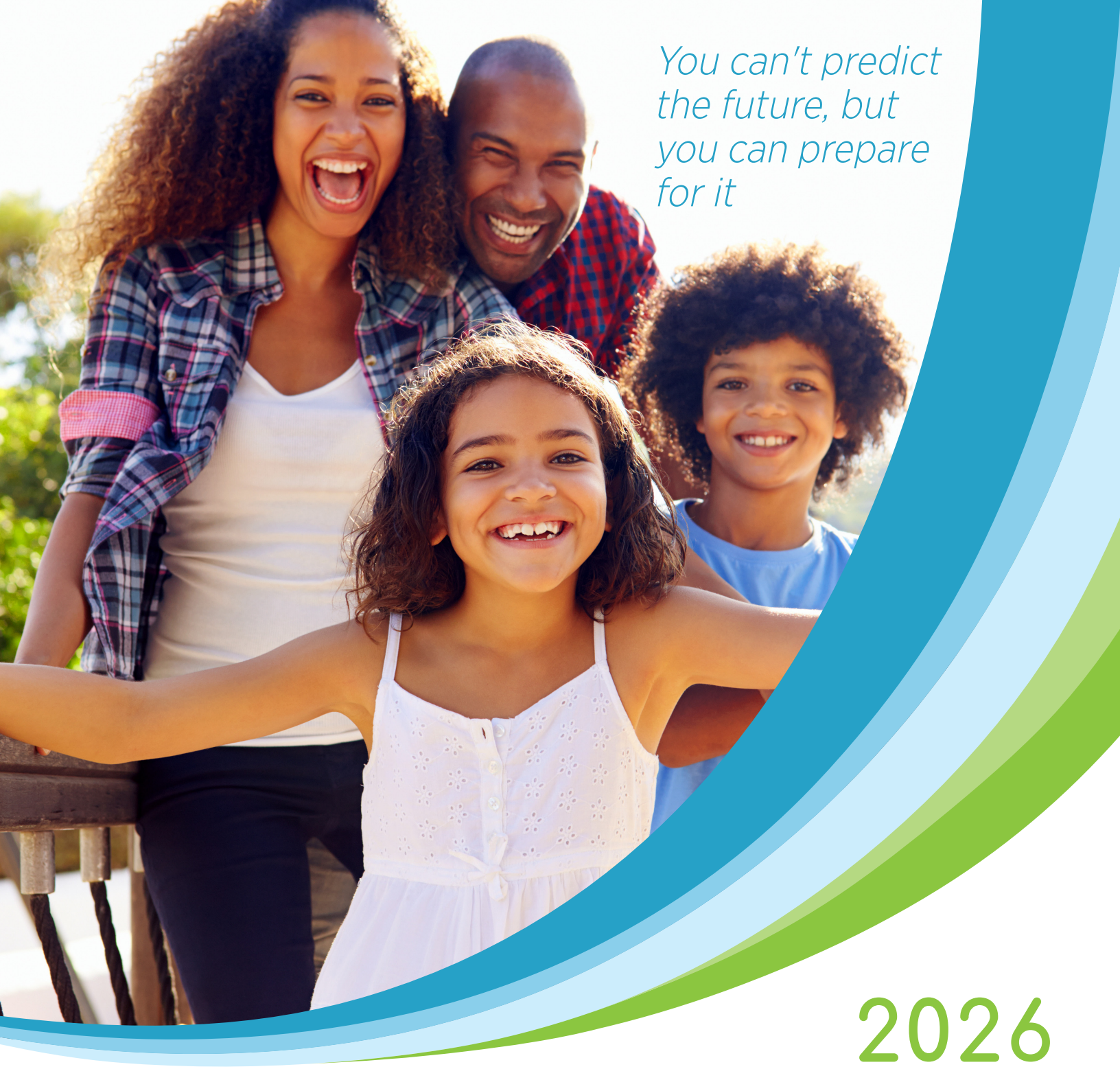

You can't predict the future, but you can prepare for it

2026

Benefit Guide

Note: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 10 in the Important Notices packet for more information.

Eligibility

If you are hired as a full-time employee or permanent part-time working 20 hours or more per week, your benefits will begin the first of the month following your employment date.

Benefits

- Medical, Prescription Drug, & Vision
- Dental
- Basic Life & Accidental Death & Dismemberment
- Optional Life
- Short-Term Disability
- Long-Term Disability
- Flexible Spending Accounts
- Virginia Retirement System and Deferred Compensation

*Some benefits are not available to part-time employees.

Dependent Eligibility

You can enroll your dependents on your plans. Eligible dependents include: a covered Employee's Spouse; a covered Employee's Child; a covered Employee's Qualified Dependent under a Qualified Medical Child Support Order; a covered Employee's Child; or Qualified Dependent who is totally disabled. A Child will be eligible for coverage under the Plan until the end of the month in which he or she turns age 26. Certain children have mental or physical challenges that prevent them from living independently. The dependent age does not apply to these enrolled children as long as these challenges were present before they reached age 26. Biological children, stepchildren, and adopted children will be eligible for coverage until age 26 without regard to student status, marital status, financial dependency or residency status with the Employee or any other person, except that stepchildren may only be eligible for coverage under the Plan as long as a natural parent remains married to the Employee. Foster children and other children for whom a court has ordered the employee (and/or the employee's legal spouse) to assume sole permanent custody may be covered until the end of the month in which they turn 26 provided their principal place of residence is with the employee; they are a member of the employee's household; they receive over one-half of their support from the employee; and custody (or placement in the case of foster children) was awarded (or made) prior to the child's 18th birthday.

Making Changes During the Year

Choose your benefits carefully. Medical, dental and flexible spending account contributions are made on a pre-tax basis and IRS regulations state that you cannot change your pre-tax benefit options during the year unless you have a qualified life event. Qualified life events include:

- Marriage or divorce;
- Death of your spouse or dependent;
- Birth or adoption of a child;
- Your spouse terminating or obtaining new employment (that affects eligibility for coverage);
- You or your spouse switching employment status from full-time to part-time or vice versa (that affects eligibility for coverage);
- Significant cost or coverage changes; or
- Your dependent no longer qualifies as an eligible dependent.

You must notify and submit any applicable forms and/or documentation to the Benefits Administrator within 60 days of the event. The Benefits Administrator will review your request and determine whether the change you are requesting is allowed. Only benefit changes which are consistent with the qualified life event are permitted.

Medical Benefits

Henrico seeks to provide the best possible medical benefits at a reasonable cost. Employees are provided with three medical plan options that include prescription drug coverage.

Please refer to the chart on the next page for a comparison of medical plan benefits.

In-Network Advantage

Within the medical and dental plans, you have the freedom to use any provider. However, when you use an in-network provider, the percentage you pay out-of-pocket will be based on a negotiated fee, which is usually lower than the actual charges. If you use a provider who is outside of the network, you may be responsible for paying for the difference between the Usual, Customary, and Reasonable (UCR) charges and what the provider charges. You also may need to submit claim forms.

Anthem's Total Health Connections

Total Health Connections

With a dedicated advocate in your corner, health care is easier at every step. Total Health Connections is about making sure you and your family experience health care in a way that helps you feel confident, covered, and protected.

With Total Health Connections, you have your own personal health champion, called a family advocate. Your dedicated family advocate is here to help you and your family through unexpected emergencies and everyday health needs. They stay one step ahead, helping you get the care and support you need today and down the road — at no extra cost to you.

Your family advocate is here to connect you with the right care at the right time with proactive, inclusive, and compassionate support. They can help you:

- Find top-quality doctors, specialists, and care facilities in your health plan and help schedule appointments.
- Stay on top of preventive care and manage chronic conditions.
- Understand your health plan and all the benefits available to you from your employer.
- Quickly get pre-approvals for urgent medical needs, like surgery.
- Connect with our in-house clinical experts.

These experts work with you and your doctor to create a personal care plan that supports your overall wellness and ongoing health needs.

Everything you need, right on the app.

The Sydney℠ Health mobile app gives you a quick way to: chat with an advocate, check costs and view your health plan details, find additional benefits available through your employer, use your digital ID card, find local doctors in your plan, find cost and quality information for doctors, facilities, and common procedures, track your health goals and activity, and access virtual care through video visit or text chat.

Medical Benefits

The information below is a summary of medical coverage only. Please contact HR Benefits at (804) 501-7371 or HR-Benefits@henrico.gov (for General Government employees) or (804) 652-3624 hcpsbenefits@henrico.k12.va.us (for HCPS employees) for plan summaries detailing coverage information, limitations, and exclusions.

Any deductibles and copays shown in the chart below are amounts for which **you** are responsible.

Did You Know?

Nearly half of adults (48%) with medical debt are paying off $2,000 or more.

Commonwealth Fund, 2024 Biennial Health Insurance Survey, 2024

BENEFIT	ANTHEM STANDARD POS		ANTHEM PREMIER POS		ANTHEM HDHP WITH HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual/Calendar Year Deductible (Individual/Family)	Medical: $500/$750 Pharmacy: $150/$150	Medical: $750/$1,125 Pharmacy: $150/$150	Medical: $400/$600 Pharmacy: $150/$150	Medical: $600/$900 Pharmacy: $150/$150	$3,300/$6,600	In-network and out-of-network providers combined
Out-of-Pocket Maximum (Individual/Family)	Medical/Pharmacy Combined: $3,000/$6,000	$3,000/$6,000	Medical/ Pharmacy Combined: $2,500/$5,000	$2,500/$5,000	Medical/Pharmacy Combined: $4,000/$8,000	$6,000/$12,000
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Coinsurance	0%	30%	0%	30%	0%	30%
Physician Services						
Vera Whole Health Primary Care	No charge		No charge		0% after deductible	
Doctor's Office Visit	$25	30% after ded + additional costs	$20	30% after ded + additional costs	0% after deductible	30% after deductible
Specialist Office Visit	$45	30% after ded + additional costs	$40	30% after ded + additional costs	0% after deductible	30% after deductible
Preventive Care	$0	30% after ded + additional costs	$0	30% after ded + additional costs	No charge	30% after deductible
Lab & X-ray Services	$0	30% after deductible	$0	30% after deductible	0% after deductible	30% after deductible
Hospital Services						
Inpatient	30% after deductible	30% after deductible	5% after deductible	30% after deductible	0% after deductible	30% after deductible
Outpatient	30% after deductible	30% after deductible	5% after deductible	30% after deductible	0% after deductible	30% after deductible
Emergency Care	$250 (waived if admitted)		$250 (waived if admitted)		Subject to deductible. Once deductible is met, covered at 100%	
Pregnancy & Maternity Care (Prenatal)	$50/pregnancy	30% after deductible	$50/pregnancy	30% after deductible	0% after deductible	30% after deductible
PRESCRIPTION DRUGS						
Retail (30-day Supply)						
Generic	$10	$10	$10	$10	$10	$10
Preferred Brand	$30	$30	$30	$30	$30	$30
Non-preferred Brand	$55	$55	$55	$55	$55	$55
Mail Order (90-day Supply)						
Generic	$10	$10	$10	$10	$10	N/A
Preferred Brand	$60	$60	$60	$60	$60	N/A
Non-preferred Brand	$165	$165	$165	$165	$165	N/A
BI-WEEKLY AND SEMI-MONTHLY PAYCHECK DEDUCTIONS						
Employee Only	$41.00		$59.82		$22.42	
Employee + Child	$123.66		$187.90		$74.53	
Employee + Spouse	$163.25		$238.48		$101.85	
Employee + Child(ren)	$198.58		$289.22		$114.50	
Family	$298.03		$414.91		$182.85	

NOTE: Deductibles, copays, and coinsurance accumulate toward the out-of-pocket maximums. Usual, Customary, and Reasonable charges apply for all out-of-network benefits. For all other applicable pay cycles, please see henricoschools.us or henrico.gov.

NOTE: Your medical plan options must offer certain preventive care benefits to you in-network without cost sharing and these preventive care benefits generally are updated annually. Under the Affordable Care Act, the medical plans generally may use reasonable medical management techniques to determine frequency, method, treatment or setting for a recommended preventive care service. You may obtain a list of preventive care services by contacting Anthem.

Health Savings Account (HSA)

Save for future medical costs and reduce your tax bill with this special savings account available to high-deductible health plan (HDHP) participants.

Out-of-pocket medical expenses can add up quickly. Over time, health care likely will be your largest household expense. A health savings account (HSA) allows you to build up protection for future health care expenses.

Along with Henrico's contributions, you can contribute money to your HSA and use it any time for qualified health care expenses. Whatever you don't use rolls over for future years and in some circumstances may be invested. Better yet, HSAs provide tax advantages.

HSAs Deliver Triple Tax Savings

1. You don't pay federal income tax on the money you contribute.
2. You don't pay taxes on the interest you earn in your account.
3. You don't pay taxes when you use the money to pay for qualified medical services.

Keys to Growing Your Health Savings Account (HSA):

- Try not to use your HSA for routine expenses. If you can pay out-of-pocket, leave your HSA funds alone because they may grow for when you need them in the future.
- Consider electing supplemental medical benefits to cover big ticket expenses from unexpected serious illnesses or injuries and to ensure they don't wipe away the money in your HSA.
- Monitor your fund's growth. Like a 401(k), your HSA funds may in some circumstances be invested. Make sure your money is growing at an acceptable and safe pace.

HOW MUCH CAN YOU CONTRIBUTE?	ANNUAL IRS CONTRIBUTION LIMIT	ANNUAL HENRICO CONTRIBUTION	YOUR MAXIMUM CONTRIBUTION AMOUNT
Individual Coverage	$4,400*	$1,500	$2,900
Family Coverage	$8,750*	$3,000	$5,750

NOTE: If an individual reaches age 55 by the end of the calendar year, they can contribute an additional $1,000.

NOTE: Amounts change yearly per IRS guidelines.

Dental

Dental coverage is key to your overall health. Henrico offers employees three dental plan options through **Delta Dental**. Review the details about each plan carefully so you can determine which plan meets your needs. Your dental plans offer choices that cover four main types of expenses:

- Preventive and diagnostic services like routine exams and cleanings, fluoride treatments, sealants, and X-rays
- Basic services such as simple fillings and extractions, root canals, oral surgery, and gum disease treatment
- Major services such as crowns and dentures
- Orthodontia

Benefits & Cost of Coverage

BENEFIT	PPO PLUS PREMIER - HIGH OPTION			PPO PLUS PREMIER - LOW OPTION			EPO
	PPO	Premier	OON	PPO	Premier	OON	PPO
Diagnostic/Preventive (Does Not Count Towards Maximum)	100% Not subject to deductible	100% Not subject to deductible	80% Not subject to deductible	75% Not subject to deductible	75% Not subject to deductible	75% Not subject to deductible	Fixed Copay
Basic Services	80% Subject to deductible	50% Subject to deductible	50% Subject to deductible	50% Subject to deductible	50% Subject to deductible	50% Subject to deductible	Fixed Copay
Major Services	50% Subject to deductible	50% Subject to deductible	50% Subject to deductible	50% Subject to deductible	50% Subject to deductible	50% Subject to deductible	Fixed Copay
Orthodontia (Adult and Child)	50% Subject to deductible	50% Subject to deductible	50% Subject to deductible	Not Covered	Not Covered	Not Covered	50%
Annual Deductible (Individual/Family)	$50/$150	$50/$150	$50/$150	$50/$150	$50/$150	$50/$150	None
Maximum							
Calendar Year	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$3,000
Lifetime Ortho	$1,500	$1,500	$1,500	Not Covered	Not Covered	Not Covered	$2,000
SEMI-MONTHLY / BIWEEKLY PAYCHECK DEDUCTIONS							
Employee Only	$20.79			$13.94			$12.29
Employee + Child	$37.61			$25.20			$20.46
Employee + Spouse	$37.61			$25.20			$20.46
Family	$59.05			$39.52			$27.61

NOTE: For all other applicable pay cycles, please see henricoschools.us or henrico.gov.

Vision

Henrico offers employees a vision plan through Anthem that includes coverage for eye exams and eyeglasses or contact lenses.

Benefits

BENEFIT	ANTHEM BLUE VIEW VISION NETWORK	
	In-Network	Out-of-Network
Exam	$15 copay, then covered in full	$30 allowance
Lenses	35% off retail price	Not Covered
Frames	20% off retail price	Not Covered
Contact Lenses Instead of Glasses		
Conventional/Disposable	15% off retail price	Not Covered
Medically Necessary	N/A	Not Covered

NOTE: ID Card not required for vision services.

Flexible Spending Accounts (FSAs)

Reduce your tax bill while putting aside money for health care and dependent care needs.

Flexible spending accounts (FSAs) allow you to put aside money for important expenses and help you reduce your income taxes at the same time. Henrico offers two types of accounts — a health care FSA and a dependent care FSA.

Deductibles, copays, prescription drugs, medical equipment, etc.

Babysitters, day care, day camp, home nursing care, etc.

How Flexible Spending Accounts (FSAs) Work

1. Each year during the Open Enrollment period, you decide how much to set aside for health care and dependent care expenses.
2. Your contributions are deducted from your paycheck on a before-tax basis in equal installments throughout the calendar year.
3. You can use your FSA debit card to pay for eligible expenses at the point of sale, or you can pay out-of-pocket and submit a claim form for reimbursement.

Please note that these accounts are separate — if eligible, you may choose to participate in one, all, or none. You cannot use money from the health care FSA to cover expenses eligible under the dependent care FSA or vice versa.

PLAN	ANNUAL MAXIMUM CONTRIBUTION	EXAMPLES OF COVERED EXPENSES*
Health Care Flexible Spending Account	$3,300	Copays, deductibles, orthodontia, over-the-counter medications, etc.
Dependent Care Flexible Spending Account	$7,500 ($3,750 if married and filing separate tax returns)	Day care, nursery school, elder care expenses, etc.

NOTE: See IRS Publications 502 and 503 for a complete list of covered expenses.

Health Care Items You Might Not Realize Are FSA Eligible

- Sunscreen
- Heating and cooling pads
- First aid kits
- Shoe inserts and other foot grooming treatments
- Travel pillows
- Motion sickness bands

Use It or Lose It!

Be sure to calculate your FSA contributions carefully. These funds do not roll over from year-to-year, and you must actively enroll on a yearly basis. You are not automatically re-enrolled.

If you have any money left in your account(s) at the end of the plan year:

- **Health Care FSA:** You may carry over up to $660 for use in the next plan year. You have a 90-day run-out period which allows you to file claims for expenses during the previous plan year.
- **Dependent Care FSA:** You have a 90-day run-out period which allows you to file claims for expenses during the previous plan year.

Income Protection Benefits

Short-Term Disability (STD)

Short-Term Disability is available to active employees working at least 20 hours per week. This benefit replaces 60% of your pre-disability earnings. There are three elimination period options: 14-day, 28-day, or 42-day. This elimination period indicates the number of days of accrued leave or leave without pay that you must use before the benefit pays you.

Did You Know?

44% of people 65 or older have a disability.
28% of people 45 to 64 have a disability.
21% of people 18 to 44 have a disability.

Disability Insurance Statistics and Facts, 2024

For Virginia Retirement System Plan 1, Virginia Retirement System Plan 2, and permanent part-time employees, short-term disability is available.

VRS Hybrid Plan members are covered under the Hybrid-Disability Program at no cost once you have been employed for one year.

During the one year waiting period, VRS Hybrid members may enroll in STD with MetLife.

Long-Term Disability (LTD)

VRS Plan 1 and Plan 2: Employees will be covered by MetLife after 6 months of employment, up to $50,000 annually and can elect to purchase additional buy-up coverage. MetLife benefits replace 60% of an employee's covered salary after 90 days of disability.

If your annual salary is above $50,000, you may apply to protect your salary above $50,000. You may elect to cover your salary above $50,000 without answering health questions within 1) 31 days of the date you complete six months of full time service or 2) within 31 days of the date your salary exceeds $50,000, whichever is later.

More information can be found at **https://employees.henrico.gov/benefits/health-benefits/ltip/** (General Government Employees) or **https://www.henricoschools.us/page/employee-benefits** (HCPS employees).

Hybrid Employees: Employees will be covered at full salary (60% payable) after one year of employment.

Benefits Administrator Information

If you have any questions regarding eligibility, benefit plans or enrollment options or would like additional information, contact HR Benefits at **(804) 501-7371** or **HR-Benefits@henrico.gov** (for General Government employees) or **(804) 652-3624** or **hcpsbenefits@henrico.k12.va.us** (for HCPS employees).

Virginia Retirement System

Henrico County participates in the Virginia Retirement System (VRS). VRS administers retirement plans, life insurance plans, and related services for its active members. Eligible members include full-time salaried employees. Employees pay 5% of their creditable compensation each payroll and are vested when they have 5 years of VRS service credit. Your VRS plan is determined based on your eligibility date and position.

Deferred Compensation

In addition to the benefits through VRS, Henrico County offers a supplemental deferred compensation plan for full-time and permanent part-time employees. The plan allows you to save for retirement on through convenient payroll deductions on a tax-deferred or Roth (after-tax) basis.

Deferred Compensation Administrators:

General Government: Empower

HCPS: Corebridge Financial

Life Insurance

Employees are offered two types of life insurance coverage: basic (paid in full by Henrico County) and optional (paid by the employee):

Basic Coverage: All full-time eligible employees participate in a group term life insurance and accidental death and dismemberment insurance program through the Virginia Retirement System. Life insurance coverage is two times, or in the case of accidental death, four times the next highest thousand dollars above annual salary.

Optional Life: Employees covered for basic group life insurance may purchase optional group life insurance coverage in an amount equal to 8x their salary for the employee only. The member's dependent spouse and dependent children are also eligible. Enrollment, beneficiary designation, and additional information is available at **www.varetire.org**.

Henrico Voluntary Benefits

We offer a variety of additional benefits that give you options beyond health care and income protection. Please see the benefits listed below and refer to the Pierce booklet for additional details on the plans and contact information.

Aflac – Group Accident Insurance:

Help protect yourself from the unexpected. Benefits are paid directly to you (unless otherwise assigned), regardless of any other medical insurance, including a wellness benefit.

Aflac – Group Critical Illness:

Options with and without cancer. Pays lump-sum benefits for Heart Attack, Stroke, Type 1 Diabetes, & more.

Aflac – Group Hospital Indemnity:

Help protect yourself from medical bill copays and deductibles. Pays cash benefits directly to you to help cover gaps left by major medical, with no waiting periods.

Aflac – HealthAdvocate:

Health Advocacy, Medical Bill Saver, and Telemedicine value-added benefits are included when enrolled in one of Aflac's valuable group plans.

Aflac – Short-Term Disability:

This program replaces a portion of your income if you're unable to work due to a covered illness or injury—including up to 12 weeks of benefits for childbirth.

Cancer Advocate Plus:

Offers personal and precise cancer management based on your DNA, including screening, treatment, cash benefits and recovery support.

Chubb – Life Insurance with Long-Term Care:

No health questions up to $150,000 Life Insurance with $450,000 Long-Term Care. Receive up to 3x the face value available for Long-Term Care. Premiums do not increase due to age. Paid-up benefits begin to accrue after 10 years. Policy includes a terminal illness benefit. Spouse and children coverage available.

EyeMed – Vision Insurance:

Now offering a frame allowance every 12 months. EyeMed offers a large provider network that covers frames and lenses or contact lenses up to your plan maximum. Discounts on LASIK and hearing aids also available through the plan.

LegalEASE – Legal Plan:

Covers 100% of the attorney fees for fully covered services including Estate Planning and Wills, Traffic Violations, Real Estate and Credit Protection, Family Law and so much more. LegalEASE provides The Legal Corner, a free resource to all employees, regardless of participation in the legal plan.

Norton – ID Theft Protection:

All-in-one protection against threats to your identity, security and privacy. Including million-dollar protection package, identity alerts with credit monitoring, device security, Norton Secure VPN, Parental Control, etc.

Perks At Work – Employee Discount Program:

Free for all employees, offering employee pricing on your favorite brands in over 26 categories to help you save money on your vacation, gyms and childcare, electronics, home appliances, movie tickets, and more.

Rainwalk Pet Insurance:

Rainwalk offers great-value pet insurance that provides robust coverage for accidents and illnesses with limited exclusions. They provide broad, transparent, generous coverage.

Toco Auto Warranty:

Program that is designed to cover unexpected car repairs.

TransAmerica – Cancer Insurance:

Approximately 40.5% of adults will be diagnosed with cancer during their lifetime. This pre-tax policy pays cash benefits after a diagnosis of cancer or one of 45 other specified diseases. Includes an annual cancer screening benefit.

Glossary

Affordable Care Act (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime dollar limits on medical benefits, covering preventive care in-network without cost-sharing if the plan is grandfathered, etc., among other requirements.

Brand Name Drug

The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

Coinsurance

A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

Copayment (Copay)

A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Deductible

The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Employer Contribution

Each year, the company provides you with an amount of money that you can apply toward the cost of your health care premiums. The amount of the employer contribution depends on who you cover. You can see the amount you'll receive when you enroll. If you're enrolling as a new hire, the employer contribution amount will be prorated based on your date of hire.

Generic Drug

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)

High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

Health Savings Account (HSA)

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

Out-of-Pocket Maximum

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Plan Year

The year for which the benefits you choose during enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next enrollment period.

Preventive Care

Health care services you receive when you are not sick or injured—so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the Advisory Committee on Immunization Practices (ACIP).

Important Notices

Reminder of Availability of Privacy Notice

This is to remind plan participants and beneficiaries of the Henrico Health and Welfare Plan (the "Plan") that the Plan has issued a Health Plan Privacy Notice that describes how the Plan uses and discloses protected health information (PHI). You can obtain a copy of the Henrico Health and Welfare Plan Privacy Notice upon your written request to the Human Resources Department, at the following address:

Henrico, Human Resources
4301 E. Parham Road
Henrico, VA 23273-0775

HCPS Benefits
3820 Nine Mile Road
Henrico, VA 23223

If you have any questions, please contact the Henrico Human Resources Office at **(804) 501-7371** (Government) or **(804) 652-3624** (Schools).

Women's Health and Cancer Rights Act

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 including coverage for nipple and areola reconstruction (including re-pigmentation) to restore physical appearance of the breast, and chest wall reconstruction with aesthetic flat closure;
- 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 **(804) 501-7371**.

Newborns' and Mothers' Health Protection 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted, and you will continue to pay the same amount as if you were not absent.

If the absence is for more than 31 days and not more than 24 months, you may continue to maintain your coverage under the Plan by paying up to 102% of the full amount of premiums. You and your dependents may also have the opportunity to elect COBRA coverage. Contact your HR Benefit for more information.

Also, if you elect not to continue your health plan coverage during your military service, you have the right to be reinstated in the Plan upon your return to work, generally without any waiting periods or pre-existing condition exclusions, except for service-connected illnesses or injuries, as applicable.

Important Notice from Henrico About Your Prescription Drug Coverage and Medicare

Medicare Part D Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Henrico 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. Henrico has determined that the prescription drug coverage offered by the Anthem Medical Plan Medical Plan 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 (or are losing) 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 Henrico coverage will not be affected.

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

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Henrico 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 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage:

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Henrico 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 for personalized help. See the inside back cover of your copy of the "Medicare & You" handbook for their telephone number.
- Call **(800) MEDICARE** (**(800) 633-4227**). TTY users should call **(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.ssa.gov**, or
- Call **(800) 772-1213**. TTY users should call **(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).

Date: November 1, 2025
Name of Entity/Sender: Henrico
Contact: HR Benefits
Address: 4301 E. Parham Road
Henrico, VA 23273-0775
Contact: HCPS Benefits
Address: 3820 Nine Mile Road
Henrico, VA 23223
Phone Number: **(804) 501-7371** (Government)
(804) 652-3624 (Schools)

General Notice of Continuation Coverage Rights Under COBRA

Introduction

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

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

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

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;

- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

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

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

How Is COBRA Continuation Coverage Provided?

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

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

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

Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration's disability determination; the date of the covered employee's termination of employment or reduction in hours; and the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction in hours. You must also provide this notice within 18 months after the covered employee's termination or reduction in hours in order to be entitled to this extension. **Second Qualifying Event Extension of 18-Month Period of Continuation Coverage**

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

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

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

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

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

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

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

NOTE: https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

If You Have Questions

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

Plan Contact Information

For further information regarding the plan and COBRA continuation, please contact:

Henrico Benefits Supervisor
4301 E. Parham Road
Henrico, VA 23273-0775
HCPS Benefits
3820 Nine Mile Road
Henrico, VA 23223
(804) 501-7371 (Government)
(804) 652-3624 (Schools)

Summaries of Benefits and Coverage (SBCs)

Availability Notice

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

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

1. ALABAMA – Medicaid
   Website: http://myalhipp.com/
   Phone: 1-855-692-5447
2. ALASKA – Medicaid
   The AK Health Insurance Premium Payment Program
   Website: http://myakhipp.com/
   Phone: 1-866-251-4861
   Email: CustomerService@MyAKHIPP.com
   Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
3. ARKANSAS – Medicaid
   Website: http://myarhipp.com/
   Phone: 1-855-MyARHIPP (855-692-7447)
4. CALIFORNIA – Medicaid
   Health Insurance Premium Payment (HIPP) Program
   Website: http://dhcs.ca.gov/hipp
   Phone: 916-445-8322
   Fax: 916-440-5676
   Email: hipp@dhcs.ca.gov
5. COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
   Health First Colorado Website:
   https://www.healthfirstcolorado.com/
   Health First Colorado Member Contact Center:
   1-800-221-3943/State Relay 711
   CHP+: https://hcpf.colorado.gov/child-health-plan-plus
   CHP+ Customer Service: 1-800-359-1991/State Relay 711
   Health Insurance Buy-In Program (HIBI):
   https://www.mycohibi.com/
   HIBI Customer Service: 1-855-692-6442
6. FLORIDA – Medicaid
   Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
   Phone: 1-877-357-3268
7. GEORGIA – Medicaid
   GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
   Phone: 678-564-1162, Press 1
   GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
   Phone: 678-564-1162, Press 2
8. INDIANA – Medicaid
   Health Insurance Premium Payment Program
   All other Medicaid
   Website: https://www.in.gov/medicaid/
   http://www.in.gov/fssa/dfr/
   Family and Social Services Administration Phone: 1-800-403-0864
   Member Services Phone: 1-800-457-4584
9. IOWA – Medicaid and CHIP (Hawki)
   Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
   Medicaid Phone: 1-800-338-8366
   Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
   Hawki Phone: 1-800-257-8563
   HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
   HIPP Phone: 1-888-346-9562
10. KANSAS – Medicaid
    Website: https://www.kancare.ks.gov/
    Phone: 1-800-792-4884
    HIPP Phone: 1-800-967-4660
11. 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://kynect.ky.gov
    Phone: 1-877-524-4718
    Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
12. 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)
13. MAINE – Medicaid
    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
14. MASSACHUSETTS – Medicaid and CHIP
    Website: https://www.mass.gov/masshealth/pa
    Phone: 1-800-862-4840
    TTY: 711
    Email: masspremassistance@accenture.com
15. MINNESOTA – Medicaid
    Website: https://mn.gov/dhs/health-care-coverage/
    Phone: 1-800-657-3672
16. MISSOURI – Medicaid
    Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
    Phone: 573-751-2005
17. MONTANA – Medicaid
    Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
    Phone: 1-800-694-3084
    Email: HHSHIPPProgram@mt.gov
18. NEBRASKA – Medicaid
    Website: http://www.ACCESSNebraska.ne.gov
    Phone: 1-855-632-7633
    Lincoln: 402-473-7000
    Omaha: 402-595-1178
19. NEVADA – Medicaid
    Medicaid Website: http://dhcfp.nv.gov
    Medicaid Phone: 1-800-992-0900
20. NEW HAMPSHIRE – Medicaid
    Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
    Phone: 603-271-5218
    Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
    Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
21. NEW JERSEY – Medicaid and CHIP
    Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
    Phone: 1-800-356-1561
    CHIP Premium Assistance Phone: 609-631-2392
    CHIP Website: http://www.njfamilycare.org/index.html
    CHIP Phone: 1-800-701-0710 (TTY: 711)
22. NEW YORK – Medicaid
    Website: https://www.health.ny.gov/health_care/medicaid/
    Phone: 1-800-541-2831
23. NORTH CAROLINA – Medicaid
    Website: https://medicaid.ncdhhs.gov/
    Phone: 919-855-4100
24. NORTH DAKOTA – Medicaid
    Website: https://www.hhs.nd.gov/healthcare
    Phone: 1-844-854-4825
25. OKLAHOMA – Medicaid and CHIP
    Website: http://www.insureoklahoma.org
    Phone: 1-888-365-3742
26. OREGON – Medicaid
    Website: http://healthcare.oregon.gov/Pages/index.aspx
    Phone: 1-800-699-9075
27. PENNSYLVANIA – Medicaid and CHIP
    Website: https://www.pa.gov/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
    Phone: 1-800-692-7462
    CHIP Website: https://www.pa.gov/agencies/dhs/resources/chip.html
    CHIP Phone: 1-800-986-KIDS (5437)
28. RHODE ISLAND – Medicaid and CHIP
    Website: http://www.eohhs.ri.gov/
    Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
29. SOUTH CAROLINA – Medicaid
    Website: https://www.scdhhs.gov
    Phone: 1-888-549-0820
30. SOUTH DAKOTA – Medicaid
    Website: http://dss.sd.gov
    Phone: 1-888-828-0059
31. TEXAS – Medicaid
    Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
    Phone: 1-800-440-0493
32. UTAH – Medicaid and CHIP
    Utah's Premium Partnership for Health Insurance (UPP)
    Website: https://medicaid.utah.gov/upp/
    Email: upp@utah.gov
    Phone: 1-888-222-2542
    Adult Expansion Website: https://medicaid.utah.gov/expansion/
    Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
    CHIP Website: https://chip.utah.gov/
33. VERMONT – Medicaid
    Website: https://dvha.vermont.gov/members/medicaid/hipp-program
    Phone: 1-800-250-8427
34. VIRGINIA – Medicaid and CHIP
    Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
    https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
    Medicaid/CHIP Phone: 1-800-432-5924
35. WASHINGTON – Medicaid
    Website: https://www.hca.wa.gov/
    Phone: 1-800-562-3022
36. WEST VIRGINIA – Medicaid and CHIP
    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)
37. WISCONSIN – Medicaid and CHIP
    Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
    Phone: 1-800-362-3002
38. WYOMING – Medicaid
    Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
    Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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