comparing Medicare and employer-provided health insurance can be frustrating. SmartMatch will help you decide which plan is best by considering your needs and matching you with an advisor to help you make the best decision.

To start, call **855-248-1648** or visit SmartConnect's Benefits GPS at **https://gps.smartmatch.com/pareto**.

Medical Summaries for HDHP/HSA Plans

MEDICAL	HDHP/HSA $6,350 Plan			HDHP/HSA $3,500 Plan		
Freedom Select/HealthLink	**Tier 1**	**In-Network**	**Out-of-Network**	**Tier 1**	**In-Network**	**Out-of-Network**
Calendar Year Deductible ▪ Individual ▪ Family	 $6,350 $12,700	 $6,350 $12,700	 $10,000 $20,000	 $3,500 $7,000	 $3,500 $7,000	 $5,000 $10,000
Calendar Year Out-of-Pocket Maximum ▪ Individual ▪ Family	 $6,350 $12,700	 $6,350 $12,700	 $20,000 $40,000	 $6,350 $12,700	 $6,350 $12,700	 $10,000 $20,000
Coinsurance	N/A	0%	30%	N/A	20%	50%
		You Pay			**You Pay**	
Preventive Care	0%	0%	30%*	0%	0%	50%*
Primary Care Physician ▪ Adults and dependents over age 19 ▪ Dependents under age 19	0%*	0%*	30%*	0%*	20%*	50%*
Specialist	0%*	0%*	30%*	0%*	20%*	50%*
Urgent Care	0%*	0%*	30%*	0%*	20%*	50%*
Diagnostic X-ray and Lab	0%*	0%*	30%*	0%*	20%*	50%*
Complex Imaging	0%*	0%*	30%*	0%*	20%*	50%*
Emergency Room		0%*			20%*	
Inpatient Hospital Services	0%*	0%*	30%*	0%*	20%*	50%*
Outpatient Services	0%*	0%*	30%*	0%*	20%*	50%*

PHARMACY	HDHP/HSA $6,350 Plan			HDHP/HSA $3,500 Plan		
	Tier 1	**In-Network**	**Out-of-Network**	**Tier 1**	**In-Network**	**Out-of-Network**
Retail *Up to 30-day supply* ▪ Preferred generic ▪ Preferred brand name ▪ Non-preferred brand name	 0%* 0%* 0%*	 0%* 0%* 0%*	 0%* 0%* 0%*	 $10 copay* $45 copay* $90 copay*	 $10 copay* $45 copay* $90 copay*	 $10 copay* $45 copay* $90 copay*
Mail Order *Up to 90-day supply* ▪ Preferred generic ▪ Preferred brand name ▪ Non-preferred brand name	 0%* 0%* 0%*	 0%* 0%* 0%*	 Not covered	 $25 copay* $112.50 copay* $225 copay*	 $25 copay* $112.50 copay* $225 copay*	 Not covered

* What you will pay after your deductible is met.

Medical Summaries for PPO Plans

MEDICAL	PPO $3,000 Plan			PPO $5,000 Plan		
Freedom Select/HealthLink	**Tier 1**	**In-Network**	**Out-of-Network**	**Tier 1**	**In-Network**	**Out-of-Network**
Calendar Year Deductible ▪ Individual ▪ Family	 $3,000 $6,000	 $3,000 $6,000	 $5,000 $10,000	 $5,000 $10,000	 $5,000 $10,000	 $5,000 $10,000
Calendar Year Out-of-Pocket Maximum ▪ Individual ▪ Family	 $6,350 $12,700	 $6,350 $12,700	 $10,000 $20,000	 $6,350 $12,700	 $6,350 $12,700	 $10,000 $20,000
Coinsurance	N/A	50%	50%	N/A	50%	50%
	You Pay			**You Pay**		
Preventive Care	0%	0%	50%*	0%	0%	50%*
Primary Care Physician ▪ Adults and dependents over age 19 ▪ Dependents under age 19	0%	$50 copay $0	50%*	0%	$50 copay $0	50%*
Specialist	0%	$50 copay	50%*	0%	$50 copay	50%*
Urgent Care	0%	$50 copay	50%*	0%	$50 copay	50%*
Diagnostic X-ray and Lab ▪ X-ray, blood work	N/A	50%*	50%*	N/A	50%*	50%*
Complex Imaging ▪ CT/PET scans, MRIs	N/A	50%*	50%*	N/A	50%*	50%*
Emergency Room	N/A	50%*		N/A	50%*	
Inpatient Hospital Services	0%	50%*	50%*	0%	50%*	50%*
Outpatient Services	0%	50%*	50%*	0%	50%*	50%*

PHARMACY	PPO $3,000 Plan			PPO $5,000 Plan		
	Tier 1	**In-Network**	**Out-of-Network**	**Tier 1**	**In-Network**	**Out-of-Network**
Retail *Up to 30-day supply* ▪ Preferred generic ▪ Preferred brand name ▪ Non-preferred brand name ▪ Non-preferred specialty	 $10 copay $45 copay $90 copay $250 copay	 $10 copay $45 copay $90 copay $250 copay	 $10 copay $45 copay $90 copay $250 copay	 $10 copay $45 copay $90 copay $250 copay	 $10 copay $45 copay $90 copay $250 copay	 $10 copay $45 copay $90 copay $250 copay
Mail Order *Up to 90-day supply* ▪ Preferred generic ▪ Preferred brand name ▪ Non-preferred brand name ▪ Non-preferred specialty	 $25 copay $112.50 copay $225 copay $625 copay	 $25 copay $112.50 copay $225 copay $625 copay	Not covered	 $25 copay $112.50 copay $225 copay $625 copay	 $25 copay $112.50 copay $225 copay $625 copay	Not covered

* What you will pay after your deductible is met.

Health Care Options

Becoming familiar with your options for medical care can save you time and money.

HEALTH CARE PROVIDER		Symptoms	Average Cost	Average Wait
Non-Emergency Care				
 VIRTUAL VISITS	Access to care via phone, online video, or mobile app whether you are home, work, or traveling; medications can be prescribed **24 hours a day, 7 days a week**	▪ Allergies ▪ Cough/cold/flu ▪ Rash ▪ Stomachache	$	**2-5 minutes**
 DOCTOR'S OFFICE	Generally, the best place for routine preventive care; established relationship; able to treat based on medical history **Office hours vary**	▪ Infections ▪ Sore and strep throat ▪ Vaccinations ▪ Minor injuries/sprains/ strains	$	**15-20 minutes**
 RETAIL CLINIC	Usually lower out-of-pocket cost than urgent care; when you can't see your doctor; located in stores and pharmacies **Hours vary based on store hours**	▪ Common infections ▪ Minor injuries ▪ Pregnancy tests ▪ Vaccinations	$	**15 minutes**
 URGENT CARE	When you need immediate attention; walk-in basis is usually accepted **Generally includes evening, weekend, and holiday hours**	▪ Sprains and strains ▪ Minor broken bones ▪ Small cuts that may require stitches ▪ Minor burns and infections	$$	**15-30 minutes**
Emergency Care				
 HOSPITAL ER	Life-threatening or critical conditions; trauma treatment; multiple bills for doctor and facility **24 hours a day, 7 days a week**	▪ Chest pain ▪ Difficulty breathing ▪ Severe bleeding ▪ Blurred or sudden loss of vision ▪ Major broken bones	$$$$	**4+ hours**
 FREESTANDING ER	Services do not include trauma care; can look similar to an urgent care center, but medical bills may be 10 times higher **24 hours a day, 7 days a week**	▪ Most major injuries except trauma ▪ Severe pain	$$$$$$	**Minimal**

Note: Examples of symptoms are not inclusive of all health issues. Wait times described are only estimates. This information is not intended as medical advice. If you have questions, please call the phone number on the back of your medical ID card.

Health Savings Account

A Health Savings Account (HSA) is more than a way to help you and your family cover current health care expenses — it is also a tax-exempt tool to supplement your retirement savings and to cover future health costs.

An HSA is a type of personal savings account that is always yours even if you change health plans or jobs. The money in your HSA (including interest and investment earnings) grows tax-free and spends tax-free if used to pay for current or future qualified medical expenses. There is no "use it or lose it" rule — you do not lose your money if you do not spend it in the calendar year — and there are no vesting requirements or forfeiture provisions. The account automatically rolls over year after year.

HSA Eligibility

You are eligible to open and contribute to an HSA if you are:

- Enrolled in an HSA-eligible HDHP
- Not covered by another plan that is not a qualified HDHP, such as your spouse's health plan
- Not enrolled in a Health Care Flexible Spending Account
- Not eligible to be claimed as a dependent on someone else's tax return
- Not enrolled in Medicare or TRICARE
- Not receiving Veterans Administration benefits

You can also use HSA funds to pay health care expenses for your dependents, even if they are not covered by the HDHP.

Maximum Contributions

Your HSA contributions may not exceed the annual maximum amount established by the Internal Revenue Service. The annual contribution maximums are based on the coverage option you elect:

2025 Maximum HSA Contributions	
Individual	$4,300
Family	$8,550

You decide whether to use the money in your account to pay for qualified expenses or let it grow for future use. If you are age 55 or older, you may make a yearly catch-up contribution of up to $1,000 to your HSA. If you turn 55 anytime during the plan year, you are eligible to make the catch-up contribution for the entire plan year.

Opening an HSA

If you meet the eligibility requirements, you may open an HSA at a bank of your choosing. You will receive a debit card to manage your HSA account reimbursements. Keep in mind, available funds are limited to the balance in your HSA. To begin payroll deductions into your HSA account, you will need to provide the account and routing number to Human Resources.

Important HSA Information

- Always ask your network doctor to file claims with your medical, dental, or vision carrier so you will get the highest level of benefits. You can pay the doctor with your HSA debit card for any balance due.
- You, not your employer, are responsible for maintaining ALL records and receipts for HSA reimbursements in the event of an IRS audit.
- **You may open an HSA at the financial institution of your choice. It is your responsibility to provide the account and routing number to Human Resources for payroll deductions to be deposited into your HSA**.

Flexible Spending Accounts

Allows you to set aside pretax dollars from each paycheck to pay for certain IRS-approved health and dependent care expenses. We offer two Flexible Spending Accounts, administered by **WEX.**

Health Care FSA

The Health Care FSA covers qualified medical, dental, and vision expenses for you or your eligible dependents. You may contribute up to **$3,300** annually to a Health Care FSA, and you are entitled to the full election from day one of your plan year. Eligible expenses include:

- Dental and vision expenses
- Medical deductibles and coinsurance
- Prescription copays
- Hearing aids and batteries

You may not contribute to a Health Care FSA if you enrolled in a High Deductible Health Plan (HDHP) and contribute to a Health Savings Account (HSA).

Refer to page 12 for a list of qualified FSA expenses.

Important FSA Rules

- The maximum per plan year you can contribute to a Health Care FSA is $3,300. The maximum per plan year you can contribute to a Dependent Care FSA is $5,000 when filing jointly or head of household and $2,500 when married filing separately.
- You cannot change your election during the year unless you experience a Qualifying Life Event.
- Your Health Care FSA debit card can be used for health care expenses only. It cannot be used to pay for dependent care expenses.
- The IRS has amended the "use it or lose it" rule to allow you to carry over up to **$660** in your Health Care FSA into the next plan year. The carryover rule does not apply to your Dependent Care FSA.

HOW THE HEALTH CARE FSA WORKS

You can access the funds in your FSA two different ways:

- Use your FSA debit card to pay for qualified expenses, doctor visits, and prescription copays.
- Pay out-of-pocket and submit your receipts for reimbursement. Contact WEX customer service Monday through Friday, 6:00 a.m - 9:00 p.m.
  Call – **866-451-3399**
  Email – **customerservice@wexhealth.com**
  Online – **www.wexhealth.com**

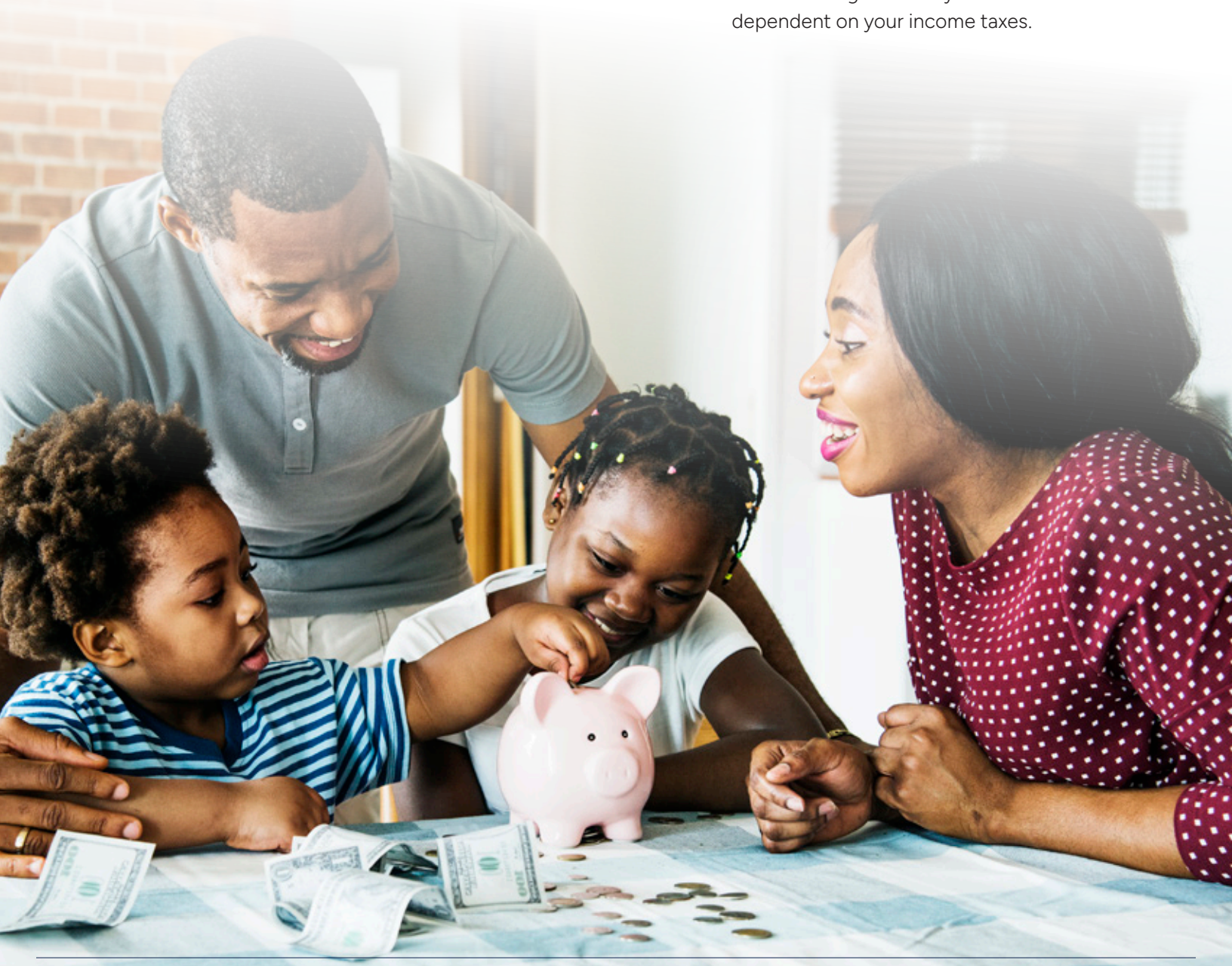
Flexible Spending Accounts

Dependent Care FSA

The Dependent Care FSA helps pay for expenses associated with caring for elder or child dependents so you or your spouse can work or attend school full-time. You can use the account to pay for daycare or babysitter expenses for your children under age 13 and qualifying older dependents, such as dependent parents. Reimbursement from your Dependent Care FSA is limited to the total amount deposited in your account at that time. To be eligible, you (and your spouse, if married) must be gainfully employed, looking for work, a full-time student, or incapable of self-care.

DEPENDENT CARE FSA CONSIDERATIONS

- Overnight camps are not eligible for reimbursement (only day camps can be considered).
- If your child turns age 13 midyear, you may only be reimbursed for the time the child was under age 13.
- You may request reimbursement for care of a spouse or dependent of any age who spends at least eight hours a day in your home and is mentally or physically incapable of self-care.
- The dependent care provider cannot be your child under age 19 or anyone claimed as a dependent on your income taxes.



HSA and FSA Expenses

The products and services listed below are examples of medical expenses eligible for payment under your HSA and Health Care FSA. This list is not all-inclusive; additional expenses may qualify, and the items listed are subject to change in accordance with IRS regulations. Please refer to IRS *Publication 502 Medical and Dental Expenses* at **www.irs.gov** for a complete description of eligible medical and dental expenses.

- Abdominal supports
- Acupuncture
- Air conditioner (when necessary for relief from difficulty in breathing)
- Alcoholism treatment
- Ambulance
- Anesthetist
- Arch supports
- Artificial limbs
- Autoette (when used for relief of sickness/disability)
- Blood tests
- Blood transfusions
- Braces
- Cardiographs
- Chiropractor
- Contact lenses
- Convalescent home (for medical treatment only)
- Crutches
- Dental treatment
- Dental X-rays
- Dentures
- Dermatologist
- Diagnostic fees
- Diathermy
- Drug addiction therapy
- Drugs (prescription)
- Elastic hosiery (prescription)
- Eyeglasses
- Fees paid to health institute prescribed by a doctor
- FICA and FUTA tax paid for medical care service
- Fluoridation unit
- Guide dog
- Gum treatment
- Gynecologist
- Healing services
- Hearing aids and batteries
- Hospital bills
- Hydrotherapy
- Insulin treatment
- Lab tests
- Lead paint removal
- Legal fees
- Lodging (away from home for outpatient care)
- Metabolism tests
- Neurologist
- Nursing (including board and meals)
- Obstetrician
- Operating room costs
- Ophthalmologist
- Optician
- Optometrist
- Oral surgery
- Organ transplant (including donor's expenses)
- Orthopedic shoes
- Orthopedist
- Osteopath
- Oxygen and oxygen equipment
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Postnatal treatments
- Practical nurse for medical services
- Prenatal care
- Prescription medicines
- Psychiatrist
- Psychoanalyst
- Psychologist
- Psychotherapy
- Radium therapy
- Registered nurse
- Special school costs for the handicapped
- Spinal fluid test
- Splints
- Surgeon
- Telephone or TV equipment to assist the hard-of-hearing
- Therapy equipment
- Transportation expenses (relative to health care)
- Ultra-violet ray treatment
- Vaccines
- Vitamins (if prescribed)
- Wheelchair
- X-rays

Dental Coverage

Our dental plans help you maintain good oral health through affordable options for preventive care, including regular checkups and other dental work. Coverage is provided through Auxiant.

Have a Dental Question?

www.auxiant.com

Call 800-245-0533

Policy #H1266

DPPO Plans

Two levels of benefits are available with the DPPO plans: in-network and out-of-network. You may see any dental provider for care, but you will pay less and get the highest level of benefits with in-network providers. You could pay more if you use an out-of-network provider.

Dental Benefits Summary

	DPPO Low Plan		DPPO High Plan	
	HCC Providers	All Other Providers	HCC Providers	All Other Providers
Calendar Year Deductible ▪ Individual ▪ Family	$50 $150	$50 $150	$25 $75	$50 $150
Calendar Year Maximum Benefit ▪ Per individual	$1,000	$1,000	$2,000	$2,000
	You Pay		**You Pay**	
Type A – Preventive Care *Exams, cleanings, bitewing and full-mouth X-rays, fluoride and sealants (for children under 17)*	$0	$0	$0	$0
Type B – Basic Restorative ▪ **Low Plan:** *Emergency exams, periodontal maintenance, fillings, harmful habit appliance (for children under 17)* ▪ **High Plan:** *Emergency exams, periodontal maintenance, fillings, harmful habit appliance (for children under 17), simple and complex oral surgery, and general anesthesia/IV sedation*	$0	20% after deductible	$0	20% after deductible
Type C – Major Restorative ▪ **High Plan only**: *Endodontics, periodontics, crowns, core buildup, bridges, dentures, and repairs*	Not covered	Not covered	$0	50% after deductible

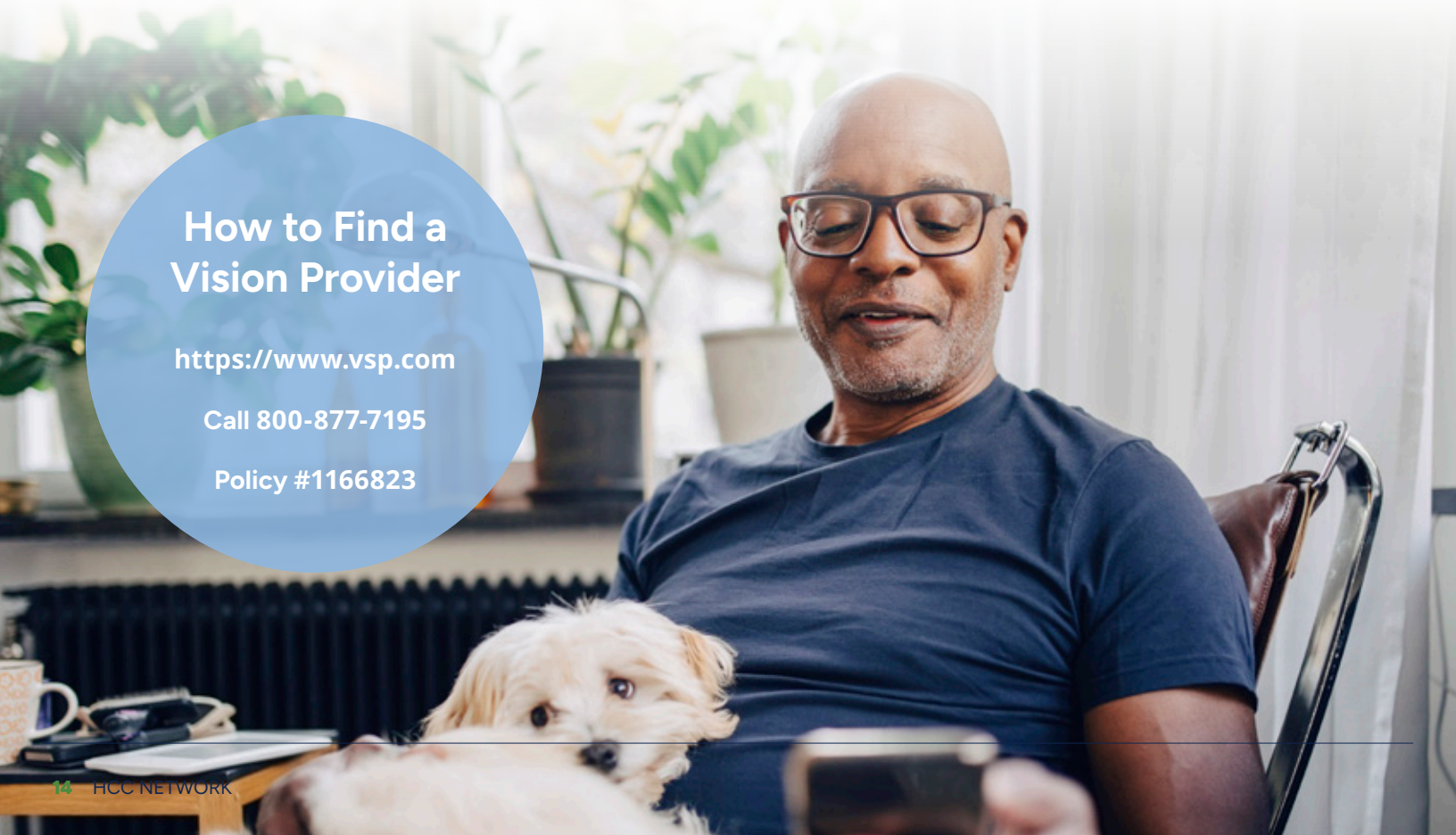
Vision Coverage

Our vision plan offers quality care to help preserve your health and eyesight. Regular exams can detect certain medical issues such as diabetes and high cholesterol, in addition to vision and eye problems.

You may seek care from any vision provider, but the plan will pay the highest level of benefits when you see an in-network provider. Coverage is provided through **Principal** using the **VSP network**.

Vision Benefits Summary

VSP NETWORK	Principal Vision Plan	
	In-Network You Pay	**Out-of-Network Reimbursement**
Exam *(Once every 12 months)*	$10 copay	Up to $45
Standard Lenses *(Once every 12 months)*		
▪ Single vision	Covered in full with $10 copay	Up to $30
▪ Lined bifocal	Covered in full with $10 copay	Up to $50
▪ Lined trifocal	Covered in full with $10 copay	Up to $65
▪ Lenticular	Covered in full with $10 copay	Up to $100
Frames *(Once every 24 months)*	$150 allowance; 20% off balance	Up to $70
Contacts *In lieu of lenses and frames* *(Once every 12 months)*		
▪ Fitting and evaluation	$60 copay	Not covered
▪ Elective	$150 allowance	Up to $105
▪ Medically necessary	Covered in full with $10 copay	Up to $210



How to Find a Vision Provider

https://www.vsp.com

Call 800-877-7195

Policy #1166823

Life and AD&D Insurance

Life and Accidental Death and Dismemberment (AD&D) insurance through **Principal** are important to financial security, especially if others depend on you for support.

With Life insurance, you or your beneficiary(ies) can use the coverage to pay off debts such as credit cards, loans, and bills. AD&D coverage provides specific benefits if an accident causes bodily harm or loss (e.g., the loss of a hand, foot, or eye). If death occurs from an accident, 100% of the AD&D benefit would be paid to you or your beneficiary(ies). Life and AD&D coverage amounts reduce 35% at age 65 and an additional 15% at age 70.

Basic Life and AD&D

Basic Life and AD&D insurance are provided **at no cost to you as a full-time employee**. You are automatically covered at $20,000 for each benefit.

You may purchase dependent coverage for $3.57 per pay period in the following amounts:

- **Spouse** – $10,000
- **Child(ren)** – $1,000 for an infant up to six months old; and $2,500 for children six months to age 26

Designating a Beneficiary

A beneficiary is the person or entity you elect to receive the death benefits of your Life and AD&D insurance policies. You can name more than one beneficiary, and you can change beneficiaries anytime via **Employee Navigator**. If you name more than one beneficiary, you must identify how much each beneficiary will receive (e.g., 50% or 25%).

Voluntary Life and AD&D

You may buy more Life and AD&D insurance for you and your eligible dependents. You and your spouse can elect or increase your coverage by two increments (up to the Guaranteed Issue amount) during Open Enrollment without providing evidence of insurability (proof of good health). If you do not elect Voluntary Life and AD&D insurance when first eligible or if you want to increase your benefit amount at a later date, you may need to show proof of good health. You must elect Voluntary Life and AD&D coverage for yourself before you may elect coverage for your spouse or children. If you leave the company, you may be able to take the insurance with you.

Voluntary Life and AD&D Available Coverage	
Employee	▪ Increments of $10,000 up to $500,000 ▪ New hire Guaranteed Issue $150,000 under age 70, or $10,000 if age 70+
Spouse	▪ Increments of $5,000 up to $200,000 not to exceed 50% of employee amount ▪ New hire Guaranteed Issue $30,000 under age 70, or $10,000 if age 70+
Child(ren)	▪ Birth to 14 days - $1,000 ▪ 14 days age 26 - $2,000, $5,000 or $10,000 not to exceed 50% of employee amount

VOLUNTARY LIFE AND AD&D RATES

Rates are based on your age and elected benefit amount. Please see **Employee Navigator** for the per-pay-period cost of adding or increasing these coverages for you and your dependents.

ACCELERATED DEATH BENEFIT

If you are terminally ill, you may be able to receive a portion of your life benefit.

Disability Insurance

Disability insurance provides partial income protection if you are unable to work due to a covered accident or illness. We offer Voluntary Short Term Disability (STD) **for you to purchase**, and we provide Long Term Disability (LTD) insurance at **no cost to you** through **Principal**.

Voluntary Short Term Disability

Voluntary STD coverage pays a percentage of your weekly salary if you are temporarily disabled and unable to work due to an illness, pregnancy, or non-work-related injury. STD benefits are not payable if the disability is due to a job-related injury or illness. If a medical condition is job-related, it is considered Workers' Compensation, not STD. Rates for this coverage are based on your age and elected benefit amount.

Please see **Employee Navigator** for the per-pay-period cost of adding or increasing this coverage for yourself.

Voluntary Short Term Disability	
Benefits Begin	15th day
Percentage of Earnings You Receive	60%
Maximum Weekly Benefit	$1,000
Maximum Benefit Period	11 weeks
Pre-existing Condition Exclusion	3/12*

*Benefits may not be paid for any condition treated within three months prior to your effective date until you have been covered under this plan for 12 months.

Long Term Disability

LTD insurance pays a percentage of your monthly salary for a covered disability or injury that prevents you from working for more than 90 days. Benefits begin at the end of an elimination period and continue while you are disabled up to five years.

Long Term Disability	
Benefits Begin	91st day
Percentage of Earnings You Receive	60%
Maximum Monthly Benefit	$5,000
Maximum Benefit Period	Up to five years
Pre-existing Condition Exclusion	6/12**

**Benefits may not be paid for any condition treated within six months prior to your effective date until you have been covered under this plan for 12 months.

Employee Assistance Program

The Employee Assistance Program (EAP) from **Magellan** helps you and family members cope with a variety of personal or work-related issues.

This program provides confidential counseling and support services at little or no cost to you to help with:

- Relationships
- Work/life balance
- Stress and anxiety
- Will preparation and estate resolution
- Grief and loss
- Childcare and eldercare resources
- Substance abuse

Call **800-450-1327** or visit **https://member.magellanhealthcare.com** for support at any hour of the day or night.

Supplemental Benefits

Important: These are fixed indemnity policies, not health insurance.

These fixed indemnity policies may pay you a limited dollar amount if you are sick or hospitalized. You are still responsible for paying the cost of your care.

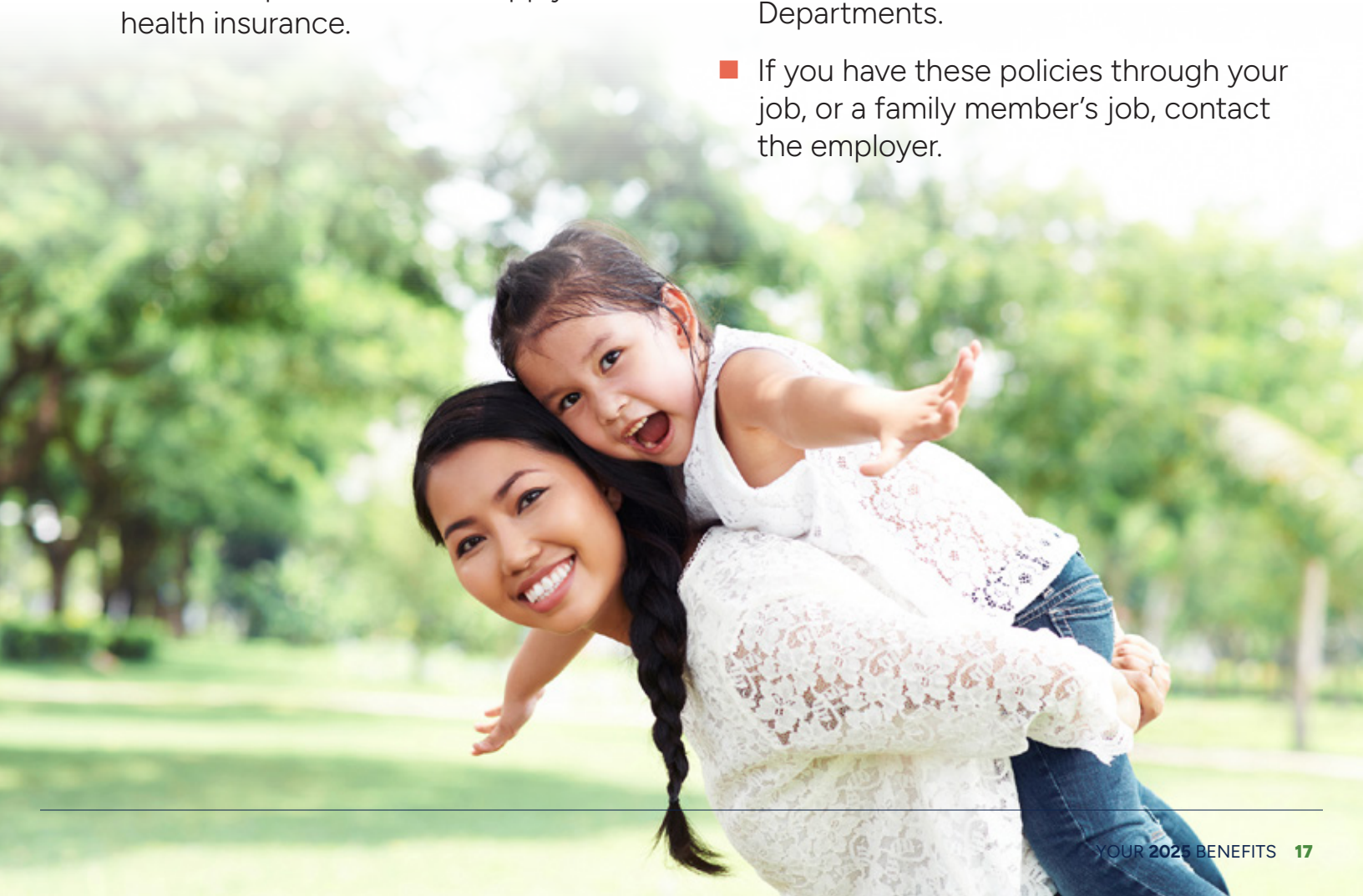
- The payment you get is not based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy is not a substitute for comprehensive health insurance.
- Since this policy is not health insurance, it does not have to include most federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit **www.healthcare.gov** or call **1-800-318-2596** (TTY: **1-855-889-4325**) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about these policies?

- For questions or complaints about these policies, contact your State Department of Insurance. Find its number on the National Association of Insurance Commissioners' website (**www.naic.org**) under Insurance Departments.
- If you have these policies through your job, or a family member's job, contact the employer.



Supplemental Benefits

You and your eligible family members have the opportunity to enroll in additional coverage that complements our traditional health care programs.

Health insurance covers medical bills, but if you have an emergency, you may face unexpected out-of-pocket costs such as deductibles, coinsurance, travel, and non-medical expenses. These plans are offered through **Principal** and are portable.

Accident Insurance

Accident insurance provides affordable protection against a sudden, unforeseen accident. It helps offset the direct and indirect expenses resulting from an accident, such as copayments, deductibles, ambulance, physical therapy, and other costs not covered by traditional health plans. The chart below lists only a few benefits available under this plan. See plan document for full details.

CONDITION/SERVICE	Benefit
Quadriplegia	100%
Coma	$15,000
Burns	$500-$5,000
Dislocation	$1,500-$7,500
Fracture	$500-$10,000
Wellness Benefit Once per year per individual	$50
Accidental Death & Dismemberment ▪ Employee ▪ Spouse ▪ Child	 $25,000 $12,500 $6,250
Loss of life, or loss of both hands or both feet or one hand and one foot	100%
Loss of speech and hearing in both ears or loss of sight in both eyes	100%
Death on common carrier	Additional 200%
Death while wearing a seat belt/airbag	Additional 25%

Please see **Employee Navigator** for the per-pay-period cost of adding or increasing this coverage for yourself.

Critical Illness Insurance

Critical Illness insurance helps pay the cost of non-medical expenses related to a covered critical illness or cancer. The plan provides a lump sum benefit payment to you upon first and second diagnosis of any covered critical illness or cancer. The benefit can help cover expenses such as lost income, out-of-town treatments, special diets, daily living, and household upkeep costs. See the plan document for complete details and coverages.

Benefit Amounts Available

- **Employee:** $5,000 increments to $100,000
- **Spouse:** $2,500 increments to $50,000 or 50% of employee's benefit
- **Child(ren):** Automatically covered for 25% of employee's benefit

CONDITION	1st Occurrence Benefit
Alzheimer's Disease, Invasive Cancer, Heart Attack, Stroke, Major Organ Failure, Coronary Artery Bypass	100% of benefit amount
Partial Benefit Cancer, Infectious Disease	25% of benefit amount
Childhood Conditions	100%
Health Screening Benefit One per covered person per calendar year	$50

Please see **Employee Navigator** for the per-pay-period cost of adding or increasing this coverage for yourself.

Employee Contributions

Biweekly Cost (24 deductions)

MEDICAL COVERAGE	HDHP/HSA $6,350 Plan	HDHP/HSA $3,500 Plan	PPO $3,000 Plan	PPO $5,000 Plan
Employee Only	$107.23	$128.26	$164.29	$158.20
Employee + Spouse	$439.45	$481.51	$553.57	$541.38
Employee + Child(ren)	$406.23	$446.19	$514.65	$503.06
Employee + Family	$838.12	$905.41	$1,020.72	$1,001.21
DENTAL COVERAGE	**Low Plan**		**High Plan**	
Employee Only	$8.71		$19.65	
Employee + Spouse	$19.72		$39.29	
Employee + Child(ren)	$23.14		$50.09	
Employee + Family	$36.45		$69.73	
VISION COVERAGE				
Employee Only	$4.00			
Employee + Spouse	$7.99			
Employee + Child(ren)	$7.59			
Employee + Family	$11.93			
BASIC LIFE AND AD&D				
Employee Only	Paid by HCC Network			
VOLUNTARY LIFE AND AD&D				
Employee Spouse Child(ren)	See rates in Employee Navigator			
SHORT TERM DISABILITY				
Employee Only	See rates in Employee Navigator			
LONG TERM DISABILITY				
Employee Only	Paid by HCC Network			
SUPPLEMENTAL BENEFITS	**Accident Insurance**		**Critical Illness Insurance**	
Employee Only Employee + Spouse Employee + Child(ren) Employee + Family	See rates in Employee Navigator		See rates in Employee Navigator	

Important Notices

Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

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

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Special Enrollment Rights

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later 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 enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for, such assistance.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact:

HCC Network
819 S. Business Highway 13
Lexington, MO 64067
660-259-2440

Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with HCC Network and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

Important Notices

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. HCC Network has determined that the prescription drug coverage offered by the HCC Network medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare prescription drug plan, as long as you later enroll within specific time periods.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription drug plan, you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7 but as a general rule, if you delay your enrollment in Medicare Part D after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting HCC Network at the phone number or address listed at the end of this section.

If you choose to enroll in a Medicare prescription drug plan and cancel your current HCC Network prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

For more information about this notice or your current prescription drug coverage:

Contact the Human Resources Department at **660-259-2440**.

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You may also request a copy.

For more information about your options under Medicare prescription drug coverage:

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

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you can call them at **800-772-1213**. TTY users should call **800-325-0778**.

Important Notices

Remember: Keep this Creditable Coverage notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

January 1, 2025
HCC Network
819 S. Business Highway 13
Lexington, MO 64067
660-259-2440

Notice of HIPAA Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information known as protected health information (PHI), includes virtually all individually identifiable health information held by a health plan – whether received in writing, in an electronic medium or as oral communication. This notice describes the privacy practices of the Employee Benefits Plan (referred to in this notice as the Plan), sponsored by HCC Network, hereinafter referred to as the plan sponsor.

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. It is important to note that these rules apply to the Plan, not the plan sponsor as an employer.

You have the right to inspect and copy protected health information which is maintained by and for the Plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask the Human Resources Department to amend the information. For a full copy of the Notice of Privacy Practices describing how protected health information about you may be used and disclosed and how you can get access to the information, contact the Human Resources Department.

Complaints: If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint, please contact the Privacy Officer.

HCC Network
819 S. Business Highway 13
Lexington, MO 64067
660-259-2440

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

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

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

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

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

Important Notices

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2024. Contact your State for more information on eligibility.

Alabama – Medicaid

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

Alaska – Medicaid

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

Arkansas – Medicaid

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

California– Medicaid

Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

Colorado – Health First Colorado (Colorado's Medicaid Program) and Child Health Plan Plus (CHP+)

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

Florida – Medicaid

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

Georgia – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

Indiana – Medicaid

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

Iowa – Medicaid and CHIP (Hawki)

Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

Important Notices

Kansas – Medicaid

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

Kentucky – Medicaid

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

Louisiana – Medicaid

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

Maine – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine Relay 711

Massachusetts – Medicaid and CHIP

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

Minnesota – Medicaid

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

Missouri – Medicaid

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

Montana – Medicaid

Website: https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

Nebraska – Medicaid

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

Nevada – Medicaid

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

New Hampshire – Medicaid

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

New Jersey – Medicaid and CHIP

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

New York – Medicaid

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

North Carolina – Medicaid

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

North Dakota – Medicaid

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

Important Notices

Oklahoma – Medicaid and CHIP

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

Oregon – Medicaid

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

Pennsylvania – Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

Rhode Island – Medicaid and CHIP

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

South Carolina – Medicaid

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

South Dakota - Medicaid

Website: https://dss.sd.gov
Phone: 1-888-828-0059

Texas – Medicaid

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

Utah – Medicaid and CHIP

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

Vermont– Medicaid

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

Virginia – Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

Washington – Medicaid

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

West Virginia – Medicaid and CHIP

Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

Wisconsin – Medicaid and CHIP

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

Wyoming – Medicaid

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

To see if any other States have added a premium assistance program since **July 31, 2024**, or for more information on special enrollment rights, you can contact either:

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

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

Important Notices

Continuation of Coverage Rights Under COBRA

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if you are covered under the HCC Network group health plan you and your eligible dependents may be entitled to continue your group health benefits coverage under the HCC Network plan after you have left employment with the company. If you wish to elect COBRA coverage, contact your Human Resources Department for the applicable deadlines to elect coverage and pay the initial premium.

Plan Contact Information

HCC Network
Charlene Hunter
819 S. Business Highway 13
Lexington, MO 64067
660-259-2440

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

- Emergency services – If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- Certain services at an in-network hospital or ambulatory surgical center – When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.

Important Notices

If you get other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact your insurance provider. Visit **www.cms.gov/nosurprises** for more information about your rights under federal law.

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This brochure highlights the main features of the HCC Network employee benefits program. It does not include all plan rules, details, limitations, and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. HCC Network reserves the right to change or discontinue its employee benefits plans anytime.