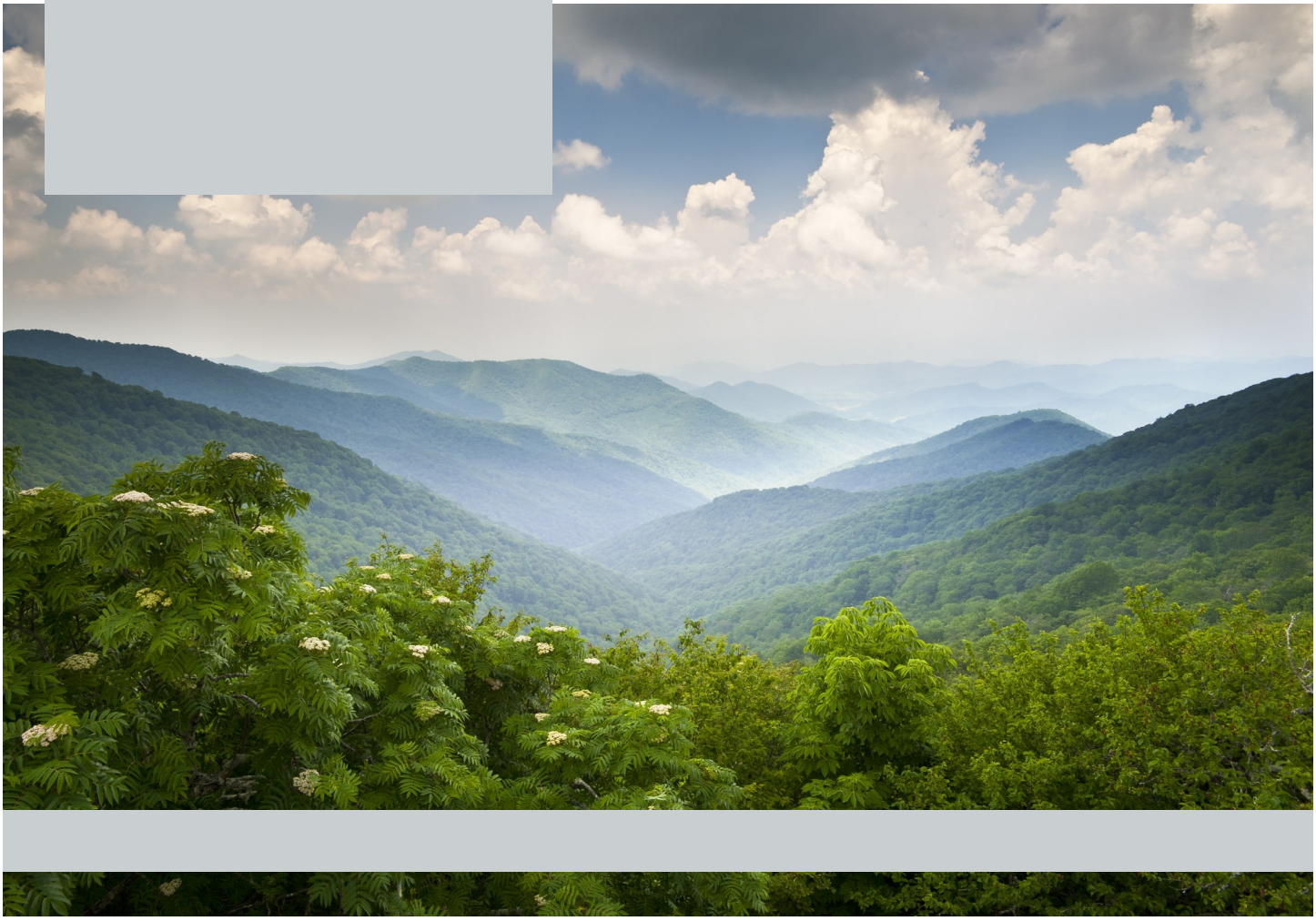
Benefits Enrollment Guide

2024

Lincotek



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Enrollment Checklist

Information You Need to Know:

- ☐ You can enroll in benefits during your initial enrollment period as a newly eligible associate, during Annual Open Enrollment, or if you experience a Qualifying Life Event (QLE).
- ☐ The plan year is January 1, 2024— December 31, 2024
- ☐ Generally, you can only change your benefit elections during the annual benefits enrollment period. However, you may be able to change some of your benefit elections upon the occurrence of certain change in status events, provided you properly notify your Employer and the change is permitted under the plan terms. Examples of these Qualifying Life Events (QLEs) are found on the next page.
- ☐ Educate yourself on all of the benefit options that are available to you. Review this Benefits Guide carefully as you consider your plan choices.
- ☐ If you are electing coverage for your eligible dependents, proof of dependent eligibility may be required.

Current Employees:

- ☐ Actively enroll between October 30, 2023 and November 3, 2023.
- ☐ Verify your 2024 benefits elections and deductions on the first paycheck you receive after your January 1 effective date to confirm everything is correct. If you see any errors, notify Human Resources immediately, otherwise corrections will not be honored.

New Hires:

- ☐ Be sure to make your elections **before your benefits effective date**. If you do not make elections, then you may not be able to enroll until the next open enrollment period.
- ☐ When you elect certain benefits, you may receive an ID card in the mail. Your ID card contains important information about you, your employer group and the benefits to which you are entitled. Always remember to carry your ID card with you, present it when receiving health care services or supplies, and make sure your provider always has an updated copy of your ID card.
- ☐ If you need to replace your ID card, or need an additional card, you can request another by contacting the carrier or by visiting the carrier's website online to print another copy.
- ☐ Verify your 2024 benefits elections and deductions on the first paycheck you receive after your effective date to confirm everything is correct. If you see any errors, notify Human Resources immediately, otherwise corrections will not be honored.

Eligibility & Enrollment

Lincotek is proud to offer a comprehensive program of benefits to service the diverse needs of our workforce, and we are committed to continually enhancing and expanding our offerings. The information in this document is meant to familiarize you with the benefits and programs currently offered in 2024. During the Annual Open Enrollment period, the benefits you elect will be effective January 1, 2024. For new hires, benefits are effective 1st of the month following 30 days. Please remember that this guide is not intended to cover all provisions of all plans, but rather is a quick reference tool to help answer most of your basic questions. Please see each carrier's benefits Summary Plan Description or Certificate of Coverage for complete details of the benefits.

Am I Eligible?

Eligibility and required contributions for these benefits and programs depend on both your employee classification and whether you elect to extend coverage to your dependents.

Individuals eligible for coverage under the plans include:

- Your legal spouse or domestic partner
- Your dependent child(ren) up to age 26, regardless of full-time student status or marital status
- Your unmarried child(ren) of any age who, prior to age 26, has been declared incapable of self-support due to mental or physical disability

Once eligible, you will enroll in benefits using an online portal called ADP.

Qualifying Life Events (QLE)

Once you have made your benefit elections and your enrollment is closed, you cannot make changes until the next open enrollment period unless you experience a QLE such as:

- Marriage, divorce or legal separation
- Birth, adoption or placement for adoption
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan
- Gain or loss of eligibility for CHIP or Medicare*

*You have 30 days from the date of the QLE to notify Human Resources and provide appropriate documentation to change your benefits. The exception to this rule is in the case of CHIP or Medicare benefits which allow a 60-day notification period.

Please note: Not every QLE permits a change in benefit plan elections. A change in election is permitted only when it is determined that the QLE affects eligibility for coverage of the employee, a spouse or a dependent under a benefit plan and in accordance with Section 125 regulations.

Plan	Eligibility	Benefits Effective Date
Medical & Prescription	Full-time, actively at work and scheduled to work 30+ hours per week	Benefits are effective 1st of the month following 30 Days
Dental		
Vision		
Flexible Spending Accounts (FSA)		
Healthcare Savings Account (HSA)		
Basic & Voluntary Life		
Long-Term Disability		
Short-Term Disability		
Accident and Critical Illness		
EAP/Travel Assistance		

Medical Insurance – HDHP Plan

Lincotek medical and prescription drug insurance is provided through Blue Cross Blue Shield of NC. Below is a brief summary of the High Deductible Health Plan (HDHP). If you elect this plan option, you may also participate and contribute to a Health Savings Account (HSA). However, you may ***not*** participate in a Health Care FSA plan. In order to make the best use of your benefits and out-of-pocket expenses, we strongly encourage the use of in-network providers, Tier 1 drugs whenever possible, and Urgent Care facilities instead of Emergency room visits when appropriate.

Blue Cross Blue Shield of NC HDHP Plan — 5000 Plan		
Services	**In-Network (You Pay)**	**Out-of-Network (You Pay)**
Calendar Year Deductible—embedded Individual / Family	$5,000 / $10,000	$10,000 / $20,000
Calendar Year Out-of-Pocket Maximum—embedded Individual / Family	$5,000 / $10,000	$11,250 / $22,500
Coinsurance	0%	30%
Preventive Care Services	100% covered, no charge	30% after deductible
Primary Care Office Visit	0% after deductible	30% after deductible
Specialist Office Visit	0% after deductible	30% after deductible
Urgent Care Facility	0% after deductible	30% after deductible
Emergency Room	0% after deductible	0% after deductible
Inpatient Services	0% after deductible	30% after deductible
Outpatient Services	0% after deductible	30% after deductible
Prescription Drugs	**Retail (up to 30-day supply)**	**Out of Network**
- Tier 1 / Generic - Tier 2 / Preferred Brand Name - Tier 3 / Non-Preferred Brand Name - Tier 4 / Specialty	0% after deductible 0% after deductible 0% after deductible 0% after deductible	0% after deductible 0% after deductible 0% after deductible 0% after deductible

BCBS of NC Medical – HDHP 5000 Plan	Per Pay Period Deductions
Employee Only	$30.37
Employee + Spouse	$153.18
Employee + Child(ren)	$122.40
Family	$210.64

Medical Insurance – PPO 4000 Plan

Lincotek and prescription drug insurance is provided through Blue Cross Blue Shield of NC. Below is a brief summary the PPO 4000 Plan. In order to make the best use of your benefits and out-of-pocket expenses, we strongly encourage the use of in-network providers, Tier 1 drugs whenever possible, and Urgent Care facilities instead of Emergency room visits when appropriate. Log in to Blue Connect to select your Primary Care Provider (PCP). Your copay is waived for your first 3 visits to your selected PCP.

Blue Cross Blue Shield of NC PPO - 4000 Plan		
Services	**In-Network (You Pay)**	**Out-of-Network (You Pay)**
Calendar Year Deductible—embedded Individual / Family	$4,000 / $8,000	$8,000 / $16,000
Calendar Year Out-of-Pocket Maximum—embedded Individual / Family	$8,000 / 16,000 (includes deductible, coinsurance and copays)	$16,000 / $32,000 (includes deductible, coinsurance and copays)
Coinsurance	30% or 50%	60%
Preventive Care Services	100% covered, no charge	60% after deductible
Primary Care Office Visit*	$35 copay	60% after deductible
Telehealth	$10 copay	Not Available
Specialist Office Visit	50% after deductible	60% after deductible
Urgent Care Facility	$100 copay	$200 copay
Emergency Room	50% after deductible	50% after deductible
Inpatient Services	$250 per admit copay, then 30% after	$500 per admit copay, then 60% after
Outpatient Services	50% after deductible	50% after deductible
Prescription Drugs	**Retail (up to 30-day supply)**	**Out of Network**
- Tier 1 / Generic - Tier 2 / Preferred Brand Name - Tier 3 / Non-Preferred Brand Name - Tier 4 / Specialty - Tier 5 / Nonpreferred Specialty	$10 copay $35 copay $60 copay 25% to a maximum of $100 25% to a maximum of $100	$10 copay $35 copay $60 copay 25% to a maximum of $100 25% to a maximum of $100

BCBS of NC Medical – PPO 4000 Plan	Per Pay Period Deductions
Employee Only	$31.96
Employee + Spouse	$161.20
Employee + Child(ren)	$128.48
Family	$221.67

Medical Insurance – PPO 2000 Plan

Lincotek and prescription drug insurance is provided through Blue Cross Blue Shield of NC. Below is a brief summary of the PPO 2000 Plan. In order to make the best use of your benefits and out-of-pocket expenses, we strongly encourage the use of in-network providers, Tier 1 drugs whenever possible, and Urgent Care facilities instead of Emergency room visits when appropriate. Log in to Blue Connect to select your Primary Care Provider (PCP). Your copay is waived for your first 3 visits to your selected PCP.

Blue Cross Blue Shield of NC PPO Plan - 2000 Plan		
Services	**In-Network (You Pay)**	**Out-of-Network (You Pay)**
Calendar Year Deductible—embedded Individual / Family	$2,000 / $4,000	$4,000 / $8,000
Calendar Year Out-of-Pocket Maximum—embedded	$4,000 / 8,000 (includes deductible, coinsurance and copays)	$8,000 / $16,000 (includes deductible, coinsurance and copays)
Coinsurance	20%	50%
Preventive Care Services	100% covered, no charge	30% after deductible
Primary Care Office Visit	$35 copay	50% after deductible
Telehealth	$10 copay	Not Available
Specialist Office Visit	$70 copay	50% after deductible
Urgent Care Facility	$70 copay	$140 copay
Emergency Room	$500 copay	$500 copay
Inpatient Services	20% after deductible	50% after deductible
Outpatient Services	20% after deductible	50% after deductible
Prescription Drugs	**Retail (up to 30-day supply)**	**Out of Network**
- Tier 1 / Generic - Tier 2 / Preferred Brand Name - Tier 3 / Non-Preferred Brand Name - Tier 4 / Specialty - Tier 5 / Nonpreferred Specialty	$10 copay $35 copay $60 copay 25% to a maximum of $100 25% to a maximum of $100	$10 copay $35 copay $60 copay 25% to a maximum of $100 25% to a maximum of $100

BCBS of NC Medical	Per Pay Period Deductions
Employee Only	$38.58
Employee + Spouse	$194.59
Employee + Child(ren)	$155.08
Family	$267.58

Click on image below for information on the difference between a PPO and a High Deductible Health Plan

When and Where to Get Health Care

Telehealth Virtual Visits

- Average wait time: 5 minutes
- Available 24/7/365
- Basic physician care from your PC, phone, laptop or tablet

Retail Health Clinics

- Average wait time: 15 minutes
- Available extended hours
- Basic care from a nurse practitioner

Primary Care Physician

- Scheduled visits
- Diagnose & treat a range of issues for the whole family
- Refer you to the right care when you need a specialist

Urgent Care Clinic

- Average wait time: 45 minutes
- Immediate quality care on a walk-in basis when your doctor is unavailable

Emergency Room

- Average wait time: 4 hours
- Available 24/7/365
- Emergency care when your life or health is threatened

Things to think about

- Non-emergency care delivered in the ER costs 5 times more than in a doctor's office or clinic
- Research studies indicate that between 8-27% of ER visits could have been treated in a less expensive care setting
- ER doctors do not typically have your full medical history, so they must order expensive tests to determine a diagnosis and course of treatment.
- Patients, when possible, should be treated by their primary care physician for non-emergency conditions in order to promote consistent, preventive and quality care.

Blue Cross Blue Sheild—Blue Connect Portal

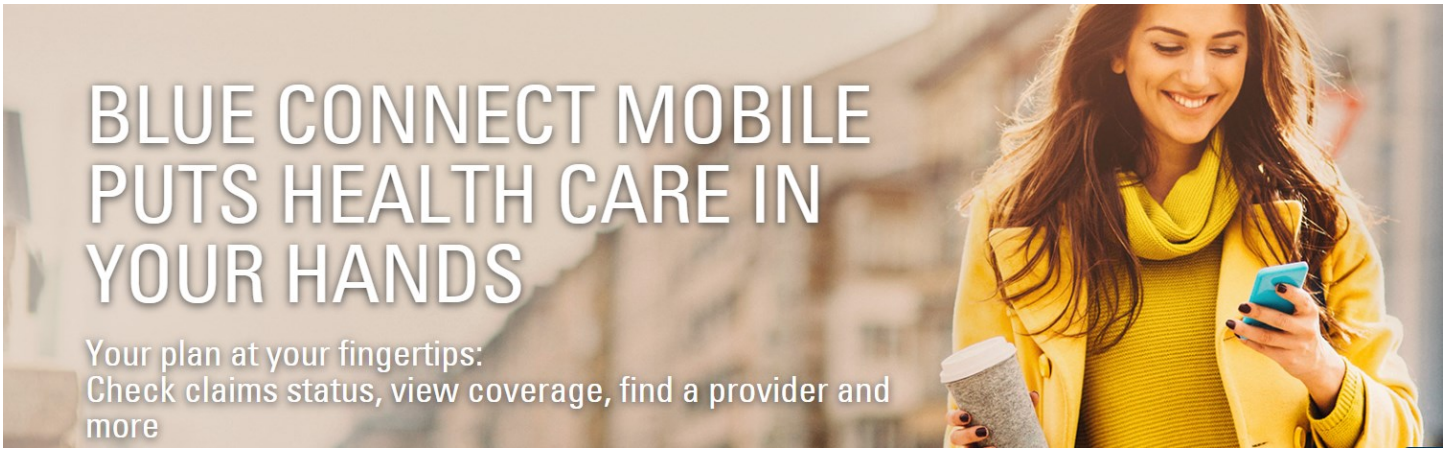
YOUR HEALTH in your hands

Blue Connect and **Blue Connect Mobile℠** are your guides to managing your health plan and health care. Whether at home or on the go, Blue Connect and Blue Connect Mobile give you access to the tools and information you need.

BlueConnect™

TO GET STARTED

Visit ***BlueConnectNC.com*** to register, or scan the QR code to download the mobile app.



Blue Connect Mobile℠
The app is available for free.

Here's what you can do with Blue Connect Mobile:

- Sign in with AppleTouch ID, Android Fingerprint ID or Apple Face ID[1]
- See the status of your open claims and your claims history
- Track your benefits, deductibles, out-of-pocket expenses and spending account balances
- See and share your digital Member ID card
- Find doctors, hospitals and urgent care in your network with our powerful search tools
- Send secure messages to Customer Service using your Blue Connect Inbox.

1 Not all compatible devices can use Touch, Face or Fingerprint Sign-In.

Teladoc

General Medical

24/7 access to doctors from anywhere

TELADOC. BlueCross BlueShield of North Carolina

Talk to a U.S.-licensed doctor for non-emergency conditions 24/7 from anywhere you are. We treat:

- Bronchitis
- Flu
- Rashes
- Sinus infections
- Sore throats
- And more

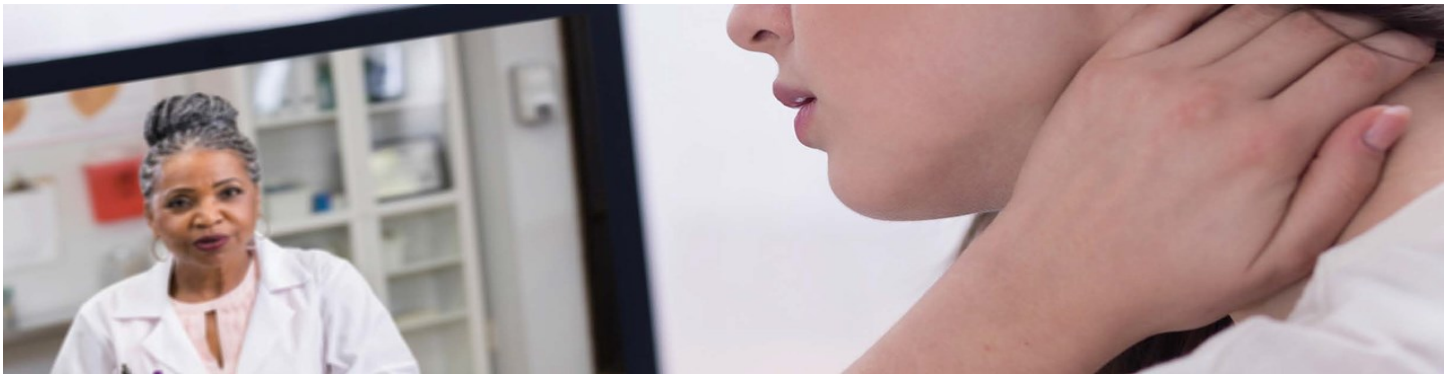
How it works:

1. Download the app, go online or call us to set up your account or log in
2. Complete or update a brief medical history
3. Request a visit and talk to a doctor within minutes

Learn more

Teladoc.com

Teladoc for Minor Acute Care and Behavioral Health



FAQs

Teladoc telehealth services for minor acute care and behavioral health

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) is excited to offer telehealth services from Teladoc. With telehealth, you can see or speak with a board-certified doctor or behavioral health specialist via phone, computer or the Teladoc app. Teladoc's doctors can diagnose symptoms, prescribe non-narcotic medication (if needed) and send e-prescriptions to your local pharmacy.[1]

Telehealth is a good care option for minor health problems when you can't see your regular doctor. It's also a convenient choice when you want to speak to a counselor or therapist. Below, you'll find answers to questions you may have about this benefit.

GETTING STARTED

Should I wait until I'm sick to create a Teladoc account?

It's best to activate your account now. That way, it's ready when you need it. (There's no charge for signing up.) Be sure to fill out your medical history profile and indicate your preferred pharmacy should you need a prescription called in.

Does this replace my primary care doctor?

Teladoc is a convenient alternative to your doctor for non-emergency conditions. In fact, we encourage you to list your primary care doctor when activating your Teladoc account. That way, you can share the results of your consult with them – and your medical records stay up-to-date.

Is it private and secure?

Absolutely. Teladoc complies with the Health Insurance Portability and Accountability Act (HIPAA). It uses secure video through your computer, tablet or the Teladoc mobile app. You may also choose to visit with a doctor by phone. Your personal health information is never shared with your employer.

What devices are supported?

You can access Teladoc on mobile or land lines as well as most Apple and Android mobile devices by downloading the Teladoc app. On a desktop or laptop, you'll need a high-speed internet connection, a webcam with a resolution of at least 1.3 megapixels and a microphone (most webcams have a built-in microphone). After activating your account, you can test that your computer setup will work if you've chosen a video visit.

3 ways to sign up today

So it's ready when you need it!

Download the Teladoc mobile app
(iOS- / Android-supported)

Go to *Teladoc.com* and click "Log in/Register"

Call 1-800-835-2362 (1-800-TELADOC)

Please Note:

You must wait until your health plan effective date before registering for telehealth services.

Teladoc for Minor Acute Care and Behavioral Health cont'd

HOW TO USE IT

Who are the Teladoc doctors?

All Teladoc doctors are U.S. board-certified with 15 years of experience, on average. Their specialties include primary care, pediatrics and family medicine. So, they can treat a wide range of conditions. For behavioral health, Teladoc has a national network of licensed doctoral-level psychologists and master's level counselors, as well as board-certified psychiatrists. When you log in, you'll only be shown doctors licensed to practice in the state you're located in at the time of the visit.

What is the difference between counselors and psychiatrists?

Counselors provide guidance and support by talking to you. They do not prescribe medications. Psychiatrists are medical doctors who primarily prescribe medication for the treatment of behavioral health conditions.

Can a doctor prescribe medication from a consult?

If the Teladoc doctor believes a prescription is needed, he or she can write one for non-narcotic medicines.[1] It's sent electronically to your pharmacy of choice.

Can I use this for my child?

Yes. Teladoc has pediatricians on call. When you register, set up your child's record under your account. Parents must be present on any consult for children under age 18.[2,3]

Can I rate the Teladoc doctors I see?

We encourage it! After a consult, you'll get a survey to give feedback on the doctor you saw. The results are reviewed for quality as part of Teladoc's continuous improvement process. Teladoc's internal medical board also reviews randomly selected appointments.

I have a question that isn't listed here. What should I do?

For questions about Teladoc, visit ***Teladoc.com***. For questions about your insurance, please call the phone number on your Blue Cross NC member ID card.

What does it cost?

With Teladoc, the cost is transparent. You'll see prices once you log in to your account. This means you know what you'll be paying before you start a consult. You'll only be charged after you choose to consult with an Teladoc doctor – and your appointment time and payment details are confirmed. Teladoc accepts most major credit and debit cards, and it's a qualified expense for HSAs, HRAs and FSAs. You can cancel an appointment for a full refund if it's at least 24 hours in advance.

Teladoc Acute Care and Behavioral Health Consultations Fees

Type of Provider/Visit	Fee
Initial Psychiatric Visit*	$180
Ongoing Psychiatric Visits for Individual/Family	$95
Initial Therapist Visit**	$95
Ongoing Therapist Visits	$85
General Medicine / Acute Care	$55

The fees noted are the most you will pay for a service. Some plans will have a copay or deductible and coinsurance based on what your employer has chosen. Once you register, your Teladoc portal will reflect the correct cost share for your plan.

* Teladoc charges a flat fee regardless of length of visit but consultation fees vary by type of provider/visit. Member's cost share will apply. Employers may pay up to these amounts depending on plan. HSA plans are subject to deductible.

** Therapists include psychologists, licensed social workers and family therapists.

WHEN TO USE IT

When can I use Teladoc?

Phone and video consults are available 24 hours a day, seven days a week (including holidays) for minor acute care. Behavioral health services are available by appointment seven days a week.

Is it right for any medical problem?

Teladoc is designed to handle non-emergency medical conditions like the flu or pink eye. It's not intended to replace your primary care doctor. And it should not be used in medical emergencies. If you have a life-threatening emergency, call 911 right away.

What conditions can Teladoc treat for acute care?

Teladoc's doctors can diagnose and treat many non-emergency health problems:

- Allergies
- Cough, cold and flu
- Diarrhea
- Ear problems
- Fever[2]
- Headaches
- Insect bites
- Nausea and vomiting
- Sinus problems
- Sore throat
- Urinary problems[3]
- And more

What behavioral health conditions can Teladoc address?

Just like with acute care, Teladoc can support you when you're facing a wide range of conditions:

- Addictions
- Anxiety
- Depression
- Grief and loss
- Relationship issues
- Substance use
- Stress
- And more

Can I use Teladoc when I travel?

Yes. Phone and video consultations are available in every state. Teladoc ensures the doctor or behavioral health specialist you see is fully licensed to practice medicine in the state you're in.[4]

Health Savings Account (HSA)

If you enroll in the High Deductible Health Plan (HDHP), you should consider contributing to a Health Savings Account (HSA), administered by PayFlex. With an HSA, you can gain more control over your health care expenses because contributions, interest and withdrawals for qualified health care expenses are all tax-advantaged.

Why have an HSA?

- If you elect the High Deductible Health Plan (HDHP) and select an HSA, the Company will contribute to your HSA annually
- Contributions are pre-tax
- Withdrawals to pay for eligible expenses are never taxed
- Accumulated interest earnings are tax-deferred, and if used to pay for eligible expenses, are not taxed upon withdrawal
- Use the money in the account to pay for eligible health care expenses throughout your life– including retirement, there is no time limit on spending your HSA funds
- The balance in your HSA account can be invested

Eligibility Requirements for Contributing to an HSA:

- Must be enrolled in a High Deductible Health Plan (HDHP)
- Must not be enrolled in Medicare
- Must not be covered by other medical insurance(s) which do not meet the definition of a HDHP such as a Health Care Flexible Spending Account (FSA), Health Reimbursement Arrangement (HRA), Tricare, VA benefits (including your spouse's)
- May not be claimed as a dependent on another individual's tax return

Health Savings Account (HSA)			
Coverage Level	**IRS 2024 Contribution Limits***	**EMPLOYER 2024 Contribution**	**Employee 2024 Maximum Contribution****
Employee Only	**$4,150**	$600	$3,550
Employee + Spouse	**$8,300**	$1000	$7,300
Employee + Child(ren)	**$8,300**	$1000	$7,300
Family Coverage	**$8,300**	$1000	$7,300

*If you are married and your spouse is enrolled in an HDHP and has an HSA, the combined total of you and your spouse's HSA cannot exceed the federal maximum for family level coverage.

**If you are age 55 or older, you may make an additional pre-tax catch-up contribution of $1,000 per year.

All HSA participants will receive an HSA debit card from PayFlex. Use your Debit Card for doctor's office visits, prescription drug copays, or any other valid medical, dental or vision expenses. Please retain all receipts to verify expenses, if required.

A full list of qualified expenses can be found in IRS Publication 502, at www.irs.gov/pub/irs-pdf/p502.pdf.

Click on image below for more information on Health Savings Account (HSA)

Flexible Spending Accounts (FSAs)

Lincotek continues to offer Health Care and Dependent Care Flexible Spending Accounts (FSAs), administered by Flores. FSAs allow you to pay for eligible health care and dependent care expenses with pre-tax dollars which can increase your take-home pay. The Dependent Care FSA is offered to everyone, no matter what medical plan you may be covered under, through Lincotek or elsewhere.

There are two types of FSAs to choose from:

Health Care FSAs may be used to pay for eligible medical, prescription, dental and vision expenses not fully covered by your insurance plans for you and your tax eligible dependents. If you are enrolled in the HDHP Plan, you are not eligible to participate in the Health Care FSA.

Dependent Care FSAs may be used to pay for eligible expenses related to the care and supervision of your child (to age 13) or adult dependent on your tax return. Eligible expenses include child or adult daycare, after school care, nursery school, nanny or babysitter. You must accumulate the funds in your Dependent Care FSA before you can be reimbursed.

A full list of qualified expenses can be found in IRS Publication 502, at www.irs.gov/pub/irs-pdf/p502.pdf.

2024 IRS Contribution Limits	Maximum	Rollover
Health Care FSA	$3,050	$610
Dependent Care FSA	$5,000 (or $2,500 if married and filing separately)	N/A

FSA Rollover: Flores allows participants to carry over up to $610 in unused money in the Health Care and/or Limited Purpose FSA at the end of the plan year to be used to reimburse expenses incurred in the next year. Any amount in excess of $610 will be forfeited, so plan accordingly. You must enroll in the FSA the next year to get the rollover allowance.

Click on image below for more information on Flexible Spending Account (FSA)

Dental Insurance

Lincotek dental plan is administered by Mutual of Omaha. There You may continue to seek treatment from the dentist of your choice, but you will always realize your biggest savings by visiting in-network providers whenever possible. The chart below provides a summary of your dental benefits.

Dental Plans		
	Low Plan—Orthodontia Not Included	High Plan– Orthodontia Included
Services	**In-Network/Out of Network* (You Pay)**	**In-Network/Out of Network* (You Pay)**
Calendar Year Deductible Individual / Family	$50 / $150	$50 / $150
Calendar Year Maximum	$1,000	$1,500
Preventive Services (Covered services include oral exams, cleanings and x-rays)	Covered at 100%, not subject to deductible	Covered at 100%, not subject to deductible
Basic Services (fillings, root canals, endodontics, extractions)	20% after deductible	20% after deductible
Major Services (inlays, onlays, periodontics, bridgework, dentures)	50% after deductible	50% after deductible
Rollover Benefit	If total in-network claims per individual does not exceed $500, Mutual of Omaha will rollover $250 to the following year annual maximum. Employee must complete one cleaning and examination in a plan year to be eligible.	If total in-network claims per individual does not exceed $750, Mutual of Omaha will rollover $375 to the following year annual maximum. Employee must complete one cleaning and examination in a plan year to be eligible.
Orthodontia—Child Only	Not Covered	50% with a lifetime maximum of $1,000
Waiting Period	None	None

*Out of network claims will paid at 90% of Usual & Customary. Usual & Customary charges are based on prevailing cost of services with geographic areas for the insurance company.

Mutal of Omaha Dental Plans	Per Pay Period Deductions Low Plan	Per Pay Period Deductions High Plan
Employee Only	$6.59	$8.57
Employee + Spouse	$12.83	$16.94
Employee + Child(ren)	$16.18	$22.51
Family	$24.40	$33.61

Dental Reference Tools

Dental Insurance

Online Reference Guide for Plan Members

You have a great dental plan – now learn how to make full use of it to ensure proper dental health for you and your family.

With online access you can:

1. View benefits information, eligibility and claims
2. Print or view Explanation of Benefits (EOBs)
3. Print, view or request ID cards
4. Locate a provider, by ZIP code or address

Getting Started

1. Go to MutualofOmaha.com/dental
2. Click on the "Member Portal Link" and select the "Register Now" button. You will enter your Member ID number (located on your member ID card) or the last 4 digits of your Social Security Number and follow the instructions to create your user name and password.

Visit as many times as you need to view or print copies of your coverage information.

Logging On

1. Go to MutualofOmaha.com/dental
2. Enter your username and password
3. Click the "Login" button

Mutually Preferred℠

Online Tools

This section provides you with an overview of your access to benefits information including:

- View your coverage information and eligibility
- Individuals included under your plan
- Access to view, print or request an ID card
- After you've visited the dentist, use the "Claims" tab to find historical claim data
- View or print your Explanation of Benefits (EOB) from the "Documents" tab

Access a Claim Form

If you visit an out-of-network provider, you can download a claim form from the home page.

Locate a Provider Two Ways

You have complete freedom to select a provider of your choice, either in network or out of network. You can access the provider search two ways! From the home page, use the Provider Quick Search tool to locate a provider by using your ZIP code or address. You also have access to a provider search page after you log into the Member Portal via the "Providers" tab.

Customer Service

800-927-9197

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

Voluntary Vision Insurance

Lincotek vision plan is administered by Mutual of Omaha, utilizing the EyeMed's Insight network of providers. You may seek treatment from the provider of your choice, but you will realize your biggest savings by visiting in-network providers whenever possible. Please see the summary below for an outline of covered services.

Vision Plan		
Services	**In-Network (You Pay)**	**Out-of-Network* Reimbursement**
Eye Exam	$10 copay	Up to $37
Standard Lenses (instead of contacts) - Single - Bifocal - Trifocal - Lenticular - Standard Progressive Lenses (add on to Bifocal copay)	 $25 copay $25 copay $25 copay $25 copay $65 copay	 Up to $20 Up to $36 Up to $64 Up to $64 Up to $36
Frames (instead of contacts)	$130 allowance, then 20% discount over allowance	Up to $58
Contact Lenses (instead of glasses) - Conventional - Disposable - Medically Necessary**	 $130 allowance 15% discount over allowance $130 allowance Covered in full	 Up to $89 Up to $104 Up to $210
Frequency - Exam - Lenses or Contacts - Frames	Based on Date of Service 12 months 12 months 24 months	

*Out-of-network amounts are reimbursed to member.

** Contact lenses may be deemed medically necessary when vision cannot be corrected with glasses due to extreme vision problems, contact lenses will be deemed elective when vision can be corrected by glasses but contacts are worn.

Mutal of Omaha	Per Pay Period Deductions
Employee Only	$2.07
Employee + Spouse	$4.71
Employee + Child(ren)	$5.24
Family	$7.97

Vision Reference Tools

Vision Insurance

Online Reference Guide for Plan Members

You have a great vision insurance plan. Now learn how you can make full use of our vision plan website to ensure proper vision health for you and your family.

With online access you can:

- View benefits information
- View claims history and Explanation of Benefits
- Locate a provider
- Access forms or submit a claim online

Getting Started

- Log on to MutualofOmaha.com/vision
- Click on "View my vision benefits"
- Click the "Create an account" button – enter your name, date of birth, member ID number (located on your member ID card) and follow the instructions to select your username and password

Logging On

- Go to MutualofOmaha.com/vision
- Click on "View my vision benefits"
- Enter your username and password
- Click the "Login" button

Online Tools and Resources

View your benefits

- Coverage and effective dates
- Dependents included in the plan
- Benefits used by you and your dependents
- Print ID cards

Track Claims

Access a claim form

If you visit an out-of-network provider, you will have to pay for services out-of-pocket and submit a claim form located in the "Forms" section.

Find a provider

Once you've created an account and signed in, click "Provider Locator." From here, you can search by ZIP code or "use my location" to find a provider near you.

Download the EyeMed Members App on your iPhone, iPad or Android to view benefit information and ID card.

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

Cost of Coverage

BCBS of NC Medical – HDHP 5000 Plan	Per Pay Period Deductions
Employee Only	$30.37
Employee + Spouse	$153.18
Employee + Child(ren)	$122.40
Family	$210.64

BCBS of NC Medical – PPO 4000 Plan	Per Pay Period Deductions
Employee Only	$31.96
Employee + Spouse	$161.20
Employee + Child(ren)	$128.48
Family	$221.67

BCBS of NC Medical – PPO 2000 Plan	Per Pay Period Deductions
Employee Only	$38.58
Employee + Spouse	$194.59
Employee + Child(ren)	$155.08
Family	$267.58

Mutual of Omaha Dental Plans	Per Pay Period Deductions Low Plan	Per Pay Period Deductions High Plan
Employee Only	$6.59	$8.57
Employee + Spouse	$12.83	$16.94
Employee + Child(ren)	$16.18	$22.51
Family	$24.40	$33.61

Mutual of Omaha Vision Plan	Per Pay Period Deductions
Employee Only	$2.07
Employee + Spouse	$4.71
Employee + Child(ren)	$5.24
Family	$7.97

Life and AD&D Insurance

Basic Life Insurance

Lincotek provides full-time employees with Basic Term Life and Accidental Death and Dismemberment (AD&D) Insurance administered through Mutual of Omaha. Please remember to review and update your beneficiary designation annually.

Benefit	Basic Life and AD&D Insurance
Employee Life	1x your base annual earnings minimum $50,000, up to a maximum of $300,000
Basic AD&D Amount	Matches Employee Life amount
Age Reduction Schedule	65% at age 65 40% at age 70 25% at age 75
Waiver of Premium	Included
Conversion	Included (must apply within 31 days of termination date)

Voluntary Life and AD&D Insurance

Lincotek is offering employees who would like to supplement their Basic Term Life and AD&D insurance benefits the opportunity to purchase additional coverage through Mutual of Omaha. You may elect Voluntary Life & AD&D for yourself, your spouse and your dependents in the amounts shown in the table below. Please note, you must elect Voluntary Life for yourself in order to enroll your spouse and/or eligible dependents. Dependent children are eligible for coverage through age 26.

Benefit	Voluntary Life and AD&D Insurance
Employee Life and Matching AD&D Amount	Increments of $10,000, 5x annual salary up to $500,000
Employee Guarantee Issue Amount	5X annual salary, up to $200,000
Spouse Life	$5,000 increments, 100% of employee's benefit, up to $250,000
Spouse Guarantee Issue Amount	100% of employee's benefit, up to $30,000
Employee, Spouse & Child AD&D	AD&D amount is equal to the amount of voluntary term life insurance for employees and eligible dependents
Dependent Child Life	Increments of $1,000, minimum benefit $2,000 maximum benefit $10,000
Age Reduction Schedule	65% at age 65 40% at age 70 25% at age 75
Waiver of Premium	Included
Conversion and Portability Options	Included (must apply within 31 days of termination date)

Voluntary Life and AD&D Insurance	
Employee/ Spouse Age	**Monthly Premiums (per $1,000)**
<25	$0.053
25-29	$0.063
30-34	$0.085
35-39	$0.095
40-44	$0.106
45-49	$0.158
50-54	$0.243
55-59	$0.454
60-64	$0.698
65-69	$1.342
70-74	$2.177
75+	$2.177
AD&D Rate per $1,000	Employee—$0.020, Spouse & Child—$0.032
Child Life Rate per $1,000	$0.213

Spouse rate based on employee's age and will terminate when employee attains age 70

Short-Term Disability

Short-Term Disability

Lincotek provides all full-time eligible employees with Short-Term Disability Benefits administered through Mutual of Omaha. There is no cost to you for this valuable coverage. Disability benefits protect a portion of your income in the event of any injury, accident or illness that keeps you from working.

Benefits are provided in the event of becoming disabled for more than 14 days due to a non-work related accident or illness. The plan pays 60% of an eligible employees' pre-disability base weekly earnings, to a maximum of $2,500 per week for a qualified disability.

Benefit Detail	Short-Term Disability
Elimination Period	14 days for accident or illness
Benefits Duration	24 weeks
Benefit Percentage	60% of weekly income
Maximum Benefit	$2,500 per week

Long-Term Disability

Long-Term Disability

Long-Term Disability (LTD) Benefits provide continued protection if you are still deemed disabled when STD benefits are exhausted.

Lincotek provides all full-time eligible employees with Long-Term Disability Benefits administered through Mutual of Omaha. There is no cost to you for this valuable coverage. Benefits are provided on the 181st day of disability, payable up to Social Security Normal Retirement Age (SSNRA). Income loss is replaced at 60% of your base monthly earnings, to a maximum of either $10,000 per month for a qualified disability.

Benefit Detail	Long-Term Disability
Waiting Period	180 days
Benefits Duration	Benefits are paid to the later of either age 65 or Social Security Normal Retirement Age (SSNRA)
Benefit Percentage	60% of monthly income
Maximum Benefit	$10,000 Active Full-time employees
Pre-Existing Conditions*	3/12

**A pre-existing condition is a condition, regardless of cause, for which a medical device, diagnosis, care or treatment was recommended or received in the 3 months prior to your enrollment date. The plan will not pay benefits for any pre-existing conditions that result in disability during your first 12 consecutive months of coverage.*

Voluntary Critical Illness

Lincotek provides eligible full-time employees with the opportunity to purchase Critical Illness Insurance through Mutual of Omaha. You pay the full cost of this coverage. Critical Illness insurance helps you cover the costs associated with being diagnosed with a specified condition. The table below outlines some of the conditions that are covered, as well as the benefit amount. The benefit is paid as a lump sum to you.

Benefit Category	Condition	Percentage of Payout
Heart/Circulatory	Heart Attack Heart Transplant Stroke	100%
Organ	Major Organ Transplant End Stage Renal Failure	100%
Cancer	Cancer (Invasive)	100%
	Carcinoma in Situ Benign Brain Tumor	25%

$50 – A health screening benefit of $50 is payable once per calendar year for each insured person, within 90 days of when a claim has occurred.

Please see benefit summary for full list of eligible specific diseases.

Benefit	Voluntary Critical Illness
Employee	$5,000, $10,000, $15,000 or $20,000
Spouse	$5,000 minimum amount, 100% of employee benefit amount, up to
Dependent Child	50% of employee benefit, up to $10,000
Guarantee Issue Amount	Employee- $20,000 Spouse- $10,000 Child- $10,000

Monthly Rates	
Age	**Employee/Spouse Rate per $1,000 of Monthly Benefit**
< 30	$0.29
30-39	$0.51
40-49	$1.10
50-59	$2.32
60-69	$4.88
70-79	$9.11
80-90	$12.57
Child insurance is automatic. A separate premium is not required.	

Voluntary Accident

Lincotek provides eligible full-time employees with the opportunity to purchase Accident Insurance through Mutual of Omaha. You pay the full cost of this coverage. Accident Insurance helps you cover the costs associated with being in a covered accident. The table below highlights some of the accidents and conditions that are covered, as well as the benefit amount. This benefit is paid as a lump sum to you.

Initial Care and Emergency — Most Initial Care/Emergency benefits requires treatment or service withing 72 hours of an accident.	
Emergency Room	$200
Urgent Care Center	$125
Initial Physician Office Visit	$100
Emergency Transportation	
Ground Ambulance	$300
Air Ambulance	$1,500
Hospital, Surgical and Diagnostic as the result of an accident — Initial hospital admission and confinement must begin within 90 days of an accident. ICU must begin within 30 days of an accident. Diagnostic services, except for X-Ray, must be received with 30 days of an accident. X-ray services must be received with 90 days.	
Hospital	
Admission	$1,500
Daily Confinement (Up to 365 days per accident)	$300 per day
ICU Confinement (Up to 15 days per accident)	$600 per day
Rehab. Facility Confinement (Up to 30 days per accident)	$150 per day
Surgical	
Exploratory/Arthroscopic (365 days)	$200
Abdominal/Cranial/Thoracic (365 days)	$2,000
Eye Procedure (90 days)	$400
Diagnostic	
X-Ray	$75
Diagnostic Exam	$300
Additional Benefit—within 90 days of when a claim has occurred	
Health Screening	$50

Please see benefit summary for full list of eligible accident benefits.

Mutual of Omaha Accident Insurance	Per Pay Period Deductions
Employee Only	$5.00
Employee + Spouse	$8.17
Employee + Child(ren)	$8.76
Family	$11.89

Voluntary Hospital— Injury or Sickness

Lincotek provides eligible full-time employees with the opportunity to purchase Voluntary Hospital Insurance through Mutual of Omaha. You pay the full cost of this coverage. Hospital insurance is for treatment for injury or sickness and helps you cover the costs associated with being injured or sick. The table below highlights some of the benefits that are covered, as well as the benefit amount. This benefit is paid as a lump sum to you.

Hospital Admission & Confinement—due to injury or sickness	
Hospital Admission—*limited to a combined total of 2 admissions, with a claim separation of 30 days, per policy year. Hospital Admission & Hospital ICU Admission benefits are not payable on the same day*	
Hospital Admission	$1,000
ICU Admission	$2,000
Hospital Confinement—*limited to a combined total of 30 days per policy year. Hospital/ICU confinement benefits are not paya-*	
Daily Hospital Confinement	$100 per day
Daily ICU Confinement	$200 per day
Daily Newborn Nursery Care Confinement	$75 per day, 2 days per policy year

Mutual of Omaha Hospital Injury or Sickness Insurance	**Per Pay Period Deductions**
Employee Only	$8.13
Employee + Spouse	$18.70
Employee + Child(ren)	$11.22
Family	$22.44

Additional Benefits

Employee Assistance Program (EAP)

We all face difficulties in our life. During those times, having outside help can make the difference between solving a problem and continuing to struggle through periods of confusion, indecision and personal crisis. Lincotek is pleased to offer an Employee Assistance Program (EAP) administered by a new carrier this year Mutual of Omaha. Your EAP gives you confidential access to a licensed professional counselor who will provide short-term assistance with issues that are having an impact on your life and ability to focus on work. Some highlights of the EAP include:

Mutual of Omaha's Employee Assistance Program (EAP) assist employees and their eligible dependents with personal and job-related concerns, including:

- Emotional well-being
- Family and relationships
- Legal and financial
- Healthy lifestyles
- Work and life transitions

EAP Benefits

As an employee, or eligible dependent, of your company your EAP benefits include:

- Access to EAP professionals 24 hours a day, seven days a week
- Information and referral services
- Service for employees and eligible dependents
- Access to a library of educational articles, handouts and resources via **mutualofomaha.com/eap**
- Online Resources for:
  - Substance use
  - Dependent and Elder Care resources

Blue Cross Blue Shield Global—Core

Healthcare coverage when you are traveling or living abroad

As a Blue Cross and Blue Shield member, you take your healthcare benefits with you when you are abroad. Through the Blue Cross Blue Shield Global® Core program, you have access to doctors and hospitals around the world.

Always carry your current member ID card.

• Before you travel, contact your Blue Cross and Blue Shield (BCBS) company for coverage details. Coverage outside the United States may be different.

• If you need to locate a doctor or hospital, call the Service Center for Blue Cross Blue Shield Global Core (see number below). An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization if necessary.

• If you need inpatient care, call the Service Center (see number below) to arrange direct billing. In most cases, you should not need to pay upfront for inpatient care except for the out-of-pocket expenses (noncovered services, deductible, copayment and coinsurance) you normally pay. The hospital should submit the claim on your behalf.

To learn more about Blue Cross Blue Shield Global Core:

TheBlueCard®
Now, Home Is Where The Card Is®

- Visit www.bcbsglobalcore.com.
- Use the Blue Cross Blue Shield Global Core app for Android*, iPhone, and iPod touch.** (Rates from your wireless provider may apply).
- Call your BCBS company.
- Call the Service Center at 1.800.810.2583 or collect at 1.804.673.1177, 24 hours a day, seven days a week.

Contact Information

Service	Vendor/Contact	Phone Number	Website/Email
Human Resources	**Sarah Roberts** (Dayton and Providence Plants) **Patricia Clark** (Molalla and Memphis Plants) **Sol Arteaga**	1-937-387-0300 1-503-759-2278 1-954-806-4580	sarah.roberts@lincotek.com patricia.clark@lincotek.com sol.arteaga@lincotek.com
Medical Plan or Prescription Drugs	**Blue Cross Blue Shield of North Carolina**	877-275-9787	www.blueconnectnc.com
Health Savings Account (HSA)	**PayFlex**	888-879-9280	www.payflex.com
Flexible Spending Account (FSA)	**Flores**	800-532-3327	www.flores247.com
Dental	**Mutual of Omaha**	800-927-9197	www.mutualofomaha.com/dental
Vision	**Mutual of Omaha**	833-279-4358	www.mutualofomaha.com/vision
Life	**Mutual of Omaha**	800-775-8805	www.mutualofomaha.com
Disability	**Mutual of Omaha**	800-877-5176	www.mutualofomaha.com
Critical Illness & Accident	**Mutual of Omaha**	800-877-5176	www.mutualofomaha.com

Find the nearest Retail Health Clinic locations at:

- **www.ccaclinics.org/membership/clinic-locations**
- **www.cvs.com/minuteclinic/clinic-locator**
- **www.walgreens.com/pharmacy/healthcare-clinic/locations**
- **www.riteaid.com/shop/info/pharmacy/services/rediclinic**

The information in this Enrollment Guide is presented for illustrative purposes and was taken from various summary plan descriptions and benefit information. While every effort was made to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health

Terminology Tip Sheet

Patient Protection and Affordable Care Act (ACA): The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA) is a United States federal statute signed into law by President Obama in March 2010. The law puts in place comprehensive health insurance reforms.

Annual Limit: A cap on specific benefits your insurance plan will pay for services in a year while you're enrolled in a particular health insurance plan. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for that particular service for the rest of the year.

Out-of-Pocket Maximum: The most a Plan member must pay towards covered medical expenses in a benefit period for both network and non-network services. Once you meet this out-of-pocket maximum, the Plan pays 100% of the cost of covered services for the remainder of the benefit period.

Coinsurance: Your share (a percentage) of costs of a covered health care service you must pay after you have met your deductible.

Copayment: A fixed amount ($20, for example) you pay for a covered health care service.

Deductible: The amount you pay for covered health care services before your insurance plan starts to pay. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest. Many plans pay for in-network preventive care before you meet your deductible or may pay the balance for a service, after you pay a copayment, prior to satisfying the deductible. Some of your dental options also have a deductible, generally for basic and major dental care services only.

Embedded Deductible and Embedded Out of Pocket Maximum: embedded deductible and embedded out of pocket maximum, no single individual on a family plan will have to pay a deductible and out of pocket maximum higher than the individual deductible and out of pocket maximum amount.

Brand Formulary Drugs: The brand formulary is an approved, recommended list of brand-name medications. Drugs on this list are available to you at a lower cost than drugs that do not appear on this preferred list.

Generic Drugs: These drugs are usually the most cost-effective. Generic drugs are chemically identical to their brand-name counterparts. Purchasing generic drugs allows you to pay a lower out-of-pocket cost than if you purchase formulary or non-formulary brand name drugs.

Maintenance Drugs: Prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

Non-Formulary Drugs: These drugs are not on the recommended formulary list. These drugs are usually more expensive than drugs found on the formulary. You may purchase brand-name medications that do not appear on the recommended list, but at a significantly higher out-of-pocket cost to you.

Specialty Drugs: Prescription medications that require special handling, administration or monitoring. These drugs may be used to treat complex, chronic and often costly conditions. Injectable drugs are an example of Specialty Drugs.

Primary Care Physician (PCP): The health care professional who monitors your health needs and coordinates your overall medical care, including referrals for tests or specialists.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services. These providers agree to accept pre-determined rates when servicing members, and will cost you the least out-of-pocket.

Qualifying Life Event: An occurrence that qualifies the subscriber to make an insurance coverage change, most often to pre-tax benefits, outside of Open Enrollment.

Required Annual Notices

Women's Health and Cancer Rights Act Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. The deductibles and coinsurance that apply can be found on pages 5-7 of this guide.

If you would like more information on WHCRA benefits, contact your Human Resources Department.

Newborns' and Mothers' Health Protection Act Model Language

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 a 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).

Required Annual Notices– CHIP

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).**

State	Program	Website	Phone Number
Alabama	Medicaid	http://myalhipp.com/	1-855-692-5447
Alaska	Medicaid	The AK Health Insurance Premium Payment Program: http://myakhipp.com/ CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	1-866-251-4861
Arkansas	Medicaid	http://myarhipp.com/	1-855-MyARHIPP (855-692-7447)
California	Medicaid	http://dhcs.ca.gov/hipp hipp@dhcs.ca.gov	916-445-8322
Colorado	Medicaid and CHiP	https://www.healthfirstcolorado.com/ https://www.colorado.gov/pacific/hcpf/child-health-plan-plus https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program	1-800-221-3943 1-800-359-1991 / State Relay 711 1-855-692-6442
Florida	Medicaid	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268
Georgia	Medicaid	https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp	678-564-1162 ext 2131
Indiana	Medicaid	http://www.in.gov/fssa/hip/ https://www.in.gov/medicaid/	1-877-438-4479 1-800-457-4584
Iowa	Medicaid and CHIP	https://dhs.iowa.gov/ime/members http://dhs.iowa.gov/Hawki https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	1-800-338-8366 1-800-257-8563 1-888-346-9562
Kansas	Medicaid	https://www.kancare.ks.gov/	1-800-792-4884
Kentucky	Medicaid	https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KIHIPP.PROGRAM@ky.gov https://kidshealth.ky.gov/Pages/index.aspx https://chfs.ky.gov	1-855-459-6328 1-877-524-4718
Louisiana	Medicaid	www.medicaid.la.gov www.ldh.la.gov/lahipp	1-888-342-6207 1-855-618-5488 (LaHIPP)
Maine	Medicaid	https://www.maine.gov/dhhs/ofi/applications-forms	1-800-442-6003 TTY: Maine relay 711

Required Annual Notices – CHIP pg 2

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

State	Program	Website	Phone Number
Massachusetts	Medicaid and CHIP	https://www.mass.gov/info-details/masshealth-premium-assistance-pa	1-800-862-4840
Minnesota	Medicaid	https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp	1-800-657-3739
Missouri	Medicaid	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana	Medicaid	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	1-800-694-3084
Nebraska	Medicaid	http://www.ACCESSNebraska.ne.gov	Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
Nevada	Medicaid	https://dhcfp.nv.gov	1-800-992-0900
New Hampshire	Medicaid	https://www.dhhs.nh.gov/oii/hipp.htm	603-271-5218
New Jersey	Medicaid and CHIP	hhttp://www.state.nj.us/humanservices/dmahs/clients/medicaid/ http://www.njfamilycare.org/index.html	609-631-2392 1-800-701-0710
New York	Medicaid	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina	Medicaid	https://medicaid.ncdhhs.gov/	919-855-4100
North Dakota	Medicaid	http://www.nd.gov/dhs/services/medicalserv/medicaid/	1-844-854-4825
Oklahoma	Medicaid and CHIP	http://www.insureoklahoma.org	1-888-365-3742
Oregon	Medicaid	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html	1-800-699-9075
Pennsylvania	Medicaid	https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx	1-800-692-7462
Rhode Island	Medicaid and CHIP	http://www.eohhs.ri.gov/	855-697-4347, or 401-462-0311
South Carolina	Medicaid	https://www.scdhhs.gov	1-888-549-0820
South Dakota	Medicaid	http://dss.sd.gov	1-888-828-0059
Texas	Medicaid	http://gethipptexas.com/	1-800-440-0493
Utah	Medicaid and CHIP	https://medicaid.utah.gov/ http://health.utah.gov/chip	1-877-543-7669
Vermont	Medicaid	http://www.greenmountaincare.org/	1-800-250-8427
Virginia	Medicaid CHIP	https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp	1-800-432-5924
Washington	Medicaid	https://www.hca.wa.gov/	1-800-562-3022 ext. 15473
West Virginia	Medicaid	http://mywvhipp.com/	1-855-MyWVHIPP (1-855-699-8447)
Wisconsin	Medicaid CHIP	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
Wyoming	Medicaid	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	1-800-251-1269

Required Annual Notices– HIPAA SERs

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards 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).

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 after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Human Resources Department.

Notes


Lincotek