Amwins

2023 Plan Year EMPLOYEE BENEFITS PACKAGE

AMWINS

Table of Contents

Insurance Terms and Definitions

PPO (PREFERRED PROVIDER ORGANIZATION)

A PPO is a type of insurance network. In this type of network, you may choose to to obtain care in or out of your network. If you choose to visit a "Preferred", or "In-Network", provider, your out of pocket expense will be significantly less than if you visit a provider outside your network. The reason for this is the In network provider agrees to accept set, contracted rates as payment in full for their services in return for being part of the insurance carrier's Preferred Provider network.

DEDUCTIBLE

The amount you pay before the insurance carrier starts sharing the expense of your medical care. Major medical expenses apply to the deductible like inpatient/outpatient surgeries, MRI's, CT Scans, etc…

EMBEDDED DEDUCTIBLE

This only applies to employees who have dependents enrolled on their plans. In an Embedded deductible, no member of the family unit can satisfy more than the single deductible during the deductible period. Even though the family is subject to the family deductible as a whole, no one person can satisfy more than the single deductible.

DEDUCTIBLE PERIOD

This is the 12 month time period in which all medical expenses that would apply to your deductible accumulate. Your deductible will reset after this period ends. This time period is important to note, because it does not always align with your plan year

CO-INSURANCE

After you've reached your deductible for the year, the insurance carrier will split the balance of the major medical expense with you. They pay a percentage and you pay a percentage of your medical expense until you've reached your Out of Pocket Maximum

OUT OF POCKET MAXIMUM

This is the maximum amount you will pay for covered medical expenses during your deductible period

CO-PAYS

This is a set Dollar amount you pay when you receive medical care from a PCP, Specialist, Urgent Care, Emergency Room, or Pharmacy. It's called a CO-pay, because you pay the set dollar amount and your insurance carrier pays the rest of the actual charge from the doctor/facility. Co-pays DO NOT apply to the deductible

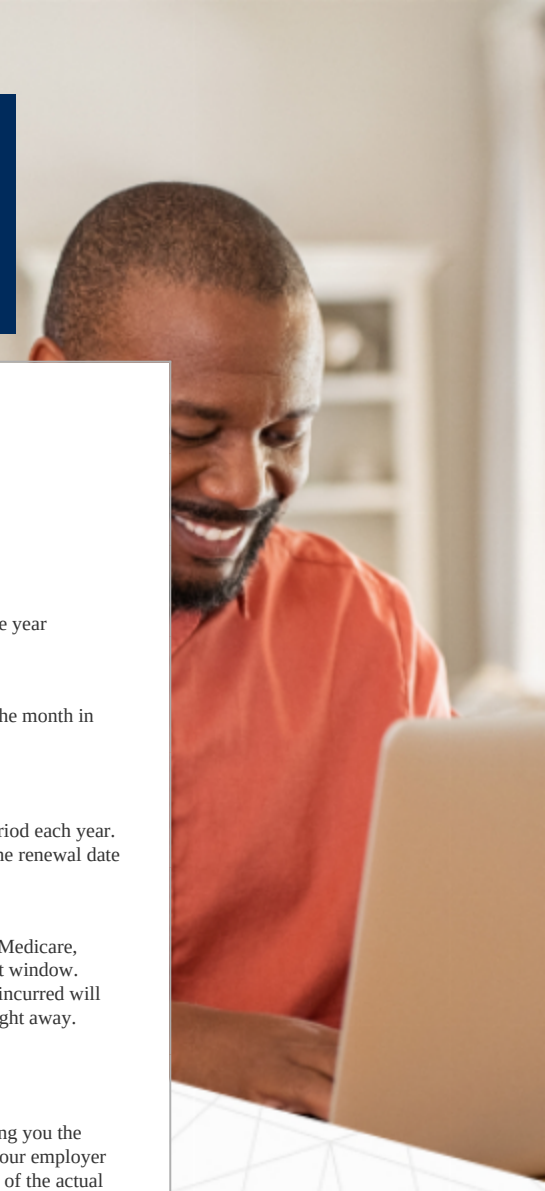
NEGOTIATED RATE (CONTRACTED RATE)

When a Provider (doctor, facility, pharmacy or hospital) contracts with an insurance carrier, they are considered In-Network. Part of the contract states that the provider will accept a lower payment (lower than what they normally charge) from the insurance carrier as payment in full. This lower payment is the Negotiated Rate.

EXPLANATION OF BENEFITS

Commonly referred to as an "EOB". The EOB is a very useful document as it explains how the insurance carrier processed your claim. It shows the billed charges from the provider, the network discount applied, and what the resulting Negotiated Rate is. (Provider Charge - Network Discount = Negotiated Rate) It also shows whether the service was applied to your deductible or paid as a co-pay. It is not a bill, but merely an explanation of how the insurance carrier paid your claim.

Important Items to Remember



NEW HIRE WAITING PERIOD

New employees are eligible for company insurance benefits: The day after 30 days of continuous full time employment

TERMINATION OF BENEFITS

When your employment with the company is terminated, your benefits will stop: At the end of that month

ELIGIBLE EMPLOYEES

To be eligible for company benefits, you must be a full time employee working an average of 30 hours per week during the year

DEPENDENT CHILDREN

Children under the age of 26 are eligible to be covered under the benefits. They will be taken off of the plan at the end of the month in which they turn 26

OPEN ENROLLMENT

You can make changes to your plans (enroll in coverage, waive coverage, add/drop dependents, etc..) during this time period each year. Open enrollment occurs 30 days prior to your plan renewal. All changes made during this time period will take effect on the renewal date

MAKING PLAN CHANGES DURING THE YEAR

If you've had a major life event (getting married, having a child, getting divorced, losing coverage, becoming eligible for Medicare, etc…) during the year, you're able to make coverage changes to your plan even though it's outside of the Open Enrollment window. Please turn in all paperwork within 30 days of your Qualifying Event to ensure it will be processed timely and any claims incurred will be paid. PLEASE NOTE: If adding a newborn baby to your plan, the baby's social security number will not be available right away. Please submit the paperwork without it, and provide it once's it's available

COBRA

PLEASE NOTE: In the event your employment is terminated with the company, you will receive a packet in the mail giving you the opportunity to continue your Medical, Dental and Vision benefits for up to 18 months. This is called COBRA coverage. Your employer DOES NOT contribute to this coverage as they may when you are employed with them. You will be responsible for 102% of the actual cost of the insurance if you wish to continue with it.

STAY IN NETWORK

To obtain the best benefits, it's important to stay in the insurance carrier's network. Always check online or verify over the phone that a doctor or hospital is in network BEFORE your visit. Also, when having a procedure done in a hospital/facility, ask the hospital staff to make sure EVERY doctor/nurse/radiologist/anesthesiologist/etc... is in your network

EXPLANATION OF BENEFITS

Commonly referred to as an "EOB". The EOB is a very useful document as it explains how the insurance carrier processed your claim. It shows the billed charges from the provider, the network discount applied, and what the resulting Negotiated Rate is. (Provider Charge - Network Discount = Negotiated Rate) It also shows whether the service was applied to your deductible or paid as a co-pay. It is not a bill, but merely an explanation of how the insurance carrier paid your claim.

NEED A NEW ID CARD OR ANOTHER ID CARD FOR A DEPENDENT?

You can register for the insurance carrier's website where you can print out temporary ID cards and order new cards, or you can contact: Jane Doe at ABC Insurance Services Email: Phone:

HAVE QUESTIONS ABOUT AN INSURANCE CLAIM?

PLEASE HAVE COPIES OF YOUR EXPLANATION OF BENEFITS ALONG WITH A COPY OF YOUR BILL(S) READY & CONTACT:
Jane Doe at ABC Insurance Services
Email:
Phone:

Health Insurance

	Aetna | 2500 80/50		Aetna | 2250 HSA
DEDUCTIBLE	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**
Single	$2,500	$5,000	$2,250
Family	$5,000	$15,000	$4,500
COINSURANCE			
Member %	20%	50%	0%
OUT OF POCKET MAXIMUM			
Single	$6,000	$15,000	$3,450
Family	$12,000	$45,000	$6,900
COMMONLY USED SERVICES			
Primary Care Physician Office Visit	$35	50% after the deductible	$30 after the deductible
Specialist Office Visit	$70	50% after the deductible	$60 after the deductible
Urgent Care	$75	50% after the deductible	$75 after the deductible
Emergency Room	$500	$500	$500 after the deductible
PREVENTIVE CARE			
Preventive Services	0%	50% after the deductible	0%
MAJOR MEDICAL EXPENSES			
Outpatient Surgery	20% after the deductible	50% after the deductible	$250 after the deductible
Inpatient Hospitalization / Surgery	20% after the deductible	50% after the deductible	$250 after the deductible
CT scan, PT scan, MRI	20% after the deductible	50% after the deductible	0% after the deductible
Hospital Newborn Delivery	20% after the deductible	50% after the deductible	$250 after the deductible
PRESCRIPTION DRUG COVERAGE			
Prescription Deductible	$0	N/A	Major Medical
Generic (Tier 1)	$10	N/A	$10 after the deductible
Brand Name (Tier 2)	$50	N/A	$50 after the deductible
Non-Preferred (Tier 3)	$80	N/A	$80 after the deductible
Specialty (Tier 4)	20%	N/A	20% after the deductible
Specialty (Tier 5)	40%	N/A	40% after the deductible
Mail Order - 90 day Supply	$20 / $100 / $160 / 20% / 40%	N/A	2 X co-pays after the deductible
PLAN INFORMATION			
Plan Year	January 1st - December 31st		January 1st - December 31st
Deductible Period	January 1st - December 31st		January 1st - December 31st
Deductible Explanation	Embedded		Aggregate
Network Type	PPO		PPO
Network Name	Choice POS II		Choice POS II
Member Website	www.aetna.com		www.aetna.com
Customer Service Phone Number	1-888-802-3862		1-888-802-3862

Plan Explanation

Click on the Plan name for a copy of your SBC

Disclaimer

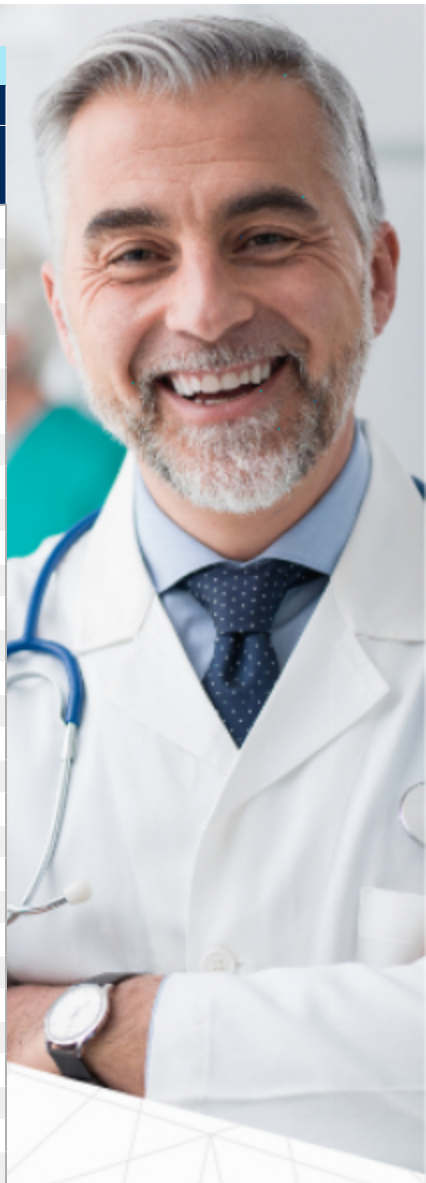
Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage

2500 80/50

PREMIUM PER EMPLOYEE PAYCHECK		
AGE	EMPLOYEE ONLY	SPOUSE/ CHILDREN
< 15	$26.48	$52.96
15	$28.83	$57.67
16	$29.74	$59.47
17	$30.63	$61.27
18	$31.61	$63.21
19	$32.57	$65.15
20	$33.58	$67.15
21	$34.62	$69.23
22	$34.62	$69.23
23	$34.62	$69.23
24	$34.62	$69.23
25	$34.75	$69.51
26	$35.45	$70.89
27	$36.28	$72.55
28	$37.62	$75.25
29	$38.74	$77.47
30	$39.29	$78.58
31	$40.12	$80.24
32	$40.95	$81.90
33	$41.47	$82.94
34	$42.02	$84.05
35	$42.30	$84.60
36	$42.58	$85.15
37	$42.85	$85.71
38	$43.13	$86.26
39	$43.68	$87.37
40	$44.24	$88.48
41	$45.07	$90.14
42	$45.86	$91.73
43	$46.97	$93.95
44	$48.36	$96.72
45	$49.98	$99.97
46	$51.92	$103.85
47	$54.11	$108.21
48	$56.59	$113.19
49	$59.05	$118.11
50	$61.82	$123.65
51	$64.56	$129.12
52	$67.57	$135.14
53	$70.62	$141.23
54	$73.90	$147.81
55	$77.19	$154.38
56	$80.76	$161.52
57	$84.36	$168.72
58	$88.20	$176.40
59	$90.11	$180.21
60	$93.95	$187.89
61	$97.27	$194.54
62	$99.45	$198.90
63	$102.18	$204.37
64+	$103.85	$207.69

2250 HSA

PREMIUM PER EMPLOYEE PAYCHECK		
AGE	EMPLOYEE ONLY	SPOUSE/ CHILDREN
< 15	$44.13	$70.62
15	$48.06	$76.89
16	$49.56	$79.29
17	$51.06	$81.69
18	$52.68	$84.28
19	$54.29	$86.86
20	$55.96	$89.54
21	$57.69	$92.31
22	$57.69	$92.31
23	$57.69	$92.31
24	$57.69	$92.31
25	$57.92	$92.68
26	$59.08	$94.52
27	$60.46	$96.74
28	$62.71	$100.34
29	$64.56	$103.29
30	$65.48	$104.77
31	$66.87	$106.98
32	$68.25	$109.20
33	$69.12	$110.58
34	$70.04	$112.06
35	$70.50	$112.80
36	$70.96	$113.54
37	$71.42	$114.28
38	$71.88	$115.02
39	$72.81	$116.49
40	$73.73	$117.97
41	$75.12	$120.18
42	$76.44	$122.31
43	$78.29	$125.26
44	$80.59	$128.95
45	$83.31	$133.29
46	$86.54	$138.46
47	$90.18	$144.28
48	$94.32	$150.92
49	$98.42	$157.48
50	$103.04	$164.86
51	$107.59	$172.15
52	$112.62	$180.18
53	$117.69	$188.31
54	$123.17	$197.08
55	$128.65	$205.85
56	$134.60	$215.35
57	$140.59	$224.95
58	$147.00	$235.20
59	$150.18	$240.28
60	$156.58	$250.52
61	$162.12	$259.38
62	$165.75	$265.20
63	$170.31	$272.49
64+	$173.08	$276.92



Dental Insurance

Guardian | PPO Dental 1000 - No Ortho

DEDUCTIBLE	IN-NETWORK	OUT-OF-NETWORK
Single	$50	$50
Family	$150	$150
MAXIMUM THE CARRIER WILL PAY		
Annual Maximum	$1,000	$1,000
FREQUENCIES		
Cleaning	1 per 6 months	
Exam	1 per 6 months	
DENTAL COVERAGE		
Cleanings	0%	0%
Exams	0%	0%
X-Rays	0%	0%
Sealants	0%	0%
Fillings	20%	20%
Simple Extractions	20%	20%
Root Canal	20%	20%
Periodontal Gum Disease	20%	20%
Oral Surgery	20%	20%
Crowns	50%	50%
Dentures	50%	50%
Bridges	50%	50%
Implants	50%	50%
Orthodontia	N/A	N/A
Orthodontia Lifetime Maximum	N/A	
Orthodontia Maximum Age	N/A	
OUT OF NETWORK EXPLANATION		
	Out of network dentists are NOT contracted with your dental insurance carrier. After you pay for the service based on your benefit plan, the insurance carrier will pay the out of network dentist what 90 out of 100 dentists in your area charge for that service. In some cases, the out of network dentist does not consider this as payment in full (like an in-network dentist would) and may "Balance bill" you. That is, they may ask you to pay the difference.	
PLAN INFORMATION		
Waiting Period for Major Services	None	
Plan Year	December 1st - November 30th	
Network Type	PPO	
Network Name	Guardian	
Member Website	www.guardianlife.com	
Customer Service Phone Number	1-888-482-7342	

PREMIUMS ARE PER PAYCHECK	
Employee Only 345	$4.62
Family 345	$27.69

Plan Explanation

Dental Insurance explanation - brief synopsis of the plan details for the year. This text could include special instructions on how to use the plan, or any other relevent information employees need to know about their plan.

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage

Vision Insurance

Eyemed | PPO Vision

VISION COVERAGE	IN-NETWORK	OUT-OF-NETWORK
Eye Exam	$10	up to $40
Single Vision Lens	$25	Up to $30
Lined Bi-Focal Lens	$25	Up to $50
Lined Tri-Focal Lens	$25	Up to $70
Lenticular Lens	$25	Up to $70
Contact Lens Allowance	$130	Up to $210
Frame Allowance	$130	Up to $91
FREQUENCIES		
Exam Frequency	Once every 12 months	
Lens Frequency	Once every 12 months	
Frame Frequency	Once every 24 months	
OUT OF NETWORK EXPLANATION		
	While you will receive a reimbursement when you go out of network, the out of network provider may not file the claim for you. You may have to file the claim yourself	
PLAN INFORMATION		
Plan Year	November 1st - October 31st	
Network Name	Access	
Member Website	www.eyemed.com	
Customer Service Phone Number	1-866-804-0982	

PREMIUMS ARE PER PAYCHECK	
Employee Only	$2.31
Family	$9.23

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage

Short Term Disability

Lincoln | STD

STD INSURANCE BENEFITS	
How does my insurance carrier define Disability?	Loss of Duty
Weekly Benefit	60% to $500
When do benefits start? (Elimination period)	1st day Accident / 7th day sickness
How long do my benefits pay out?	13 weeks
Are there any limitations on coverage for Pre-Exisitng conditions?	None
Is Maternity Covered?	Yes
Guaranteed Insurability	Up to $500 weekly
Taxation of Benefit	Benefit is not taxed
PLAN INFORMATION	
Plan Year	2020
Member Website	www.website.com
Customer Service Phone Number	1234567890

PREMIUM PER EMPLOYEE PAYCHECK	
< 20	$0.462
20 - 24	$0.923
25 - 29	$1.385
30 - 34	$1.846
35 - 39	$2.308
40 - 44	$2.769
45 - 49	$3.231
50 - 54	$3.692
55 - 59	$4.154
60 - 64	$4.154
65 - 69	$4.154
70 - 74	$4.154
75 - 79	$4.154
80+	$4.154

PREMIUM CALCULATION

_____	/	__$10__	x	_____	=	_____
% of weekly pay		per $10		Unit Rate		Premium per paychecks

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage

Long Term Disability

Lincoln | LTD

LTD INSURANCE BENEFITS	
How does my insurance carrier define Disability?	Loss of Duty
Monthly Benefit	60% to $3,000
When do benefits start? (Elimination period)	90 days
How long do my benefits pay out?	SSNRA
Are there any limitations on coverage for Pre-Exisitng conditions?	3/12
Own Occupation Limitation	2 years
Guaranteed Insurability	up to $3,000
Taxation of Benefit	Benefit is not taxed
PLAN INFORMATION	
Plan Year	2020
Member Website	www.website.com
Customer Service Phone Number	1234567890

PREMIUM PER EMPLOYEE PAYCHECK	
< 20	$0.462
20 - 29	$0.923
30 - 39	$1.385
40 - 49	$1.846
50 - 59	$2.308
60 - 69	$2.769
70 - 79	$3.231
80 - 89	$3.692
90+	$4.154

PREMIUM CALCULATION

_____	/	___$100___	x	_____	=	_____
Monthly Pay		per $100		Unit Rate		Premium per paychecks

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage

Supplemental Life Insurance

Lincoln | Supp Life

LIFE INSURANCE BENEFITS	
Employee Life Insurance Coverage	$10,000 Increments
Spouse Life Insurance Coverage	$5,000 Increments
Child(ren) Life Insurance Coverage	$10,000
Accidental Death & Dismemberment	Matches Life
Age Reduction Schedule	35% @ 65
Guaranteed Insurability	$100,000
Beneficiary	File with HR
Taxation of Benefit	Not taxed
PLAN INFORMATION	
Plan Year	January 1st - December 31st
Member Website	www.lincoln.com
Customer Service Phone Number	555-555-5555

PREMIUMS ARE PER PAYCHECK	
< 20	$0.023
20 - 29	$0.046
30 - 39	$0.069
40 - 49	$0.092
50 - 59	$0.115
60 - 69	$0.138
70 - 79	$0.162
80 - 89	$0.185
90+	$0.208

PREMIUM CALCULATION

_____	/	____$1,000____	x	_____	=	_____
Coverage Amount		per $1,000		Unit Rate		Premium per paychecks

Plan Explanation

Life Insurance explanation - brief synopsis of the plan details for the year. This text could include special instructions on how to use the plan, or any other relevent information employees need to know about their plan.

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage

Accident Insurance

Principal | Accident

INJURY	SCHEDULED BENEFIT
Burn - 2nd Degree	$100
Burn - 3rd degree	$100
Coma	$100
Concussion	$100
Dental Injury	$100
Dislocation - Hip	$100
Dislocation - Knee	$100
Dislocation - Shoulder	$100
Fracture - Hip	$100
Fracture - Skull	$100
Fracture - Arm	$100
Fracture - Hand	$100
Quadriplegia	$100
Paraplegia	$100
Loss of Speech	$100
Loss of Hearing	$100
Wellness Benefit	$100
Accidental Death & Dismemberment	$100
PLAN INFORMATION	
Plan Year	January
Member Website	pop.com
Customer Service Phone Number	555-5555

PREMIUM PER EMPLOYEE PAYCHECK			
10 YEAR AGE BANDS			
AGE BANDS	EMPLOYEE	SPOUSE	CHILDREN
< 20	$2.31	$4.15	$4.15
20 - 29	$4.62	$8.31	$8.31
30 - 39	$6.92	$12.46	$12.46
40 - 49	$9.23	$16.62	$16.62
50 - 59	$11.54	$20.77	$20.77
60 - 69	$13.85	$24.92	$24.92
70 - 79	$16.15	$29.08	$29.08
80 - 89	$18.46	$33.23	$33.23
90+	$20.77	$37.38	$37.38

Plan Explanation

Accident Insurance explanation - brief synopsis of the plan details for the year. This text could include special instructions on how to use the plan, or any other relevent information employees need to know about their plan.

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage

Critical Illness Insurance

Aetna | Voluntary Critical Illness Plan

CRITICAL ILLNESS BENEFIT	
Minimum Benefit	$10,000
Maximum Benefit	$30,000
Employee Scheduled Benefit	100%
Spouse Scheduled Benefit	50% of Employee Benefit
Child Scheduled Benefit	50% of Employee Benefit
Guaranteed Insurability	Yes
Pre-Existing Condition Clause	No
Wellness Benefit	50
ILLNESS	**% OF SCHEDULE BENEFIT**
Cancer	100%
Cancer - Carcinoma in situ	25%
Heart Attack	100%
Major Organ Failure	100%
Stroke	100%
PLAN INFORMATION	
Plan Year	Jan 1, 2023 - Dec 31, 2023
Member Website	aetna.com
Customer Service Phone Number	833-359-0128

PREMIUM PER EMPLOYEE PAYCHECK

10 YEAR AGE BANDS

AGE BANDS	EMPLOYEE		SPOUSE		CHILDREN
	NON-SMOKING	SMOKING	NON-SMOKING	SMOKING	
< 20	$4.62	$4.62	$4.62	$4.62	$4.62
20 - 29	$9.23	$9.23	$9.23	$9.23	$9.23
30 - 39	$13.85	$13.85	$13.85	$13.85	$13.85
40 - 49	$18.46	$18.46	$18.46	$18.46	$18.46
50 - 59	$23.08	$23.08	$23.08	$23.08	$23.08
60 - 69	$27.69	$27.69	$27.69	$27.69	$27.69
70 - 79	$32.31	$32.31	$32.31	$32.31	$32.31
80 - 89	$36.92	$36.92	$36.92	$36.92	$36.92
90+	$41.54	$41.54	$41.54	$41.54	$41.54

Plan Explanation

Critical Illness Insurance explanation - brief synopsis of the plan details for the year. This text could include special instructions on how to use the plan, or any other relevent information employees need to know about their plan.

Disclaimer

Disclaimer: This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage

Flexible Savings Account

WHAT IS A FLEXIBLE SAVINGS ACCOUNT (FSA)?

An FSA is an employer-sponsored spending account that allows employees to set aside pretax earnings to pay for eligible health care or dependent care expenses

ARE THERE ANY CONTRIBUTION LIMITS?

Yes, in 2023, you can contribute up to $3,050 into your FSA tax free

WHAT ARE FSA ELIGIBLE EXPENSES?

Eligible Expenses under the FSA are called Qualified Medical Expenses (QME). These are defined in IRS Publication 502. Examples of qualified medical expenses are Deductibles, Office Visits, Prescription Drugs, Hospital bills, Dental charges, Lenses & Frames, etc…

HOW DO I USE IT?

Your employer will provider you with a debit card that you can swipe, or you may have to submit claim forms or receipts along with itemized bills from your provider to obtain remibursement.

DO I HAVE TO SAVE RECEIPTS FOR MY EXPENSES?

This depends on how you have your plan set up. In most cases, yes, it's a good idea to save receipts.

WHO IS ELIGIBLE FOR AN FSA?

Full time employees are eligible to participate and contribute to FSA's. Business owners are generally not eligible.

WHEN CAN I ENROLL FOR AN FSA?

Since the contributions are made via pre-tax payroll deductions you may only enroll at open enrollment or when you have a mid year qualifying event.

DO I HAVE TO USE ALL FUNDS BEFORE THE END OF THE YEAR?

This depends on how your plan is set up. In nmost cases, you must use all or the bulk of your funds before the ne dof the year. You may have the option to rollover up to $610 from year to year.

WHEN CAN I ACCESS THE FUNDS?

Since this is an employer owned account, you have access to all funds from the 1st day of the plan year.

HOW DO I CONTRIBUTE?

You contribute to the FSA through pre-tax payroll deductions

ARE THERE ANY CONTRIBUTION LIMITS FOR DEPENDENT CARE?

Yes, in 2023, you can contribute up to $5,000 into your Dependent Care FSA tax free

DOES Spider-Man Inc. CONTRIBUTE TO MY FSA?

This depends on how your employer chooses to set this up

WHAT TAX BENEFITS ARE THERE?

You are able to pay for QME's through pre-tax FSA contributions

IS THE FSA PORTABLE?

No - this is an employer owned account and it is not portable

MEMBER WEBSITE

www.ahr.net

CUSTOMER SERVICE PHONE NUMBER

1-800-570-3757

Health Savings Account

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

A Health Savings Account (HSA) is a personal savings account that you can use to pay for Qualified medical expenses on a tax free basis.

ARE THERE ANY CONTRIBUTION LIMITS?

Yes. For 2023, if you are enrolled in emplopyee only coverage, you can contribute up to $3,850 during the year. For family coverage, this limit is $7,750. If you are between ages 55 and 64, you can contriute an extra $1,000 per year.

WHAT ARE HSA ELIGIBLE EXPENSES?

Eligible Expenses under the HSA are called Qualified Medical Expenses (QME). These are defined in IRS Publication 502. Examples of qualified medical expenses are Deductibles, Office Visits, Prescription Drugs, Hospital bills, etc… Please note: There are penalties if you use the HSA for Non -QME's.

CAN I USE MY HSA TO PAY INSURANCE PREMIUMS?

Generally, no. You cannot use HSA funds to pay for insurance Premiums. There are a couple caveats to this. You can purchase long term care insurance (specific age guidelines apply), COBRA coverage and Medicare supplement coverage with HSA funds.

HOW DO I USE IT?

In most cases, your HSA bank will provide you with a debit card. Use this to be for any prescriptions or doctor visits at the time of service or you can use it to pay for any bills you receive in the mail.

WHO IS ELIGIBLE FOR AN HSA?

Employees and their dependents that are enrolled in a Qualified High Deductible health plan

WHEN CAN I ENROLL IN AN HSA?

Typically, you'll enroll in an HSA during your open enrollment period when you make your annual benefit elections.

DO I HAVE TO USE ALL FUNDS BEFORE THE END OF THE YEAR?

No - all unused funds remain in your account - just likie a regular savingsa account

WHEN CAN I ACCESS THE FUNDS?

Through a debit card or checks provided by the HSA bak you use.

HOW DO I CONTRIBUTE?

In most cases, your employer will allow you to contribute through pre-tax payroll deductions. You can also contribute outside of payroll - be sure to talk to your tax consultant about these contributions to make sure you receive all the tax benefits available.

CAN I CONTRIBUTE AFTER I TURN 65?

Generally, no. You cannot contribute after you turn 65, but you can use any funds you have left in your account.

DOES Spider-Man Inc. CONTRIBUTE TO MY HSA?

Yes.
Employee Only Amount: Family Amount:

WHAT TAX BENEFITS ARE THERE?

The goal of the HSA is to allow you to pay for m edical expenses tax free. If you choose to contribute via payroll deductions, the money is taken out pre-tax. If you make contributions on your own, you will able to deduct these amounts on your taxes for that year.

IS THE HSA PORTABLE?

Yes. The HSA is your personal savings account. The money in this account is yours no matter where you are employed.

MEMBER WEBSITE

https://www.hsabank.com/

CUSTOMER SERVICE PHONE NUMBER

1-800-357-6246

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 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 60 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Amwins,GA,555-555-5555,GA@amwins.com.

Patient Protection Model Disclosure

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

ANTHEM generally ALLOWS the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Amwins,GA,555-555-5555,GA@amwins.com.

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider. For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from ANTHEM or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Amwins,GA,555-555-5555,GA@amwins.com

Newborn's Act Disclosure

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).

WHCRA 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
- 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. Therefore, the following deductibles and coinsurance apply: .

If you would like more information on WHCRA benefits, call your plan administrator 555-555-5555

WHCRA Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, 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? Call your plan administrator at 555-555-5555 for more information.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your employer via the information provided below

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit 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 numbered to correspond to the Marketplace application.

3. Employer Name Amwins		4. Employer indentification Number (EIN) 12-3456789
5. Employer Address 123 Amwins Blvd.		6. Employer Phone Number 555-555-5555
7. City Anywhere	8. State US	9. Zip 12345
10. Who can we contact about employee health coverage at this job? Amwins,GA,555-555-5555,GA@amwins.com		
11. Phone number (If different from above) 555-555-5555		12. Email address GA@amwins.com

Here is some basic information about health coverage offered by this employer

- As your employer, we offer a health plan to:

☐ All Employees, Eligible employees are:

☑ Some Employees, Eligible employees are:

FT EE's

• With respect to dependents:

☑ We do offer coverage, Eligible dependents are:

Spouses and children under ag 26

☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ **Yes** (Go to question 15) ☐ **No** (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often ? ☐ Weekly ☐ Every 2 weeks ☐ Twice a week ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often ? ☐ Weekly ☐ Every 2 weeks ☐ Twice a week ☐ Monthly ☐ Quarterly ☐ Yearly

General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

** 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
- 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."

RETIREE COVERAGE ONLY:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Amwins, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- Retiree coverage only: Commencement of a proceeding in bankruptcy with respect to the employer;; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Amwins.

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 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, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at 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 period* 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.

* https://www.medicare.gov/sign-up-change-plans/joining-a-health-or-drug-plan/special-circumstances-special-enrollment-periods

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/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

Amwins,GA,555-555-5555,GA@amwins.com

Important Notice from Amwins 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 Amwins 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. Amwins has determined that the prescription drug coverage offered by the JOE'S BEST PLAN EVER 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 drugplan.

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, your current Amwins coverage WILL be affected. 10/35/60.
If you do decide to join a Medicare drug plan and drop your current Amwins coverage, be aware that you and your dependents WILL 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 Amwins 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 Amwins 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 drugplans.
For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call1-877-486-2048.

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 1-800-772-1213 (TTY 1-800-325-0778).
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 (apenalty).

Date: 10/21/2022
Contact--Position/Office: GA
Address: 123 Amwins Blvd.,Anywhere,US,12345
NameofEntity/Sender: Amwins
PhoneNumber: 555-555-5555

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)**.

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, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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+)	FLORIDA – Medicaid
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	INDIANA – 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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone:1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 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	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
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: href="https://dhhr.wv.gov/bms/" https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone:304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	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 July 31, 2023, or for more information on special enrollment rights, contact either:

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

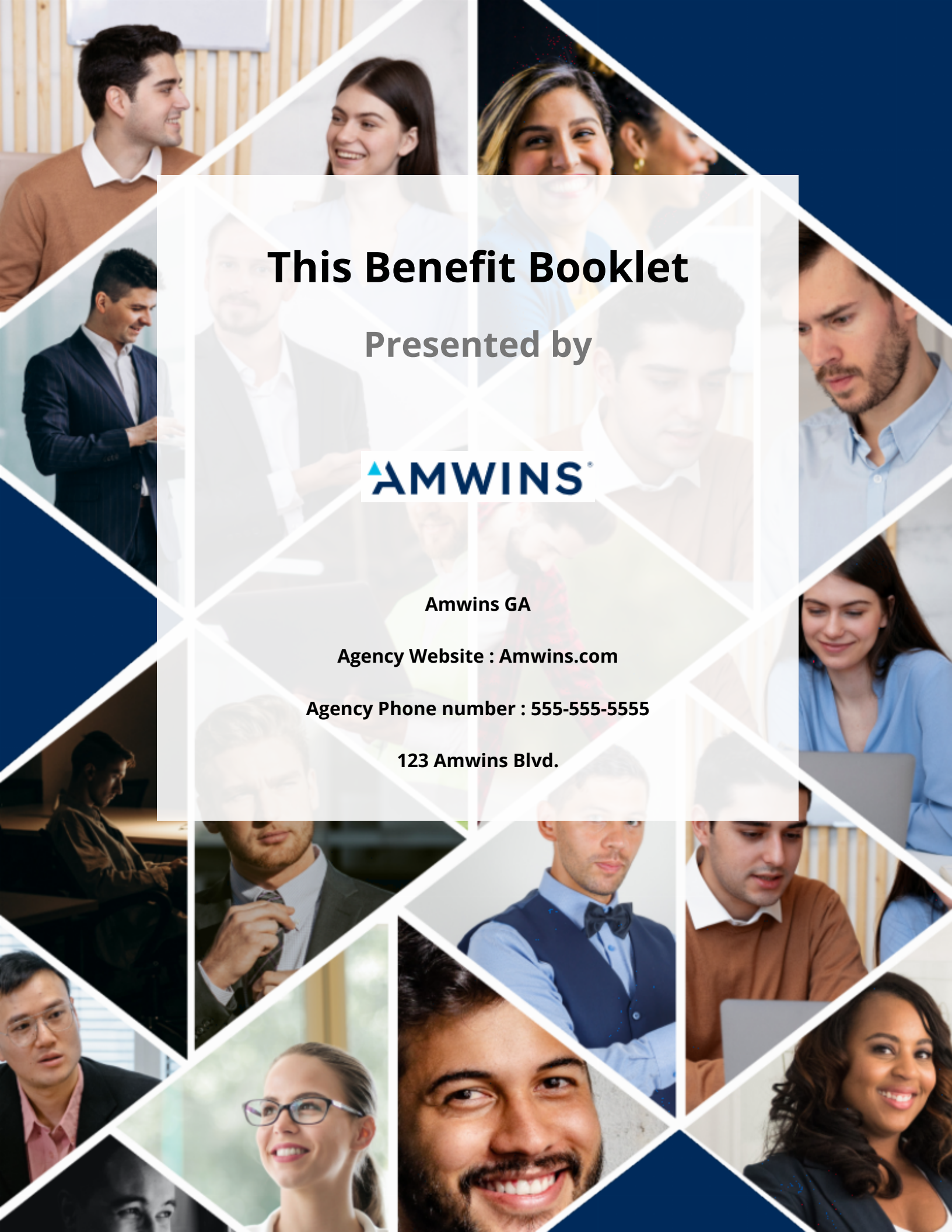
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
https://www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Notes



This Benefit Booklet

Presented by

AMWINS

Amwins GA

Agency Website : Amwins.com

Agency Phone number : 555-555-5555

123 Amwins Blvd.