

2025 - 2026

Benefits Guide



Carolina Family
Health Centers, Inc.

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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 26 for more details.

This Benefit Guide gives you a summary of your benefit offerings for the new year. It's sourced from summary plan descriptions and benefit details, but keep in mind that there might be some differences. If there's any confusion, the actual plan documents are the final word.



Welcome

Welcome!

We are pleased...

to announce the launch of our annual benefits program, a time when we come together to review and select the benefits options for the upcoming year.


As leaders, we understand the importance of providing comprehensive and competitive benefits that support the well-being and financial security of our valued employees. This guide has been designed to assist you in making informed decisions about your benefits.

We encourage you to take the time to explore the various benefits available, share with family members in your household, and make choices that align with your personal goals and priorities. **Your well-being is our priority, and we are committed to providing you with a benefits package that supports your overall health, happiness, and success.**

Sincerely,

Carolina Family Health Centers, Inc.

How to Use This Guide

When you see a...	You can...
QR Code	Easily click on or scan the QR code to access additional resources.
Term you're unfamiliar with or the light bulb	<div></div> <div>Head to the glossary on page 23 to gain a deeper understanding of important terms and phrases related to your benefits.</div> <div>The light bulb icon signifies key terms or phrases that are crucial for you to know to make more informed decisions about your benefits.</div>

Benefit Highlights & Resources

Check out the [quick highlights](#) for the 2025 – 2026 plan year

Medical	Medical will remain with BCBS of NC, with slight changes to the PPO plan design, but rates and all other plan designs will remain the same.
Spending Accounts	IRS contribution amounts for Health Savings Accounts and Flexible Spending Accounts have increased.
Dental	There are no changes to carrier or plan design, however, there is a slight increase in premium.
Vision	There are no changes to carrier or plan design
Life Insurance	There are no changes to carrier or plan design
Additional Benefits	There are no changes to carrier or plan design

Have Questions?

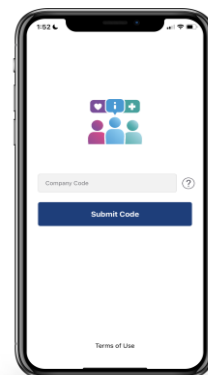
If you have any questions about benefit offerings or the enrollment process, you can contact Nurys Rivera at nrivera@cfhcnc.org.

iNGAGED Benefits Mobile App

The iNGAGED Benefits mobile app is your on-the-go benefits resource!

With the app, employees and their dependents can easily view benefit plan documents and resources 24/7, quickly contact a benefit carrier and store images of your ID cards for easy access.

Download iNGAGED Benefits for free from the Apple App Store or Google Play and login using our company code: **cfhc**



Eligibility & Enrollment

Who is eligible for benefits?

Full-time employees working 30 hours or more per week and their eligible dependents are eligible to enroll in the benefits outlined in this guide.

Eligible dependents may include:

- Your legal spouse
- Your children up to age 26
- Disabled dependents over the age 26

Can I make a change after submitting my benefit elections?

The majority of your benefits will be paid for through pre-tax payroll deductions under a Section 125 cafeteria plan. Due to the rules of the cafeteria plan, it's important to note that you are unable to make changes to your benefit elections until the next open enrollment period unless you experience a qualifying life event.

These events can include, but are not limited to, marriage, divorce, or the birth of a child. In the event that you do experience a qualifying life event and wish to modify your benefit elections, it is crucial that you promptly notify your benefits administrator as some deadlines will apply. Please be aware that election changes requested after the designated timeframe or without a qualifying life event will not be approved.

Eligibility & Enrollment

When do I enroll?

During the open enrollment period, you must make an appointment with an enrollment counselor to enroll or decline coverage this year. Please note – if you are enrolled in a spending account, you must make elections each year to continue participating in the plan.

The annual open enrollment period is May 19th through May 30th.

If you are hired after the open enrollment period, you are eligible for our medical and vision benefits on the 1st of the month following 30 days of employment. For Flexible Spending, you must work one year prior to being eligible. For Dental benefits, you are eligible following 90 days of employment. For all other benefits we offer, you are eligible on the 1st of the month following 90 days of employment.

The benefits you select either during open enrollment or the new hire period will be effective through June 30th, 2026.

How do I enroll?

Enrolling in benefits is easy!

1. Login to <https://www.employeenavigator.com/benefits/account/login> using your existing username and password if you've logged into the system before. If you are a new user, click on "Register as a new user" and provide the following information:
2. Your first and last name
3. Company Identifier: **CarFamHeaCen2023**
4. The last 4 digits of your Social Security Number / ID
5. Birth Date in (mm/dd/yyyy) format
6. Click "Start Enrollment" to begin the enrollment process and enter your personal and dependent information.
7. Walk through each step of the enrollment and click "Save & Continue" at the bottom of each screen to save your elections.
8. If there is a benefit you do not wish to enroll in, click "Don't want this benefit?" at the bottom of the screen.
9. Once you have finished, review the benefits you have elected and click to sign to complete your enrollment.



Additional enrollment instructions can be found here!





Core Benefits

Medical Plans



Below outlines your plan options through BCBSNC. Networks frequently change, so it is always a good idea to confirm your provider's participation is in-network to avoid additional costs. Please refer to your plan document for specific details. See the glossary for definition of terms used on this page.



	BCBS of NC HDHP Blue Options	BCBS of NC PPO 1-2-3 Blue Options	BCBS of NC PPO 2500.80 Blue Options
Services	In-Network	In-Network	In-Network
Deductible Individual / Family	Embedded \$2,750 / \$5,500	Embedded \$3,500 / \$7,000	Embedded \$2,500 / \$5,000
Coinsurance Plan Pays / You Pay	100% / 0%	80% / 20% 60% / 40%	80% / 20%
Out-of-Pocket Max Individual / Family	\$2,750 / \$5,500	\$7,000 / \$14,000	\$9,200 / \$18,400
Preventive Services	Covered at 100% **	Covered at 100% **	Covered at 100% **
Primary Care	Deductible then 0%	\$25 Copay	\$35 Copay
Specialist Visit	Deductible then 0%	Deductible then 40%	\$70 Copay
BCBSNC Telemedicine	Deductible then 0%	No Charge	No Charge
Urgent Care	Deductible then 0%	\$100 Copay	\$70 Copay
Emergency Room	Deductible then 0%	Deductible then 40%	\$500 Copay
Inpatient Hospital	Deductible then 0%	\$250 per admission; Deductible then 20%	Deductible then 20%
Outpatient Facility	Deductible then 0%	Deductible then 40%	Deductible then 20%

*Out-of-Network benefits are available; see your summary of benefits for coverage details

**Preventive service are covered at 100%. If however, additional services are needed (additional lab work, x-ray, MRI, etc.), charges will apply.

Charges are paid based on the codes your provider uses to bill.

Plan summary designs can be found in employee navigator for your reference.

Your Cost - Biweekly Employee Deductions					
	Employee Only	Employee & Spouse	Employee & Child	Employee & Child(ren)	Employee & Family
BCBS of NC HDHP	\$0	\$364.01	\$116.64	\$272.12	\$629.03
BCBS of NC PPO 1-2-3	\$28.34	\$383.88	\$142.32	\$294.15	\$642.69
BCBS of NC PPO 2500.80	\$54.01	\$440.94	\$177.99	\$343.27	\$722.65

Pharmacy Information



Enrolling in medical coverage provides prescription drug coverage through BCBSNC. Below highlights information about the prescription drug plan offered!

	BCBS of NC HDHP	BCBS of NC PPO 1-2-3	BCBS of NC PPO 2500.80
In-Network Benefits			
Tier 1	Deductible then 0%	\$10	\$10
Tier 2	Deductible then 0%	\$25	\$15
Tier 3	Deductible then 0%	\$35	\$35
Tier 4	Deductible then 0%	\$75	\$50
Tier 5	Deductible then 0%	25% up to \$200 max	25% up to \$100 max

Where to Find Details

The most up-to-date drug lists and drug management program information is located below:

- www.bcbsnc.com

If your medication is not listed, ask your doctor about an equivalent medication that is listed on the formulary.

Retail Pharmacy Discount Programs

Pharmacies offer generic medication programs for 30 and 90-day supplies for less than \$10. Several popular maintenance medications are offered through these generic programs. In order to take advantage of these programs, take your prescription to one of the participating pharmacies and present to the pharmacist. You will not need to show your Provider ID card. It's that easy to start saving money!

Pharmacy Information



Why pay more for your prescriptions?

While medications can be a necessity, the high price tag associated with prescriptions doesn't have to be a requirement. Here are a few resources available to you to help your prescriptions fit your budget.



Use the Mail

If you are currently taking any maintenance medications, take advantage of the cost savings and convenience of our Mail Order Program. Specialty drugs must be obtained directly through BCBSNC. BCBSNC will fill and ship your specialty medication right to your home.



Shop Around

Did you know you can compare drug prices based on your zip code at www.bcbsnc.com? You can also review medications that are considered equivalent to the drug you have been prescribed to see if there is a generic or lower cost alternative to discuss with your medical provider.

BCBSNC Resources



BCBSNC is a trusted and reputable healthcare provider, committed to delivering exceptional medical services and prioritizing the well-being of its members. With your medical plan, you gain access to a wide range of valuable resources, ensuring comprehensive care for you and your family.

Here are a few of the additional resources available to you:

Blue365

Discover Blue365, an exclusive program offered by BlueCross BlueShield that brings you a world of health and wellness benefits. As a valued member, you can enjoy a wide range of discounts and deals on fitness, personal care, healthy living, and more.

Here's what Blue365 has to offer:

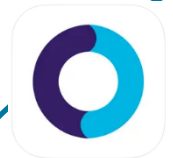
- ✓ Savings on Fitness and Wellness
- ✓ Discounts on Personal Care
- ✓ Deals on Healthy Living
- ✓ Exclusive Member Perks

Blue365 is your key to a healthier and happier life. Start exploring the exclusive benefits today and access Blue365 through your MyHealthToolkit account.

Teladoc Health

Get quick care from anywhere with Teladoc telemedicine visits! A telemedicine visit lets you see and talk to a doctor from your laptop or mobile device. Teladoc is available to you through our medical plan. Please refer to our plan details to determine any potential costs associated with virtual visits.

Telemedicine doctors can treat cold and flu symptoms, sinus and pinkeye, allergies, migraines, rashes and much more! You can access Teladoc by calling +1855-549-2214, by visiting <https://teladoc.com>, or by downloading the Teladoc Health app.



Health Programs



Employee Assistance Program (EAP)

Our EAP can offer valuable support by providing confidential counseling and resources to help you with personal and work-related issues. The EAP is available for free to all employees and immediate family members.

EAP services include up to five in-person consultations, referrals, and resources.

EAPs can help with issues such as:

- marital and family concerns
- depression
- substance abuse
- grief and loss
- financial entanglements
- finding daycares
- legal guidance
- other personal issues

Studies show that employees who used EAP services reported higher levels of work-life balance and lower levels of work-family conflict. *

** Journal of Occupational Health Psychology*



Reach out to EmployeeConnect 24/7 toll free at +1888-628-4824, or you can visit their website at www.GuidanceResources.com.

Your EAP username: LFGSupport and EAP password: LFGSupport1.

Health Savings Account (HSA)

An HSA is a tax-advantaged account that you can put money into to save for future medical expenses. HSA funds can be used to pay for eligible medical, dental and vision expenses. Unused money grows tax-free and can be invested with a minimum balance.

What are the details?

Who is eligible? Anyone who is:



- Covered by a High Deductible Health Plan (HDHP)
- Not covered on another medical plan that is not a HDHP
- Not enrolled in Medicare benefits
- Not enrolled in Tricare
- Not eligible to be claimed on another person's tax return

Your contributions



Your contribution to an HSA is entirely voluntary and can be adjusted based on your individual needs and financial goals. Contributions are made on a pre-tax basis and the IRS poses limits on the amount you can contribute.

For 2025, your IRS contribution limits are:

- \$4,300 individual and \$8,550 family
- For those 55 and older, you have a \$1,000 catch-up contribution

What are eligible expenses?



The IRS maintains a list of all eligible expenses, common qualified expenses include acupuncture, ambulance services, dental treatment, contact lenses, doctor's fees, and hearing aids.

View the complete list of qualified expenses at:

<https://www.irs.gov/publications/p502/index.html>.



Who owns the account?

The account is yours and remains with you even if you leave the company. Additionally, one of the best features of an HSA is that money left over at the end of the year remains in the account so you can use it any time in the future.

Spending Accounts

Flexible Spending Accounts (FSA)

FSAs provide you with an important tax advantage that can help you pay for expenses on a pre-tax basis. By anticipating your family's costs for the next year, you can actually lower your taxable income.

You must enroll in your FSA every year to contribute. Your FSA plan options are shown below.

Healthcare FSA

- Allows employees who are not enrolled in an HDHP or contributing to an HSA to pay for certain IRS-approved medical care expenses with pre-tax dollars.
 - **The annual maximum contribution of \$3,300 can be used for eligible health care related expenses, including medical, dental and vision expenses.**
 - **You can rollover a maximum of \$500 per plan year, any amount over \$500 remaining in your FSA will be forfeited.**
-

Dependent Care FSA

- Allows employees to use pre-tax dollars toward qualified dependent care such as caring for children under age 13 or caring for elders.
 - **The annual contribution maximum is \$5,000 (or \$2,500 if married and filing separately).**
 - **There is no rollover for Dependent Care FSAs.**
 - Funds must be deducted from your paycheck before they are eligible to be used for reimbursement
-

Supplemental Health Benefits



The supplemental health benefit options below can be used to customize your coverage to complement your medical plan options. If you elect any of the voluntary options below, you will be responsible for the cost of the benefit. For more information on rates, please see your enrollment site.

Wellness benefits provide payment directly to you when you or a covered member receive health screenings or preventive exams. It's a great way to ensure you're not just protected financially, but also supported in maintaining a healthy lifestyle!

Accident Insurance

Accident Insurance pays a lump-sum benefit directly to you based on the type of injury sustained and treatment needed. This policy has on/off job coverage and it includes a \$100 Wellness Benefit paid annually for each member who receives a health screening.

Accident coverage can help to reimburse you for expenses like:

- ✓ Ambulance transportation
- ✓ Coverage for medical expenses, hospital stays, and surgeries
- ✓ Therapy charges and rehabilitation costs
- ✓ Financial support in case of injury from an accident
- ✓ No medical exam required for quick and easy coverage

Wellness Benefit:

\$100

Critical Illness Insurance

Critical Illness pays a lump sum benefit directly to you upon diagnosis of a covered illness after the plan's effective date of coverage. There are multiple payouts automatically included and a benefit can be paid for each covered condition. Coverage can be taken with you when you leave Carolina Family Health Center and includes a \$100 Wellness Benefit annual health screening benefit for each covered member.

Critical illness coverage helps cover expenses related to the diagnosis of:

- ✓ Cancer
- ✓ Heart attack
- ✓ Kidney failure
- ✓ Blindness
- ✓ Coma

Wellness Benefit:


\$100

Hospital Indemnity Insurance

This plan works as a supplemental insurance plan designed to pay for the costs of a hospital admission that may not be covered by other insurance. This plan pays cash directly to you to cover out-of-pocket expenses. The payments can be used for any purpose including medical copays, deductibles, or regular expenses (food, rent, utilities).

Dental




Below provides an overview of your available dental plan. Using an in-network provider will offer you the lowest service pricing. Age and frequency limits may apply to some services. Please refer to your plan document for specific details and note that out-of-network providers can balance bill you the difference between what they charge and the carrier's **reasonable and customary amount**.  MaxRewards® is included with your dental plan. A covered person may be eligible for the rollover amount for preventive, basic, and major services. You can rollover \$400 per calendar year on in-network services, and \$250 for out-of-network services. The maximum rollover account balance is \$1,000.

Benefits	Dental Plan Lincoln	
	In-Network	Out-of-Network
Calendar Year Deductible (Basic & Major Only) Individual / Family	\$50 / \$150	\$50 / \$150
Calendar Year Benefit Maximum	\$1,500	\$1,500
Preventive Services Exams, Cleanings, X-rays, Fluoride, Space Maintainers, Sealants, Harmful Habit Appliance	100%	100%
Basic Services Fillings, Extractions, Consultations, Resin/Stainless Steel Crowns, Simple Extractions, Periodontal Maintenance, Labs, Occlusal Adjustments	90%	90%
Major Services Crowns, Dentures, Bridges, Endodontics, Periodontics, Biopsy's, Surgical Extractions, Oral Surgery, General Anesthesia, Endodontics, Scaling & Root Planning, Dentures, Implants, Full-Mouth Debridement	50%	50%
Orthodontia Dependent children up to age 26, if full-time student	50%	50%
Orthodontia Lifetime Maximum	\$1,000	\$1,000

Your Cost - Biweekly Employee Deductions				
	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
Dental Plan	\$19.29	\$36.41	\$46.17	\$66.50

Vision



Below provides an overview of your available vision plan. Using an in-network provider will offer you the lowest service pricing. Frequency limits may apply to some services. Please refer to your plan document for specific details and note that out-of-network providers can balance bill you the difference between what they charge and the carrier's reasonable and customary amount. 

Blue 20/20 Vision Plan BCBS	
Benefits	In-Network
Exam	\$10 Copay
Frames	\$25 Copay; then \$150 allowance + 20% off
Lenses	\$25 Copay
Elective Contacts	\$150 allowance
Frequency of Services	
Exams	Once every 12 months
Frames	Once every 24 months
Lenses or Contacts	Once every 12 months

Your Cost - Biweekly Employee Deductions				
	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
BCBSNC Vision Plan	\$3.53	\$6.71	\$7.06	\$10.38

Life & Disability





Lincoln Financial Basic Life and AD&D Insurance

Full-time employees receive employer-paid group life and accidental death and dismemberment (AD&D) insurance in the amount of up to 1.5 times their annual salary up to \$300,000 max. Your benefit amount will begin reducing at age 70. Don't forget to keep your beneficiaries up to date.

Lincoln Financial Voluntary Life and AD&D Insurance

You have the option to purchase voluntary life and AD&D insurance in the increments listed below through the convenience of payroll deduction. If you elect when first eligible, you may elect coverage up to the Guaranteed Issue amount without having to answer any medical questions. Employee and spouse benefits begin to reduce at employee age 70; employee and spouse rates are based on employee age. Employees must be enrolled to enroll dependents. Additionally, don't forget to keep your beneficiaries up to date!

Voluntary Life & AD&D Insurance	
Employee Coverage	Increments of \$25,000 up to 5 times your annual earnings up to \$150,000.
Spouse Coverage	Increments of \$5,000 up to \$75,000, not to exceed 2.5 times the employee's elected benefit amount. Employee must be covered to request dependent coverage.
Child Coverage	Increments of \$2,500 up to \$10,000 Employee must be covered to request dependent coverage.
 Evidence of Insurability	You will be required to provide EOI if you are applying for coverage outside of when you are first eligible, if you are applying for above the guarantee issue amount when you are first eligible, or applying to increase your coverage amounts.
 Guaranteed Issue	Employee: Guarantee Issue amount of \$150,000. Employee's over age 70, Guarantee Issue amount is \$50,000. Spouse: Guarantee Issue amount of \$30,000.

Life & Disability



Lincoln Financial Disability

In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income.

	Short-Term Disability	Long-Term Disability
Coverage Paid By	Employee	Carolina Family Health Center
Percentage of Income Replaced	60%	60%
Benefits Begin	On the 8th day	On the 90th day
Benefits Duration	13 weeks	Social Security Normal Retirement Age
Maximum Benefit	\$1,000 per week	Up to \$10,000 max per month

**Long-term disability benefits are specific to the employee. A benefit statement can be found on Employee Navigator for further information.*

Pre-Existing Exclusions	
Short-Term Disability	Any disability that occurs within the first 12 months of coverage as a result of a pre-existing condition which was treated within 3 months prior to the coverage effective date will be excluded.
Long-Term Disability	Any disability that occurs within the first 12 months of coverage as a result of a pre-existing condition which was treated within 3 months prior to the coverage effective date will be excluded.

Additional Benefits



Employee Discount Program

BenefitHub is your home to save on thousands of items all through an easy-to-use, exclusive discount marketplace. BenefitHub negotiates the best discounts on the market for you and many of the offers include additional cash back to make it the best overall value to you. Not only saving you money, but time and hassle, too.

Enjoy discounts, rewards, and perks on thousands of the brands you love in a variety of categories:

- Travel
- Apparel
- Entertainment
- Beauty & Spa
- Auto
- Local Deals
- Restaurants
- Tickets
- Electronics
- Education
- Health & Wellness
- Sports & Outdoors

Getting started is easy!

1. Go to CFHCNC.benefithub.com
2. Create an account using referral code: **1GFCKP**
3. Complete registration
4. Start shopping with our discounts!



Things to know

Important Terms



Actively at Work	Being physically present at your place of employment and actively performing the duties of one's occupation on a full-time basis, often a qualifying factor in coverage.
Coinsurance	A percentage of a health care cost that the covered employee pays after meeting the deductible.
Copayment (Copay)	A fixed dollar amount for each doctor visit that the covered employee pays for a health care service, usually when the service is received. For example, a primary care doctor may charge a nominal copay per visit.
Deductible	A fixed dollar amount that the covered employee must pay out-of-pocket each calendar year before the plan will begin reimbursing for non-preventive health expenses. Plans usually require separate limits for individual and other coverage tiers.
Embedded vs. Non-Embedded Deductibles	An embedded deductible refers to a deductible that applies to each individual within a family plan, while a non-embedded deductible applies to the entire family as a whole.
Explanation of Benefits (EOB)	A record of a person's past and current health events. A "detailed receipt." Ask for this whenever you have a medical service performed for your records. FSAs, HSAs and HRAs will sometimes need this additional verification.
Evidence of Insurability (EOI)	Is a record of a person's past and current health events. It is used by insurance companies to verify whether a person meets the definition of good health.
Guaranteed Issue (GI)	A requirement that health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. Except in some states, GI doesn't limit how much you can be charged if you enroll.
In-Network	Doctors, clinics, hospitals, and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.
Out-of-Network	A health plan will cover treatment for doctors, clinics, hospitals, and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than in-network providers.
Out-of-Pocket Maximum	The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including copayments and coinsurance.
Preventive Care	Most health plans must cover a set of preventive services – like shots and screening tests – at no cost to you. Visit https://www.healthcare.gov/coverage/preventive-care-benefits/ to view free preventive services for all adults, women, and children.
Premium	The amount the employee pays for insurance.
Reasonable and Customary	Refers to the standard charges for medical services or treatments that are considered reasonable and customary within a specific area and are used as a basis for determining the amount of coverage provided by an insurance policy.

Key Contacts



Benefit	Whom To Call	Phone Number	Email or Website
Medical	BCBSNC	+1877-258-3334	www.bcbsnc.com
Dental	Lincoln Financial	+1800-487-1485	www.lincolnfinancial.com
Vision	BCBS	+1877-258-3334	www.bcbsnc.com
Health Savings Account	Health Equity	+1866-346-5800	www.helahtequity.com
Flexible Spending Account	Health Equity	+1800-487-1485	www.healthequity.com
Life and AD&D Voluntary Life and AD&D Disability	Lincoln Financial	+1800-487-1485	www.lincolnfinancial.com
Supplemental Health Accident Critical Illness Hospital Indemnity	Lincoln Financial	+1800-487-1485	www.lincolnfinancial.com
Employee Assistance Program	Lincoln Financial	+1800-487-1485	www.lincolnfinancial.com

Carolina Family Health Centers, Inc. Health and Welfare Benefits Annual Notices

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law for the 2025 plan year.

Enclosures:

- Medicare Part D Creditable Coverage Notice
- HIPAA Special Enrollment Rights Notice
- Women's Health Cancer Rights Act (WHCRA) Notice
- Newborns' Mothers Health Protection Act (NMHPA) Notice
- HIPAA Notice of Privacy Practices
- COBRA General Notice
- Your Rights and Protections Against Surprise Medical Bills
- Health Insurance Marketplace Coverage Options And Your Health Coverage – New Hires
- Children's Health Insurance Program (CHIP) Notice

Carolina Family Health Centers, Inc. herein be referred to as "Employer"

BCBSNC will herein be referred to as "Medical Plan(s)"

Nurys Rivera will herein be referred to as "Plan Administrator"

You can contact your Plan Administrator at +1252-293-0013 x 341 or nrivera@cfhcnc.org.

The attached legal notices packet includes certain legal notices applicable to most employers that offer health and welfare benefit plans. We have prepared this packet for you based on our knowledge of your benefits as our client and our understanding of the notices requirements as a broker in the insurance industry and not as legal or tax advice. These notices may require certain modifications to fit your exact circumstances in order to fulfill your legal obligations. There may also be other legal notices applicable to you that are not included within this packet. We recommend you review these notices with your legal counsel prior to distributing them to your employees and plan participants, and we are happy to assist you and/or your legal counsel with this review process.

IMPORTANT NOTICES

MEDICARE PART D CREDITABLE COVERAGE NOTICE

Important Notice From Your Employer About Your Prescription Drug Coverage And Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan while enrolled in the Employer's coverage as an active employee, please note that your Employer coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced.

IMPORTANT NOTICES

Medicare will usually pay primary for your prescription drug benefits if you participate in your Employer's coverage as a former employee.

You may also choose to drop your Employer's coverage. If you do decide to join a Medicare drug plan and drop your current Employer's coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with your Employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your Employer changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call +1-800-MEDICARE (+1800-633-4227). TTY users should call +1877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at +1800-772-1213 (TTY +1800-325-0778).

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

Date:	07/01/25
Name of Entity/Sender:	Carolina Family Health Centers, Inc.
Contact--Position/Office:	Nurys Rivera
Address:	303 Green Street East Wilson, NC – 27893 United States
Phone Number:	+1252-293-0013 x 341

HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE

If you are declining enrollment in your Employer's group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to

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enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact your plan administrator.

WOMEN'S HEALTH CANCER RIGHTS ACT (WHCRA) NOTICE

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA) NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA NOTICE OF PRIVACY PRACTICES

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

The Employer sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Employer, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or

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received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

- (1) your past, present or future physical or mental health or condition;
- (2) the provision of health care to you; or
- (3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by the Employer, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Employer's HIPAA Privacy Officer or:

Carolina Family Health Centers, Inc.
Attention: HIPAA Privacy Officer
Corina Buzard, Chief Compliance Officer
303 Green Street East
Wilson, NC 27893
+1252-293-0013 x 230

Effective Date

This Notice as revised is effective July 1st, 2025.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above or on our intranet. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose

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information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

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Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;

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- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities

We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research

We may disclose your protected health information to researchers when:

- (1) the individual identifiers have been removed; or
- (2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits

We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You

When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.

We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

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Other Disclosures

Personal Representatives

We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- (1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
- (2) treating such person as your personal representative could endanger you; or
- (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members

With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations

Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

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- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures

You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see [Your Rights Under HIPAA](#).

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Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling +1877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

** Continuation Coverage Rights Under COBRA **

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. 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;

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- 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 continuation coverage 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;
- 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: Nurys Rivera.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This

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extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), 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 www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the 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.

Plan contact information

Contact Nurys Rivera at nrivera@cfhcnc.org.

¹ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

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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 haven't 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 **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance 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 **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

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

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

When balance billing isn't 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.

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- 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've been wrongly billed, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to [learn more about protections from surprise medical bills](#) and for [contact information for the state department of insurance or other similar agency/resource in your state](#) to learn if you have any rights under applicable state law. Please click on your state in the map for contact information to appear.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE – NEW HIRE INFORMATION

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

Part A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of

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premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.²³

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at +1800-318-2596. TTY users can call +1855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July

² Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

³ An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender:	Carolina Family Health Centers, Inc.
Contact--Position/Office:	Nurys Rivera
Address:	303 Green Street East Wilson, NC
Phone Number:	+1252-293-0013 x 341

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Part B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is ordered to correspond to the Marketplace application.

"An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

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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 March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid Website: http://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) & 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.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	INDIANA – Medicaid Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki) Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	KANSAS – Medicaid Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

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<p>KENTUCKY – Medicaid</p> <p>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</p>	<p>LOUISIANA – Medicaid</p> <p>Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
<p>MAINE – Medicaid</p> <p>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</p>	<p>MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
<p>MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p>MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPPProgram@mt.gov</p>	<p>NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
<p>NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p>NEW HAMPSHIRE – Medicaid</p> <p>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</p>
<p>NEW JERSEY – Medicaid and CHIP</p> <p>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)</p>	<p>NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p>NORTH CAROLINA – Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p>NORTH DAKOTA – Medicaid</p> <p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>

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OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	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	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhpp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

