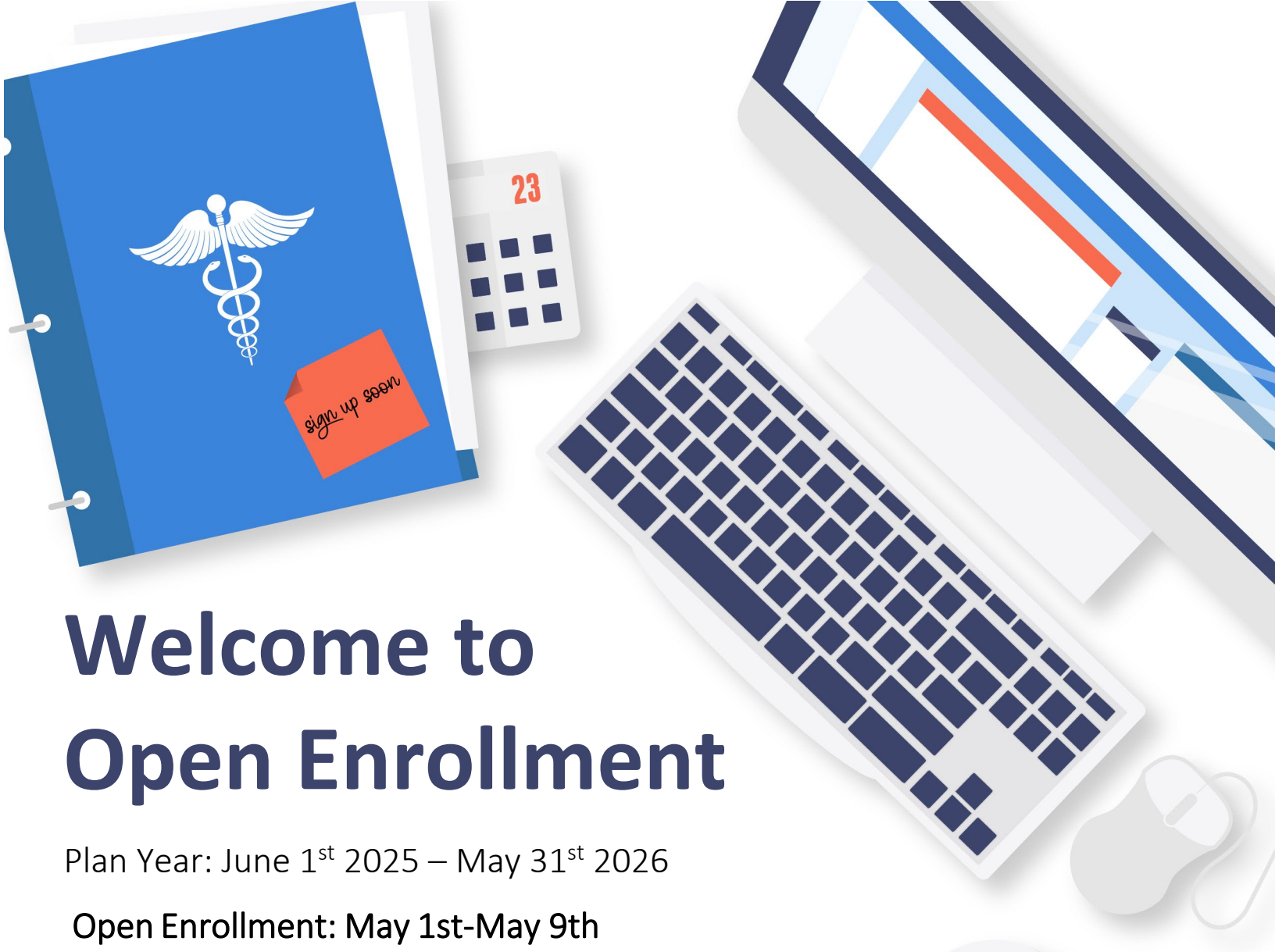


Welcome to Open Enrollment

Plan Year: June 1st 2025 – May 31st 2026

Open Enrollment: May 1st-May 9th

VanKirk Bros. CONTRACTING
SUTTON, NE

Ellerbrock-Norris

ACRISURE

Your Cost

Your Weekly (52) Cost

Medical

	Medical - Meritain			
	Weekly Premium	Employee Weekly Premium	Van Kirk Weekly Contribution	COBRA-Monthly
Employee Only	$250.16	**$40.00**	$210.16	$1,105.77
Employee + Spouse	$470.30	**$130.00**	$340.30	$2,078.72
Employee + Child(ren)	$419.48	**$120.00**	$299.48	$1,854.09
Employee + Family	$692.20	**$140.00**	$552.20	$3,059.54

Dental

	Delta Dental
Employee Only	$9.41
Employee + Spouse	$18.08
Employee + Child(ren)	$23.82
Employee + Family	$36.52

Vision

	Sunlife
Employee Only	$1.92
Employee + Spouse	$3.84
Employee + Child(ren)	$4.22
Employee + Family	$6.14

Voluntary Short-Term Disability

Dependent on Salary - Please See Portal for Rates

Critical Illness

Age Banded - Please See Portal for Rates

Accident

Employee Only	$3.67
Employee + Spouse	$5.55
Employee + Child(ren)	$5.76
Employee + Family	$7.64

Hospital Indemnity

Employee Only	$4.48
Employee + Spouse	$11.48
Employee + Child(ren)	$7.93
Employee + Family	$14.93

Important Contact Information

	Company	Coverage Area	Contact Information
VanKirk Bros. CONTRACTING SUTTON, NE	**Enroll Assist**	Call to enroll into benefits and/or ask any questions.	1-800-351-1151 or https://guardian.benselect.com/enroll/login.aspx?ReturnUrl=%2fenroll
MERITAIN HEALTH An Aetna Company	**Meritain Health (TPA)**	Medical Administrator: call for medical questions	1-877-559-2055 or www.meritain.com
SmithRx	**Smith Rx**	Pharmacy Benefit Manager: call for pharmacy questions	1-844-454-5201 or www.mysmithrx.com
DELTA DENTAL	**Delta Dental**	Dental: Benefits, Claims and Providers	1-866-827-3319 or https://www.deltadentalne.org
Sun Life	**SunLife**	Vision: Benefits, Claims and Providers	1-800-877-7195 or https://www.vsp.com/
Guardian	**Guardian**	Disability, Accident, Critical Illness, Hospital Indemnity	1-888-600-1600 or www.Guardiananytime.com
CancerCARE Right Care. Right Time. Right Place.	**Cancer CARE**	Helping Members diagnosed with Cancer	1-877-640-9610 or cancermanagement@cancercareprogram.net
KISx Card Keep It Simple Surgery	**KISx Card**	Surgery and Imaging direct contracting solution	1-877-GET-KISX or info@getkisx.com
Teladoc HEALTH	**Teladoc**	FREE telehealth vendor; contact to schedule a virtual appointment	1-800-835-2362 or https://www.teladoc.com/
Advocate24	**Advocate24**	Provider locating, billing questions, ID card requests, price comparisons, plan questions	1-866-891-3306 or careadvocates@healthcomp.com

Pick the best benefits for you and your family.

Van Kirk Bros strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of our benefits—that's why we've put together this Open Enrollment Guide.

Open enrollment is a short period each year when you can make changes to your benefits. This guide will outline all the different benefits offers, so you can identify which offerings are best for you and your family.

Elections you make during open enrollment will become effective on June 1st, 2025. If you have questions about any of the benefits mentioned in this guide, please don't hesitate to reach out to HR.

Welcome to Open Enrollment

Who is Eligible?

If you are a full-time employee, and have exceeded your eligibility period, you are eligible to enroll in the benefits described in this guide. Employees may also cover their eligible dependents and pay the applicable premium for their coverage. Eligible dependent(s) include: Spouse, Children up to age 26 (regardless of student, marital, or dependent status), and Dependent Children of any age who are incapable of supporting themselves due to mental/physical handicaps (proof of Social Security required).

How to Enroll

Please follow these steps for online completion:
Go to https://guardian.benselect.com/enroll

- Enter your social security number (SSN) as your login
- Enter your PIN – your PIN is the last four digits of your SSN and the last two digits of your birth year
- For example, if your SSN is 462-26-2222, and your birth year is 1985, your pin would be 222285

Once you have registered and are logged in you can:

- **Review your current benefit elections**
- **Verify your personal and dependent information**
- **Make your new benefit elections**

****For telephonic enrollment, please use the instruction listed below in RED.**

When to Enroll

Coverage for newly hired employees will be effective the June 1, 2025-May 31, 2026. Open enrollment begins on May 1, 2025 and runs through May 9, 2025. The benefits you choose during open enrollment will become effective on June 1, 2025.

***Please note that the deductible year runs from June 1, 2025-May 31, 2026.**

The Enroll Assist Team is available to help with all questions regarding enrollment and to assist you with the enrollment process. For assistance, please call **(800) 351-1151** to speak with a benefit team member from 7:00 am to 7:00 pm CST Monday – Friday.

How to Make Changes

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. All eligible changes must be communicated to the carrier within 31 days of the Qualifying Event. Qualified changes in status include:

- Marriage, divorce, or legal separation
- Birth or adoption of a child or change in child's dependent status or commencement or termination of adoption proceedings
- Death of spouse, child, or another qualified dependent
- Change in residence due to an employment transfer for you or your spouse
- Change in spouse's benefits or employment status, or enrollment/loss of other group coverage

If I want to make changes, what must be completed?

If you do not wish to make any changes there is no need to take any action at this time, your coverage will be automatically carried into the new plan year. If you do wish to make changes, please refer to the "How to Enroll" section on the previous page.

Health Insurance

Your Medical/Rx benefits will be administered by Meritain utilizing the Aetna Choice POS II network. As a reminder, the plan does provide coverage for both in and out-of- network providers; however, when an out-of-network provider is utilized, the member may be responsible for additional charges. For network providers visit: https://www.aetna.com/dsepublic/#/contentPage?page=providerSearch&site_id=mymeritain&language=en[1]

Services	Medical - Meritain	
Network	Aetna Choice POS II(open Access)	
Annual Deductible	**In- Network**	**Out-of- Network**
Individual	$1,000	$2,000
Family	$2,000	$4,000
Coinsurance (Plan/Member)		
	60%/40%	40%/60%
Out-of-Pocket Maximum		
Individual	$3,000	$6,000
Family	$6,000	$12,000
Physicians Visit		
Preventive Care	**No Charge**	**60% after Deductible**
In- Office	$30 Copay	60% after Deductible
Specialist	$60 Copay	60% after Deductible
Telemedicine	**Teladoc - No Charge**	**Teladoc - No Charge**
Urgent Care	$60 Copay	60% after Deductible
Emergency Room (True Emergency)		
*non-emergency medical	$150 copay, then 40% coinsurance *$500 Copay then deductible then 40%	Paid at the Participating Provider level of benefit. *$500 Copay then deductible then 60%
Hospital/Surgical		
In-Patient Hospital	40% Coinsurance	60% after Deductible
Out-Patient Hospital	40% Coinsurance	60% after Deductible

Prescription Drugs		
	Participating Pharmacy	**Non-Participating Pharmacy**
	Retail/Mail Order - 30 days/90 days	**Retail - 30 days**
Generic	$10 Copay/$30 Copay	$10 Copay(plus 25% penalty)*
Preferred Drug	$35 Copay/$105 Copay	$35 Copay(plus 25% penalty)*
Non-Preferred Drug	$70 Copay/ $210 Copay	$70 Copay(plus 25% penalty)*
		*** Mail Order: Not Covered**

*Please note that the deductible year runs from June 1, 2025-May 31, 2026.

MERITAIN HEALTH
An Aetna Company

Meritain Connect

A fresh new connection to your benefits plan

Did you know you can find a variety of healthcare tools and resources at **www.meritain.com**?

Your member website, Meritain Connect, gives you 24-hour access to a number of tools and resources that can help you manage your health benefits.

With Meritain Connect you can:

- Check your eligibility and benefits.
- Find the status of claims.
- View your Explanations of Benefits (EOBs).
- Review your benefit plan document.
- View deductibles and out-of-pocket limits.
- Check FSA and HRA balances, if applicable.

Access to Meritain Connect is as easy as 1-2-3

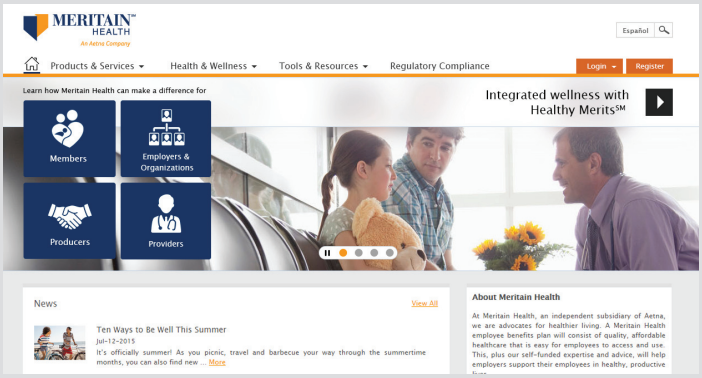
If you have an account, simply log in. If you're a new user, you'll need to register with these simple steps. When you're registering, you'll need your member ID and group ID from your ID Card. (If you're new to the plan, you'll receive your ID Card in the mail soon.)

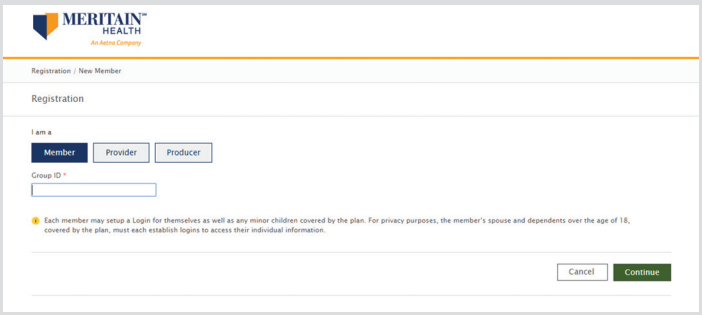
Step 1

Go to www.meritain.com and click *Register*.

Step 2

Select *Member* under *I am a* and enter your group ID. Then, click *Continue*. You may be prompted to enter your Index number. This is found on your ID Card, if applicable.





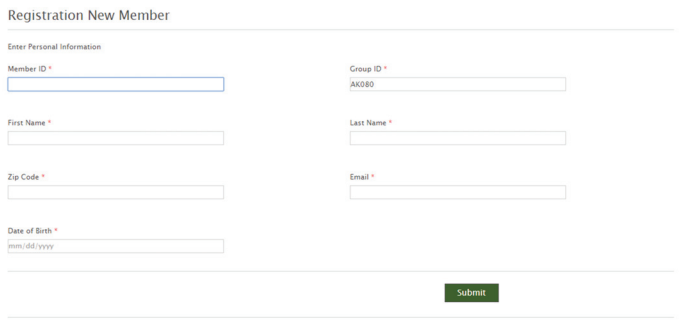
Step 3

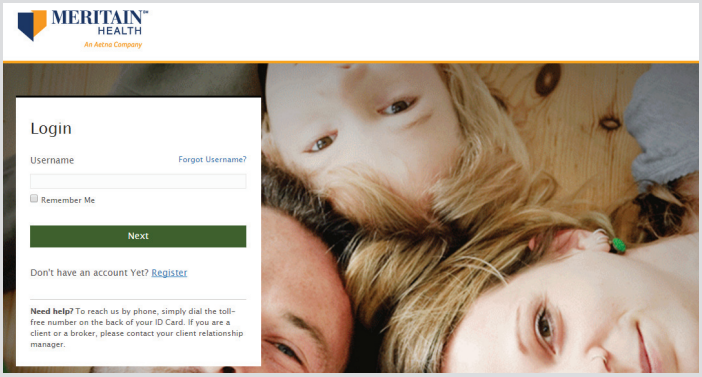
You'll need to enter the following information, then select *Submit*:

- Member ID (located on your member ID Card)
- First name (employee, spouse or dependent)
- Zip code
- Date of birth (mm/dd/yyyy)
- Group ID (located on your member ID Card)
- Last name (employee, spouse or dependent)
- Email (personal address)

Then, you will create a username and password. After you confirm your email address—you're done!

You can now log in to your Meritain Connect account with your new username and password.





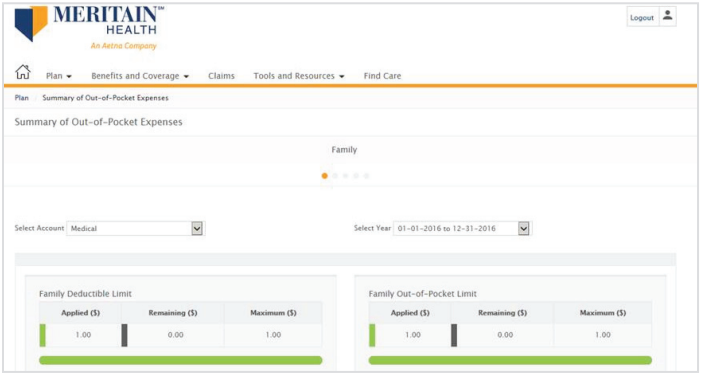
Need help registering for Meritain Connect? You can call us at the number on your ID Card for assistance.

What you'll find at Meritain Connect

Simply click the name of each function in the top banner of Meritain Connect to access the following options. Click *Home* to return to the welcome page.

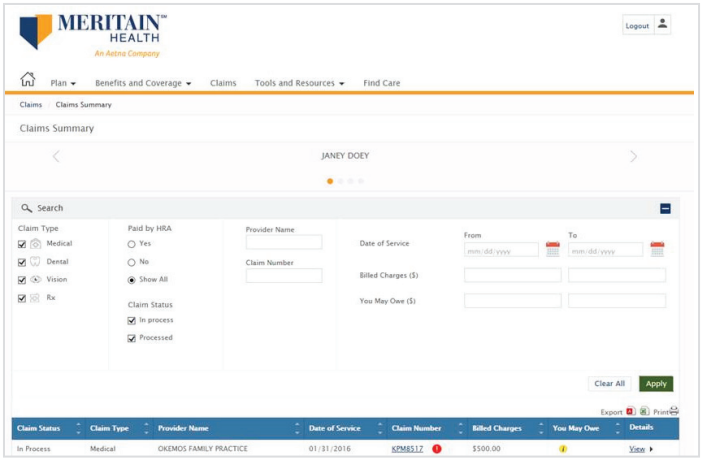
Healthcare Plan Overview

You can view deductibles and out-of-pocket maximums by clicking on *Summary of Out-of-Pocket Expenses.*



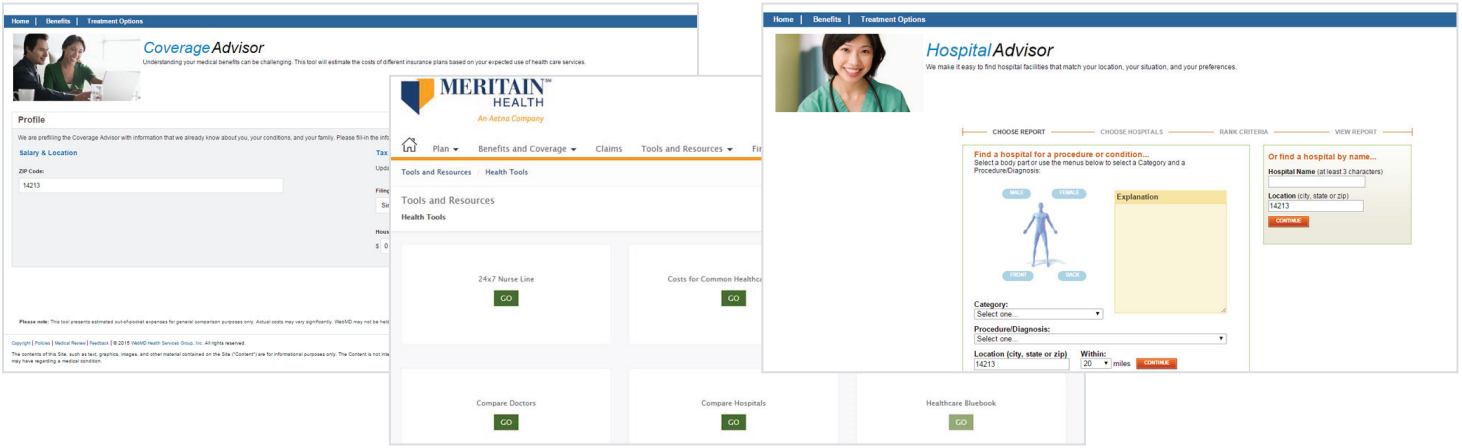
Claim Information

Just click *Claims* to view your claim information. The *Apply* button lets you view all claims. Claims with statuses of *received, in review, processed* or *void* will be displayed. You can view and print the Explanation of Benefits (EOBs) by clicking the link under the claim number.



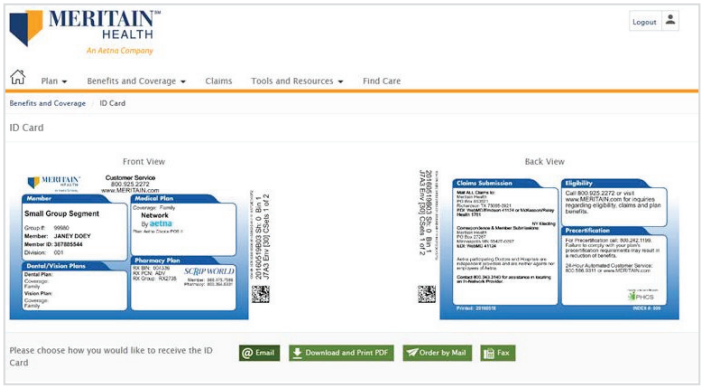
Cost Information/Health and Wellness

For links to cost comparison tools and health and wellness links, simply click *Health Tools* under *Tools & Resources.*



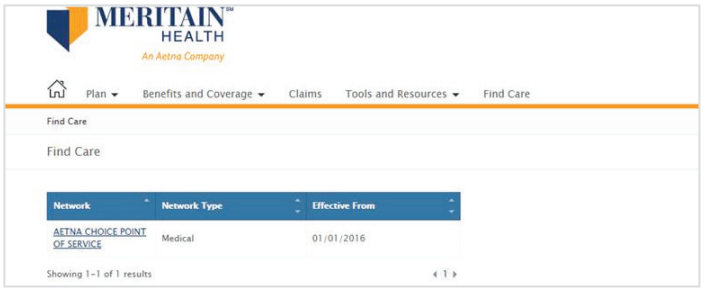
ID Cards

You can click *ID Cards* under *Benefits and Coverage* to view a temporary ID Card or order additional cards. You can click the Plan dropdown to view some of the site's key features, including FSA or HRA balances, if applicable.



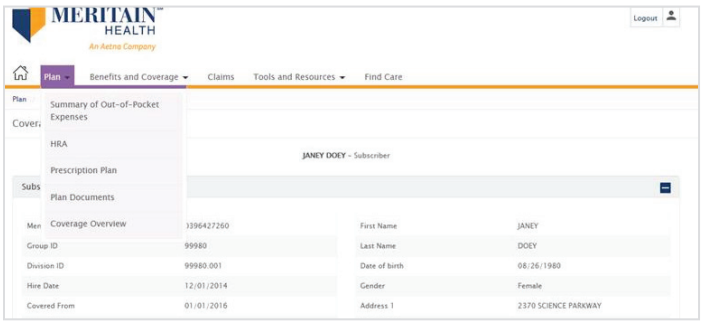
Find Care

It's easy to find an in-network doctor, clinic or hospital with Meritain Connect—just click *Doctors And Hospitals* to get started. Next, click the name of your network to be taken to the provider finder.



Flexible Spending Account or Health Reimbursement Arrangement (if applicable)

You can view FSA or HRA information, if applicable, when you click the *Plan* dropdown.



Other Features

Just click on each feature to access your information.

- **User Documentation**

  To view the member portal reference guide for more information on available features, just click the *User Documentation* link in the footer of your page.

- **Account Settings**

  You can change your password or store your email address when you click *Account Settings*—it's the person icon next to *Log out* in the upper right hand corner of your page.

You can click *Home* at any time to return to the welcome page.

Important information about Meritain Connect

Spouses and dependents

Per the HIPAA Privacy Regulations, spouses and dependents over age 18 have partially protected healthcare information. To access their information, they'll need to register for their Meritain Connect account using the previous steps. You can view financial information for all dependents, regardless of age.

Returning user login

When returning to the website after your account has been created, just enter your established username and password in the login box.

Incorrect login

You can click *Home* to return to the home page and try again if you receive an incorrect login message.

Website support

If you need help with the login process or forgot your username or password, we're here to help. You can contact customer service using the phone number printed on your ID Card.

If you need help navigating www.meritain.com or registering your Meritain Connect account, simply call us at the number located on your ID Card.

MERITAIN℠ HEALTH

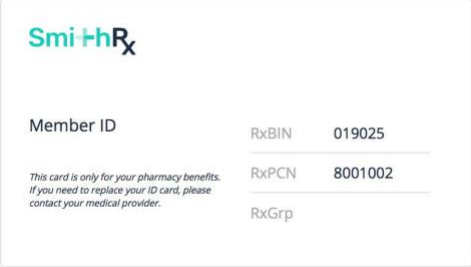
An Aetna Company

Understanding Your Prescription Benefit Program

Providing you with the tools and resources to help you make better drug therapy decisions

Your Prescription Benefit Plan through SmithRx.
SmithRx is your new prescription benefit provider. SmithRx is dedicated to giving you the best service and resources to help you and your family make better healthcare decisions.

Using Your Prescription Drug Card at Retail
You will receive a prescription card from your employer. Please present your new prescription card along with your prescription to any of our 67,000+ retail pharmacies every time you fill your prescription. You can access a participating pharmacy list at www.mysmithrx.com.



Using Your Home Delivery Benefit
Taking advantage of your home delivery benefit may enable you to receive up to a 90-day supply of your brand maintenance medication(s) at a discounted price through **Serve You**. Just ask your physician to write a new prescription to Serve You for home delivery. To get started you can ask your physician to:

- **E-prescribe or Fax:** Have your doctor electronically prescribe or fax your prescription to (866) 494-0364. Faxed prescriptions may only be sent by a doctor's office and must include patient information and diagnosis for timely processing.
- **Phone:** Your doctor can "call in" the prescription to (800) 759-3203 with an IVR option.

Please note: For prompt delivery, please provide your payment information by faxing or mailing in your completed order form to PO Box 26096, Milwaukee, WI 53226 and calling **(800) 759-3203**.

Online Tools at www.mysmithrx.com
Secure online connection, protecting your confidentiality and providing:

- Drug formulary & lookup tools
- Trusted drug and health condition information & education
- Real-time benefit information
- View and download pharmacy claims
- Find a participating pharmacy
- Download claim reimbursement, prior authorization request, specialty pharmacy enrollment, and mail order forms

Formulary Changes
To help provide our customers with access to safe, high-quality and cost- effective prescription benefits, it is necessary to classify some drugs as preferred and others as non-preferred drugs on the SmithRx formulary. Access our full formulary at www.mysmithrx.com to see how your medication is classified.

Additional requirements for coverage or limits on certain medications may include:

Your Plan may have additional requirements for coverage or limits for select prescription medications. These requirements and limits ensure that members use these medications in the most effective way and also help the Plan control medication costs. A team of practicing physicians and pharmacists developed these requirements and limits to help your Plan provide quality coverage to members. Please consult the formulary on our website for more information.

Quantity Limits
For certain medications, your Plan may limit the amount of the medication that will be covered per prescription or for a defined period of time. For example, your Plan may provide up to 30 units per 30-day period for a formulary medication.

Step Therapy
In some cases, your Plan requires you to first try one medication to treat your medical condition before it will cover another medication for that condition. For example, if Drug A and Drug B both treat your medical condition, your Plan may require your physician to prescribe Drug A first. If Drug A does not work for you, then your Plan will cover Drug B.

Prior Authorization
If your physician prescribes a medication requiring a prior authorization, you will need to go through a prior authorization process. We review requests for these selected medications to help ensure appropriate and safe use of medications for your medical condition(s). Your physician can call, fax, or submit prior authorization requests electronically. For a list of select medications that require prior authorization, please contact Customer Service at (844) 454-5201.

SmithRx

TELADOC®

You've got **Teladoc** 24/7 access to doctors by phone or video

Set up your account, it's easy!

1

Create account

Use your phone, the app, or our website to create an account and quickly complete your medical history.

2

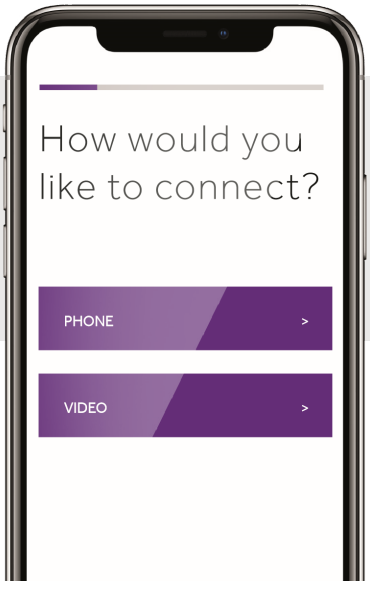
Request a visit

Use your device to request a visit and a Teladoc doctor will contact you at the requested time.

3

Feel better

Your doctor will diagnose your symptoms and even prescribe medicine, if needed.



Download the app and talk to a doctor for free

Teladoc.com 1-800-TELADOC (835-2362)

Available on the iPhone App Store

ANDROID APP ON Google play

264553274_09062018

CancerCARE

Right Care. Right Time. Right Place.

What is CancerCARE?

CancerCARE is a cutting-edge program designed to optimize the treatment of your cancer and increase the likelihood of your speedy recovery. It is a free benefit provided by your health plan sponsor to help maximize your treatment and well-being.

How do I benefit from the CancerCARE Program?

- 1 in 2 men and 1 in 3 women will be diagnosed with cancer in their lifetime
- Cancer care is costly. CancerCARE specialists can help maximize your benefit coverage and lower out-of-pocket expenses
- Approximately 28% of cancer diagnoses are incomplete or incorrect. CancerCARE's Pathology/ DiagnosticCOE network will affirm select diagnoses for correct treatment planning from the beginning
- Receive access to clinical trials at leading centers, often providing more effective treatment and better outcomes
- When applicable, you will be encouraged to obtain care at INTERLINK's CancerCOE Network (Centers of Excellence). The CancerCOE Network is comprised of the nation's leading centers for cancer treatment

What does the program offer?

- Increased benefit coverage for evidenced-based cancer treatment
- Coordination and navigation of your cancer care, including access to skilled oncology experts to help you through your cancer treatment decisions
- Guidance on cancer treatment plans based off of the most current evidence-based treatment protocols developed by an alliance of world renowned cancer specialists
- Opportunity to obtain care in your community or at a national center
- Physician access to evidence-based drug and biologic dosing that helps protect from under or over treatment of cancer
- INTERLINK's CancerCOE Network; a network of the nation's leading cancer centers

How do I use this program?

- When you or a covered family member is diagnosed with cancer, benefits are increased by calling and registering with CancerCARE online at **http://cancercare.interlinkhealth.com/1908/step-1-intake** or via phone at **1-877-640-9610.**

What happens when I call?

- You will speak with an intake specialist who will collect your demographic information and provide information about the program
- If you have questions or concerns, you will have access to a skilled oncology nurse
- You will be given information on how to ensure you receive the most appropriate treatment for your diagnosis based on most current evidence
- You will be provided educational materials and directed to online resources
- You will have access to the CancerCARE program throughout your entire cancer treatment for questions or concerns as long as eligible

877-640-9610

https://cancercare.interlinkhealth.com

SURGERY. SIMPLIFIED.

To help you be healthy.

The KISx Card is a surgery & imaging program that your employer has made available to you for the most common surgical & imaging procedures. Some of the most typical procedures through The KISx Card include: Orthopedic, General Surgery, Colonoscopies, MRI, CT and PET Scans. If you utilize the program, you will receive your procedure at **NO COST** to you.

CALL

Call a KISx Card Nurse at 877-GET-KISX to find out more about your procedure and how the program works. We will assist you in finding the right facility nearby.

SCHEDULE

A KISx Card Nurse will help schedule your procedure. Upon scheduling, they will then provide you with a voucher to take to your initial consultation.

PROCESS

BE HEALTHY

After you have had your procedure through a KISx Card Provider, your KISx Card Nurse will follow up to make sure you are making a full recovery. We want to make sure you are getting better so you can live a healthy life!

SAVE

You will pay **$0** out of pocket for choosing a KISx Card provider. Every aspect of your procedure is covered through the KISx Card.

KISxCard™

Keep It Simple Surgery

HOW IT **WORKS?**

Before seeking In-Network Providers through your health plan, just call a KISx Card Nurse regarding your elective procedure. By choosing a KISx Card provider, you will always pay **$0**.

CALL, SCHEDULE, SAVE **BE HEALTHY**

GET IN **TOUCH**

Phone: 877-GET-KISX

Email: info@getKISx.com

Dental Insurance

Your dental benefits will be administered by Delta Dental.

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings, and X-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

For network providers visit: **www.deltadentalne.org**

	Dental Plan
Calendar Year Deductible	
Individual Deductible	$100 per person for life
Family Deductible	$150
Dental Services	
Maximum Annual Benefit (Per person)	$1,000
Preventive Services *Cleanings, Oral Exams/Xrays*	No Charge
Basic Services *Fillings, Simple Extractions, Perio, & Endo*	80% Covered by insurance
Major Services *Oral Surgery, Root Canal, Crown, Bridges*	55% Covered by Insurance
Orthodontia	
Lifetime Maximum	50% up to $1,000

Vision Insurance

Your vision benefits will be administered by SunLife.

Driving to work, reading a news article, and watching TV are all activities you likely perform every day. Your ability to do all these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Van Kirk Bros. vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

The Preferred Provider directory can be found here: **www.sunlife.com**

	SunLife Vision	
Copays		
Eye Exam	$10 Copay	Once every 12 Months
Materials	$25 Copay	Once every 12 Months
Lenses		
Standard single vision **Standard lined bifocal** **Standard lined trifocal** **Standard lenticular**	$25 Copay	Once every 12 Months
Frames		
Frames	$130 Allowance	Once every 24 Months
Contacts (In lieu of glasses)		
Contact Lenses	$130 Allowance - Fitting fee may apply	Once every 12 Months

Just one call

Advocate24

To Answer the Important Questions…

Which Doctor is Right for Me?

Recommendations for Primary care providers and Specialists in your area.

Is My Bill Correct?

Advocate24 offers bill review services for Medical, Dental, and Vision bills.

Is This the Best Price for This Procedure?

Our Concierge service offers price comparisons for procedures and prescription drugs at providers near you.

Which Medical Plan is best for me? Does my Insurance Cover This?

Knowing what plans might be the best fit for you and your family, what the plans cover, and how to access care can be daunting. Your Advocate is here to help anytime with understanding coverage and assistance with managing your benefits.

ACRISURE®

HealthComp

866-891-3306

customerserve@healthcomp.com

Guardian®

Watch our video
How short term disability insurance can supplement your income.

Short term disability insurance

Disability insurance covers a part of your income, so you can pay your bills if you're injured or sick and can't work.

Disability may be more common than you might realize, and people can be unable to work for all sorts of different reasons. There are times when many disabilities can be caused by Illness, including common conditions like heart disease and arthritis. However, many disabilities aren't covered by workers' compensation.

Who is it for?

If you rely on your income to pay for everyday expenses, then you should probably consider disability insurance. It helps ensure that you'll receive a partial income if you're injured or too sick to work.

What does it cover?

Many disability insurance plans pay out a portion or percentage of your income if you're diagnosed with a serious illness or experience an injury that prevents you from doing your job.

Why should I consider it?

Accidents happen, and you can't always anticipate if or when you'll become sick or injured. That's why it's important to have a disability policy that helps you pay your bills in the event of being unable to collect your normal paycheck.

You will receive these benefits if you meet the conditions listed in the policy.

Partial income replacement

Mike injures his back in a bicycle accident and can't work for 13 weeks.

Unpaid time off work: **13 weeks**

Elimination period: **1 week**

After a 1-week elimination period following his accident, Mike's Guardian Short Term Disability policy kicks in and replaces **$400** of his weekly income for the remaining **12 weeks** of his rehabilitation.

This gives him a total of **$4,800** to cover his expenses while he's unable to work.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

Van Kirk Sand and Gravel
ALL ELIGIBLE EMPLOYEES
2021-117408 (03/23)

Kit created 04/19/2022
Group number: 00036275

Guardian®

Watch our video
How accident insurance can get you back on your feet.

Accident insurance

Accidents happen. With accident insurance, you can help them hurt a bit less.

Accident insurance is an extra layer of protection that gives you a cash payment to help cover out-of-pocket expenses when you suffer an unexpected, qualifying accident.

Who is it for?

Nobody can predict when an accident might happen. That's why accident insurance is an important add-on policy for people who want to supplement the health and disability insurance coverage they already have individually or through an employer.

What does it cover?

Accident insurance pays you lump sum benefits after an accident happens. This could be a severe burn, broken bone or emergency room visit. Our accident insurance policies also offer an increased benefit that pays extra for children injured while playing an organized sport like soccer, baseball, lacrosse, or football.

The child must be covered at the time the accident occurred and be 18 years of age or younger.

Why should I consider it?

Health coverage may become more expensive, with higher co-pays, premiums, and deductibles. Accident insurance can be a simple, affordable way to help supplement and cover additional expenses your health and disability insurance may not cover, including x-rays, ambulance services, deductibles, and even things like rent or groceries.

Plus, accident insurance is portable and payments are made directly to you.

You will receive these benefits if you meet the conditions listed in the policy.

Added support during recovery

Amanda breaks her leg falling off her bike and needs emergency treatment.

Average non-surgical broken leg treatment expense: **$2,500**

Average Major Medical deductible: **$1,500**

Major Medical covers 80% of the surgical cost after the deductible is met, but Amanda's still responsible for 20%: **$200**

Total out-of-pocket amount for Amanda (deductible + coinsurance): **$1,700**

Amanda's Guardian Accident policy pays her a benefit of **$1,700,** which covers all of her out-of-pocket expenses.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

Van Kirk Sand and Gravel
ALL ELIGIBLE EMPLOYEES
2021-117413 (03/23)

Kit created 04/19/2022
Group number: 00036275

Guardian®

Watch our video
How critical illness insurance helps cover the costs of treatment.

Critical illness insurance

Critical illness insurance may help you cover expenses not covered by your health insurance.

It's a cash payment you receive if you ever experience a serious illness like cancer, a heart attack, or a stroke, giving you the financial support to focus on recovery.

Who is it for?

Critical illness insurance is a supplemental policy for people who already have health insurance. It provides you with an additional payment to cover expenses like deductibles, treatments, and living costs.

What does it cover?

Critical illnesses include strokes, heart attacks, Parkinson's disease and cancer. Our policies can cover over 30 major illnesses, helping you stay financially stable by paying you a lump sum if you're diagnosed with one of them.

Why should I consider it?

Health coverage is becoming more expensive, with higher co-pays, premiums, and deductibles. Critical illness insurance is an affordable way to supplement and pay for additional expenses that your health insurance doesn't cover. Our policies typically provide payments for the first and second time you're diagnosed with a covered illness.

Plus, critical illness insurance is portable and payments are made directly to you.

You will receive these benefits if you meet the conditions listed in the policy.

Critical costs

John is hospitalized after a heart attack, and has to cover the cost of five days as an inpatient.

Average heart attack hospitalization expense: **$53,000**

Average Major Medical deductible: **$1,500**

Major Medical covers 80% of the cost after the deductible is met, but John's still responsible for 20%: **$10,300**.

Total out-of-pocket amount for John (deductible + coinsurance): **$11,800**.

John has a **$10,000** Guardian Critical Illness policy, which covers the majority of these out-of-pocket expenses.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

Guardian®

Watch our video
How hospital indemnity insurance can give you a comfortable stay.

Hospital indemnity insurance

Hospital indemnity insurance can cover some of the cost associated with a hospital stay, letting you focus on recovery.

Being hospitalized for illness or injury can happen to anyone, at any time. While medical insurance may cover hospital bills, it may not cover all the costs associated with a hospital stay. That's where hospital indemnity coverage can help.

Who is it for?

Hospital indemnity insurance is for people who need help covering the costs associated with a hospital stay if they suddenly become sick or injured.

What does it cover?

If you are admitted to a hospital for a covered sickness or injury, you'll receive payments that can be used to cover all sorts of costs, including:

- Deductibles and co-pays.
- Travel to and from the hospital for treatment.
- Childcare service assistance while recovering.

Why should I consider it?

Health coverage is becoming more expensive, with higher co-pays, premiums, and deductibles. Hospital indemnity insurance can help pay for out-of-pocket costs associated with being hospitalized, giving you more of a financial safety net for unplanned expenses brought on by a hospital stay.

Plus, hospital indemnity insurance is portable and payments are made directly to you – even if you didn't incur any out-of-pocket expenses.

You will receive these benefits if you meet the conditions listed in the policy.

Be prepared

John is hospitalized after a heart attack, and has to cover the cost of five days as an inpatient.

Average heart attack hospitalization expense: **$53,000**

Average Major Medical deductible: **$1,500**

Major Medical covers 80% of the cost after the deductible is met, but John's still responsible for 20%: **$10,300**.

Total out-of-pocket amount for John (deductible + coinsurance): **$11,800**.

John's Guardian Hospital Indemnity policy pays him **$1,000** for hospital admission.

The policy gives him a total payment of **$1,000** to help cover the out-of-pocket amount.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

Van Kirk Sand and Gravel
ALL ELIGIBLE EMPLOYEES
2020-105936 (07/22)

Kit created 04/19/2022
Group number: 00036275

Annual Required Notices

HIPAA Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual die.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

COBRA Continuation Coverage

COBRA is:
The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most employers with group health benefit plans to offer employees the opportunity to continue temporarily their group health care coverage under their employer's plan if their coverage otherwise would cease due to termination, layoff, or other change in employment status (referred to as "qualifying events").

How Long Must COBRA Continuation Coverage Be Available?
Up to 18 months for termination or reduction of hours
Up to 29 months to employees who are determined to have been disabled at any time during the first 60 days of COBRA coverage and to the disabled employee's nondisabled benefits
Up to 36 months for spouses and dependents due to an employee's death, divorce, or legal separation

What Plans Are Subject to COBRA?
Group health, vision, dental and health care spending account (EMSP) plans are subject to COBRA.

What Specific Events Can Be Qualifying Events?

- Death of employee
- Voluntary or involuntary termination of employment (other than by reason of gross misconduct)
- Retirement
- Reduction in hours
- Divorce or legal separation
- Dependent child ceasing to be a dependent

If you have questions:
Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to Human Resources. 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* For more information about the Marketplace, visit *www.HealthCare.gov.*

Women's Health and Cancer Rights Act (WHCRA) Notices

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. If you would like more information on WHCRA benefits, call your plan administrator at (123) 456-7890.

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 (123) 456-7890 for more information.

Continuation of Health Coverage During Family and Medical Leave (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to a total of 12 weeks of unpaid, job-protected leave during any 12-month period to eligible employees for certain family and medical reasons. This provision is intended to comply with the laws and any pertinent regulations, and its interpretation is governed by them.

For the duration of FMLA leave, the employer must maintain the employee's health coverage. The employee may continue the plan benefit for himself or herself and his or her dependents on the same terms as if the employee had continued to work. The employee must pay the same contributions toward the cost of the coverage that he or she made while working. If the employee fails to make the payments on a timely basis, the employer, after giving the employee written notice, can end the coverage during the leave if payment is more than 30 days late. Upon return from a FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefit, and other employment terms. The use of a FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

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 more than 48 hours (or 96 hours).

Special Enrollment Notice

This notice provides information to ensure that you understand your right to apply for group health plan coverage. If you decline enrollment for yourself or eligible dependents because of other health insurance or group health plan coverage, you may be able to later enroll in this plan if you or dependent loses eligibility for that coverage. However, you must request enrollment within 31 days after coverage ends (or after the employer stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you become eligible, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from or determined to be eligible for such assistance. In addition, if you have a new dependent because of marriage, birth, adoption, or place for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days following the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Human Resources.

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 January 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)	Website: Health Insurance Premium Payment (HIPP) Program 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: 1-800-766-9012
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	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: (617) 886-8102
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: http://www.nd.gov/dhs/services/medicalserv/medicaid/ 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: http://gethipptexas.com/ 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://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**

Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://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 January 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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OMB Control Number 1210-0137 (expires 1/31/2026)

Medicare Part D Creditable Coverage Notice

Important Notice from Keystone Glass Company 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 Keystone Glass Company 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. Keystone Glass Company has determined that the prescription drug coverage offered by the 2023 Plan Year is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Keystone Glass Company coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Keystone Glass Company 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 Keystone Glass Company 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 call Jan Doe at (123) 456-7890. 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 Keystone Glass Company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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 (a penalty).

NOTICE REGARDING WELLNESS PROGRAM

Keystone Glass Company's wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for [be specific about the conditions for which blood will be tested.] You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive for completing the program. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting HR.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Keystone Glass Company may use aggregate information it collects to design a program based on identified health risks in the workplace, Keystone Glass Company's wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) [indicate who will receive information such as "a registered nurse," "a doctor," or "a health coach"] to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your HR.

Health Insurance Exchange Notice

For Employers Who Offer a Health Plan to Some or All Employees

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.[1]

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:

An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such cost

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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

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

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

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

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

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the No Surprises Help Desk, operated by the U.S. Department of Health and Human Services, at 1-800-985-3059.

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

Glossary of Health Insurance Terms

This list defines many common healthcare terms you might not know. This glossary explains what the words and phrases mean for health insurance.

Allowed Amount - The highest amount we will cover (pay) for a service.

Benefit Period - When services are covered under your plan. It also defines the time when benefit maximums, deductibles and coinsurance limits build up. It has a start and end date. It is often one calendar year for health insurance plans.

Coinsurance - A certain percent you must pay each benefit period after you have paid your deductible. This payment is for covered services only. You may still have to pay a copay. *Example: Your plan might cover 80 percent of your medical bill. You will have to pay the other 20 percent. The 20 percent is the coinsurance.*

Coinsurance Limit (or Maximum) - The most you will pay in coinsurance costs during a benefit period.

Copayment (Copay) - The amount you pay to a healthcare provider at the time you receive services. You may have to pay a copay for each covered visit to your doctor, depending on your plan. Not all plans have a copay.

Covered Charges - Charges for covered services that your health plan paid for. There may be a limit on covered charges if you receive services from providers outside your plan's network of providers.

Covered Service - A healthcare provider's service or medical supplies covered by your health plan. Benefits will be given for these services based on your plan.

Deductible - The amount you pay for your healthcare services before your health insurer pays. Deductibles are based on your benefit period (typically a year at a time). *Example: If your plan has a $2,000 annual deductible, you will be expected to pay the first $2,000 toward your healthcare services. After you reach $2,000, your health insurer will cover the rest of the costs based on the co-insurance/out of pocket maximum agreement.*

HSA (Health Savings Account) - An account that lets you save for future medical costs. Money put in the account is not subject to federal income tax when deposited. Funds can build up and be used year to year. They are not required to be spent in a single year. HSAs must be paired with certain high-deductible health insurance plans (HDHP).

Inpatient Services - Services received when admitted to a hospital and a room and board charge is made.

Medically Necessary (or Medical Necessity) - Services, supplies or prescription drugs that are needed to diagnose or treat a medical condition. Also, an insurer must decide if this care is:

- Accepted as standard practice. It can't be experimental or investigational.
- Not just for your convenience or the convenience of a provider.
- The right amount or level of service that can be given to you.

Example: Inpatient care is medically necessary if your condition can't be treated properly as an outpatient service.

Network Provider/In-network Provider - A healthcare provider who is part of a plan's network.

Non-covered Charges - Charges for services and supplies that are **not** covered under the health plan.

Non-network Provider/Out-of-network Provider - A healthcare provider who is **not** part of a plan's network. Costs associated with out-of-network providers may be higher or not covered by your plan.

Outpatient Services - Services that do not need an overnight stay in a hospital. These services are often provided in a doctor's office, hospital or clinic.

Out-of-pocket Cost - Cost you must pay. Out-of-pocket costs vary by plan and each plan has a maximum out of pocket (OOP) cost.

PPO (Preferred Provider Organization) - A type of insurance plan that offers more extensive coverage for the services of healthcare providers who are part of the plan's network, but still offers some coverage for providers who are not part of the plan's network.

Premium - Payments you make to your insurance provider to keep your coverage. The payments are due at certain times.