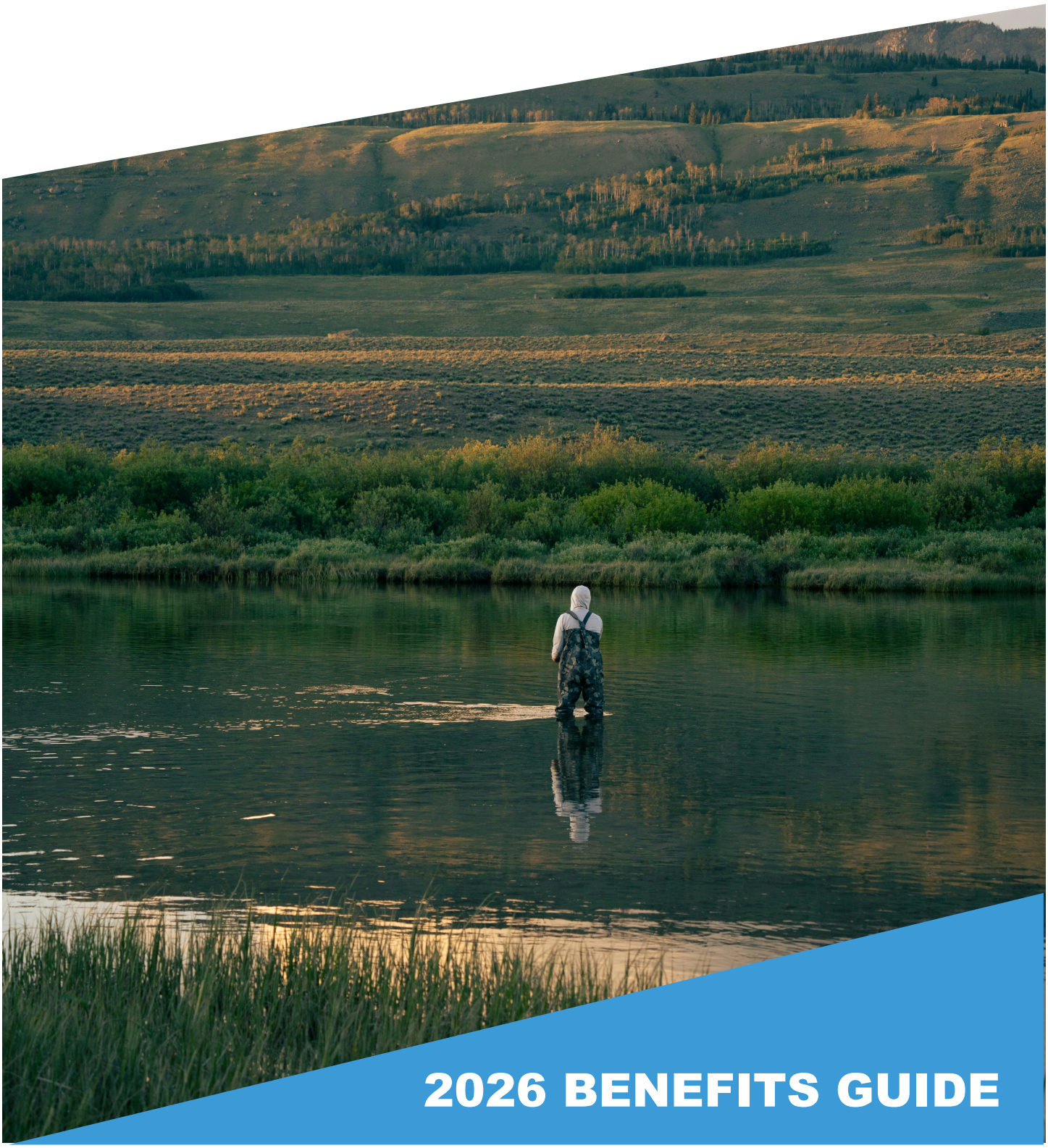


2026 BENEFITS GUIDE

Enrollment Guidelines

Welcome to the Benefits Guide for Carbon County WY. This Guide provides a quick overview of the benefits program and helps to remove confusion that sometimes surrounds Employee benefits. The benefits program was structured to provide comprehensive coverage for you and your family. Benefit programs provide a financial safety net in the event of unexpected and potentially catastrophic events.

ELIGIBILITY

You are eligible to enroll in the medical benefits program if you are a full-time employee working 30 or more hours per week. Benefits for newly hired employees will take effect the first of the month following the date of qualified employment.

Your legally recognized spouse and your married or unmarried dependent children are eligible for medical coverage if less than 26 years of age. Your unmarried dependent children are eligible for dental coverage until midnight the day before the 19th birthday (24th birthday if a full-time student). Your unmarried dependent children are eligible for vision coverage until the end of the month they turn age 19 (24 if a full-time student). Disabled unmarried children over age 26 may be eligible to continue benefits after approval of necessary applications.

For Dental, Vision, Basic Life, and supplemental Life coverages; Actively at Work Provisions apply, including dependent non-confinement.

OPEN ENROLLMENT

Open enrollment for health, dental and vision is once a year, and benefit elections will take effect January 1st. Flexible Spending Account enrollment is in December.

Participants may add or drop coverage or make changes to their coverage at this time. Late entrants (employees or dependents who apply for coverage more than 30 days after the date of individual eligibility) are also provided an opportunity to enroll for coverage during the plan's open enrollment. The elections you make stay in effect the entire plan year, unless a qualifying life event occurs.

If you enrolled in Voluntary Life when you were first eligible, you may increase your benefit by 1 increment not to exceed the guaranteed issue amount.

QUALIFYING LIFE EVENTS

Generally, you can only change your benefit elections during the annual Open Enrollment period. However, you may make changes during the plan year if you have a qualifying event.

Qualifying events include:

- Marriage
- Divorce
- Birth
- Adoption
- Death
- Loss of Coverage

When you have a qualifying event, you have 30 days to complete your enrollment for health, dental, vision or other benefit coverages. You may be asked to provide proof of the change and/or proof of eligibility. (You have 60 days to complete and return a new enrollment /change form after coverage under Medicaid or CHIP terminates.)

POINTS OF INTEREST

Upon voluntary termination of employment, if the last day worked is the 1st-15th, then medical coverage will end the 15th of the month. If the last day of employment was the 16th through the end of the month, medical coverage will end the last day of the month. Upon involuntary termination of employment, coverage will end on the day of termination of employment.

Benefit Contacts

Blue Cross Blue Shield Wyoming	Medical Plan	(800) 211-2966 www.yourwyoblue.com
Prime Therapeutics	Prescription Benefit Manager	(877) 794-3574 (833) 599-0448 ESI Home Delivery (833) 599-0512 Specialty Pharmacy www.MyPrime.com
Amaze	Virtual Care	(720) 577-5251 Account needs Download the app for medical needs
Guardian	Dental	(888) 600-1600 www.GuardianAnytime.com
VSP	Vision	(800) 877-7195 www.vsp.com
RMR	FSA/HRA/Dependent Care	(888) 722-1223 rockymountainreserve.com
Standard	Life/AD&D, Voluntary Life	(800) 628-8600 Life Services Toolkit: Standard.com/mytoolkit
Aflac	Voluntary Supplemental Insurance	(307) 823-2425 Nathan_gortemaker@us.Aflac.com
WY Retirement System	Pension Benefits and 457 Deferred Comp	(307) 777-7691 www.retirement.state.wy.us
Masa Medical Transportation Services	Air and Ground Ambulance	Customer Service: (800) 432-3226 Emergency Access: (800) 643-9023 www.MASAMTS.com
Carbon County	Ashley Jolly	(307) 328-7825 hr@carboncountywy.gov Human Resources
Agile Benefits Consulting	Kellie Grady Consultant/Account Manager	(307) 640-0359 kgrady@agilebenefitsconsulting.com
Novo Connection	Mary Ann Kastrup Sr. Client Experience Coordinator	(303) 222-0010 mkastrup@novoconnection.com

Medical Benefits

Carbon County WY offers medical benefits through Blue Cross Blue Shield of WY. This medical plan balances affordability with the freedom to go outside the network. You may choose an in-network or an out-of-network provider. In-network providers have agreed to provide services at a discounted fee. For out-of-network providers, you are responsible for charges above the out-of-network allowance for services, in addition to the deductible and coinsurance. To find an in-network provider, visit www.yourwyoblue.com .

Benefit	Plan A Medical Benefits		Plan B Medical Benefits	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$500/single $1,000/family	$1,000/single $2,000/family	$1,000/single $2,000/family	$2,000/single $4,000/family
Out-of-Pocket Maximum (Includes deductible, coinsurance and copays)	$2,500/single $5,000/family	$4,000/single $8,000/family	$3,500/single $7,000/family	$7,000/single $14,000/family
Accident Benefits – within 90 days of accident	Paid at 100% for the first $300. Then subject to normal plan benefits			
Preventive Care	0%, Deductible Waived	20%, After Deductible	0%, Deductible Waived	30%, After Deductible
Office Visit (PCP)	$25 Copay Deductible Waived	20%, After Deductible	$25 Copay Deductible Waived	30%, After Deductible
Office Visit Specialist	$50 Copay Deductible Waived	20%, After Deductible	$50 Copay Deductible Waived	30%, After Deductible
Urgent Care	$75 copay	20% After Deductible	$75 copay	30% After Deductible
Emergency Room	$250 Copay, Deductible Waived		$250 Copay, Deductible Waived	
Ambulance	10%, After Deductible	20% After Deductible	20%, After Deductible	30% After Deductible
Diagnostic Lab and X-Ray	10%, After Deductible	20%, After Deductible	20%, After Deductible	30% After Deductible
Advanced Imaging (CT/PET scans/MRI's)	10%, After Deductible	20%, After Deductible	20%, After Deductible	30% After Deductible
Family deductible and out-of-pocket amounts are embedded. This means an individual would not pay more than the individual deductible/out-of-pocket amounts. Your In-network and Out-of-network accumulators do cross accumulate.				

Medical Benefits (Continued)

Benefit	Plan A Medical Benefits		Plan B Medical Benefits	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient Hospital	10%, After Deductible	20%, After Deductible	20%, After Deductible	30%, After Deductible
Inpatient Hospital	10%, After Deductible	20%, After Deductible	20%, After Deductible	30%, After Deductible
Maternity Prenatal Office Visits Delivery and All Inpatient Services	$25 Copay 10% After Deductible	20% After Deductible 20%, After Deductible	$25 Copay 20% After Deductible	30% After Deductible 30% After Deductible
Mental Health & Substance Abuse Office Outpatient	$25 Copay Deductible Waived	20%, After Deductible	$25 Copay Deductible Waived	30%, After Deductible
Mental Health & Substance Abuse Inpatient	10%, After Deductible	20%, After Deductible	20%, After Deductible	30%, After Deductible
Prescriptions – through Prime Therapeutics Retail – 30-day supply Generic Preferred Non-Preferred Specialty Generic Preferred Non-Preferred	 $5 copay $35 copay $50 copay $5 copay $100 copay $100 copay	 Not covered Not covered Not covered Not covered Not covered Not covered	 $5 copay $35 copay $50 copay $5 copay $100 copay $100 copay	 Not covered Not covered Not covered Not covered Not covered Not covered
Retail or Mail – 90-day supply through Prime Therapeutics Generic Preferred Non-Preferred Specialty	 $15 copay $105 copay $150 copay N/A	 Not covered Not covered Not covered Not covered	 $15 copay $105 copay $150 copay N/A	 Not covered Not covered Not covered Not covered

If a Member chooses a brand drug when a generic drug is available and authorized by the Provider, the Member must pay the difference in cost between the brand drug and the generic drug. This difference does not apply to the out-of-pocket maximum.

What you pay and what the plan pays:
This Summary of Benefits shows how much you pay for care, and how much the plan pays. It's a brief listing of what is included in your benefits plan. For more detailed information, see your summary plan description at www.yourwyoblue.com.

Family deductible and out-of-pocket amounts are embedded. This means an individual would not pay more than the individual deductible/out-of-pocket amounts.

Your In-network and Out-of-network accumulators do cross accumulate.

Making extraordinary care ordinary

Set-up your Amaze account now, so you'll have us when you need us.

Amaze Offers:

- Urgent Care
- Chronic Medical Condition Management
- Mental Health Support
- Health Education Center
- Prescriptions
- Imaging, Testing & Specialist Referrals
- Billing Support
- Care for the Whole Family

The Amaze Difference

- ✓ We don't bill you or your insurance
- ✓ We stay with you until your problem is resolved
- ✓ We follow-up
- ✓ We are always here when you need us

Access your Amaze Health account in two easy steps:

Step 1: Download the Amaze app. Search for "Amaze Health" in your app store or scan this QR code from your mobile device to go directly to the Amaze app in your app store.

Step 2: Log in to the Amaze app. Your username is your email address (either your company email or personal email). Once you enter your username, follow the steps to set a password for the first time.

If you don't know your username, please search your email inbox for login credentials from Amaze Member Services or call 720-577-5251 and we'll help you retrieve your username.

Setting Up Your Amaze Account

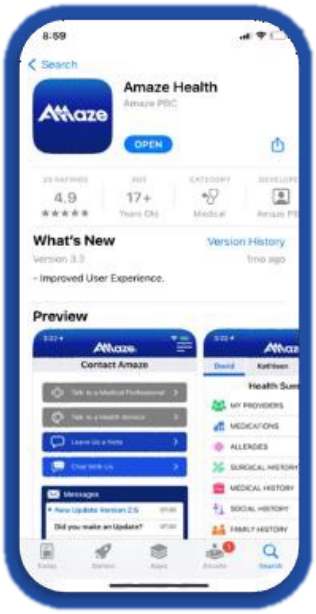
You'll soon learn how Amazing it is to have a provider at the touch of a button whenever you need one. But before you can make that first call or send your first message, you need to complete your account setup.

Step One

Check your email for your username and to set your password. If you can't find your welcome email, please call us at **720-577-5251.**

Step Two

Once you've set your password, download the app on your smartphone and log in!



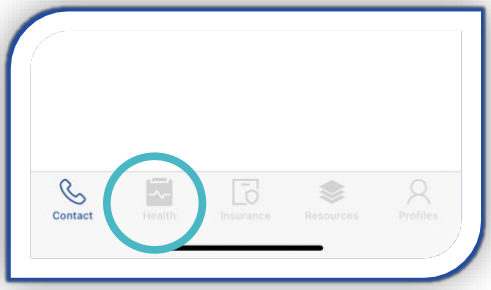
If you have <u>any</u> issues with either of these steps, please give us a call. Our team is here to help!

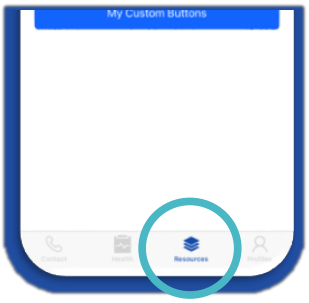
Step Three

Click on the 3 lines in the upper right-hand corner and select add family members to add your spouse and children under age 26 to your account.

Step Four

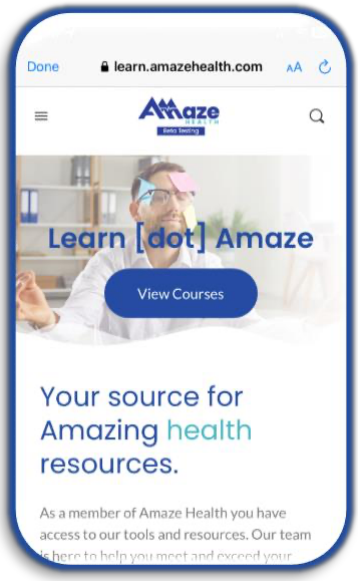
At the bottom of the screen, you have several options. Please go through the health summary tab and enter your information.





Step Six

Take a tour of our Education Center, Learn [dot] Amaze, where you can learn how to better manage your health & wellness.



Step Five

At the bottom of the screen, click on resources to view your personal notes, research tools, and our Education Center.

That's it! Your setup is now complete, and you have full access to all the features at Amaze Health.

Wellness Rewards

$$ EARN MONEY TOWARDS HEALTH EXPENSES! $$
PARTICIPATION IS VOLUNTARY!

BLOOD DRAW

$250 in your HRA!

No need to sign up! Simply get your blood drawn and/or have a wellness exam or screening.

- **Participate in the county's organized blood draw for free. Just show up and you will be signed up.**
- **Receive $250.00 in your HRA. Spouses can receive an additional $250 in the employee's HRA.**

EXAMS / SCREENINGS

$50 each in your HRA!

Get the following screenings, most of which are free and get $50 per test in your HRA. Spouses are also eligible, and the funds go into the employee's HRA. Turn in the proof of service form to HR and get your HRA money!

- **Mammogram**
- **Colonoscopy**
- **Pap or cervical cancer screening**
- **Prostate exam**
- **Skin cancer screening**

Rewards are limited to one of each service per individual per year.

Who can participate?

Active county employees and spouses covered by the county's health insurance with BCBS.

Why should I participate?

- Monitor and take charge of your health.
- Earn up to a maximum of $450 per year in an HRA. Eligible spouses can also earn up to an additional $450 in the employee's HRA.

What is an HRA?

HRA is a Health Reimbursement Arrangement. Basically, it is an account you can use to help pay for eligible medical, dental, vision and other expenses. Use for Rx, towards your deductible, copays, etc.... to help reduce your out of pocket costs.

Why would the county pay me to have these tests done?

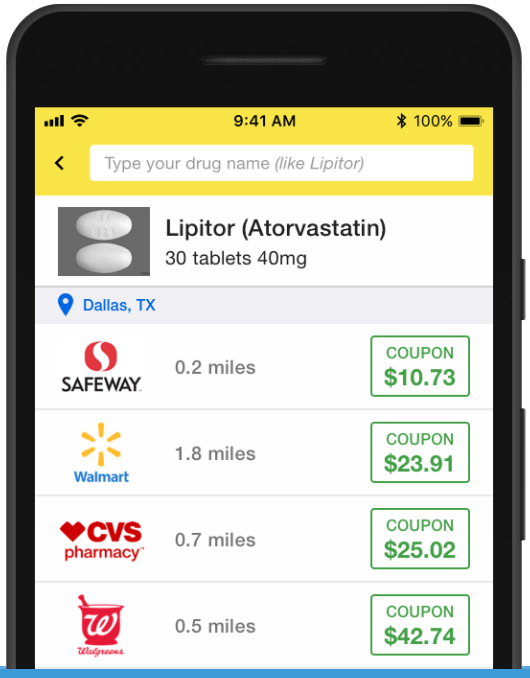
The county is partially self-insured. This means county dollars plus your premiums pay for claims. We are not in a pool with other groups. The county wants members to find issues early to potentially avoid large claims later. That's the motivation! Individual test results are private under federal law and never shared with the county!

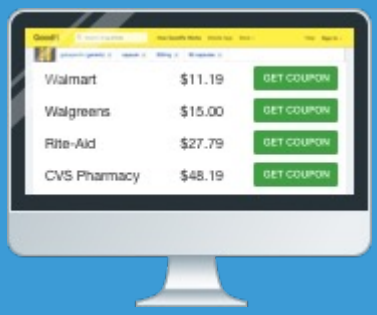
GoodRx – The Free Rx Savings Solution

Drug prices vary widely between pharmacies. GoodRx finds the lowest prices and discounts.

How?

1. Collect and compare prices for every FDA-approved prescription drug at more than 70,000 U.S. pharmacies
2. Find free coupons to use at the pharmacy
3. Show the lowest price at each pharmacy near you





Compare Prices
GoodRx collects prices and discounts from over 70,000 U.S. pharmacies

Print Free Coupons
Or send coupons to your phone by email or text message

Save Up To 80%
Show the coupon to your pharmacist for massive savings on your meds

GoodRx

Available on the App Store

ANDROID APP ON Google Play

Managing health conditions can be overwhelming.

Let KnovaSolutions® help.

KnovaSolutions is a voluntary health support program that is available at no cost to eligible employees and their dependents on the County's health plan. Our team can help simplify health care for you and your family.

Eligible members will be connected to a dedicated nurse who will consult with a clinical support team that includes a pharmacist, dietitian, and more.

This team can help you:

- *Cut through the confusion of health decisions.*
- *Get help understanding diagnostic test results and treatment options.*
- *Get answers to medication questions.*
- *Learn stress management techniques and more.*

KnovaSolutions staff members will call you if you qualify.

Any information you share will be protected in accordance with the Health Insurance Portability Accountability Act.

"KnovaSolutions has been a big help to me...I would recommend this kind of assistance to anyone with ongoing health management issues, especially those which are more complicated."

workpartners

Paydhealth

Select Drugs and Products™ Program

The Plan's Select Drugs and Products™ Program allows you to take an active role in helping the Plan reduce your costs, while allowing the Plan to continue to offer generous healthcare benefits to all Participants. The Plan is sponsoring this program at no cost to you. If you are prescribed a drug included on the Paydhealth Select Drugs and Products™ List, you must enroll in the Program to comply with benefit requirements.

Plan Members Taking Specialty Drugs – 1 – 2 – 3

1. Paydhealth will initiate outreach to you by text message or phone call.

2. Complete the digital enrollment application which will allow Paydhealth to match you to alternate funding programs.
   Note: you may be asked to provide household size and income information.

3. Your Paydhealth Case Coordinator will coordinate with the you and the pharmacy to ensure you are able to get your medication in a timely manner.

A Case Coordinator is available (8:00 am to 8:00 pm CST) to guide you through the enrollment process and the program. Please respond to calls from your Case Coordinator in a timely manner.

This program keeps your application confidential and will not share your information with any 3rd party solicitors. If you would like to complete your application over the phone or speak with a Paydhealth Case Coordinator, please call (877) 869-7772. Common questions and answers about your Plan's Select Drugs and Products™ Program on the other side of this

There are two reasons why you are receiving this important message:

- Your Plan has added an important program that includes the Paydhealth Select Drugs and Products™ List*.
- Your Plan is continuing to offer generous specialty drug benefits while attempting to reduce your costs and the Plan's.

*The Paydhealth Select Drugs and Products™ List includes drugs typically prescribed by a specialist for multiple sclerosis, hepatitis C, Crohn's disease, hemophilia, cancer, psoriasis, rheumatoid arthritis, transplants, HIV/AIDS, and other complex conditions.

How It Works

What is the Select Drugs and Product™ Program?

The Select Drugs and Products™ Program provides advocacy services to assist you by identifying and facilitating your enrollment in programs that may reduce or eliminate your out-of-pocket costs for eligible specialty drugs, products, and services. A Case Coordinator will contact you to guide you through the program. The Plan continues to offer generous healthcare benefits but needs your help to continue to meet this goal.

Your active role in helping the Plan reduce its costs and yours is important. The Plan is sponsoring this program at no cost to you. However, you may be required to pay a portion of the cost to acquire your specialty drug, product or service depending on specific situations.

What is the Enrollment Requirement for the Select Drugs and Products™ Program?

The Plan requires you to enroll in the Select Drugs and Products™ Program by following the three-step process outlined above, that starts with a response to texts or calls from the Paydhealth Case Coordinator in a timely manner.

What happens after I enroll in the Select Drugs and Products™ Program?

After enrolling in the Select Drugs and Products™ Program, you will be asked to complete certain documentation related to the alternate funding programs identified by your Case Coordinator. This will include providing required documents and information to the alternate funding program from you and may require your prescriber's participation as well. Your timely responses will help you avoid any delays in processing your documentation.

Your Case Coordinator will help you obtain your eligible specialty drugs, products or services and reduce your out-of-pocket costs by coordinating alternative forms of funding. After your acceptance into an alternate funding program, your Case Coordinator will contact you before and after each refill to ensure there is no disruption in your treatment and the funding.

TRAVEL MEDICAL BENEFIT

If you need care in one of the specialty areas listed below you could be eligible for the Travel Medical Care Benefit. Coverage must be in WY, CO, UT or MT except for cancer, additional locations at University of Texas MD Anderson Center; Johns Hopkins Kimmel Cancer Center in Maryland & Taussig Cancer Institute at the Cleveland Clinic in Ohio.

- Full deductible waived. If you've already met your deductible, you will be eligible for a credit.
- $200 per day reimbursement for travel expenses including: food, lodging, airfare, car rental, and gas
- Travel expense reimbursement benefit limited to $2,500 per calendar year, per participant (about 17 days)
- Must retain receipts for reimbursement
- Travel with up to one companion

Travel Benefit Steps

- Confirm you are eligible by calling BCBS of Wyoming at 800-442-2376
- To Find a Blue Distinction Center: visit bcbs.com/why-bcbs/blue-distinction
- Get your deductible waived and travel with a companion
- Get up to $200 per day for: food, lodging, and travel (limited to $2500/year/member)
- Retain travel receipts and mail to:
  BCBS Wyoming, Attn: Case Management, 4000 House Avenue, Cheyenne, WY 82001

Specialty Areas
(Available for deductible waiver/credit & travel reimbursement)

- Cardiac care
- Knee and Hip Replacement
- Transplants
- Cancer
- Spine Surgery

Note: Member is responsible for checking that the provider is an in-network provider. If the provider is out-of-network, Member may be balanced billed.

Blue Distinction is a travel reimbursement benefit for expenses incurred for certain medical treatment that is done at one of the Blue Distinction Center through Blue Cross Blue Shield of Wyoming. Centers of Distinction are located in Wyoming, Colorado, Utah and Montana. For more information about Blue Distinction Centers log on to: bcbs.com/why-bcbs/blue-distinction/

BDC
Hospitals recognized for their expertise in delivering specialty care.

BDC+
Hospitals recognized for their expertise and efficiency in delivering specialty care.

Why is MASA necessary?

- **Only MASA MTS programs can give you complete peace of mind from all emergency medical transport bills after even the best insurance companies have paid their part.**
- **Americans today suffer from a *false sense of security* that their medical coverage will pay for all costs associated with emergency or critical care transport. The reality is that the majority of *Americans are only partially covered* for these high costs*. Only MASA MTS can provide complete protection.**
- **As the cost of medical transport increases each year, and insurance coverage decreases, only MASA MTS will be able to prevent these increased costs from impacting you directly.**

What is covered with MASA?

- **Emergency Air Transport**
- **Emergency Ground Ambulance Transport**
- **With MASA it does NOT matter which company picks you up in a life-threatening situation, you are covered. There are over 300 air ambulance companies in the United States and even more ground EMS companies.**
- **With MASA MTS you are covered in all 50 states and with any ground or emergency air ambulance**

MASA MTS ensures…

- **NO health questions**
- **NO age limits**
- **NO claim forms**
- **NO deductibles**
- **NO network limitations**

Simply said – EVERYONE is eligible!

Cost…

Just $14/month or $160/year

Learn how to save money and protect your family from financial hardship when an emergency strikes.

Customer Service: (800) 432-3226
Emergency Access: (800) 643-9023
www.MASAMTS.com

***NAICS- Understanding Air Ambulance Insurance, Consumer Alert**

Flexible Spending Account Enrollment Guide

ROCKY MOUNTAIN reserve

What is an FSA?

A health Flexible Spending Account (FSA) allows individuals to use pre-tax dollars to pay for medical expenses not covered by insurance. A Dependent Care FSA (DCFSA) allows individuals to use pre-tax dollars for daycare or dependent care expenses. The dependent care FSA (DCFSA) cannot be used to pay for medical expenses. Individuals elect to contribute a portion of their paychecks pre-tax to a Health FSA or Dependent Care FSA and then can use those funds for eligible expenses.

Know the Rules:

Health (medical) FSA

The IRS maximum for 2026 is $3,400. Employers may set a lower limit.

Participants may claim and be paid out their entire annual election at any time.

Every expense must be substantiated. Participants must be able to provide receipts, statements or bills for all expenses if substantiation is requested. Documents must include the date, amount and description of the expense or service.

Only eligible expenses can be reimbursed. Medical expenses are defined by IRS rules. Expenses generally include items and services for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. See IRS Publication 502.

All over-the-counter drugs are eligible along with all menstrual care products.

Only "out-of-pocket" medical expenses are eligible for reimbursement. Medical expenses covered by insurance or any other plan or program are not eligible for reimbursement.

Expenses for personal use or cosmetic surgery are not eligible for reimbursement. See IRS Publication 502.

Medical expenses reimbursed under the health (medical) FSA may not be used to claim a federal income tax deduction.

Health FSA and Dependent Care FSA

- Contributions are subject to the IRS "use-it-or-lose-it" rule. However, for the health FSA, the employer may adopt a provision allowing up to a $680 (2026) carry over of unclaimed monies. Unclaimed monies not carried over are forfeited at the end of the plan year.
- Elections cannot be changed during the plan year, unless the participant has a change of status. IRS Regulations define a change of status.
- Expenses must be incurred by a participant, spouse or eligible dependents during the current plan year and while participating. Expenses are incurred when the medical care is provided and not when the expense is billed, the bill is due or when the bill is paid.
- Every employer sets the deadline when claims and documentation must be submitted after the end of the plan year. It is usually 60 or 90 days after the end of the plan year.

Limited Purpose (dental & vision) FSA

- Employees contributing to a HSA may only participate in a "limited" health FSA not a "general" health FSA. A limited health FSA can only be used to pay for "out of pocket" dental and vision expenses.
- Please note when using the debit card for the Limited Purpose FSA it must be at a dental or vision facility that their MCC code is registered as a dental or vision facility. Otherwise it may pull from your HSA.

Dependent Care FSA

- Participants may only be paid what they have contributed at any point in time.
- Participants must be ready to provide receipts for dependent care expenses.
- Dependent care expenses reimbursed by the dependent care FSA may not be used to claim the day care credit.

Tax Savings Examples:

Dave, a single taxpayer, earns $27,000/year and has eligible medical expenses of $1,200/year.
Dave's annual savings realized by participating in the FSA is **$327**.

Michael and Sharon, working parents, earn a total of $48,000/year. They have $5,000 in child care expenses and $1,000 per year in eligible medical expenses.
Their annual savings realized by participating in the FSA is **$1,637**.

Assumptions are based off of 15% Federal, 4.63% State, and 7.65% FICA tax

PO Box 631458 · Littleton, CO 80163 · (888) 722-1223 · fax (866) 557-0109 · https://www.RockyMountainReserve.com

Eligible Expenses

ROCKY MOUNTAIN reserve

Common Eligible Medical Expenses:

- Eyeglasses, eye exams, sunglasses (prescription)
- Over-the-counter drugs
- Menstrual care products
- Eye surgery
- Fertility enhancement
- HMO expenses
- Hearing aids, batteries, and exams
- Hospital services
- Immunizations, vaccines, flu shots
- Laboratory fees
- LASIK eye surgery
- Medicines (prescribed)
- Obstetric services
- Optometrist
- Orthodontia
- Prescription drugs
- Psychiatric care
- Psychologist
- Speech therapy
- Stop smoking programs
- Surgery/operations
- Therapy
- Vasectomy
- Wheelchair
- X-rays

Dual Purpose Expenses That Potentially Qualify:

The expense must be for a specific medical reason and be accompanied by a *prescription*.

- Massage therapy
- Vitamins
- Supplements
- Herbal supplements
- Natural medicines
- Aromatherapy
- Weight-loss program
- Health club dues

Ineligible Expenses:

- Cosmetic surgery
- Long term care
- Hair transplant/re-growth
- Maternity clothes
- Nutritional supplements
- Personal use items: such as toiletries, cotton swabs, toothbrush, toothpaste, facial care, shampoo
- Teeth whitening
- Drunk driving classes

Health Care Reform & Over-the-Counter Items:

Over-the-Counter Medicine and Drugs ***do not*** require a prescription to be eligible for reimbursement under the plan.

- Allergy medications
- Antacids
- Anti-diarrhea medicine
- Bug-bite medication
- Cold medicine
- Cough drops and throat lozenges
- Diaper rash ointments
- Hemorrhoid medication
- Incontinence supplies
- Laxatives
- Muscle/joint pain products/rubs
- Nicotine medications, gum, patch-es
- Pain relievers
- Sinus medications, nasal sprays, nasal strips
- Sleep aids
- Wart removal medication

These are only examples and this list is not all-inclusive -- it only provides some of the more common expenses.
Additional information is available in IRS Publication 502 and on our website: https://www.rockymountainreserve.com

Over-The-Counter Items:

- Band-aids/bandages
- Cold/hot packs for injuries
- Condoms
- Contact lens solutions
- Diabetic supplies
- First aid kits
- Medical alert bracelets/necklaces
- Pregnancy test kits
- Thermometers

Dependent Care Eligible Expenses:

- A dependent receiving care must be a child under the age of 13, or a tax dependent unable to provide for their own care, who resides with you. The care must be necessary for you or your spouse to be gainfully employed or to go to school. Care may be provided by anyone other than your spouse or your children under the age of 19. Expenses for schooling, kindergarten, over-night care, and nursing homes are not reimbursable. **See IRS Publication 503**.
- The maximum you can elect, in a calendar year, is equal to the smallest of the following:
  - $5,000 – Married and filing federal taxes jointly or a single parent
  - $2,500 – Married and filing separate federal tax return
- The amount contributed year-to-date, is available for reimbursement.

Access to Your FSA Money

Access with a Debit Card

Pay for Expenses with a Debit Card

1. Easy to use- the Benefits Card is a stored-value card that simplifies the process of paying for qualified expenses.
2. Restricted by merchant code (MCC) to healthcare-related merchants where Visa is accepted.
3. It pays directly at the point of sale - No waiting for reimbursement!
4. You can use it to pay for online mail-order prescriptions.
5. **You must save all receipts and be prepared to provide receipts if they are requested.**

Save All Receipts For Purchases Made With The Benefit Card

Please remember to keep receipts for all purchases made with the Benefit Card. Per IRS regulations, Rocky Mountain Reserve may request itemized receipts to verify the eligibility of purchases made with the card.

- All receipts or other proofs of purchase must include the date of service, name of provider, dollar amount, and a description of the purchased service or product.
- Any receipt that does not contain the detailed information described above is not acceptable. Credit card receipts and canceled checks are not acceptable.
- If the requested receipt is lost or otherwise unavailable, most providers can provide a detailed statement documenting FSA eligible purchases.
- An Explanation of Benefits (EOB) is sufficient documentation to substantiate a transaction. Additional documentation will be requested UNLESS the transaction matches a co-payment, a previously approved repetitive expense, or was at a merchant that has installed the inventory information approval system referenced above.
- If a receipt is requested, Rocky Mountain Reserve will email a request within hours. Participants can mail, fax, email, upload the receipt online, or take a picture and submit it through the mobile app.

No Receipt Retailers

Some retailers have installed an inventory information approval system for most medical expenses and receipts will not be requested.

Below is a sample of some of the retailers who have installed the inventory information approval system:

1-800 Contacts	Costco	King Soopers	Safeway
Albertsons	CVS	Kroger	Sam's Club
City Market	Drugstore.com	Rite Aid	Target

Submit Claims for Reimbursement

Submit Claims Through a Mobile Application

Take a picture of your receipt and submit it with your reimbursement request through the mobile application. You can also look up your account balance and recent transactions. Claims submitted through the mobile application receive **high priority**. To download the mobile application: **Search for "RMR Benefits"**

Submit Claims Through a Web Portal

Participants may file requests for reimbursement directly to Rocky Mountain Reserve through **https://www.rockymountainreserve.com**. Claims submitted through the web portal receive **high priority.**

Submit Claims Manually

Participants may also file requests for reimbursement directly to RMR through fax, mail, or email.

Fax: 866.557.0109 **E-mail**: claims@rmrbenefits.com **Mail**: PO Box 631458 Littleton, CO 80163

Claims are paid by direct deposit or check.

Online & Mobile Access

www.rockymountainreserve.com

To Create Your Online Account:

1. Navigate in your browser to user.rmrbenefits.com/login
2. Select **Register** to setup your online account for the first time
3. Enter your Date of Birth and Unique ID (likely your 9 digit SSN)
4. Fill in or choose your required login & profile information
5. Verify your email
   After registering, you'll receive an email. You must click the verification link in that email to fully register your account
6. Enter Your Debit Card #
   If your account/benefit has a debit card you'll be asked to provide your card number after logging into the portal

With Online Access You Can:

- View balance
- View transaction history
- Download statements
- Submit claims and upload receipts
- View debit card receipt requests and upload receipts

RMR Benefits

RMR Benefits

Download the mobile application and gain real-time access to your account

Search "RMR Benefits" in the app store

PO Box 631458 · Littleton, CO 80163 · (888) 722-1223 · fax (866) 557-0109 · https://www.RockyMountainReserve.com

Dental Benefits

Carbon County offers voluntary dental benefits through Guardian Life Insurance Company. Taking care of your teeth is about more than just covering cavities and cleanings. It also means accounting for more expensive dental work, and your overall health. You may choose any dentist. You are responsible for charges above the 90th Percentile for the same services, in addition to the deductible and coinsurance.

SERVICES	BENEFIT
Deductible	$50 / Single 3 Members / Family Maximum Out-of-Network reimbursed at the 90th Percentile
Calendar Year Maximum Lifetime Maximum	$1,500/person Preventive Services apply to the Calendar Year Maximum $1,500/person Lifetime Orthodontia Maximum
Preventive Services • Oral exams • X-rays • Cleanings • Space Maintainers	100%, deductible waived
Basic Services • Fillings • Oral Surgery • General Anesthesia • Simple Extractions • Periodontics • Endodontics	80%, after deductible 6 month waiting period for employees who previously waived dental coverage. Late Entrant Penalties do not apply if enrolling during Open Enrollment Period; or, if coverage was waived initially due to coverage under another group plan as long as the enrollment is within 30 days of the loss. No waiting period for newly eligible employees.
Major Services • Crowns • Inlays & onlays • Prosthodontics • Repair & Maintenance of Crowns, Bridges & Dentures	50%, after deductible 1 year waiting period for employees who previously waived dental coverage. Late Entrant Penalties do not apply if enrolling during Open Enrollment Period; or, if coverage was waived initially due to coverage under another group plan as long as the enrollment is within 30 days of the loss. No waiting period for newly eligible employees.
Orthodontia	50%, after deductible 12 month waiting period from date of enrollment for all new enrollees. Limits: Child(ren) up to age 19

Vision Benefits

The Vision plan through VSP provides access through a national network including both private practice and retail chain providers.

To find a Participating Provider, visit **www.vsp.com**.

You can elect either contacts or lenses every calendar year / frames every other calendar year

Go to VSP.com and click **Create an Account** to set up your member account to view your benefits

	VSP Provider
Routine Eye Exam Frequency:	$20 Copay Retinal Screening covered after maximum copay of $39 Once every calendar year
Frames Wide Selection Featured Brands Additional Savings Frequency:	 $200 Allowance ($110 Costco frame allowance) $220 Allowance (not available at Walmart, Sam's Club, or Costco) 20% off amounts over allowance Every other calendar year
Lenses (in lieu of Contacts) Single Vision, Lined Bifocals, Lined Trifocals, and Impact-resistant lenses for children Frequency:	Glass or Plastic - Lined $20 Materials Copay Once every calendar year
Lens Enhancements: Factory Scratch Coating Standard Polycarbonate Progressive Lenses Photochromic Lenses UV Coating Anti-Reflective Coating Tint	 Included Included (Children) / $31 - $35 after Copay (Adults) Included $70 - $82 after Copay $16 after Copay $41 after Copay $15 after Copay (Included for Pink I & II)
Additional Pair of Glasses	20% Discount on Prescription & Non-Prescription
Contact Lenses (In lieu of Lenses) Elective Lenses Fitting & Evaluation Frequency:	 $130 allowance, Copay does not apply 15% Discount with Maximum Copay of $60 Once every calendar year
PREMIER PROGRAM	Maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations. (located on www.vsp.com)
eyeconic	Eyeconic is the preferred VSP online retailer where you can shop in-network with your vision benefits with over 70 brands of contacts, eyeglasses, and sunglasses. Includes Virtual Try-on Tool, free shipping and returns.
Out-of-Network Benefits	Out-of-Network is Subject to Applicable Copays and then reimbursed as follows: **Exam**: Up to $45 **Frames**: Up to $70 **Single Vision:** Up to $30 **Lined Bifocal:** Up to $50 **Lined Trifocal:** Up to $65 **Necessary Contacts:** Up to $210 **Elective Contacts:** Up to $105

Note: When using a non-network provider, the participant pays the full fee to the provider, and VSP reimburses the customer for services rendered up to the maximum allowance, after the applicable Copay. All receipts must be submitted at the same time.

TruHearing Hearing Aid Discount Program

vsp exclusive member extras

VSP® Vision Care members can save up to 60% on the latest brand-name prescription and over-the-counter hearing aids. Dependents and even extended family members are eligible for exclusive savings too.

TruHearing®
truhearing.com/vsp

Hearing loss is growing in the workplace

Like vision loss, hearing loss can have a huge impact on productivity and overall quality of life. Unfortunately, 38 million Americans need hearing aids, 70% of the people with hearing loss don't treat it, and only 30% seek treatment.[1] And the high cost of hearing aids is a major factor keeping people from addressing their hearing loss.

Ninety-six percent of customers surveyed would recommend TruHearing to their friends and family.[2]

More than just great pricing

TruHearing also provides members with:

- One year of follow-up visits for fittings, adjustments, and cleanings
- A 60-day trial
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement
- 80 free batteries per hearing aid on all non-rechargeable aids

Plus, members get:

- Access to a national network of more than 7,000 hearing healthcare providers
- Straightforward, nationally fixed pricing on a wide selection of the latest brand-name hearing aids
- High-quality, low-cost batteries delivered to your door

Best of all, if your organization already offers a hearing aid allowance, members can combine it with TruHearing prices to reduce their out-of-pocket expense even more!

Over-the-counter hearing aids are also available through phone or online orders.[3]

Here's how it works:

Contact TruHearing.
Members and their family call **877.396.7194** and mention VSP.

Schedule exam.
TruHearing will answer questions and schedule a hearing exam with a local provider.

Attend appointment.
The provider will perform a hearing exam, make a recommendation, order the hearing aids through TruHearing, and fit them for you.

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call 877.396.7194 with questions.

1. Kochkin S. MarkeTrak VIII: The key influencing factors in hearing aid purchase intent. Hearing Review. 2012; 19(3):12–25. "Quantifying the Obvious: The Impact of Hearing Instruments on Quality of Life." The Hearing Review. Kochkin and Rogin. Jan 2000. **2**. Based on a 2018 satisfaction study of VSP members. **3**. Over-the-counter hearing aids are different from prescription hearing aids.

VSP is providing information to its members, but does not offer or provide any discount hearing program. VSP makes no endorsement, representations or warranties regarding any products or services offered by TruHearing, a third-party vendor. TruHearing is not insurance and not subject to state insurance regulations. For additional information, please visit **vsp.com/offers/special-offers/hearing-aids/truhearing**. For questions, contact TruHearing directly. Not available directly from VSP in the states of Washington and California.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

Classification: Public

EMPLOYER-PAID LIFE/AD&D

Standard Insurance

LIFE

Life Insurance Amount	$20,000
Reduction Schedule	By 35% at age 65, and to 50% of the original amount at age 70
Accelerated Benefit	75%
Conversion	If your insurance reduces or ends, you may be eligible to convert your existing Life insurance to an individual life insurance policy without submitting proof of good health, as long as you apply with 30 days of termination.
Waiver of Premium	Your Life premiums may be waived if you become totally disabled while insured under this plan for 180 days and are under age 60. Coverage could continue without cost to age 65.

AD&D Loss must occur within 365 days after the accident

Loss of Life Sight of Both Eyes Both Hands Both Feet Any Combination	100% of Death Benefit
Sight of One Eye One Hand One Foot	1/2 of Death Benefit
Additional Benefits	Seat Belt ($10,000) / Air Bag ($5,000) Loss of Thumb and Index Finger (25% of AD&D Benefit) Loss of Speech and/or Hearing (50% of AD&D Benefit) Loss of Use / Paralysis (50% to 100% of AD&D Benefit) Child Education (up to $5,000) Spouse Training (up to $5,000) Repatriation (10% of the Life Benefit) Day Care (up to $5,000) Travel Assistance Public Transportation (100% of the AD&D Benefit otherwise payable) Portability Line of Duty (100% of the AD&D Benefit otherwise payable) Occupation Assault (50% of the AD&D Benefit)) Please refer to your Plan Document for Details

Employee-Paid Dependent Life

	Spouse $2,000 Dependent Children $1,000 Live birth through age 25 Continues 5 months after you die with no premiums being charged
Employee Cost:	$1.21 / month

If you are incapable of active work because of sickness, injury, or pregnancy on the day before your scheduled effective date, insurance will not become effective until the day after you complete one full day of active work

VOLUNTARY LIFE/AD&D

Insured by Standard Insurance

Life Insurance	
Employee Elections	Increments of $10,000 to $500,000 (to 8x earnings combined with Basic Life benefit) **$250,000 Guaranteed Insurability**
Spouse Elections	Increments of $5,000 to $250,000, limited to 50% of Employee Benefit **Guaranteed Issue up to $50,000.** Amounts over that will require evidence of insurability. Spouse rates are based on Employee's age.
Dependent Children to Age 26	$10,000 up to 100% of Employee Benefit Child rates include ALL children from Live Birth.
Enrollment	Each Employee can choose either Life only, or Life with AD&D After enrolling, Employee can elect to enroll Spouse and/or Children, and can elect either Life or Life and AD&D (if employee enrolled in AD&D)
Age Reductions	Employee & Spouse benefit reduces to 65% at age 65, and to 50% of original benefit at age 70 (premiums also reduce based on new benefit)
Living Care / Accelerated Benefit	75% of the amount of life insurance is available to you if are terminally ill
Accidental Death & Dismemberment **Pays in addition to the Life Benefit**	100% Loss of Life, Both Hands, Both Feet, Sight of Both Eyes, Loss of One Hand & One Foot, Loss of one Hand & Sight of One Eye, Loss of One Foot & Sight of One Eye, Loss of Speech & Hearing, Quadriplegia 50% Loss of Sight in One Eye, Loss of Speech or Hearing, Loss of One Hand or One Foot, Paraplegia, Hemiplegia 25% Loss of Thumb & Index Finger of Same Hand
Additional AD&D Benefits	Public Transportation Additional 100% of the amount of AD&D Insurance Benefit otherwise payable if the accident occurs while you are riding as a fare-paying passenger on Public Transportation, and die as a result of the accident. Occupational Assault While actively at work you suffer a loss for which an AD&D benefit is payable, and the loss is the result of an act of physical violence against you that is punishable by law and is evidenced by a police report - additional benefit is the lesser of $25,000 or 100% of the amount of AD&D insurance benefit otherwise payable for the loss of your life. Disappearance Death will be presumed if you disappear and the disappearance is caused solely and directly by an accident that reasonably could have caused loss of life; occurs independently of other causes; and continues for a period of 365 days after the date of the accident, despite reasonable search efforts.

Annual Benefit Increase	If members enroll for a minimum benefit when first eligible, they have the ability to enroll for additional coverage at the next enrollment by up to 1 increment each year, to the maximum benefit shown above.
Conversion	If your insurance reduces or ends, and you were insured for 3 years, you may be eligible to convert your existing Life insurance to an individual whole life insurance policy without submitting proof of good health, as long as you apply with 31 days of termination.
Portability	If your insurance ends because your employment terminates you may be eligible to purchase term insurance for yourself and your dependents without submitting evidence of insurability. On the date your employment terminates you must be able to perform with reasonable continuity the material duties of at least one gainful occupation for which you are reasonably fitted; under age 75; must have been continuously insured under this policy for at least 12 months; and submit application with the first payment within 31 days of termination. If you are unable to meet these requirements, refer to conversion and waiver of premium provisions.

Contributions / Rates

Age	Per $1,000 of Benefit
0 - 29	$0.07
30 - 34	$0.08
35 - 39	$0.09
40 - 44	$0.12
45 - 49	$0.17
50 - 54	$0.26
55 - 59	$0.46
60 - 64	$0.66
65 - 69	$1.27
70+	$2.42

AD&D	$0.035

Can add to EE, SP, or CH rates show above
Employee must enroll for dependents to enroll

Children	$2.00 / all children covered

Things can happen on the road. Passports get stolen or lost. Unforeseen events or circumstances derail travel plans. Medical problems surface at the most inconvenient times. Travel Assistance can help you navigate these issues and more at any time of the day or night.[1]

You and your spouse are covered with Travel Assistance — and so are kids through age 25 — with your group insurance from Standard Insurance Company (The Standard).[2]

Security That Travels with You

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including:

Visa, weather and currency exchange information, health inoculation recommendations, country-specific details and security and travel advisories

Credit card and passport replacement and missing baggage and emergency cash coordination

Help replacing prescription medication or lost corrective lenses and advancing funds for hospital admission

Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains[3]

Connection to medical care providers, interpreter services, local attorneys and assistance in coordinating a bail bond

Return travel companion if travel is disrupted due to emergency transportation services or care of minor children if left unattended due to prolonged hospitalization

Assistance with the return of your personal vehicle if your emergency transportation services leave it stranded

Evacuation arrangements in the event of a natural disaster, political unrest and social instability

Contact Travel Assistance

800.872.1414
United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda

Everywhere else
+1.609.986.1234

Text:
+1.609.334.0807

Email:
medservices@assistamerica.com

Get the App

Get the most out of Travel Assistance with the Assist America Mobile App.

Click one of the links below or scan the QR code to download the app. Enter your reference number and name to set up your account. From there, you can use valuable travel resources including:

- One-touch access to Assist America's Emergency Operations Center
- Worldwide travel alerts
- Mobile ID card
- Embassy locator

Reference Number:
01-AA-STD-5201

Download on the App Store

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | **standard.com**

1 Travel Assistance is provided through an arrangement with Assist America, Inc. and is not affiliated with The Standard. Travel Assistance is subject to the terms and conditions, including exclusions and limitations of the Travel Assistance Program Description. Assist America, Inc. is solely responsible for providing and administering the included service. Travel Assistance is not an insurance product. This service is only available while insured under The Standard's group policy.

2 Spouses and children traveling on business for their employers are not eligible to access these services during those trips.

3 Participants are responsible for arranging transportation from the point of injury or illness to the initial point of medical care or assessment and the cost related to this transportation. Any emergency evacuation services provided by Assist America, Inc. must be arranged by Assist America, Inc.

SI 14684

Travel Assistance EE
(4/23)

RETIREMENT BENEFITS

Pension Plan:

The retirement benefit of a pension plan provides a monthly payment for life once you meet service and age requirements. This "defined benefit" is based on your age, years of service, and salary while participating. Those working at least 30 hours per week for Carbon County are required to participate and a pre-tax deduction is made from your monthly paycheck. Contact Human Resources or review your check stub for the current percentage.

Vesting Requirements: After obtaining 48 months of service, you are eligible to elect a monthly benefit at retirement age. Months of service are calculated based on actual hours worked. The 48 months of service do not have to be consecutive months.

You are eligible for unreduced ("full") retirement when:

Under Tier 1, you reach age 60 and are vested; Under Tier 2, you reach age 65 and are vested; or under either tier, you meet the requirements of the Rule of 85, which means your age plus your years of service in WRS equal 85 or more.

Law enforcement is eligible once you reach age 60 and are vested or you have 20 years of service at any age.

Tiers: If you made a contribution to the Plan for service prior to Sept. 1, 2012, you are in Tier 1. If you made your first contribution to the Plan for service on or after Sept. 1, 2012, you are in Tier 2.

457 Deferred Compensation Plan:

A Powerful Savings Tool That Can Make Having a Comfortable Retirement a Whole Lot Easier

You invest for retirement. You contribute a portion of your salary to the plan each month, and your contributions are automatically deducted from your paycheck – before you're tempted to spend that money on something else. This plan offers both pre-tax and post-tax options.

Wyoming Retirement System

Visit WY Retirement's website at **www.retirement.state.wy.us** to calculate your benefit, login to your account, and to find general information about your plan. Periodically the WY Retirement educator visits Carbon County and employees can setup individual appointments to discuss your personal situations.

Wyoming
RETIREMENT SYSTEM
Partnering to build financial security for members and their families

IMPORTANT NOTICES

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 or your dependents in this plan if you or your dependents lose eligibility for that other coverage, or if the employer stops contributing towards your or your dependents' other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). To be eligible for these Special Enrollment rights you must have completed a waiver when you were first eligible stating that you were declining because of other group health insurance coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. In the case of marriage, eligible individuals must submit their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins.

Women's Health & Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, benefits under this Plan are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following Covered Charges, as you determine appropriate with your attending Physician: 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; and Prostheses and treatment of physical complications of the mastectomy, including lymphedema. The amount you must pay for such Covered Charge (including Copayments and any Deductible) are the same as are required for any other Covered Charge. Limitations on benefits are the same as for any other Covered Charge.

Wellness Program Disclosure

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 307-328-7825 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of Carbon County WY and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

(1) your past, present, or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact Human Resources at 307-328-7825.

Effective Date

This Notice is effective September 23, 2013.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by internal company email.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations
In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health activities. These activities generally include the following:
- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law-enforcement official-
- in response to a court order, subpoena, warrant, summons, or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when:
(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures
The following is a description of disclosures of your protected health information we are required to make.
Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures
Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:
(1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or
(2) treating such person as your personal representative could endanger you; and
(3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights You have the following rights with respect to your protected health information:
Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to Human Resources. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to Human Resources.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.
To request an amendment, your request must be made in writing and submitted to Ashley Jolly at 215 W. Buffalo St, Rm 218, Rawlins, WY 82301. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.
- If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to Human Resources. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.
Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request to Human Resources at 307-238-7825. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply-for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request to Human Resources at 307-238-7825. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
To obtain a paper copy of this notice, contact Human Resources at 307-238-7825.

Complaints. If you believe that your privacy rights under this Notice have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact Human Resources at 307-238-7825 or 215 W. Buffalo St, Rm 218, Rawlins, WY 82301. All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

You may also file a written complaint directly with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Room 509F, Hubert H. Humphrey Building, Washington, D.C. 20201, or the appropriate Regional Office of the Office for Civil Rights. You may also call them at 1-877-696-6775; or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

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 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.

[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.

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 through your employment, please check your health plan's summary plan description or contact your Human Resources Department.

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 Carbon County WY		4. Employer Identification Number (EIN) 83-6000104
5. Employer address 215 W Buffalo St, Rm 218		6. Employer phone number 307-328-7825
7. City Rawlins	8. State WY	9. ZIP code 82301
10. Who can we contact about employee health coverage at this job? Ashley Jolly		
11. Phone number (if different from above)	12. Email address hr@carboncountywy.gov	

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:

    Employees working 30 hours or more per week. Coverage is effective the 1st of the month following your date of employment

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Legally recognized spouse, children to the end of the month they attain age 26, unmarried disabled children already insured over age 26.

  - ☐ We do not offer coverage.

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

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

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services 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 – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
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)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	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/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

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

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

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

MEDICARE PART D NOTICE

Important Notice from Carbon County WY 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 Carbon County WY 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. If neither you nor any of your dependents are eligible for or have Medicare, this notice does not apply to your or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede 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. Prime Therapeutics Management has determined that the prescription drug coverage offered by the Carbon County WY Employee Benefit 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 coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current coverage, you and your dependents will be able to get this coverage back at the next annual open enrollment period.

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 Carbon County WY and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Carbon County WY 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: October 15, 2024
Carbon County WY
Ashley Jolly
215 W. Buffalo St, Rm 218
Rawlins, WY 82301
307-238-7825

Premiums

Employee Contributions

Effective January 1 beginning with a December payroll deduction

MEDICAL PLAN	Premium Paid by Employee			
	Plan A	Plan B	Plan A Cobra	Plan B Cobra
Single	$200	$100	$1,414	$1,354
Employee + Spouse	$440	$220	$3,499	$3,342
Employee + Child	$400	$200	$3,499	$3,342
Family	$500	$250	$3,499	$3,342

DENTAL PLAN	Premium Paid by Employee
Single	$31
Employee + Spouse	$63
Employee + Child(ren)	$69
Family	$101

VISION PLAN	Premium Paid by Employee
Single	$11.89
Employee + One	$19.03
Employee + Children	$19.43
Family	$31.32

WELLNESS	Wellness Rewards
Employee	Up to $450
Spouse	Up to an additional $450
* You may carryover a combined total of $150 to the next plan year.	

EMERGENCY MEDICAL TRANSPORT PLAN	MASA
Per Employee	$14

RETIREE MEDICAL PLAN	Plan A – No Plan Choice for Retirees. 10% increase each January. Former employee and dependents drop off retiree insurance upon Medicare eligibility due to age (at 65 years old)
Single	$439
Family	$1,025