

Verus^{↑↑↑}

Employee Benefits Guide January 1, 2024 - December 31, 2024



Access benefit information online!
www.verusbenefitplans.com

CREATED BY  AssuredPartners

This Benefit Guide is a summary of your benefits as an eligible Verus employee. Each section of this Benefit Guide contains important information, so please read this overview carefully.

Please note that this overview is a summary of benefits. For a complete description of benefit provisions, refer to your certificates of coverage and insurance policies. In the event of a discrepancy between this overview and the official plan documents, benefits will be paid as outlined in the plan documents.

If you have questions about your benefits or need assistance with claims, please contact a Benefit Advocate at AssuredPartners. Benefit Advocates are professionals who are available to provide confidential assistance for you and your covered family members. Please see the following page of this overview for more information.

The benefits in this summary are effective:
January 1, 2024 through December 31, 2024

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please refer to the Medicare Part D Notice at the back of this Guide for more details

This plan intends to comply with all federally mandated benefit changes and patient protections required by the federal health care reform law. This Summary of Benefits is based on current interpretations/guidance on health care reform and could change based on future determinations and/or final regulations.

For Assistance

Provider	Benefit	Telephone	Website	Group #
Cigna	Medical & Prescription Drug	1-888-806-5094	www.cigna.com	00638553
HSA Bank	Health Savings Accounts	1-888-806-5094	www.cigna.com	00638553
Delta Dental of Washington	Dental	1-800-554-1907	www.deltadentalwa.com	01400
Vision Service Plan (VSP)	Voluntary Vision	1-800-877-7195	www.vsp.com	30087321
Accrue Solutions	Flexible Spending Accounts & Transit Benefit	888-882-1498 ext. 2	www.AccrueCMS.com	N/A
Unum	Life & Long Term Disability	1-800-421-0344	www.unum.com	710263
Health Advocate through Unum	Employee Assistance Program	1-800-854-1446	www.unum.com/lifebalance	N/A
Assist American through Unum	Travel Assistance	1-800-872-1414	www.unum.com/travelassistance	Reference #: 01-AA-UN-762490

Whom do I call with benefit questions?

If you have a benefit question or problems with a claim payment, Benefit Advocates in the AssuredPartners Employee Service Center (ESC) understand your benefits program and assist you in resolving complex issues such as claims appeals.

The ESC is available Monday through Friday, 7:30 AM to 5:00 PM Pacific Time. There is no cost to you to access the ESC, and all calls and emails are completely confidential. Your Benefit Advocate will track your issue and make sure it is resolved.





EMPLOYEE SERVICE CENTER

Phone: 1-888-343-3330
 Email: mcm.esc@assuredpartners.com
 TTY/TDD: 1-855-877-4726

Due to HIPAA Privacy regulations, AssuredPartners may need to obtain your written authorization to assist with certain issues. Your Benefit Advocate will provide you with an authorization form, if needed. Please note, the AssuredPartners ESC cannot provide legal representation, legal advice, or medical reviews.

Who is Eligible?

New employees working at least 20 hours per week are eligible to enroll in the medical/prescription drug insurance, vision insurance, dental insurance, flexible spending arrangements, and transit benefits. Employees working at least 30 hours per week will also be automatically enrolled in life and long term disability insurance, which are paid for in full by Verus. Coverage will be effective the first of the month following or coinciding with your date of hire.

Eligible dependents are limited to the following:

- Your spouse
- Your domestic partner (DP)
- Your child(ren) under age 26. An eligible child is one of the following:
 - A natural offspring of the subscriber and/or spouse/DP
 - A legally adopted child of, or child placed for adoption with, the subscriber and/or spouse/DP
 - A legally placed foster child of the subscriber and/or spouse/DP

Open Enrollment & Election Changes

As an eligible new hire and each year at open enrollment, you have the opportunity to enroll yourself and your eligible dependents in these programs. Please note, if you do not enroll in benefits when initially eligible as a new hire, you will not be able to enroll until the next open enrollment period for a January 1 effective date, unless you or your dependents experience a permitted election change event.

Permitted election change events include, but are not limited to:

- Birth or adoption of a new child
- The death of a dependent
- Marriage, divorce or legal separation
- Spouse loses coverage through his or her employer or gains access to his or her employer's sponsored coverage
- You become eligible for or lose Medicaid coverage

Most permitted election change events must be reported to Human Resources within 30 days of the event date.

FYI- Cigna is fully transitioning their clients from physical ID cards to digital ID card as of 1/1/2024. Please utilize the QR code to download the CIGNA app where you can access your digital cards.



The above is only a brief description of Verus's eligibility requirements. Please refer to your Certificate of Coverage or see Human Resources for a complete definition of eligibility.

Cost of Coverage

The amounts below will be deducted from your paycheck each month if you elect coverage. Premiums are automatically deducted pre-tax unless you instruct HR otherwise.

If you cover a domestic partner (or a domestic partner's children), deductions will be taken on a post-tax basis unless they qualify as dependents under the Internal Revenue Code Section 152. In addition, unless your domestic partner qualifies under IRC Section 152, Verus's contribution to your domestic partner or their children's premium will be included in your taxable income.

The below outlines the monthly premiums to participate in the medical, vision, and dental plans.

Medical, Rx: Cigna

Option 1: \$3,000 High Deductible Medical/Rx

	You Pay	Verus Pays	Total Premium
Employee Only	\$121.47	\$688.35	\$809.82
Employee & Spouse	\$273.31	\$1,548.77	\$1,822.08
Employee & Child(ren)	\$212.57	\$1,204.59	\$1,417.16
Employee & Family	\$364.42	\$2,065.02	\$2,429.44

Option 2: \$1,500 Low Deductible Medical/Rx

	You Pay	Verus Pays	Total Premium
Employee Only	\$226.90	\$804.46	\$1,031.36
Employee & Spouse	\$603.35	\$1,717.21	\$2,320.56
Employee & Child(ren)	\$451.22	\$1,353.67	\$1,804.89
Employee & Family	\$835.41	\$2,258.69	\$3,094.10

Dental: Delta Dental of Washington

	You Pay	Verus Pays	Total Premium
Employee Only	\$4.77	\$42.89	\$47.65
Employee & Spouse	\$9.91	\$89.19	\$99.10
Employee & Child(ren)	\$10.64	\$95.76	\$106.40
Employee & Family	\$15.79	\$142.11	\$157.90

Voluntary Vision: Vision Service Plan (VSP)

	You Pay	Verus Pays	Total Premium
Employee Only	\$7.98	\$0.00	\$7.98
Employee & Spouse	\$12.77	\$0.00	\$12.77
Employee & Child(ren)	\$13.04	\$0.00	\$13.04
Employee & Family	\$21.02	\$0.00	\$21.02

Medical Benefits

We are pleased to provide you with comprehensive medical plans offered through Cigna. You will get the highest level of benefits when you receive covered services and supplies from a network provider. If the provider you see does not contract with Cigna, you may be responsible for amounts over the allowable charge, in addition to applicable copays, deductibles, coinsurance, etc. Below is a brief description of your medical coverage under this plan.

Cigna		
	Option 1: High Deductible	Option 2: Low Deductible
In Network Benefits - Open Access Plus (OAP) Network		
Deductible Per calendar year	\$3,000 Individual \$6,000 Family (aggregate)	\$1,500 Individual \$3,000 Family
Out-of-Pocket Maximum Per calendar year (includes deductible & copays)	\$6,000 Individual \$12,000 Family	\$5,000 Individual \$10,000 Family
Preventive Care	No Charge, deductible waived	No Charge, deductible waived
Telehealth Visit	20% coinsurance after deductible	\$30 copay, deductible waived
Office Visit	20% coinsurance after deductible	\$30 copay, deductible waived
Urgent Care Visit	20% coinsurance after deductible	\$30 copay, deductible waived
Chiropractic Services (12 visits per calendar year)	20% coinsurance after deductible	\$30 copay, deductible waived
Acupuncture (12 visits per calendar year)	20% coinsurance after deductible	\$30 copay, deductible waived
Outpatient Lab & X-Ray	20% coinsurance after deductible	20% coinsurance, deductible waived
Outpatient Surgery	20% coinsurance after deductible	20% coinsurance after deductible
Inpatient Hospital Services	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room	20% coinsurance after deductible	\$150 copay, then 20% coinsurance after deductible
Mental Health Benefits	20% coinsurance after deductible	Office visit / Telehealth visit: \$30 copay Inpatient: 20% coinsurance after deductible
Out of Network Benefits		
Deductible Per calendar year	\$3,000 Individual \$6,000 Family (aggregate)	\$1,500 Individual \$3,000 Family
Out-of-Pocket Maximum Per calendar year (includes deductible & copays)	\$6,000 Individual \$12,000 Family	\$5,000 Individual \$10,000 Family
Most Other Services	50% coinsurance after deductible	50% coinsurance after deductible

Prescription Benefits

When you enroll in the medical plan, you also receive coverage for prescription drugs. Cigna's prescription drug plan gives you coverage for a wide range of prescriptions.

Cigna		
	Option 1: High Deductible	Option 2: Low Deductible
In Network Benefits - Open Access Plus (OAP) Network		
Deductible Per calendar year	Combined with medical	None
Out-of-Pocket Maximum Per calendar year	Combined with medical	Combined with medical
Retail Pharmacy 30 day supply limit	20% coinsurance after deductible	\$15/\$30/\$50 copay
Mail Order Pharmacy 90 day supply limit	20% coinsurance after deductible	\$38/\$75/\$125 copay

Both plans use Cigna's Advantage 3-Tier prescription drug list. The drug list categorizes prescription drugs into three tiers based on their value. The costs shown above are Generic/Preferred Brand/Non-Preferred Brand. Drugs can change tiers during the year; you can check what tier your drug is in at www.cigna.com

Certain prescription drugs may have limitations or requirements. Contact Cigna for more information.

Cigna Tools and Resources

myCigna.com

Activate your account on myCigna.com. It's quick, easy, and the best way to manage your plan. With myCigna.com, you can:

- Find in-network doctors, care, and cost estimates
- Get access to 7 million+ verified patient reviews from other Cigna members
- Connect with virtual care (telehealth) providers 24/7
- Print or view your ID card
- Manage prescriptions or find a pharmacy

myCigna Mobile App

The myCigna app uses one-touch access, making it easy for you to update your profile settings and personalize, organize, and access your health information (including your ID card!) on the go.

MDLive Telehealth Service

It's not always easy to find time for the health care you need. After all, doctors' appointments traditionally involve time and travel. That can lead to putting off care until problems become more serious and potentially more expensive.

That's why Cigna has partnered with MDLive to offer a comprehensive suite of convenient virtual care options - available by phone or video whenever it works for you. MDLive board-certified doctors, dermatologists, psychiatrists, and licensed therapists have an average of over 10 years of experience and provide personalized care for hundreds of medical and behavioral health needs.

Primary Care

- Preventive care checkups / wellness screenings available at no cost
- Routine care visits, with the provider of your choice, to help manage conditions
- Prescriptions available through home delivery or at a local pharmacy, if appropriate
- Orders for biometrics, blood work, and screenings

Dermatology

- Care for common skin, hair, and nail conditions, including acne, eczema, psoriasis, rosacea, suspicious spots, and more
- Dermatologists review pictures and symptoms with diagnosis usually within 24 hours
- Prescriptions available, if appropriate

Urgent Care

- On-demand 24/7/365, including holidays
- Care for hundreds of minor medical conditions
- A convenient and affordable alternative to urgent care centers and the emergency room
- Prescriptions available, if appropriate

Behavioral Health

- Care for issues such as anxiety, stress, life changes, grief, and depression
- Schedule an appointment that works for you, with the provider of your choice
- Access to psychiatrists and therapists

Cigna Tools and Resources

Happify

A free app with science-based games and activities that are designed to help defeat negative thoughts, gain confidence and reduce stress and anxiety. 60+ interactive programs available, including self-reflection activities, articles, audio content, webinars and more. Sign up and download the free app at happify.com/Cigna

iPrevail

iPrevail is designed to decrease feelings of post-traumatic stress disorder, anxiety and depression. Start by signing up for iPrevail on myCigna.com. After completing a short quiz, you will be matched with a personalized support program. Each week a new concept is covered with new social and clinical activities. Messages can be sent to your coach and others, day or night, 24/7. Sign up for iPrevail at myCigna.com

Ginger

Ginger offers confidential mental healthcare through behavioral health coaching via text-based chats, self-guided learning activities and content, and, if needed, video-based therapy and psychiatry. Support is available anytime, anywhere for a variety of mental health challenges all from the privacy of your smartphone. Visit ginger.com/connect or download the ginger app. In the app you will be asked who sponsors your access to ginger, you will want to select "My Health Plan"

Talkspace

A digital space for private and convenient mental health support. With Talkspace, you can choose your therapist from a list of recommended, licensed providers and receive support day and night from the convenience of your device (iOS, Android, and Web). Members can exchange unlimited messages (text, voice, and video) with their personal therapist upon registering. Members are granted a complimentary, 10-minute video session to get to know their new therapist; additional video sessions can be scheduled, and you will work with the same therapist throughout your journey. To get started visit talkspace.com/covered

Health Savings Accounts

When you enroll in the high deductible health plan, a health savings account (HSA) will open for you through HSA Bank. This account can help you fund your deductible, coinsurance, and other qualified medical expenses. When you successfully open the account, you may choose to make contributions to the account directly from your paycheck. All employees who elect the HSA will receive \$41.67 per paycheck deposited into their account from Verus from their eligibility date through their last paycheck of the year. For employees who are enrolled for the full year, this is a total employer contribution of \$1,000.

What is a qualified High Deductible Health Plan?

A qualified high deductible health plan (HDHP) is the only type of plan that allows you to make contributions to a tax-advantaged HSA. With the exception of preventive care, all medical and pharmacy expenses are your responsibility until you meet the annual deductible. After you meet the deductible, coinsurance may apply until you meet your out of pocket maximum.

What is a Health Savings Account?

An HSA is a tax-advantaged account you can use to pay for medical expenses. Contributions, investment earnings and qualified withdrawals are all exempt from federal income tax, FICA tax and most state income tax (excludes California)*.

You may make contributions through payroll deduction up to IRS limits. The annual limit depends upon whether you are enrolled in the qualified HDHP with self-only coverage or with dependents, as well as how much of the year you are covered by a qualified HDHP.

Please be conservative when contributing towards the HSA mid-calendar year, as contribution limits are prorated based on the number of months you are enrolled in a qualified HDHP. The IRS imposes a penalty on excess contributions in the form of an income tax and a 6% additional tax on the excess contribution amount. You are responsible for tracking your contributions to ensure you don't exceed the maximum allowable contribution. See 2024 limits on the bottom of page 11.

Who qualifies for an HSA?

All employees eligible for health benefits may enroll in the HDHP option, but under strict IRS rules, not everyone is eligible to contribute to or receive contributions to a HSA. To be an eligible individual and qualify for an HSA, you must meet the following requirements:

- You must be covered under a qualified HDHP on the first day of the month.
- You have no other health coverage except what is permitted (e.g. a limited-purpose health FSA or HRA).
- You are not enrolled in Medicare (including Medicare Part A).
- You cannot be claimed as a dependent on someone else's tax return (except your spouse's).

Under the IRS's last-month rule, you are considered to be an eligible individual for the entire year if you are an eligible individual on the first day of the last month of your tax year (December 1 for most taxpayers), as long as you remain an eligible individual for at least 13 months.

Who can use the HSA?

You do not pay taxes on the funds you use to pay for qualified health care expenses. The following individuals can use HSA funds:

1. You and your spouse.
2. All dependents you claim on your tax return.
3. Any person you could have claimed as a dependent on your return except that:
 - The person filed a joint return,
 - The person had gross income above the IRS dependent income limit, or
 - You, or your spouse if filing jointly, could be claimed as a dependent on someone else’s tax return.
4. Your child under age 27 at the end of your tax year.

What are Eligible Medical Expenses?

You can use your HSA to pay for a wide range of eligible medical expenses for yourself, your spouse or tax dependents. Funds used to pay for eligible medical expenses are always tax-free, and you can continue to use your HSA funds even if you’re not covered by an HSA-compatible plan.

- Deductibles, coinsurance
- Dental care – braces, dentures
- Vision care – glasses, contacts, Lasik surgery
- Medical equipment
- COBRA premiums
- Long Term Care insurance
- Prescription medications

For additional information, please refer to IRS publication 502, “Medical and Dental Expenses.”

Funds used to pay for qualified medical expenses, referred to by the IRS as distributions, are tax free (certain state income taxes apply). If you use your HSA to pay for an ineligible expense, you must report it on your federal income tax return and pay the related taxes, plus a penalty. (After age 65, the penalty does not apply.)

HSA Perks

- Money put in your HSA is tax free and earns interest tax free (excludes California).*
- Money left in your account at the end of the plan year rolls over to the next year.
- You own the money in your HSA so you keep it even if you change plans or jobs.

HSA Limits

- 2024 contribution limits, as established by the IRS, are \$4,150 for employee only coverage and \$8,300 if you cover at least one dependent.
- Verus’s contribution counts toward these maximums.
- An additional \$1,000 “catch-up” contribution is allowed for individuals over age 55.

***There are a few states that do not conform with federal tax rules regarding HSAs. In California and New Jersey, HSA contributions and earnings are subject to state income taxes. In New Hampshire, interest and dividend earnings are taxable above a certain dollar amount. Please consult your personal tax advisor for additional information.**

Dental Benefits

We are pleased to offer you a dental plan through Delta Dental of Washington. This is a Delta Dental PPO Preferred Provider plan. You can choose any dentist; however, if you select a dentist who is part of the Delta Dental PPO network, your benefits will be paid at a higher level, and your out-of-pocket expenses will likely be lower.

Delta Dental of Washington

	Preferred PPO Dentist	Participating (Premier) or Non-Participating Dentist
Deductible Per calendar year	\$50 Individual \$150 Family	\$50 Individual \$150 Family
Individual Benefit Maximum Per calendar year	\$1,000	\$1,000
Class 1 - Diagnostic & Preventive Exams, prophys, x-rays, fluoride, & sealants (does not apply to Individual Benefit Maximum)	No charge	20% coinsurance, deductible waived
Class 2 - Restorative Services Restorations, endodontics, periodontics, oral surgery	20% coinsurance, after deductible	30% coinsurance, after deductible
Class 3 - Major Services Crowns, dentures, partials, bridges, implants	50% coinsurance, after deductible	60% coinsurance, after deductible
TMJ - Surgical and Non-Surgical Treatment \$1,000 annual maximum, \$5,000 lifetime maximum	50% coinsurance, after deductible	50% coinsurance, after deductible

Balance Billing: If you visit a non-participating dentist, you may be responsible for charges that exceed the plan's maximum reimbursement levels, in addition to the deductible and plan cost share.

Pre-Treatment Estimate: If your dental work will be extensive, you should have your dentist submit the proposed treatment plan to Delta Dental before you begin treatment. Delta Dental will provide you with a summary of the plan's coverage and your estimated out-of-pocket costs.

Find a Dentist: You can find a participating dentist in your area by visiting the Delta Dental of Washington website. Be sure to select the appropriate plan- **Delta Dental PPO**- and follow the prompts.

MySmile Personal Benefits Center: To get the most from your benefits, register for MySmile on deltadentalwa.com. Whether you need to check benefits, find a dentist, or have general questions, you'll find the answers you need.

At MySmile Personal Benefits Center you can:

- Check your coverage
- Print ID cards
- Check claim status or retrieve prior claim information
- Find a dentist
- View your dental activity
- Compare average dental costs in your location

Voluntary Vision Benefits

We offer a voluntary vision plan through Vision Service Plan (VSP). Coverage includes in and out of network benefits for routine eye exams and vision hardware. As a VSP member, you may receive extra discounts and savings on laser vision correction, prescription glasses and contacts.

VSP Choice Provider		
	Frequency	You pay
Vision Exam	Every 12 Months	\$10 copay
Prescription Glasses		\$25 copay
Basic Lenses*	Every 12 Months	Included in glasses copay
Premium Lenses**		Premium progressive lenses: \$80- \$90 Custom progressive lenses: \$120- \$160 Average savings of 35- 40% on other lens enhancements
Frames	Every 24 Months	Included in glasses copay up to: \$130 allowance for a wide selection of frames \$150 allowance for featured frame brands 20% savings on the amount over your allowance \$70 Costco frame allowance
Contact Lenses (contacts and exam)	Every 12 Months in lieu of Prescription Glasses	Up to \$60 for exam Lenses covered up to \$130 Copay does not apply

* Basic lenses include single vision, lined bifocal, lined trifocal, and basic progressive lenses. Basic lenses also include polycarbonate lenses for dependent children.

** Premium lenses include premium and custom progressive lenses, and all other lens enhancements.

Extra savings:

- Average savings of 35-40% on lens enhancements (such as anti-reflective coating and scratch-resistant coating).
- Extra \$20 to spend on featured frame brands. Go to vsp.com/specialoffers for details.
- 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam; or get 20% from any VSP provider within 12 months of your last WellVision Exam.
- No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam.
- Average 15% off the regular price or 5% off the promotional price of laser vision correction; discounts only available from contracted facilities.

When you visit a VSP doctor, tell them you have VSP. There is no ID card necessary. If you'd like a card for reference, you can print one on VSP.com.

Prefer shopping online? Use your VSP benefits at www.eyeconic.com, VSP's preferred online eyewear store.

Flexible Spending Accounts

Accrue Solutions administers our Health Care, Limited Purpose Health Care, and Dependent Care Flexible Spending Accounts (FSAs). The money you elect to contribute will be deducted out of your paychecks on a pre-tax basis, enabling you to pay less in taxes and have more disposable income.

Health Care FSA

Your Annual Contribution Maximum: \$3,200

Allows you to pay for qualified medical, dental or vision out-of-pocket health care expenses.

Limited Purpose Health Care FSA

Your Annual Contribution Maximum: \$3,200

Specifically for those members enrolled in an HSA medical plan. Allows you to pay for out-of-pocket dental and vision expenses only.

*Dependent Care FSA

Your Annual Contribution Maximum: \$5,000 (per household)

Allows you to pay for daycare expenses for children under age 13, dependent elder care, or care for other tax dependents unable to care for themselves while both you and your spouse work or go to school full time.

Note: If you have a traditional Health Care FSA and move to the high deductible plan, your traditional Health Care FSA will be terminated without a grace period prior to your first day in the high deductible plan due to IRS regulations.

Grace Period & Runout Period

There is a grace period, which gives you extra time to incur more claims after the end of the plan year that can be applied to your prior year's FSA balance. All receipts for eligible expenses are due by the dates shown below.

	Due Dates	
	2023 Plan Year	2024 Plan Year
Incur Claims Until	March 15, 2024	March 15, 2025
Receipts are Due	March 31, 2024	March 31, 2025

Note: Beginning January 1 all claims should be submitted to our new administrator, Accrue Solutions.

FSA Rules

Specific IRS rules govern the operation of FSAs, including the following:

- "Use It or Lose It" - You will forfeit any money left in an FSA at the end of the runout period.
- Only expenses incurred before the end of the month in which you terminate employment are eligible for reimbursement, unless you continue your FSA via COBRA.
- All caregivers using the Dependent Care FSA must have a tax ID or Social Security number. This information must be included on your federal tax return.
- If you choose to have dependent care expenses reimbursed by your Dependent Care FSA, those same expenses cannot be claimed for a dependent care tax credit on your federal income tax return. Consult a tax advisor for more information and to help you choose the best approach for your circumstances.

How much should I contribute?

Before you enroll in the FSA, use this chart to estimate your out-of-pocket expenses for the calendar year.

Medical

Deductibles	\$
Coinsurance	\$
Copays	\$

Dental

Deductibles	\$
Coinsurance	\$

Vision

Copays	\$
Examinations	\$
Glasses	\$
Contact Lenses	\$

Miscellaneous

Other Qualified Medical Expenses	\$
ANNUAL TOTAL	\$

How to submit claims:

1. Website: AccrueCMS.com
2. Email: Claims@AccrueCMS.com
3. Mobile App: Download the AccrueCMS mobile app
4. Mail: Accrue Solutions, 3000 Internet Blvd, Ste 530, Frisco Tx, 75034

Reminder: It's Important to Save Your Receipts!

The IRS requires the Accrue Card be used only for eligible expenses. Usually, FSA vendors can verify these expenses automatically, however there are times where you may be asked to submit an itemized receipt. When this happens, make sure you submit the receipts as soon as possible to avoid having your Card suspended.

Commuter Benefits

The Accrue Solutions Commuter program allows you to pay for your work-related transit expenses using pre-tax dollars. Once registered on the website (www.AccrueCMS.com) you can place an order for your monthly transit needs. The order amount will be deducted from your paycheck pre-tax and loaded onto your Accrue Solutions debit card. You can then use the Accrue Solutions debit card in place of a personal debit or credit card to purchase services at any transit or parking facility that accepts MasterCard. There is no claim filing required, and there is no open enrollment period for this program. Employees can join for any month.

Life Insurance Benefits

Eligible employees are automatically enrolled in life insurance through Unum at no cost to you. Your life insurance benefit is equal to 2 times your annual earnings to a maximum of \$500,000. Any amount over \$450,000 is subject to medical underwriting. Benefit reductions begin at age 65.

Long Term Disability Insurance Benefits

Verus provides eligible employees with long term disability insurance through Unum, which replaces a portion of your income if you were to become sick or injured and unable to work.

Your benefits begin after a 180 day elimination period of continuous disability from the date of your disabling condition. The plan will pay 66 2/3% of your covered pre-disability earnings up to a maximum monthly benefit of \$15,000. How long you are eligible for benefits is determined by the extent of your disability and ability to work. The plan will not pay benefits for a disability that results from a pre-existing condition for your first 12 months of coverage.

Travel Assistance Program

Also, through your life insurance coverage, you, your spouse, and your dependent children have access to worldwide travel assistance services through Assist America. Whenever you travel 100 miles or more from home, be sure to keep this service in mind. Add the number to your cell phone contacts so it's always close at hand, or download the Assist America Mobile App. Whether traveling for business or pleasure, just one phone call can connect you and your family to these medical and other important services 24 hours a day:

- Hospital admission assistance
- Emergency medical evacuation
- Prescription replacement assistance
- Transportation for a friend or family member to join a hospitalized patient
- Care and transport of unattended minor children
- Emergency message services
- Referrals to Western-trained, English-speaking medical providers
- Legal and interpreter referrals
- Passport replacement assistance

Employee Assistance Program (EAP) and Work/Life Balance Services

Verus provides a completely confidential Employee Assistance Program (EAP) and Work/Life Balance Services through Health Advocate for all employees who are eligible for the Unum LTD plan. These services are available to all employees who are eligible for the Unum LTD plan, their spouse or domestic partner, dependent children, parents, and parents-in-law. Expert support is available 24/7 over the phone or online.

Employee Assistance Program (EAP)

Your EAP is designed to help you lead a happier and more productive life at home and at work. Call for confidential access to a Licensed Professional Counselor. You can get up to three visits, available at no cost to you, per issue per year.

A Licensed Professional Counselor can help you with:

- Stress, depression, anxiety
- Relationship issues, divorce
- Anger, grief, loss
- Job stress, work conflicts
- Family and parenting problems
- And more

Work/Life Balance

You can also reach out to a specialist for help with balancing work and life issues. Just call and a Work/Life Specialist can answer your questions and help you find resources in your community.

Ask your Work/Life Specialist about:

- Child care and elder care
- Financial services, debt management, credit report issues
- Identity theft
- Legal questions
- Reducing your medical or dental bills
- And more

Annual Notices

SURPRISE MEDICAL BILLING

COVID-19 relief legislation addresses “surprise” medical bills sent to consumers when they receive unplanned medical care from certain providers, such as out-of-network emergency facilities, out-of-network care received at in-network facilities, and air ambulance transportation. When services fall within the surprise billing protections, cost-sharing is restricted to in-network levels and balance billing (i.e., seeking to collect from the patient more than the applicable cost-sharing amount) is prohibited. Explanations of Benefits (EOB) will include a notice of these balance billing requirements and protections.

NOTICE OF PRIVACY PRACTICES

Effective Date: January 1, 2024

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.**

If you have any questions about this notice, please contact Mellisa Ingraham at 206-622-3700 or mingraham@verusinvestments.com.

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 unable 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.

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 have to 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 dies.

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 and we will mail a copy to you.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

You may be eligible to participate in the Verus Health Plan. A federal law called HIPAA requires that we notify eligible participants about the right to enroll in the plan under its "special enrollment provision."

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

To request special enrollment or obtain more information, contact **Mellisa Ingraham at 206-622-3700**.

NOTICE OF THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

This notice is being sent to you as required by the Women's Health and Cancer Rights Act of 1998, which states you must be advised annually of the presence of benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry of the breasts, prostheses and complications resulting from a mastectomy. Please refer to your medical benefit booklet for additional information. Benefits for these services may be subject to annual deductibles and coinsurance consistent with those established for other benefits.

NOTICE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

MEDICARE PART D – YOUR PRESCRIPTION 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 Verus 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. Verus has determined that the prescription drug coverage offered by Verus 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 through 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 Verus coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Verus coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact the Human Resources Department or your Benefit Advocate for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

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 Verus 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 November 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 ABC 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.

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).

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).

Date: 01/01/2024

Name of Entity/Sender: Verus

Contact--Position/Office: Mellisa Ingraham/Benefits Manager

Address: 800 Fifth Ave, Suite 3900, Seattle, WA 98104

Phone Number: 206-622-3700

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 –

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
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

ALABAMA – Medicaid

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

ALASKA – Medicaid

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

ARKANSAS – Medicaid

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

CALIFORNIA – Medicaid

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

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

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

FLORIDA – Medicaid

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

GEORGIA – Medicaid

Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid

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)

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

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
MINNESOTA – 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
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
NEBRASKA – Medicaid
Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid and CHIP
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: https://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
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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.

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

**Share this Employee Benefits Guide
with your family**



AssuredPartners

1325 Fourth Avenue, Suite 2100

Seattle, WA 98101

1-800-347-2303

www.assuredpartners.com/seattle