





Louisa County & Louisa County Public Schools 2026-2027 Employee Benefits Guide

INNOVATIVE INSURANCE GROUP

CONTENTS

Welcome 3
Pre-Tax & Post-Tax Deductions 4
Qualifications & Important Facts 5
Open Enrollment 6
Employee Navigator Enrollment Instructions 7
Medical Plan Comparison 8
Medical Plan Rates 9
Voluntary Dental Rates 13
Virtual Care & EAP 14
Anthem Plan Access 15
Dental 16
Physical Form 19
Health Savings Account (HSA) 20
Flexible Spending Account (FSA) 21
Limited Purpose FSA 23
Dependent Care FSA 24
Long Term Disability 26
Colonial Life Benefits 28
Trustmark Universal Life 29
Contacts 31
Additional Benefits 32
Required Notices 33

2026 - 2027 Open Enrollment

It's time to enroll in your benefits!

Innovative Insurance Group, will be on-site and available for Virtual Enrollments throughout your Open Enrollment period, May 1st - May 15th.

The IIG Team and a team of benefits professionals will be available to educate you on all benefit options, review prior elections to make sure you are adequately covered for the coming plan year and ensure your 2026-2027 choices fit your lifestyle and budget.

This year Louisa County and Public Schools will continue to offer the following benefits to all full-time employees:

- Medical, Dental and Vision – The Local Choice Program
- Stand Alone Dental – Delta Dental
- Flexible Spending Account, Dependent Care Account, and Health Savings Accounts - Ameriflex
- Accident insurance – Colonial Life
- Cancer insurance – Colonial Life
- Critical illness insurance - Colonial Life
- Disability insurance - Colonial Life
- Hospital indemnity insurance - Colonial Life
- Term life insurance - Colonial Life
- Universal Life -Trustmark

WHAT DO YOU NEED TO ENROLL?

We know it's a busy time of year, but taking the time to meet with a benefits professional is very important. Open Enrollment is the one time a year all staff can confirm, change, add or cancel coverage(s). **Visit Your Benefits Website for to See What's New This Year, Open Enrollment Details, Virtual Enrollment Assistance, and Benefit Information At-A-Glance. www.louisacountybenefits.com**

- Because understanding your benefits it's so valuable, we have scheduled teams of benefits counselors to • conveniently be on-site for you. They will also be available virtually if you are unable to meet while they are at your location.

- Virtual Enrollment links will be sent for you to meet with a benefits counselor during your Open Enrollment. Or you can call the Enrollment Call Center.

- Enrollment Call Center: 888-650-3003

When it's time to enroll, you'll need the following information:

- The names, Social Security numbers, dates of birth and addresses of any/all dependents you may wish to enroll in one or more of the plans
- Life insurance beneficiary information
- Proof of dependent status (marriage certificate, birth certificate, court order) if adding a new dependent to medical or dental insurance plans

Core benefit list, product details and/or hyperlinks are provided by a third party and are being offered for informational purposes only and as a service to our customers. Colonial Life in no way controls, guarantees, endorses, sponsors, or promotes these products or their intellectual property, and is not responsible for the accuracy of the information.

PRE-TAX & POST-TAX BENEFITS

LOUISA COUNTY GOVERNMENT AND SCHOOLS

PRE-TAX BENEFITS

Health Insurance
The Local Choice - Anthem

Dental Insurance
The Local Choice - Delta Dental of VA

Vision Insurance
The Local Choice -Blue View Vision

Health Savings Accounts
Ameriflex

- Individual Maximum $4,400/year
- Family Maximum $8,750/year

HSA plans can only be established in conjunction with a qualified High- Deductible Health Plan (HDHP)

Louisa County Government & Schools contribute $22.92 per pay period ($550 annually) to employees enrolled in a Qualifying High-Deductible Health Plan (HDHP)

Flexible Spending Accounts
Ameriflex

- Medical Reimbursement FSA Maximum: $3,400/year | Minimum: $100/year
- Limited Purpose FSA* Maximum: $3,400/year | Minimum: $100/year
- Dependent Care Reimbursement FSA Maximum: $7,500/year (If married filing separately - $3,750/year) | Minimum: $100/year

**Limited Purpose FSA funds can only be used for qualifying vision,*

***** NOTE: FSA RE-ENROLLMENT REQUIRED ** If you do not enroll for 2026-2027 benefits, your contribution will stop effective June 30TH, 2026.***

Dental Insurance
DeltaDentalof VA
(Stand Alone Policy)

Cancer Benefits
Colonial Life

Accident Benefits
Colonial Life

Medical Bridge / Hospital Indemnity Benefits
Colonial Life

POST-TAX BENEFITS

Short-term Disability Benefits
Colonial Life

Long-Term Disability Benefits The Standard

Critical Illness
Colonial Life

Term Life Insurance
Colonial Life

Universal Life Insurance
Trustmark

THINGS YOU NEED TO KNOW

QUALIFICATIONS

- Government Employees working 40 hours or more per week are eligible for all benefits.
- All Full-time School Employees are eligible for all benefits.
- All employees are eligible for the Colonial Life options, including Short-Term Disability (Educator Plan).
- Eligible dependents include legal spouse and children (biological, adopted, step, and/or foster). It is your responsibility to notify your employer within 30 days of any changes to dependent eligibility (birth, marriage, divorce, etc.)

IMPORTANT FACTS

- The plan year for The Local Choice benefits (Anthem Health, Delta Dental & Blue View Vision), Health Savings Accounts, Spending Accounts, Delta Dental (Stand-Alone policy), Colonial Insurance products, Trustmark Universal Life, and The Standard Long-Term Disability lasts from **July 1, 2026 through June 30, 2027.**
- Deductions for The Local Choice benefits (Anthem Health, Delta Dental & Blue View Vision) and Delta Dental (Stand-Alone policy) will begin June 2026. Deductions for Health Savings Accounts, Spending Accounts, Colonial Insurance products, and Trustmark Universal Life will begin July 2026.
- Health FSA Rollover Provision: Your employer provides the rollover option for your FSA plan. Please see the Flexible Spending Account section of your benefit booklet for more information on this provision. *Participants must re-elect coverage for any of the rollover funds (up to $680) to be rolled over into the new plan year. Failure to elect an FSA account will result in a "Use It or Lose It" scenario.*
- If signing up for any coverage on your spouse and/or children, please have their dates of birth and social security numbers available when speaking with the Benefits Representative.
- If you will be receiving a new debit card, whether you are a new participant or to replace your expired card, please be aware that it may take up to 30 days following your plan effective date for your card to arrive. Your card will be delivered by mail in a plain white envelope. During this time you may use manual claim forms for eligible expenses. Please note that your debit card is good through the expiration date printed on the card.
- Elections made during this enrollment period **CANNOT BE CHANGED AFTER THE ENROLLMENT PERIOD** unless there is a family status change as defined by the Internal Revenue Code. Examples of a family status change are: marriage, divorce, death of a spouse or child, birth or adoption of a child, termination or commencement of a spouse's employment, or the transition of spouse's employment from full-time to part-time, or vice-versa. Once a family status change has occurred, an employee has 30 days to notify **Innovative Insurance Group(888.676.9496), Human Resources or Payroll** to request a change in elections.
- Flexible Spending Account expenses must be incurred during the Plan Year in order to be eligible for reimbursement.
- An employee has 90 days after the plan year ends to submit claims for spending account expenses that were incurred during the plan year. Please note that if employment terminates during the plan year, that employee's plan year ends the day employment ends. The employee has 90 days after the termination date to submit claims.
- With Dependent Care Flexible Spending Accounts, the maximum reimbursement you can request is equal to the current account balance in your Dependent Care account. You cannot be reimbursed more than has actually been deducted from your pay.
- As a married couple, one spouse cannot be enrolled in a Medical Reimbursement FSA at the same time the other opens or contributes to an HSA.
- Some policies may include a pre-existing condition clause. Please read your policy carefully for full details.
- An employee taking a leave of absence, other than under the Family & Medical Leave Act, may not be eligible to re-enter the Flexible Benefits Program until the next plan year. Please contact your Benefit Administrator for more information.

EMPLOYEE BENEFITS GUIDE

LOUISA COUNTY GOVERNMENT AND SCHOOLS



IN PERSON

During your open enrollment periods, a benefits counselor will be available in person to answer any questions you may have an assistance in the enrollment process. Please see the Open Enrollment schedule for location dates and times.



VIRTUAL

During open enrollment you will have access to virtual enrollment sessions with benefits counselors, no appointments necessary. Call the Enrollment Center during your open enrollment period, 7am - 5pm for benefit questions or enrollment assistance. 888-650-3003

ENROLLMENT PERIOD: MAY 1ST - MAY 15TH

You can make the following benefit elections online during the enrollment period.

- Enroll in, change or cancel TLC plans. (Medical, Dental, Vision)
- Enroll in, change or cancel Health Savings Account (HSA)
- Enroll in, change or cancel Dental Insurance.(Delta Stand-Alone Policy)
- enroll/RE-Enroll in Flexible Spending Accounts (Medical Reimbursement, Limited Purpose and Dependent Care)
- Enroll in, change or cancel Universal Life Insurance
- Enroll in, change or cancel Colonial Life coverage

You will need to re-enroll in the Flexible Spending Accounts and Health Savings Accounts if you want them to continue each year.

THE FOLLOWING BENEFIT ELECTIONS MUST BE MADE BY PAPER APPLICATION, ENROLLMENT IS NOT AVAILABLE ONLINE.

Trustmark changes and cancellations will be completed on paper applications. If you would ike to make any change to your current election, please be sure to complete the Trustmark application and return it to:

- Louisa County Government - Christy Talley, Human Resources
- Louisa County Public Schools - Shanice Goode, Benefits Specialist

**Trustmark - if you do not take action, your current level of coverage will remain in effect. If you have previously waived coverage, and wish to continue in that status, you do not need to take action.*

ACCESS YOUR BENEFITS ONLINE WHENEVER, WHEREVER

www.louisacountybenefits.com

Introducing Our New Benefit System

EMPLOYEE NAVIGATOR



Starting May 1st we'll be rolling out our new benefit system for Open Enrollment, Qualifying Events, and all year long benefit access.
Please Note: You must register and create a NEW username & password.

Company Identifier:

Louisa County Employees:
LouisaCounty

Louisa School Employees:
LouisaSchool

Step 1:

- New Users: Click on the Registration Link in the email sent to you from Employee Navigator & Complete Account Registration. Enter the requested information (Company Identifier, First Name, Last Name, SSN & Date of Birth)
- Create your Username, Password and click Register

Step 2:

- Your account has been successfully created. You can now login using your new account by clicking the Continue button.
- For troubleshooting and login assistance please contact IIG Customer Service: 888-676-9496 or email customerservice@thinkinnovative.net



Step 3:

- Click Start to begin Open Enrollment
- If you would like to meet with a benefit counselor virtually you can call the Enrollment Call Center: 888-650-3003 or visit www.louisacountybenefits.com and click on the "SMBO Meeting" link to get started.

Anthem BlueCross BlueShield

The Local Choice

Louisa County Government & Public Schools

2026-2027 Plan Year

	High Deductible Health Plan	Key Advantage 1000	Key Advantage 500
Plan Year Deductible (applies as indicated)	In-Network / Out-of-Network	In-Network / Out-of-Network	In-Network / Out-of-Network
One Person	3,400	$1,000 / $2,000	$500 / $1,000
Family (Two or more people)	6,800	$2,000 / $4,000	$1,000 / $2,000
Plan Year out of Pocket Expense Limit	In-Network / Out-of-Network	In-Network / Out-of-Network	In-Network / Out-of-Network
Individual Out-of-Pocket Maximum	5,000 / 10,000	$5,000 / $9,000	$4,000 / $7,000
Family Out-of-Pocket Maximum	$10,000 / $20,000	$10,000 / $18,000	$8,000 / $14,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Covered Services	**In-Network Benefits Only**		
Doctor's Visits (Outpatient or In-Office)			
Primary care physicians visits - Chiropractic, Spinal Manipulations (30 Visit Limit)	20% Coinsurance, after deductible	$25 Copayment	$25 Copayment
Specialist Visits - Chiropractic, Spinal Manipulations (30 Visit Limit)	20% Coinsurance, after deductible	$40 Copayment	$40 Copayment
Shots -Allergy or Therapeutic Injections -Doctor's Office, ER, or Outpatient Setting	20% Coinsurance, after deductible	20% Coinsurance, after deductible	20% Coinsurance, after deductible
Diagnostic Tests, Labs, and X-Rays Specific conditions/diseases at doctor's office, ER, or Outpatient Setting	20% Coinsurance, after deductible	20% Coinsurance, after deductible	20% Coinsurance, after deductible
Preventive Care Visits	Covered at 100%	Covered at 100%	Covered at 100%
Emergency Room Visits	20% Coinsurance, after deductible	20% Coinsurance, after deductible	20% Coinsurance, after deductible
Hospital & Other Services (Pre-certification may be required)			
Ambulance Services	20% Coinsurance, after deductible	20% Coinsurance, after deductible	20% Coinsurance, after deductible
Inpatient Hospital Services	20% Coinsurance, after deductible	20% Coinsurance, after deductible	20% Coinsurance, after deductible
Outpatient Hospital Services	20% Coinsurance, after deductible	20% Coinsurance, after deductible	20% Coinsurance, after deductible
Outpatient Diagnostic Test, Labs, and X-Rays	20% Coinsurance, after deductible	20% Coinsurance, after deductible	20% Coinsurance, after deductible
Outpatient Therapy Services -Occupational, Speech, Physical, Cardiac, Chemotherapy, Radiation, Infusion, & Respiratory	20% Coinsurance, after deductible	20% Coinsurance, after deductible	20% Coinsurance, after deductible
Diabetic Equipment	20% Coinsurance, after deductible	20% Coinsurance, after deductible	20% Coinsurance, after deductible
Maternity			
Prenatal & Provider Services - PCP	20% Coinsurance, after deductible	$25 Copayment	$25 Copayment
Prenatal & Provider Services - Specialist	20% Coinsurance, after deductible	$40 Copayment	$40 Copayment
Hospital Services for Delivery	20% Coinsurance, after deductible	20% Coinsurance, after deductible	20% Coinsurance, after deductible
Diagnostic Tests, Labs, and X-Rays	20% Coinsurance, after deductible	20% Coinsurance, after deductible	20% Coinsurance, after deductible
Behavioral Health			
Inpatient Treatment/Residental Treatment	20% Coinsurance, after deductible	20% Coinsurance, after deductible	20% Coinsurance, after deductible
Partial Hospitalization (Day) Program	20% Coinsurance, after deductible	20% Coinsurance, after deductible	20% Coinsurance, after deductible
Outpatient Professional Provider Services	20% Coinsurance, after deductible	$25 Copayment	$25 Copayment
Prescription Drug Benefit*	HDHP Deductible Applies	$150 Deductible on Tier 2, Tier 3, and Tier 4 Drugs	
Tier 1	20% Coinsurance, after deductible	$10 Copayment	$10 Copayment
Tier 2	20% Coinsurance, after deductible	$30 Copay, after deductible	$30 Copay, after deductible
Tier 3	20% Coinsurance, after deductible	$45 Copay, after deductible	$45 Copay, after deductible
Tier 4	20% Coinsurance, after deductible	20 % Coinsurance, after deductible	20% Coinsurance, after deductible
Prescription Drug Benefit - Home Delivery Services- Mail Order (90-Day Supply)	20% Coinsurance, after deductible	2x Retail Copay, after deductible	2x Retail Copay, after deductible
Diabetic Supplies	20% Coinsurance, after deductible	20% Coinsurance, after deductible	20% Coinsurance, after deductible

For Illustrative purposes only. Please see your summary of benefits for full benefit description

Louisa County Government and Louisa County Public Schools
Rates Effective July 1, 2026 - June 30, 2027

The Local Choice Medical, Dental, and Vision Program -
KEY ADVANTAGE 500 / 1000 / HDHP 3400 WITH WELLNESS INCENTIVE

KEY ADVANTAGE 500 WITH WELLNESS INCENTIVE with Comprehensive Dental Employee Total Monthly Rate Information				
Coverage Level	Total Premium Amount	Employer Pays	Employee Pays	Semi-Monthly Payroll Deduction
Single	$1074.00	$964.44	$109.56	$54.78
Employee + Spouse	$1,987.00	$1,473.76	$513.24	$256.62
Employee + Child	$1,987.00	$1,650.18	$336.82	$168.41
Employee + Family	$2,899.00	$2,080.22	$818.78	$409.39
Employee and Family when both are employed by Louisa County	$2,899.00	$2,389.46	$509.54	$254.77
with Preventive Dental Employee Total Monthly Rate Information				
Coverage Level	Total Premium Amount	Employer Pays	Employee Pays	Semi-Monthly Payroll Deduction
Single	$1,054.00	$960.44	$93.56	$46.78
Employee + Spouse	$1,950.00	$1,436.76	$513.24	$256.62
Employee + Child	$1,950.00	$1,613.18	$336.82	$168.41
Employee + Family	$2,845.00	$2,026.22	$818.78	$409.39
Employee and Family when both are employed by Louisa County	$2845.00	$2,335.46	$509.54	$254.77

KEY ADVANTAGE 1000 WITH WELLNESS INCENTIVE with Comprehensive Dental Employee Total Monthly Rate Information				
Coverage Level	Total Premium Amount	Employer Pays	Employee Pays	Semi-Monthly Payroll Deduction
Single	$1,025.00	$948.44	$76.56	$38.28
Employee + Spouse	$1,898.00	$1,445.76	$452.24	$226.12
Employee + Child	$1,898.00	$1,622.18	$275.82	$137.91
Employee + Family	$2,768.00	$2,039.22	$728.78	$364.39
Employee and Family when both are employed by Louisa County	$2,768.00	$2,348.46	$419.54	$209.77
Preventive Dental Employee Total Monthly Rate Information				
Coverage Level	Total Premium Amount	Employer Pays	Employee Pays	Semi-Monthly Payroll Deduction
Single	$1,005.00	$944.44	$60.56	$30.28
Employee + Spouse	$1,861.00	$1,408.76	$452.24	$226.12
Employee + Child	$1,861.00	$1,585.18	$275.82	$137.91
Employee + Family	$2,714.00	$1,985.22	$728.78	$364.39
Employee and Family when both are employed by Louisa County	$2,714.00	$2,294.46	$419.54	$209.77

***In FY27, ALL employees must complete a Wellness Exam to receive the lower health rate in FY27.**

****Water Authority Employees Contact HR for Rates**

HDHP 3400/80% WITH WELLNESS INCENTIVE with Comprehensive Dental Employee Total Monthly Rate Information				
Coverage Level	Total Premium Amount	Employer Pays	Employee Pays	Semi-Monthly Payroll Deduction
Single	$873.00	$873.00	$0.00	$0.00
Employee + Spouse	$1,613.00	$1,337.76	$275.24	$137.62
Employee + Child	$1,613.00	$1,514.18	$98.82	$49.41
Employee + Family	$2,355.00	$1,885.22	$469.78	$234.89
Employee and Family when both are employed by Louisa County	$2,355.00	$2,194.46	$160.54	$80.27

with Preventive Dental Employee Total Monthly Rate Information				
Coverage Level	Total Premium Amount	Employer Pays	Employee Pays	Semi-Monthly Payroll Deduction
Single	$853.00	$853.00	$0.00	$0.00
Employee + Spouse	$1,576.00	$1,300.76	$275.24	$137.62
Employee + Child	$1,576.00	$1,477.18	$98.82	$49.41
Employee + Family	$2,301.00	$1,831.22	$469.78	$234.89
Employee and Family when both are employed by Louisa County	$2,301.00	$2,140.46	$160.54	$80.27

***In FY27, ALL employees must complete a Wellness Exam to receive the lower health rate in FY27.**

****Water Authority Contact HR for Rates**

Louisa County Government and Louisa County Public Schools
Rates Effective July 1, 2026 - June 30, 2027

The Local Choice Medical, Dental, and Vision Program - **KEY ADVANTAGE 500 / 1000 / HDHP 3400 WITHOUT WELLNESS INCENTIVE**

KEY ADVANTAGE 500 WITHOUT WELLNESS INCENTIVE with Comprehensive Dental Employee Total Monthly Rate Information				
Coverage Level	Total Premium Amount	Employer Pays	Employee Pays	Semi-Monthly Payroll Deduction
Single	$1,074.00	$931.09	$142.91	$71.45
Employee + Spouse	$1,987.00	$1,390.22	$596.78	$298.39
Employee + Child	$1,987.00	$1,578.99	$408.01	$204.01
Employee + Family	$2,899.00	$1,953.89	$945.11	$472.55
Employee and Family when both are employed by Louisa County	$2,899.00	$2,284.78	$614.22	$307.11

KEY ADVANTAGE 500 WITHOUT WELLNESS INCENTIVE with Preventive Dental Employee Total Monthly Rate Information				
Coverage Level	Total Premium Amount	Employer Pays	Employee Pays	Semi-Monthly Payroll Deduction
Single	$1,054.00	$928.75	$125.25	$62.63
Employee + Spouse	$1,950.00	$1,353.22	$596.78	$298.39
Employee + Child	$1,950.00	$1,541.99	$408.01	$204.01
Employee + Family	$2,845.00	$1,899.89	945.11	$472.55
Employee and Family when both are employed by Louisa County	$2,845.00	$2,230.78	$614.22	$307.11

KEY ADVANTAGE 1000 WITHOUT WELLNESS INCENTIVE with Comprehensive Dental Employee Total Monthly Rate Information				
Coverage Level	Total Premium Amount	Employer Pays	Employee Pays	Semi-Monthly Payroll Deduction
Single	$1,025.00	$918.47	$106.53	$53.26
Employee + Spouse	$1,898.00	$1,368.63	$529.37	$264.69
Employee + Child	$1,898.00	$1,557.40	$340.60	$170.30
Employee + Family	$2,768.00	$1,921.87	$846.13	$423.07
Employee and Family when both are employed by Louisa County	$2,768.00	$2,252.75	$515.25	$257.62

KEY ADVANTAGE 1000 WITHOUT WELLNESS INCENTIVE with Preventive Dental Employee Total Monthly Rate Information				
Coverage Level	Total Premium Amount	Employer Pays	Employee Pays	Semi-Monthly Payroll Deduction
Single	$1,005.00	$916.13	$88.87	$44.44
Employee + Spouse	$1,861.00	$1,331.63	$529.37	$264.69
Employee + Child	$1,861.00	$1,520.40	$340.60	$170.30
Employee + Family	$2,714.00	$1,867.87	$846.13	$423.07
Employee and Family when both are employed by Louisa County	$2,714.00	$2,198.75	$515.25	$257.62

****Water Authority Employees Contact HR for Rates**

HDHP 3400/80% WITHOUT WELLNESS INCENTIVE with Comprehensive Dental Employee Total Monthly Rate Information				
Coverage Level	Total Premium Amount	Employer Pays	Employee Pays	Semi-Monthly Payroll Deduction
Single	$873.00	$852.14	$20.87	$10.43
Employee + Spouse	$1,613.00	$1,279.97	$333.03	$166.51
Employee + Child	$1,613.00	$1,468.74	$144.26	$72.13
Employee + Family	$2,355.00	$1,796.16	$558.84	$279.42
Employee and Family when both are employed by Louisa County	$2,355.00	$2,127.05	$227.95	$113.98
with Preventive Dental Employee Total Monthly Rate Information				
Coverage Level	Total Premium Amount	Employer Pays	Employee Pays	Semi-Monthly Payroll Deduction
Single	$853.00	$832.67	$20.33	$10.17
Employee + Spouse	$1,576.00	$1,242.97	$333.03	$166.51
Employee + Child	$1,576.00	$1,431.74	$144.26	$72.13
Employee + Family	$2,301.00	$1,742.16	$558.84	$279.42
Employee and Family when both are employed by Louisa County	$2,301.00	$2,073.05	$227.95	$113.98

****Water Authority Employees Contact HR for Rates**

Louisa County & Public Schools Rates

Effective July 1, 2026 - June 30, 2027

DELTA DENTAL - STANDALONE DENTAL OPTION

Stand-Alone Delta Dental

Employee Total Monthly Rate Information			
Coverage Level	Total Premium Amount	Employer Pays	Employee Pays
Single	$41.79	$17.05	$24.74
Employee + Spouse	$91.84	$19.72	$72.12
Employee + Child	$95.12	$20.10	$75.02
Employee + Family	$146.70	$21.71	$124.99

****Water Authority Employees Contact HR for Rates**



Virtual Care Options through Sydney Health

Life is busy. When you need care and are short on time, you have many options for quick and convenient virtual care through the Sydney Health app. Use your smartphone to access virtual care solutions for all your physical and behavioral health needs, any hour of any day.

Services include:

- Comprehensive primary care, coordinated by a care team
- Wellness visits
- Preventive care and lab screenings
- 24/7 Urgent or sick care for common medical conditions like the flu, colds, allergies, pink eye, sinus infections, and more
- New prescriptions and refills
- Behavioral Health providers including therapists or psychologists, psychiatrists or EAP counselors
- Care for on-going conditions like diabetes, hypertension, and asthma
- Access to specialty care such as lactation consultants, dermatologists, and allergists

Log in to the Sydney Health app, and access the **Care Center** to view all the options available to you.

Note: Some options require a secondary app. You will be prompted to download the app during the account setup process.

Employee Assistance Program (EAP)

Your EAP gives you, your covered dependents and members of your household **up to four free confidential counseling sessions per issue** each plan year.

Turn to your EAP for information and resources about:

- Legal concerns
- Emotional well-being
- Addiction and recovery
- Work and career
- Childcare and parenting
- Helping aging parents
- Financial issues (including free credit monitoring and identity theft recovery)
- Smoking cessation



Learn all about your EAP services and resources. Call 1-855-223-9277 or visit online at https://www.anthemeap.com/the-local-choice.



Beginning July 1, 2026 ALL employees are eligible for EAP benefits regardless of Medical enrollment.

Quick Access to Your Plan

Anthem.com/tlc

Your dedicated website for health benefits documents, no log in needed

- Download your health benefits summary and member handbook
- Find a doctor and urgent care
- Learn about your Employee Assistance Program (EAP)

Anthem.com

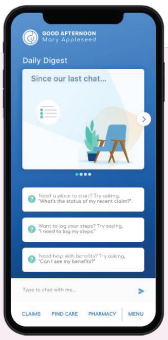
Log in to your confidential and secure account

- View your claims Download
- your ID card Find a doctor
- and urgent care Refill
- prescriptions online
- Compare costs for hundreds of medical procedures

Sydney Health mobile app

Download on the App Store

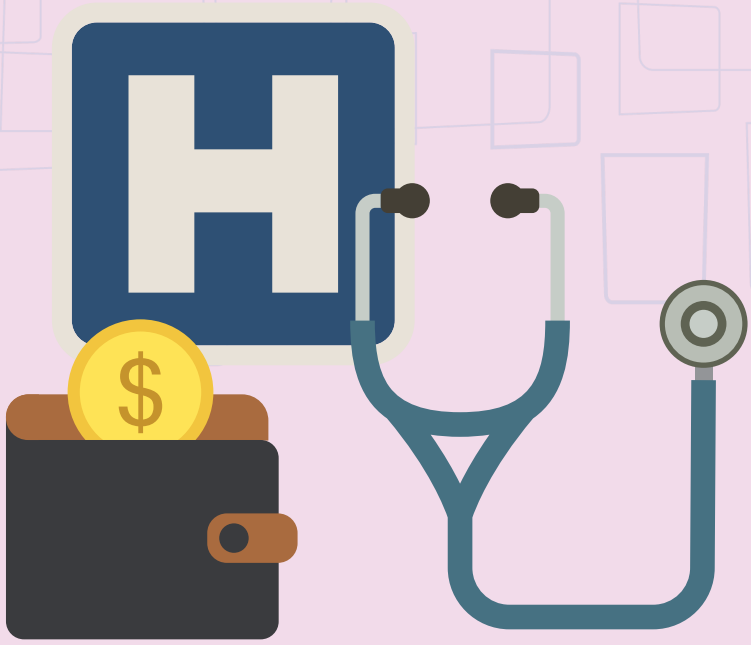
GET IT ON Google Play



Log in usingyour anthem.com usernamepassword and View your ID card **to:**

- See all your medical and pharmacy benefits in one place
- resources quickly Use the chatbot to get answers and
- Connect easily to virtual care
- Track your health goals and fitness

Visit www.thelocalchoice.virginia.gov to view the Summary of Benefits and Coverage for your plan.



DELTA DENTAL®

Delta Dental PPO Plus Premier™

Benefits for LOUISA COUNTY AND SCHOOLS

Group Number: 100541 • Effective Date: July 1, 2026

Annual Deductible *(Applies to basic and major services)*	**$25** per person; **$75** per family, per contract year
Annual Maximum	**$1,250** per person, per contract year

For the services listed below, Delta Dental will pay the stated percentage of the plan allowance based on the dentist's participation with Delta Dental.

Benefits and Limitations	Delta Dental Pays		
	In-Network		Out of Network
	Delta Dental PPO™	Delta Dental Premier®	
Diagnostic and Preventive Services	100%	100%	100%
• **Oral exams and cleanings** — Twice in a 12-month period. Periodontal cleaning is considered a regular cleaning and counts as a regular cleaning under your plan. • **Fluoride applications** — Once in a 12-month period for enrollees under age 19. • **X-rays** — Bitewing X-rays are limited to once in a 12-month period; limited to a maximum of four films or a set (seven to eight films) of vertical bitewings. Full-mouth X-rays are limited to once in a five-year period. • **Sealants** — One per tooth for members under age 16 on first and second permanent molars.			
Basic Services	80%	80%	80%
• **Fillings** — One per surface in a 24-month period. • Endodontic services — Root canal therapy. • Periodontic services — Treatment for gum disease. • **Simple extractions** • Oral surgery — Surgical extractions and other surgical procedures . • **Denture repair and recementation**			
Major Services	50%	50%	50%
• **Crowns** — One per tooth in a 60-month period for members age 12 and older. • **Prosthodontics/dentures and bridges** — Once in a 60-month period for members age 16 and older. • **Implants** — One per site for members age 16 and older.			

*Waiting periods may apply. Benefit waiting periods may be waived for new enrollees if the account is replacing a prior dental plan that covered these services. The enrollee may need to provide proof of prior credible coverage to qualify.

Continued on next page

DELTA DENTAL®

Delta Dental PPO Plus Premier™

Additional benefits included in your plan:

MaxOver™ — Allows a portion of a member's annual maximum to roll over to next year to use for future dental services.

Healthy Smile, Healthy You® — Provides additional cleanings, fluoride and/or sealants for members with certain health conditions. Visit DeltaDentalVA.com to learn more or to download an enrollment form.

Right Start 4 Kids® — Covers children up to age 13 at 100% with no deductible when you visit an in-network dentist. (For services outlined in the plan, up to the annual maximum. Subject to any limitations, exclusions and waiting periods).

Special Health Care Needs Benefit — Provides additional benefits for members with special needs. To learn more about this benefit, visit DeltaDentalVA.com/special-health-care-needs-resources.

Coverage is available for:

• Dependent children, only to the end of the month when they reach age 26 (the "limiting age").

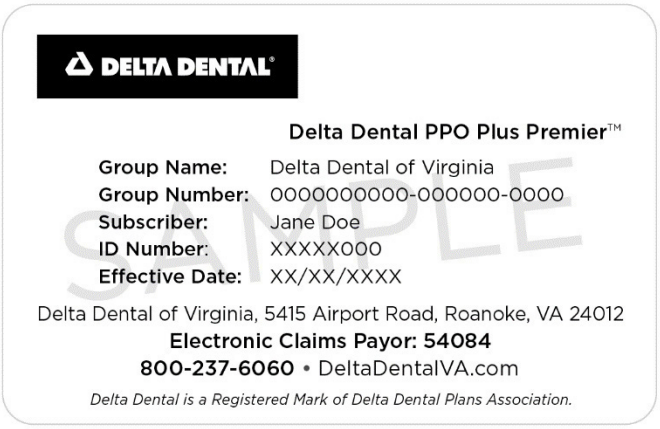
Convenient, eco-friendly options available:

At Delta Dental of Virginia, we are committed to taking actionable measures to minimize our environmental footprint.

Join us as we step toward reducing paper waste and promoting sustainability by signing up to receive your Delta Dental of Virginia explanation of benefits (EOB) digitally at **DeltaDentalVA.com/members**.

Choosing a dentist:

You may select the dentist of your choice. However, to get the most value from your dental benefits, make sure your dentist participates in the network listed at the top of your Delta Dental ID card. With Delta Dental PPO Plus Premier™, you have the option of visiting any dentist. However, your out-of-pocket costs may be lowest if you see a Delta Dental PPO™ network dentist and highest if you choose an out-of-network dentist. Delta Dental network dentists agree to discount their fees, submit claims on your behalf and not bill you for the difference. Visit **DeltaDentalVA.com** to find a participating dentist in your area.



If you visit an out-of-network dentist, Delta Dental will pay its portion of the bill and you are responsible for any coinsurance and deductible (if applicable), as well as the difference between the nonparticipating dentist's charge and Delta Dental's payment. Payment will be made to you, unless state law requires otherwise.

This fact sheet is a brief description of dental services covered under your plan and is not designed to serve as an Evidence of Coverage. If you have questions about specific benefits or limitations under your plan, call Delta Dental's Benefit Services at 800.237.6060 or visit **DeltaDentalVA.com/members** to register for an account.

TLC Dental Plan Comparison

TLC offers two levels of dental coverage to pair with your medical plan - be sure you are choosing the one that meets your needs.

Preventive Dental Option:

***Recommended if you only need cleanings & exams**

- **Provides diagnostic & preventive services only.**

Comprehensive Dental Option:

***Recommended if you anticipate fillings, root canals, orthodontic services.**

- **Provides diagnostic & preventive services**
- **Primary Dental Care**
- **Major Dental Care**
- **Adult & Child Ortho**



See a full list of dental services in the TLC Benefit Guide

LOUISA COUNTY GOVERNMENT &
LOUISA COUNTY PUBLIC SCHOOLS

ANNUAL PHYSICAL CONFIRMATION FORM

TO PARTICIPANT: An annual physical must be completed between March 1, 2026 – February 27, 2027, to receive the wellness premium for the July 2027 health insurance premiums. Please complete the top portion and take this form with you to your physician's office when you have your annual physical. Your physician must complete the bottom section, sign, and date the form and return it to you. To receive credit, you must return the original signed form to Human Resources no later than Friday, February 27, 2027. Please keep a copy of the signed form for your records.

Participant Name:_____Employer:_____

Participant Date of Birth: _____ Participant Phone Number: _____

Today's Date: _____

TO PHYSICIAN: Following the completion of the above please complete the information below, sign, and date this form, and return the original to the patient. Thank you.

Licensed Medical Professional Name (please print): _____

Medical Practice Name:_____Phone Number:_____ _

Address:_____City:_____State:_____

Licensed Medical Professional Signature: _____

Date of Annual Physical:_____

***REMINDER: File your Colonial Life wellness benefit claim each year.**

Health Savings Account

A personal tax-free savings account for healthcare expenses and investing

Use the below information to determine if a Health Savings Account (HSA) is right for you and how to best take advantage of an HSA account.

How It Works

You can enroll in a Health Savings Account (HSA) to experience tax savings on qualified healthcare expenses such as copays, deductibles, prescriptions, over-the-counter drugs and medications, and prescriptions. There is no use-or-lose rule, meaning you can save and invest when you can or spend on eligible healthcare expenses as needed.

To enroll in a HSA, you must already be enrolled in an HSA-qualifying high deductible health plan (HDHP).

As a married couple, one spouse cannot be enrolled in an FSA at the same time the other is contributing to an HSA.

The Value & Perks

- **Triple Tax Savings:** Every dollar you contribute to an HSA lowers your taxable income, funds grow tax-free, and withdrawals for qualified expenses are tax-free.
- **Employee-Owned:** It's a personal savings account owned by you. Which means you can keep it even if you switch health plans, change jobs, or retire. You'll receive an Ameriflex Debit Mastercard linked to your HSA that can be used for eligible purchases everywhere Mastercard is accepted.
- **Investing & Saving:** You can save and invest your funds with over 30 investment options. HSA funds roll over year to year, allowing long-term growth if there are no immediate spending needs.
- **Catch-Up Contributions:** Individuals ages 55 and older who are not enrolled in Medicare can make an additional $1,000 catch-up contribution to their HSA.

Eligible HSA Expenses

The IRS determines what expenses are eligible under an HSA. Below are some examples of common eligible expenses:


Deductibles & copays


Prescriptions


Dental work & orthodontia


Glasses, contacts & LASIK


Band-aids


Sunscreen

For a full list of eligible expenses, go to myameriflex.com/eligibleexpenses.

Flexible Spending Account

An account for setting aside tax-free money for healthcare expenses

Use the below information to determine if a Flexible Spending Account (FSA) is right for you and how to best take advantage of an FSA account.

How It Works

When you enroll in a Flexible Spending Account (FSA) you get to experience tax savings on qualified expenses such as copays, deductibles, prescriptions, over-the-counter drugs and medications, and thousands of other everyday items.

Can I have an FSA and an HSA?

You can't contribute to an FSA and HSA within the same plan year. However, you can contribute to an HSA and a limited purpose FSA, which only covers dental and vision expenses.

As per IRS Publication 969, an employee covered by an HDHP and a health FSA or an HRA that pays or reimburses qualified medical expenses generally can't make contributions to an HSA. An employee is also not HSA-eligible during an FSA Grace Period. An employee enrolled in a Limited Purpose FSA is HSA-eligible.

As a married couple, one spouse cannot be enrolled in an FSA at the same time the other is contributing to an HSA. FSA coverage extends tax benefits to family members allowing the FSA holder to be reimbursed for medical expenses for themselves, their spouse, and their dependents.

The Value & Perks

- **Election Accessibility:** You will have access to your entire election on the first day of the plan year.
- **Save On Eligible Expenses:** You can save up to 40% on thousands of eligible everyday expenses such as prescriptions, doctor's visits, dental services, glasses, over-the-counter medicines, and copays.
- **Keep More Money:** The funds are taken out of your paycheck "pre-tax" (meaning they are subtracted from your gross earnings before taxes) throughout the course of the year. Let's say you earn $40,000 a year and contribute $1,500 to an FSA; so, only $38,500 of your income gets taxed. That means you are increasing your take-home pay simply by participating!
- **Easy Spending and Account Management:** You will receive an Ameriflex Debit Mastercard linked to your FSA. You can use your card for eligible purchases everywhere Mastercard is accepted. Account information can be securely accessed 24/7 online and through the mobile app.

Eligible FSA Expenses

The IRS determines what expenses are eligible under an FSA. Below are some examples of common eligible expenses.



Copays, deductibles, and other payments you are responsible for under your health plan.



Routine exams, dental care, prescription drugs, eye care, hearing aids, etc.



Prescription glasses and sunglasses, contact lenses and solution, LASIK, and eye exams.



Certain OTC expenses such as Band-aids, medicine, First Aid supplies, etc. (prescription required).



Diabetic equipment and supplies, durable medical equipment, and qualified medical products or services.

For a full list of eligible expenses, go to myameriflex.com/eligibleexpenses.

The "Use-or-Lose" Rule

If you contribute dollars to a reimbursement account and do not use all the money you deposit, you will lose any remaining balance in the account at the end of the eligible claims period. This rule, established by the IRS as a component of tax-advantaged plans, is referred to as the "use-or-lose" rule.

To avoid losing any of the funds you contribute to your FSA, it's important to plan ahead as much as possible to estimate what your expenditures will be in a given plan year.

Modification to the Health FSA "Use-or-Lose" Rule:

- FSA plan participants should note that up to $680 of any unused funds from the current plan year will be rolled over into your FSA balance for the new plan year.
- The rollover modification applies to Health FSA plans only (and not to other types of FSA plans such as dependent care).
- The rollover does not affect the maximum contribution amount for the new plan year. In other words, even if you roll over the entire $680 from the previous plan year, you may still elect up to the maximum contribution limit allowed under your employer's plan.

Limited Purpose FSA

Set aside tax-free money for dental and vision expenses

Use the below information to determine if a Limited Purpose Flexible Spending Account (LPFSA) is right for you and how to best take advantage of an LPFSA account.

How It Works

A Limited Purpose Flexible Spending Account (LPFSA) is a special type of FSA that allows you to set aside tax-free money to pay for eligible dental and vision expenses. What makes an LPFSA unique is that it can be used in conjunction with a Health Savings Account (HSA), allowing you to grow your HSA funds while using the LPFSA to pay for immediate dental and vision needs.

Other than the restriction of eligible expenses to vision, dental, and orthodontia, the rules governing the LPFSA are the same as those that apply to an FSA.

The Value & Perks

- **Save On Eligible Expenses:** You can save up to 40% on qualifying expenses such as vision appointments, LASIK, contact lenses and solution, glasses, teeth cleaning, dentures, and dental and vision copays. You can contribute to an LPFSA and HSA in the same plan year, allowing you to save and grow your HSA balance, while using the LPFSA to pay for everyday expenses.
- **Keep More Money:** The funds are taken out of your paycheck "pre-tax" (meaning they are subtracted from your gross earnings before taxes) throughout the course of the year. Let's say you earn $40,000 a year and contribute $1,500 to an LPFSA; so, only $38,500 of your income gets taxed. That means you are increasing your take-home pay simply by participating!
- **Easy Spending and Account Management:** You will receive an Ameriflex Debit Mastercard linked to your LPFSA. You can use your card for eligible purchases everywhere Mastercard is accepted. Account information can be securely accessed 24/7 online and through the mobile app.

Eligible LPFSA Expenses

You can use your LPFSA to pay for expenses related to dental and vision. Below are some examples of common eligible expenses:



Vision exams, co-payments, and deductibles



LASIK, eyeglasses, contact lenses, and lens solution



Dental cleanings, dentures, and orthodontia work



Dental x-ray, co-payments, and deductibles

For a full list of eligible expenses, go to myameriflex.com/eligibleexpenses.

Dependent Care Account

Set aside tax-free money for daycare and dependent care services

Use the below information to determine if a Dependent Care Account (DCA) is right for you and how to best take advantage of an DCA account.

How It Works

When you enroll in a Dependent Care Account (DCA) you get to experience tax savings on expenses like daycare, elderly care, summer day camp, preschool, and other services that allow you to work full time.

The Value & Perks

- **Save On Eligible Expenses:** You can use a DCA to pay for qualifying expenses such as daycare, summer day care, elder care, before and after school programs, and pre-school.
- **Keep More Money:** The funds are taken out of your paycheck "pre-tax" (meaning they are subtracted from your gross earnings before taxes) throughout the course of the year. Let's say you earn $40,000 a year and contribute $1,500 to an DCA; so, only $38,500 of your income gets taxed. That means you are increasing your take-home pay simply by participating!
- **Easy Spending and Account Management:** You will receive an Ameriflex Debit Mastercard linked to your DCA. You can use your card for eligible purchases everywhere Mastercard is accepted. Account information can be securely accessed 24/7 online and through the mobile app.

Eligible DCA Expenses

The IRS determines what expenses are eligible under a DCA. Below are some examples of common eligible expenses:



Private sitter



Daycare and elder care



Summer day camp



Before- and after-school care



Nanny service



Nursery school & Pre-school

For a full list of eligible expenses, go to myameriflex.com/eligibleexpenses.

Online Account Instructions

How to Access Your Ameriflex Account:

Go to MyAmeriflex.com and click “Login” from the upper right hand corner. When prompted, select “Participant.”

How to Register Online For Your Ameriflex Spending Account:

Click the register button atop the right corner of the home screen.

1. **As the primary account holder, enter your personal information.**

- Choose a unique User ID and create a password (if you are told that your username is invalid or already taken, you must select another).
- Enter your first and last name.
- Enter your email address.
- Enter your Employee ID, which in most cases, will be the account holder’s Social Security Number(no dashes or spaces needed).

2. Check the box if you accept the terms of use.

3. Click 'register'. This process may take a few seconds. Do not click your browser’s back button or refresh the page.

4. Last, you must complete your Secure Authentication setup. Implemented to protect your privacy and help us prevent fraudulent activity, setup is quick and easy. After the registration form is successfully completed, you will be prompted to complete the secure authentication setup process:

Step 1: Select a Security Question option, and type in a corresponding answer.

Step 2: Repeat for the following three Security Questions, then click next.

Step 3: Verify your email address, and then click next.

Step 4: Verify and submit setup information,

5. The registration process is complete! Should you receive an information error message that does not easily guide you through the information correction process, please feel free to contact our dedicated Member Services Team at 888.868.FLEX (3539).

Want to Manage Your Account on the go?

Download the MyAmeriflex mobile app, available through the App Store or Google Play.

Your credentials for the MyAmeriflex Portal and the MyAmeriflex Mobile App are the same; there is no need for separate login information!

Standard Insurance Company
County of Louisa and Schools
Group Policy #160128
Effective Date July 1, 2015

Group Long Term Disability Insurance

Group Long Term Disability insurance from Standard Insurance Company helps provide financial protection for insured members by promising to pay a monthly benefit in the event of a covered disability.

The cost of this insurance is paid by County of Louisa and Schools.

Eligibility

Definition of a Member	You are a member if you are a regular employee of County of Louisa and Schools who is Virginia Retirement System (VRS) eligible who is not participating in the Virginia hybrid retirement program described in 51.1-169 of the Code of Virginia, actively working at least 30 hours per week, and a citizen or resident of the United States or Canada. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Class Definition	Class 1 - All other Members, other than Louisa County Public Schools
Eligibility Waiting Period	You are eligible on the first of the month that follows the date you become a member.

Benefits

Monthly Benefit	60 percent of the first $16,667 of monthly predisability earnings, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, etc.)
Maximum Monthly Benefit	$10,000
Minimum Monthly Benefit	$100
Benefit Waiting Period	90 days

Definition of Disability

For the benefit waiting period and the first 24 months that Long Term Disability benefits are payable, you will be considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder:

- You are unable to perform with reasonable continuity the material duties of your own occupation, or
- You suffer a loss of at least 20 percent of your predisability earnings when working in your own occupation.

You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

After the own occupation period of disability, you will be considered disabled if, as a result of a physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation.

Maximum Benefit Period

If you become disabled before age 62, Long Term Disability benefits may continue during disability until age 65 or to the Social Security Normal Retirement Age (SSNRA) or 3 years 6 months, whichever is longest. If you become disabled at age 62 or older, the benefit duration is determined by the age when disability begins:

Age	Maximum Benefit Period
62	To SSNRA, or 3 years 6 months, whichever is longer
63	To SSNRA, or 3 years, whichever is longer
64	To SSNRA, or 2 years 6 months, whichever is longer
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

Other Features and Services

- 24 hour coverage, including coverage for work-related disabilities
- Assisted Living Benefit
- Employee Assistance Program
- Reasonable Accommodation Expense Benefit
- Rehabilitation Incentive Benefit
- Rehabilitation Plan Provision
- Return to Work Incentive
- Survivors Benefit
- Temporary Recovery Provision
- Waiver of Premium while Long Term Disability benefits are payable

This information is only a brief description of the group Long Term Disability insurance policy sponsored by County of Louisa and Schools. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reduction in benefits, exclusions and when The Standard and County of Louisa and Schools may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 15557-D-VA-160128-C1 (10/22)
7565258-1152759

Colonial Life

SUPPLEMENTAL BENEFITS PAY YOU DIRECTLY SO YOU CAN PAY FOR YOUR OUT-OF-POCKET MEDICAL EXPENSES LIKE DEDUCTIBLES, COPAYS/COINSURANCE & ANNUAL MAXIMUMS



Colonial Life Supplemental Benefits:

- Group Accident
- Group Critical Illness
- Group Cancer
- Insurance Individual Disability – "Paycheck Insurance"
- Group Hospital Confinement

•replace income if you're unable to work due to an injury or illness providing bridge the gaps in your medical coverage by• lump sum benefits to help pay the

These benefits are conveniently payroll deducted and employees can select premiums that fit your budget - while still providing the benefits you need to protect life's unexpected moments.

Benefits are paid directly to you regardless of any other coverage you may have, and plans are Guaranteed- Issue NO medical questions).

out-of-pocket expenses like deductible and •Individual Term Life You're unique - and so are your benefit needs Voluntarycopays / coinsurance benefits are supplemental coverages that help you customize your benefits package to your •provide benefits to your loved ones in event of individual needs. Louisa County Virginia offers plans to help: your passing

Trustmark Universal LifeEvents® Insurance with Long-Term Care Benefit

Two important coverages for when you need them the most.



Financial security even after a loss

Protecting your loved ones is one of life's greatest responsibilities. When a family loses someone, in addition to grief, survivors may suddenly be faced with costly expenses and debts, and even a loss of income. **Universal LifeEvents can help**.

Universal LifeEvents provides a **higher death benefit during your working years**, when your needs and responsibilities are the greatest. (See reverse for more on how Universal LifeEvents works.) You can choose a plan and benefit amount that provides the **right protection for you**.

Universal LifeEvents insurance can mean those left behind are still able to pursue their own dreams, and help ensure that the **ending** of one story won't stop the **beginning** of another.

Universal LifeEvents sample rates

Sample ranges of weekly rates for employee-only, non-smoker coverage with long-term care benefit. Your exact rate may depend on additional features selected by you and/or by your employer.

Age at purchase	$25,000 Universal LifeEvents policy
30	from **$3.49 – $4.59**
40	from **$5.05 – $6.71**
50	from **$7.84 – $10.71**

Sample rates are shown for illustrative purposes only. Rates may vary by age, smoking status, state, employer and features selected by you and/or by your employer. An application for insurance must be completed to obtain coverage.

Note: your rate is "locked in" at your age at purchase!
Once you have a policy, your rate will never increase due to age.

Solving the long-term care issue

At any point in your life, you may need long-term care services, which could cost hundreds of dollars per day. Universal LifeEvents includes a **long-term care (LTC)** benefit that can help pay for these services at any age. This benefit **remains at the same** level throughout your life, so the full amount is always available when you most need it.

Here's how it works:

4% You can **collect 4% of your Universal LifeEvents death benefit per month** for up to 25 months to help pay for long-term care services.

Flexible features available:

2x **PLUS:** if you collect a benefit for LTC, your **full death benefit** is still available for your beneficiaries, as much as **doubling** your benefit.

3x **PLUS:** you can collect your LTC benefit for an **extra 25 months**, as much as **tripling** your benefit.

The LTC Benefit is an acceleration of the death benefit and is not Long-Term Care Insurance (except in LA and VA, where the LTC benefit is Long-Term Care Insurance). It begins to pay after 90 days of confinement or services, and to qualify you must meet conditions of eligibility for benefits. The LTC benefits provided by this policy may not cover all of the policyholder's LTC expenses. Pre-existing condition limitation may apply. Your policy will contain complete details. You should consult a financial advisor to determine if the long-term care benefits and the retirement benefits provided by this policy are right for you.

Universal LifeEvents is **flexible permanent** lifetime.

The younger you are when you enroll, the **more benefit** premium.

No medical exams

What would happen if you weren't around?

1 in 3 households would have immediate trouble paying for living expenses if they lost their primary earner.[1]

40% of Americans live paycheck to paycheck. Could your family afford to stay in your home?[2]

56% of Americans have less than $10,000 saved for retirement –**1 in 3** have $0 saved. Wouldn't it be nice to have some protection?[3]

What can Universal Life benefits help pay for?

- Funeral and burial costs
- Rent or mortgage payments
- Tuition and loans
- Credit card bills
- Medical expenses
- Retirement savings

Benefit for terminal illness

- **Use part of your death benefit** to help manage costs if you're diagnosed with a terminal illness.

Additional advantages

- **Keep your coverage** at the same price and benefits if you change jobs or retire.
- **Apply for coverage for family members:** spouse, children and grandchildren.

More flexible features

- **Buy term life insurance for your children.** They can later simply convert this rider to a permanent Universal Life policy.
- **Waive your policy payments** if your doctor says you're totally disabled.

You care. We listen.

[1]2018 Insurance Barometer Study LIMRA/Life Happens. [2]nielsen.com/us/en/insights/news/2015/savingspending-and-living-paycheck-to-paycheck-in-america.html. [3]gobankingrates.com/retirement/1-3-americans-0-saved-retirement. [5]An AM Best rating is an independent opinion of an insurer's financial strength and ability to meet its ongoing insurance policy and contract obligations.Trustmark is rated A (3rd out of 13 possible ratings ranging from A++ to D).

This provides a brief description of your benefits under GUL.205/IUL.205 and applicable riders HH/LTC.205, BRR.205, BXR.205,ABR.205,ADB.205, CT.205 and WP.205. Benefits, definitions, exclusions, form numbers and limitations may vary by state.This policy contains a provision that guarantees against lapse for a period of 10 years (14 years in OR; 15 years for Universal LifeEvents) as long as premiums are paid as planned. If you make changes to your coverage during this period, or pay only the minimum premium, you may prevent cash value accumulation or reduce your death benefit amount. If there is negative cash value at the end of the no-lapse period, you must pay enough premium to establish positive cash value.You may also need to maintain your policy with a higher premium than the one you paid to satisfy the no-lapse guarantee or coverage may expire prior to age 100 even if the premium shown is paid as scheduled.A policy illustration will be delivered with your policy.Your policy will contain complete information. For costs and further details of the coverage, including exclusions, any reductions or limitations and terms under which the policy may be continued in force, see your agent or write to the company. For exclusions and limitations that may apply, visit www.trustmarksolutions.com/disclosures/UL/ (A112-2216-UL). In California, review "A Consumer's Guide to Long-term Care from the Department of Aging" at: http://www.aging.ca.gov/aboutcda/publications/Taking_Care_of_Tomorrow_English/. Underwriting conditions may vary, and determine eligibility for the offer of insurance.Trustmark® and LifeEvents® are registered trademarks of Trustmark Insurance Company.

Products underwritten by Trustmark Insurance Company
Rated A (Excellent) for financial strength by AM Best.[5]

TrustmarkVB.com

Trustmark
benefits beyond benefits

©2023 Trustmark Insurance Company

A112-2425 (8-19)

CONTACTS

THE LOCAL CHOICE (TLC)
MEDICAL / DENTAL / VISION

Medical, Pharmacy, Vision/Hearing
800.552.2682

Behavioral Health and Employee Assistance Program (EAP)
855.223.9277

ID Card Order Line
866.587.6713

Coverage While Traveling (BlueCard Program)
800.810.2583

24/7 NurseLine
1-800-337-4770

Delta Dental
888.335.8296

thelocalchoice.virginia.gov
anthem.com/TLC

AMERIFLEX FLEXIBLE SPENDING ACCOUNTS

Customer Service
888.868.3539

myameriflex.com

P.O. Box 26900
Plano, TX 75026 9

MANAGE YOUR ACCOUNT ONLINE OR DOWNLOAD THE MYAMERIFLEX MOBILE APP

- Check your Balance
- Submit a Claim
- Check Claim Status
- Mark Your Card Lost or Stolen

COLONIAL LIFE
SUPPLEMENTAL BENEFIT ENHANCEMENTS

BENEFITS ARE PAID DIRECTLY TO YOU TO HELP COVER OUT-OF-POCKET MEDICAL EXPENSES & LOSS OF INCOME IF YOU ARE UNABLE TO WORK DUE TO AN ACCIDENT OR SICKNESS. (PREGNANCY IS A COVERED SICKNESS)

Enrollment (Open Enrollment & New Hires) 410.988.2555
getinfo@coloniallifemd.com

Customer Service(existing policyholders)
800.325.4368
coloniallife.com

Set-Up Policyholder Portal to view your policies, file claims & more

File Your Annual Health Screening Benefit

INNOVATIVE INSURANCE GROUP

eligibility I coverage I claims I life events
888.676.9496

customerservice@thinkinnovative.net

DELTA DENTAL

Customer Service
800.237.6060

deltadentalVA.com

THE STANDARD - LTD

Customer Service
800.628.8600

standard.com

TRUSTMARK - VOLUNTARY UL

Customer Service 800.918.8877
https://trustmarkvb.com/

ADDITIONAL BENEFITS

Virginia Association of Counties Group Self Insurance Risk Pool (VACORP) Short and Long Term Disability

Group Short Term Disability (STD) program provided for its participant by the Sponsor and administered by Anthem Life Insurance Company helps provide financial protection for covered members by promising to pay a weekly benefit in the event of a covered disability.

Group Long Term Disability (LTD) insurance from Anthem Life Insurance Company helps provide financial protection for insured members by promising to pay a monthly benefit in the event of a covered disability.

Please refer to the plan summary document and your employee handbook for specific plan details, eligibility definitions, limitations, and exclusions

Questions about your VACORP Short and Long Term Disability can be directed to:
1-844-404-2111 or www.vacorp.org/hybrid-disability/

Virginia Retirement System (VRS) Life Insurance

The Virginia Retirement System (VRS) Optional Group Life Insurance program gives you the opportunity to purchase additional insurance at favorable group rates on yourself and family. Optional group life is term insurance. Term insurance generally provides the largest immediate death protection for your premium dollar. The program is administered by the Virginia Retirement System, and is provided under a group policy issued by the Minnesota Life Insurance Company.

Questions about your employer paid life insurance coverage can be directed to:
Securian Financial
PO Box 1193, Richmond, VA 23218-1193
1-800-441-2258
https://www.varetire.org/myvrs

HEALTH PLAN COMPLIANCE NOTICES

Louisa County

4/16/2026



Provided by: Innovative Insurance Group

TABLE OF CONTENTS

CHIP Notice

COBRA General Notice

General FMLA Notice

Genetic Information Nondiscrimination Act (GINA) Disclosures

Health Insurance Exchange Notice (for companies who offer a health plan)

Medicare Part D Creditable Coverage Notice

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

Newborns' and Mothers' Health Protection Act Notice

No Surprise Billing

Notice of Patient Protections

Notice of Privacy Practices

Special Enrollment Rights Notice

Uniformed Services Employment and Reemployment Rights Act (USERRA) Notice

WHCRA Notice

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	
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	Health Insurance Premium Payment Program All other Medicaid Website: http://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
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
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	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-p Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
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)	
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	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/
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid	
	Website: http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

U Department of Labor U.S. Department of Health and Human Services

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 6156

Asistencia con las primas bajo Medicaid y el Programa de Seguro de Salud para Menores (CHIP)

Si usted o sus hijos son elegibles para Medicaid o CHIP y usted es elegible para cobertura médica de su empleador, su estado puede tener un programa de asistencia con las primas que puede ayudar a pagar por la cobertura, utilizando fondos de sus programas Medicaid o CHIP. Si usted o sus hijos no son elegibles para Medicaid o CHIP, usted no será elegible para estos programas de asistencia con las primas, pero es probable que pueda comprar cobertura de seguro individual a través del mercado de seguros médicos. Para obtener más información, visite **www.cuidadodesalud.gov**.

Si usted o sus dependientes ya están inscritos en Medicaid o CHIP y usted vive en uno de los estados enumerados a continuación, comuníquese con la oficina de Medicaid o CHIP de su estado para saber si hay asistencia con primas disponible.

Si usted o sus dependientes NO están inscritos actualmente en Medicaid o CHIP, y usted cree que usted o cualquiera de sus dependientes puede ser elegible para cualquiera de estos programas, comuníquese con la oficina de Medicaid o CHIP de su estado, llame al **1-877-KIDS NOW** o visite **espanol.insurekidsnow.gov/** para información sobre como presentar su solicitud. Si usted es elegible, pregunte a su estado si tiene un programa que pueda ayudarle a pagar las primas de un plan patrocinado por el empleador.

Si usted o sus dependientes son elegibles para asistencia con primas bajo Medicaid o CHIP, y también son elegibles bajo el plan de su empleador, su empleador debe permitirle inscribirse en el plan de su empleador, si usted aún no está inscrito. Esto se llama oportunidad de "inscripción especial", y **usted debe solicitar la cobertura dentro de los 60 días de haberse determinado que usted es elegible para la asistencia con las primas**. Si tiene preguntas sobre la inscripción en el plan de su empleador, comuníquese con el Departamento del Trabajo electrónicamente a través de **www.askebsa.dol.gov** o llame al servicio telefónico gratuito **1-866-444-EBSA (3272)**.

Si usted vive en uno de los siguientes estados, tal vez sea elegible para asistencia para pagar las primas del plan de salud de su empleador. La siguiente es una lista de estados actualizada al 31 de enero de 2026. Comuníquese con su estado para obtener más información sobre la elegibilidad –

ALABAMA – Medicaid	ALASKA – Medicaid
Sitio web: http://myalhipp.com Teléfono: 1-855-692-5447	El Programa de Pago de AK primas del seguro médico Sitio web: http://myakhipp.com Teléfono: 1-866-251-4861 Por correo electrónico: CustomerService@MyAKHIPP.com Elegibilidad de Medicaid: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Sitio web: http://myarhipp.com/ Teléfono: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Sitio web: http://dhcs.ca.gov/hipp Teléfono: 916-445-8322 Fax: 916-440-5676 Por correo electrónico: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Programa Medicaid de Colorado) y Child Health Plan Plus (CHP+)	
Sitio web de Health First Colorado: https://www.healthfirstcolorado.com/es Centro de atención al cliente de Health First Colorado: 1-800-221-3943/ retransmisor del estado: 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus Atención al cliente de CHP+: 1-800-359-1991/retransmisor del estado: 711 Programa de compra de seguro de salud (HIBI, por sus siglas en inglés): https://www.mycohibi.com/ Atención al cliente de HIBI: 1-855-692-6442	Sitio web: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Teléfono: 1-877-357-3268
Sitio web de GA HIPP: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Teléfono: 678-564-1162, Presiona 1 Sitio web de GA CHIPRA: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Teléfono: 678-564-1162, Presiona 2	Programa de pago de primas de seguro de salud Todos los demás son Medicaid Sitio web: https://www.in.gov/medicaid/ https://www.in.gov/fssa/dfr Administración de familias y servicios sociales Teléfono: 1-800-403-0864 Teléfono de servicios para miembros: 1-800-457-4584
Sitio web de Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid Teléfono de Medicaid: 1-800-338-8366 Sitio web de Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki Teléfono de Hawki: 1-800-257-8563 Sitio web de HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp Teléfono de HIPAA: 1-888-346-9562	Sitio web: https://www.kancare.ks.gov/ Teléfono: 1-800-792-4884 Teléfono de HIPP: 1-800-967-4660

KENTUCKY - Medicaid	
Sitio web del Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://www.chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Teléfono: 1-855-459-6328 Por correo electrónico: KIHIPP.PROGRAM@ky.gov Sitio web de KCHIP: https://kidshealth.ky.gov/es/Pages/default.aspx Teléfono: 1-877-524-4718 Sitio web de Medicaid de Kentucky: https://chfs.ky.gov/agencies/dmsSitio web de Medicaid de Kentucky: https://chfs.ky.gov/agencies/dms	Sitio web: https://www.ldh.la.gov/healthy-louisiana Teléfono: 1-888-342-6207 (línea directa de Medicaid) o 1-855-618-5488 (LaHIPP) Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
Sitio web por inscripción: https://www.mymaineconnection.gov/benefits/s/?language=en_US Teléfono: 1-800-442-6003 TTY: Maine relay 711 Página web por primos de seguro de salud privado: https://www.maine.gov/dhhs/ofi/applications-forms Teléfono: 1-800-977-6740 TTY: Maine relay 711	Sitio web: https://www.mass.gov/masshealth/pa Teléfono: 1-800-862-4840 TTY: 711 Por correo electrónico: masspremassistance@accenture.com
Sitio web: https://mn.gov/dhs/health-care-coverage/ Teléfono: 1-800-657-3672	Sitio web: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Teléfono: 573-751-2005
Sitio web: https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Teléfono: 1-800-694-3084 Por correo electrónico: HHSHIPPProgram@mt.gov	Sitio web: http://www.ACCESSNebraska.ne.gov Teléfono: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Sitio web de Medicaid: http://dhcfp.nv.gov Teléfono de Medicaid: 1-800-992-0900	Sitio web: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-p Teléfono: 603-271-5218 Teléfono gratuito para el programa de HIPP: 1-800-852-3345, ext. 15218 Por correo electrónico: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NUEVA JERSEY – Medicaid y CHIP	
Sitio web de Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Teléfono: 1-800-356-1561 Teléfono de asistencia de prima de CHIP: 609-631-2392 Sitio web de CHIP: http://www.njfamilycare.org/index.html Teléfono de CHIP: 1-800-701-0710 (TTY:711)	Sitio web: https://www.health.ny.gov/health_care/medicaid/ Teléfono: 1-800-541-2831
Sitio web: https://medicaid.ncdhhs.gov Teléfono: 919-855-4100	Sitio web: http://www.hhs.nd.gov/healthcare Teléfono: 1-844-854-4825
Sitio web: http://www.insureoklahoma.org Teléfono – 1-888-365-3742	Sitio web: https://cuidadodesalud.oregon.gov/Pages/index.aspx Teléfono: 1-800-699-9075
Sitio web: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program.html Teléfono: 1-800-692-7462 Sitio web de CHIP: https://www.pa.gov/en/agencies/dhs/resources/chip.html Teléfono de CHIP: 1-800-986-JIDS (5437)	Sitio web: http://www.eohhs.ri.gov/ Teléfono: 1-855-697-4347 o 401-462-0311 (Direct Rita Share Line)
Sitio web: https://www.scdhhs.gov Teléfono: 1-888-549-0820	Sitio web: http://dss.sd.gov Teléfono: 1-888-828-0059
Sitio web: https://www.hhs.texas.gov/es/servicios/finanzas/programa-de-pago-de-las-primas-del-seguro-medico Teléfono: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Sitio web: https://medicaid.utah.gov/upp/ Por correo electrónico: upp@utah.gov Teléfono: 1-888-222-2542 Sitio web de expansión para adultos: https://medicaid.utah.gov/expansion/ Sitio web de Programa de compra de Medicaid de Utah: https://medicaid.utah.gov/buyout-program/ Sitio web de CHIP: https://chip.utah.gov/espanol/

VERMONT – Medicaid	
Sitio web: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Teléfono: 1-800-250-8427	Sitio web: https://cubrevirginia.dmas.virginia.gov/learn/premium-assistance/famis-select https://cubrevirginia.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Teléfono de Medicaid/CHIP: 1-800-432-5924
Sitio web: http://www.hca.wa.gov Teléfono: 1-800-562-3022	Sitio web: http://mywvhipp.com/ Teléfono de Medicaid: 304-558-1700 Teléfono gratuito de CHIP: 1-855-MyWVHIPP (1-855-699-8447)
Sitio web: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Teléfono: 1-800-362-3002	Sitio web: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Teléfono: 1-800-251-1269

Para saber si otros estados han agregado el programa de asistencia con primas desde el 31 de enero de 2026, o para obtener más información sobre derechos de inscripción especial, comuníquese con alguno de los siguientes:

Departamento del Trabajo de EE.UU.
Administración de Seguridad de Beneficios de los Empleados
www.dol.gov/agencies/ebsa/es/about-ebsa/our-activities/informacion-en-espanol
1-866-444-EBSA (3272)

Departamento de Salud y Servicios Humanos de EE.UU.
Centros para Servicios de Medicare y Medicaid
www.cms.hhs.gov
1-877-267-2323, opción de menú 4, Ext. 6156

General Notice of COBRA Rights

(For use by single-employer group health plans)

Continuation Coverage Rights Under COBRA

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

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 Louisa County, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

Griff Carmichael
1 Woolfolk Avenue
Louisa, VA 23093

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying

event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, 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[1] 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

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA.

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.

If you have questions

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

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

2026 - 2027 Plan Year
Griff Carmichael
1 Woolfolk Avenue
Louisa, VA 23093

Modelo de aviso general de los derechos de la cobertura de continuación de COBRA

(para que usen los planes de salud grupales de un solo empleador)

Derechos de la cobertura de continuación conforme a la ley COBRA

Introducción

Le enviamos este aviso porque recientemente obtuvo la cobertura de un plan de salud grupal (el Plan). Este aviso contiene información importante acerca de su derecho a recibir la cobertura de continuación de COBRA, que es una extensión temporal de la cobertura del Plan. **Este aviso explica la cobertura de continuación de COBRA, el momento en el que usted y su familia pueden recibirla, y lo que usted puede hacer para proteger su derecho a obtenerla.** Al ser elegible para la cobertura de COBRA, también puede ser elegible para otras opciones que pueden costarle menos que la cobertura de continuación de COBRA.

El derecho a recibir la cobertura de continuación de COBRA se originó gracias a una ley federal, la Ley Ómnibus Consolidada de Reconciliación Presupuestaria (COBRA, por sus siglas en inglés) de 1985. Usted y otros familiares suyos pueden disponer de la cobertura de continuación de COBRA cuando se termine la cobertura de salud grupal. Para obtener más información acerca de sus derechos y obligaciones conforme al Plan y a la ley federal, debe revisar el resumen de la descripción del Plan o comunicarse con el administrador del Plan.

Al perder la cobertura de salud grupal, puede haber otras opciones disponibles. Por ejemplo, puede ser elegible para comprar un plan individual a través del mercado de seguros médicos. Al inscribirse en la cobertura a través del mercado de seguros médicos, puede cumplir con los requisitos para tener menores costos en las primas mensuales y gastos propios más bajos. Asimismo, puede tener derecho a un período de inscripción especial de 30 días en otro plan de salud grupal para el cual sea elegible (como un plan del cónyuge), aunque ese plan generalmente no acepte afiliados de último momento.

¿Qué es la cobertura de continuación de COBRA?

La cobertura de continuación de COBRA es la continuación de la cobertura del Plan cuando esta debería terminar debido a un evento determinado de la vida. Este acontecimiento también se conoce como “evento especifico”. Los eventos específicos se incluyen más abajo en este aviso. Después de un evento especifico, la cobertura de continuación de COBRA debe ofrecerse a cada persona considerada un “beneficiario que cumple con los requisitos”. Usted, su cónyuge y sus hijos dependientes podrían convertirse en beneficiarios que cumplan con los requisitos si la cobertura del Plan se pierde debido al evento especifico. Según el Plan, los beneficiarios que cumplan con los requisitos y que elijan la cobertura de continuación de COBRA debe pagar la cobertura de continuación de COBRA.

Si usted es un empleado, se convertirá en un beneficiario que cumple con los requisitos si pierde la cobertura del Plan debido a estos eventos especificos:

- sus horas de empleo se reducen; o
- su empleo termina por un motivo que no sea una falta grave de su parte.

Si usted es el cónyuge del empleado, se convertirá en un beneficiario que cumple con los requisitos si pierde la cobertura del Plan debido a estos eventos especificos:

- su cónyuge muere;
- las horas de empleo de su cónyuge se reducen;
- el empleo de su cónyuge termina por un motivo que no sea una falta grave por parte de su cónyuge;
- su cónyuge adquiere el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas); o
- se divorcia o se separa legalmente de su cónyuge.

Sus hijos dependientes se convertirán en beneficiarios que cumplen con los requisitos si pierden la cobertura del Plan debido a estos eventos especificos:

- el empleado cubierto muere;
- las horas de empleo del empleado cubierto se reducen;
- el empleo del empleado cubierto termina por un motivo que no sea una falta grave por parte del empleado cubierto;
- el empleado cubierto adquiere el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas);
- los padres se divorcian o se separan legalmente; o el hijo deja de ser elegible para la cobertura del Plan como “hijo dependiente”.

A veces, presentar una solicitud de declaración de quiebra conforme al Título 11 del Código de Estados Unidos puede ser un evento habilitante. Si se presenta una solicitud de declaración de quiebra con respecto a Louisa County y esa quiebra causa la pérdida de la cobertura de cualquier empleado jubilado cubierto por el Plan, el empleado jubilado se convertirá en un beneficiario que cumple con los requisitos. El cónyuge del empleado jubilado, el cónyuge sobreviviente y los hijos dependientes también se convertirán en beneficiarios que cumplen con los requisitos si la quiebra causa la pérdida de la cobertura del Plan.

¿Cuándo está disponible la cobertura de continuación de COBRA?

El Plan ofrecerá la cobertura de continuación de COBRA a los beneficiarios que cumplan con los requisitos solamente después de que se le informe al administrador del Plan que ha ocurrido un evento especifico. El empleador debe notificar los siguientes eventos habilitantes al administrador del Plan:

- la terminación del empleo o la reducción de las horas de empleo;
- la muerte del empleado;
- el hecho de que el empleado adquiera el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas).

Para todos los otros eventos especificos (divorcio o separación legal del empleado y el cónyuge, o hijo dependiente que pierde la elegibilidad para la cobertura como hijo dependiente), debe avisarle al administrador del Plan en los 60 días posteriores a que se produzca el evento habilitante. Debe proporcionarle este aviso a:

Griff Carmichael
1 Woolfolk Avenue
Louisa, VA 23093

¿Cómo se proporciona la cobertura de continuación de COBRA?

Después de que el administrador del Plan recibe el aviso de que se ha producido un evento especifico, la cobertura de continuación de COBRA se ofrecerá a cada uno de los beneficiarios que cumplan con los requisitos. Cada beneficiario que cumpla con los requisitos tendrá su propio derecho a elegir la cobertura de continuación de COBRA. Los empleados cubiertos pueden elegir la cobertura de continuación de COBRA en nombre de su cónyuge y los padres pueden elegir la cobertura de continuación de COBRA en nombre de sus hijos.

La cobertura de continuación de COBRA es la continuación temporal de la cobertura debido a la terminación del empleo o a la reducción de las horas de trabajo, y en general dura 18 meses. Determinados eventos especificos, o un segundo evento especifico durante el período inicial de cobertura, pueden permitir que el beneficiario reciba un máximo de 36 meses de cobertura.

También hay otros motivos por los cuales este período de 18 meses de la cobertura de continuación de COBRA puede prolongarse:

Extensión por discapacidad del período de 18 meses de la cobertura de continuación de COBRA

Si el Seguro Social determina que usted o alguien de su familia que esté cubierto por el Plan tiene una discapacidad y usted le avisa al respecto al administrador del Plan en el plazo correspondiente, usted y toda su familia pueden recibir una estensión adicional de hasta 11 meses de cobertura de continuación de COBRA, por un máximo de 29 meses. La discapacidad debe haber comenzado en algún momento antes de los 60 días de la cobertura de continuación de COBRA y debe durar al menos hasta el final del período de 18 meses de la cobertura de continuación de COBRA.

Extensión por un segundo evento especifico del período de 18 meses de la cobertura de continuación de COBRA

Si su familia sufre otro evento especifico durante los 18 meses de la cobertura de continuación de COBRA, su cónyuge y sus hijos dependientes pueden recibir hasta 18 meses adicionales de cobertura de continuación de COBRA, por un máximo de 36 meses, si se le avisa al Plan como corresponde acerca del segundo evento especifico. Esta extensión puede estar disponible para el cónyuge y cualquier hijo dependiente que reciba la cobertura de continuación de COBRA en el caso de que el empleado o exempleado muera, adquiera el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas), se divorcie o se separe legalmente, o si el hijo dependiente deja de ser elegible en el Plan como hijo dependiente. Esta extensión solo está disponible en el caso de que el segundo evento especifico hubiese hecho que el cónyuge o el hijo dependiente pierda la cobertura del Plan si no se hubiese producido el primer evento especifico.

¿Hay otras opciones de cobertura además de la cobertura de continuación de COBRA?

Sí. En lugar de inscribirse en la cobertura de continuación de COBRA, puede haber otras opciones de cobertura para usted y su familia a través del mercado de seguros médicos, Medicaid u otras opciones de un plan de salud grupal (por ejemplo, el plan de su cónyuge) mediante lo que se denomina un “período de inscripción especial”. Es posible que algunas de estas opciones cuesten menos que la cobertura de continuación de COBRA. Puede encontrar más información sobre muchas de estas opciones en **www.cuidadodesalud.gov**.

¿Puedo inscribirme en Medicare, en caso de ser elegible, después de que finalice la cobertura de mi plan de salud colectivo?

En general, después del período de inscripción inicial, hay un período de inscripción especial de 8 meses[1] para inscribirse en Medicare Parte A o B, que comienza cuando ocurre lo primero de lo siguiente:

- El mes posterior a la finalización del empleo.
- El mes posterior a la finalización de la cobertura del plan de salud colectivo basada en el empleo actual.

Si elige la Ley Ómnibus Consolidada de Reconciliación Presupuestaria (COBRA) y desea inscribirse en Medicare Parte B después de que finalice su cobertura de continuación, es posible que tenga que pagar una penalidad por inscripción tardía. Si se inscribe inicialmente en Medicare Parte A o B después de elegir la cobertura de continuación COBRA, el plan puede terminar su cobertura de continuación (sin embargo, si Medicare Parte A o B entra en vigencia en la fecha de la elección de COBRA o antes de esta fecha, la cobertura de COBRA no se puede descontinuar debido al derecho a Medicare, incluso si la persona se inscribe en la otra parte de Medicare después de la fecha de la elección de la cobertura de COBRA).

Si está inscrito tanto en COBRA como en Medicare, Medicare será generalmente el pagador principal. Es posible que algunos planes "disminuyan" el monto que Medicare pagaría en caso de ser el pagador principal, incluso si usted no está inscrito.

Para obtener más información, visite **www.medicare.gov/medicare-and-you**

Si tiene preguntas

Las preguntas acerca de su Plan o de sus derechos a recibir la cobertura de continuación de COBRA deben enviarse al contacto o los contactos identificados abajo. Para obtener más información sobre sus derechos según la Ley de Seguridad de los Ingresos de Jubilación de los Empleados (ERISA, por sus siglas en inglés), incluida la ley COBRA, la Ley de Atención Médica (de bajo costo) y la Protección al Paciente, y otras leyes que afectan a los planes de salud grupales, comuníquese con la oficina regional o de distrito más cercana de la Administración de Seguridad de Beneficios para Empleados (EBSA, por sus siglas en inglés) del Departamento de Trabajo de Estados Unidos en su área, o visite www.dol.gov/ebsa. (Las direcciones y los números de teléfono de las oficinas regionales y de distrito de EBSA están disponibles en el sitio web de EBSA). Para obtener más información acerca del mercado de seguros médicos, visite **www.cuidadodesalud.gov**.

Informe a su plan si cambia de dirección

Para proteger los derechos de su familia, informe al administrador del Plan sobre cualquier cambio en las direcciones de sus familiares. También debe conservar una copia, para su registro, de todos los avisos que le envíe al administrador del Plan.

Información de contacto del Plan

2026 - 2027 Plan Year
Griff Carmichael
1 Woolfolk Avenue
Louisa, VA 23093

[1] **www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-period**.

General FMLA Notice

EMPLOYEE RIGHTS

UNDER THE FAMILY AND MEDICAL LEAVE ACT

The United States Department of Labor Wage and Hour Division

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee'sjob;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Health Insurance Exchange Notice

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income..[1][2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if

---

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact:

Griff Carmichael
1 Woolfolk Avenue
Louisa, VA 23093

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Louisa County	4. Employer Identification Number (EIN) 54-6001398	
5. Employer address 1 Woolfolk Avenue	6. Employer phone number (540) 967-3413	
7. City Louisa	8. State VA	9. ZIP code 23093
10. Who can we contact about employee health coverage at this job? Griff Carmichael		
11. Phone number (540) 967-0401	12. Email address gcarmichael@louisa.org	

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

- As your employer, we offer a health plan to:
  - ☐ Some employees. Eligible employees are: Full-time benefit eligible
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are: Spouse and dependent children under age 26
  - ☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

Aviso de Intercambio de Seguros de Salud

Para los empleadores que ofrecen un plan de salud a algunos o a todos los empleados

Cobertura del Mercado de Seguros Médicos Opciones y su cobertura de salud

PARTE A: Información general

Incluso si le ofrecen cobertura de salud a través de su empleo, es posible que tenga otras opciones de cobertura a través del Mercado de Seguros Médicos ("Mercado"). Para ayudarlo a evaluar las opciones para usted y su familia, este aviso proporciona cierta información básica sobre el Mercado de Seguros Médicos y la cobertura de salud ofrecida a través de su empleo.

¿Qué es el Mercado de Seguros Médicos?

El Mercado está diseñado para ayudarle a encontrar un seguro médico que satisfaga sus necesidades y se ajuste a su presupuesto. El Mercado ofrece un "punto único de compra" para encontrar y comparar opciones de seguros médicos privados en su área geográfica.

¿Puedo ahorrar dinero en las primas de mi seguro médico en el Mercado?

Es posible que califique para ahorrar dinero y reducir su prima mensual y otros costos de bolsillo, pero solo si su empleador no ofrece cobertura o si ofrece cobertura que no se considera asequible para usted y no cumple con ciertas normas de valor mínimo (que se analizan a continuación). Los ahorros para los que es elegible dependen de los ingresos de su hogar. También puede ser elegible para un crédito fiscal que reduzca sus costos.

¿La cobertura de salud basada en el empleo afecta la elegibilidad para recibir ahorros en primas a través del Mercado?

Sí. Si tiene una oferta de cobertura de salud de su empleador que se considera asequible para usted y cumple con ciertas normas de valor mínimo, no será elegible para un crédito fiscal o pago por adelantado del crédito fiscal para su cobertura del Mercado y es posible que desee inscribirse en su plan de salud basado en el empleo. Sin embargo, usted puede ser elegible para un crédito fiscal y pagos por adelantado del crédito, que reducen su prima mensual, o una reducción en ciertos costos compartidos, si su empleador no le ofrece cobertura alguna o no le ofrece cobertura que se considera asequible para usted o cumple con las normas de valor mínimo. Si su participación del costo de la prima de todos los planes que se le ofrecen a través de su empleo es más del 9.12 %1 de su ingreso familiar anual, o si la cobertura a través de su empleo no cumple con la norma de "valor mínimo" establecida por la Ley de Cuidado de la Salud a Bajo Precio, puede ser elegible para un crédito fiscal y el pago por adelantado del crédito, si no se inscribe en la cobertura de salud basada en el empleo. Para los miembros de la familia del empleado, la cobertura se considera asequible si el costo de las primas del plan de menor costo que cubriría a todos los miembros de la familia no excede el 9.12 % de los ingresos del hogar del empleado..12

---

1 Indexado anualmente; consulte https://www.irs.gov/pub/irs-drop/rp-22-34.pdf para 2023.

2 Un plan de salud patrocinado por el empleador o basado en el empleo cumple con la "norma de valor mínimo" si la participación del plan en los costos totales de beneficios permitidos cubiertos por el plan no es inferior al 60 por ciento de dichos costos. A los efectos de la elegibilidad para el crédito fiscal para la prima, para cumplir con la "norma de valor mínimo", el plan de salud también debe proporcionar una cobertura sustancial tanto de los servicios hospitalarios como de los servicios médicos para pacientes hospitalizados.

Nota: si compra un plan de salud a través del Mercado, en lugar de aceptar la cobertura de salud ofrecida a través de su empleo, entonces puede perder el acceso a todo lo que el empleador contribuya a la cobertura basada en el empleo. Además, esta contribución del empleador, así como la contribución de su empleado a la cobertura basada en el empleo, generalmente se excluye de los ingresos para efectos del impuesto sobre la renta federal y estatal. Sus pagos de cobertura a través del Mercado se realizan después de impuestos. Además, tenga en cuenta que, si la cobertura de salud ofrecida a través de su empleo no cumple con las normas de asequibilidad o valor mínimo, pero acepta esa cobertura de todos modos, no será elegible para un crédito fiscal. Debe considerar todos estos factores al determinar si debe comprar un plan de salud a través del Mercado.

¿Cuándo puedo inscribirme en una cobertura de seguro médico a través del Mercado?

Puede inscribirse en un plan de seguro médico del Mercado durante el Período de Inscripción Abierta anual del Mercado. La Inscripción Abierta varía según el estado, pero generalmente comienza el 1 de noviembre y continúa al menos hasta el 15 de diciembre.

Fuera del Período de Inscripción Abierta anual, puede inscribirse en un seguro médico si califica para un Período de Inscripción Especial. En general, usted califica para un Período de Inscripción Especial si ha tenido ciertos eventos de vida calificativos, como casarse, tener un bebé, adoptar un niño o perder la elegibilidad para otra cobertura de salud. Dependiendo de su tipo de Período de Inscripción Especial, es posible que tenga 60 días antes o 60 días después del evento de vida calificativo para inscribirse en un plan del Mercado.

También existe un Período de Inscripción Especial del Mercado para personas y sus familias que pierden la elegibilidad para la cobertura de Medicaid o del Programa de Seguro Médico para Niños (CHIP, por sus siglas en inglés) a partir del 31 de marzo de 2023 hasta el 31 de julio de 2024. Desde el inicio de la emergencia de salud pública del COVID-19 a nivel nacional, las agencias estatales de Medicaid y CHIP generalmente no han cancelado la inscripción de ningún beneficiario de Medicaid o CHIP que estuviera inscrito a partir del 18 de marzo de 2020 hasta el 31 de marzo de 2023. A medida que las agencias estatales de Medicaid y CHIP reanuden las prácticas habituales de elegibilidad e inscripción, es posible que muchas personas ya no sean elegibles para la cobertura de Medicaid o CHIP a partir del 31 de marzo de 2023. El Departamento de Salud y Servicios Humanos de EE. UU. **ofrece un período temporal de Inscripción Especial en el Mercado para permitir que estas personas se inscriban en la cobertura del Mercado.**

Las personas elegibles para el Mercado que viven en estados atendidos por HealthCare.gov y que envían una nueva solicitud o actualizan una solicitud existente en HealthCare.gov entre el 31 de marzo de 2023 y el 31 de julio de 2024, y dan fe de una fecha de terminación de la cobertura de Medicaid o CHIP dentro del mismo período, son elegibles para un Período de Inscripción Especial de 60 días. **Eso significa que, si pierde la cobertura de Medicaid o CHIP entre el 31 de marzo de 2023 y el 31 de julio de 2024, es posible que pueda inscribirse en la cobertura del Mercado dentro de los 60 días posteriores a la pérdida de la cobertura de Medicaid o CHIP.** Además, si usted o los miembros de su familia están inscritos en la cobertura de Medicaid o CHIP, es importante asegurarse de que su información de contacto esté actualizada para asegurarse de recibir cualquier información sobre los cambios en su elegibilidad. Para obtener más información, visite HealthCare.gov o llame al Centro de llamadas del Mercado al 1-800-318-2596. Los usuarios de TTY pueden llamar al 1-855-889-4325.

¿Qué pasa con las alternativas a la cobertura de seguro médico del Mercado?

Si usted o su familia son elegibles para la cobertura de un plan de salud basado en el empleo (como un plan de salud patrocinado por el empleador), usted o su familia también pueden ser elegibles para un Período de Inscripción Especial para inscribirse en ese plan de salud en ciertas circunstancias, incluso si usted o las

personas a su cargo estaban inscritos en la cobertura de Medicaid o CHIP y perdieron esa cobertura. Generalmente, tiene 60 días después de la pérdida de la cobertura de Medicaid o CHIP para inscribirse en un plan de salud basado en el empleo, pero si usted y su familia perdieron la elegibilidad para la cobertura de Medicaid o CHIP entre el 31 de marzo de 2023 y el 10 de julio de 2023, puede solicitar esta inscripción especial en el plan de salud basado en el empleo hasta el 8 de septiembre de 2023. Confirme la fecha límite con su empleador o con su plan de salud basado en el empleo.

Alternativamente, puede inscribirse en la cobertura de Medicaid o CHIP en cualquier momento completando una solicitud a través del Mercado o solicitando directamente a través de su agencia estatal de Medicaid. Visite https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ para obtener más detalles.

¿Cómo puedo obtener más información?
Para obtener más información sobre la cobertura que ofrece a través de su empleo, consulte el Resumen de la descripción del plan de salud o comuníquese con

Griff Carmichael
1 Woolfolk Avenue
Louisa, VA 23093

El Mercado puede ayudarlo a evaluar sus opciones de cobertura, incluida su elegibilidad para cobertura a través del Mercado y su costo. Visite HealthCare.gov para obtener más información, incluida una solicitud en línea para cobertura de seguro médico e información de contacto de un Mercado de Seguros Médicos en su área.

PARTE B: Información sobre la cobertura de salud ofrecida por su empleador

Esta sección contiene información sobre cualquier cobertura de salud ofrecida por su empleador. Si decide completar una solicitud de cobertura en el Mercado, se le pedirá que proporcione esta información. Esta información está numerada según la solicitud del Mercado.

3. Nombre del empleador Louisa County	4. Número de identificación patronal (EIN) 54-6001398	
5. Dirección del empleador 1 Woolfolk Avenue	6. Número de teléfono del empleador (540) 967-3413	
7. Cuidad Louisa	8. Estado VA	9. Código postal 23093
10. ¿A quién podemos contactar sobre la cobertura de salud de los empleados en este trabajo? Griff Carmichael		
11. Número de teléfono (si es diferente al anterior) (540) 967-0401	12. Dirección de correo electrónico gcarmichael@louisa.org	

A continuación, se ofrece información básica sobre la cobertura de salud que ofrece este empleador:

- Como su empleador, ofrecemos un plan de salud para:

☐ Some employees. Eligible employees are: Full-time benefit eligible
- Respecto a los dependientes:

☐ We do offer coverage. Eligible dependents are: Spouse and dependent children under age 26

- ☐ Si se marca, esta cobertura cumple con la norma de valor mínimo y el costo de esta cobertura para usted debe ser asequible, según los salarios de los empleados.

Nota: Incluso si su empleador tiene la intención de que su cobertura sea asequible, aún puede ser elegible para un descuento en la prima a través del Mercado. El Mercado utilizará los ingresos de su hogar, junto con otros factores, para determinar si puede ser elegible para un descuento en la prima. Si, por ejemplo, sus salarios varían de una semana a otra (quizás es un empleado por horas o trabaja por comisión), si es nuevo empleado a mitad de año o si tiene otras pérdidas de ingresos, aún puede calificar para un descuento en la prima.

Medicare Part D Creditable Coverage Notice

Important Notice from Louisa County About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Louisa County 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. Louisa County has determined that the prescription drug coverage offered by the Louisa County 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 to December 7th.

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

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Louisa County coverage will be affected. You should reach out to your benefits administrator for eligibility guidelines and to see if you qualify.

If you do decide to join a Medicare drug plan and drop your current Louisa County coverage, be aware that you and your dependents will be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Louisa County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information call Griff Carmichael at (540) 967-0401. 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 Louisa County changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 4/16/2026

Name of Entity/Sender: Louisa County

Contact--Position/Office: Griff Carmichael, Director of Human Resources

Address: 1 Woolfolk Avenue Louisa, VA 23093

Phone Number: (540) 967-0401

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (540) 967-0401.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Your Rights and ProtectionsAgainst Surprise Medical Bills

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

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

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

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

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

You're protected from balance billing for:

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

https://scc.virginia.gov/pages/Balance-Billing-Protection

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

If you get other types of services at these in-network facilities, out-of-network providers **can't**

balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.
https://scc.virginia.gov/pages/Balance-Billing-Protection

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

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

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

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

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

Notice of Patient Protections

The Louisa County Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Louisa County designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact:

Griff Carmichael

1 Woolfolk Avenue

Louisa, VA 23093

For children, you may designate a pediatrician as the primary care provider.

Notice of Privacy Practices

Louisa County
1 Woolfolk Avenue
Louisa, VA 23093

Privacy Official:
Griff Carmichael
1 Woolfolk Avenue
Louisa, VA 23093

Effective Date: 07/01/2026

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law

- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

To the extent we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

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," for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

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 someone has authority to act as your personal representative, such as if someone has your 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 at:
  Griff Carmichael
  1 Woolfolk Avenue
  Louisa, VA 23093
- 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 **https://www.hhs.gov/hipaa/filing-a-complaint/index.html.**
- We will not retaliate against you for filing a complaint.

Your Choices

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

In these cases, you have both the right and choice to tell us to:

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

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

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

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

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

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

Run our organization

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

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

Pay for your health services

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

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

Administer your plan

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

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

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

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 in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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

Changes to the Terms of this Notice

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

Other Information

Notice of Special Enrollment Rights

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

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact:

Griff Carmichael

1 Woolfolk Avenue

Louisa, VA 23093

USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right to Be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
    - Initial employment;
    - Reemployment;
    - Retention in employment;
    - Promotion; or
    - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USADOL or visit its Web site at https://www.dol.gov/agencies/vets. An interactive online USERRA Advisor can be viewed at https://webapps.dol.gov/elaws/vets/userra/.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *https://www.dol.gov/sites/dolgov/files/VETS/files/USERRA-Poster.pdf*. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

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

Enrollment Notice

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: $see Summary of Benefits deductible (in-network) and see Summary of Benefits% coinsurance (in-network) and $see Summary of Benefits deductible (out-of-network) and see Summary of Benefits% coinsurance (out-of-network). If you would like more information on WHCRA benefits, call your plan administrator at (540) 967-0401.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at (540) 967-0401 for more information.