HeartShare

2025

EMPLOYEE BENEFITS GUIDE

HeartShare offers you and your eligible family members a comprehensive and valuable benefits program. This guide has been developed to assist you in learning about your benefit options and how to enroll.

We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

Welcome
TO HEARTSHARE!

INSIDE THIS GUIDE

Questions?

If you have questions about your benefits, please contact the Benefits Member Advocacy Center (Benefits MAC) at **800.563.9929** (Monday through Friday, 8:30 am to 5:00 pm ET) or go to **www.connerstrong.com/memberadvocacy**.

You may also reach out to any of the following Human Resources contacts:

- Diana Di Giacomo
  Phone: **718.422.3346**
  Email: **Diana.DiGiacomo@heartshare.org**
- Elizabeth Roden
  Phone: **718.422.3202**
  Email: **Elizabeth.Roden@heartshare.org**

Welcome to HeartShare!

Enrolling in Benefits

STEP 1: Log into the Paycom app, from the **Notification Center** or from the **Benefits section**, click the current year's **Benefits Enrollment.** Make sure to have your dependent/beneficiary information ready, such as Social Security numbers, before beginning the enrollment process.

STEP 2: Review initial instructions and click **"Start Enrollment"**. Then, enter your personal information and any dependents or beneficiaries.

STEP 3: After determining which plan will work for you, choose your coverage level, then select either to enroll or decline.

STEP 4: To complete enrollment, click **"Finalize,"** then **"Sign and Submit"**.

2025-2026 Benefit Highlights

- HeartShare partners with Aetna for Medical and Prescription drug coverage. Members enrolled in the plan will also have access to the **Health Reimbursement Account through Garner!**
- **There will be two medical plan options for the 2025/26 plan year but both will include Garner.**
- Members that utilize Garner providers will have a significant portion of their out of pocket medical expenses covered by the Garner HRA!
- If you have questions about your benefits, please contact the Benefits Member Advocacy Center (Benefits MAC) at **800.563.9929** or go to **www.connerstrong.com/memberadvocacy**. If you have questions about Garner Health, please contact Garner at **866.761.9586** or go to **www.getgarner.com**. Additional details can be found in this guide.

Eligibility & Making Plan Changes

If you are a full-time or part-time employee working 30 hours or more per week at HeartShare, you are eligible to enroll in the benefits outlined in this guide.

HEARTSHARE BENEFITS	FULL-TIME	PART-TIME (17 1/2 HOURS OR MORE)	PER-DIEM
ACCRUED TIME OFF			
Vacation (Accrued as of 1st day of employment, however not eligible for use until after 90 days)	✓	✓	
Sick (Accrued as of 1st day of employment, however not eligible for use until after 90 days)	✓	✓	
Personal (Accrued as of 1st day of employment, however not eligible for use until after 90 days)	✓	✓	
Holidays (Depends on your program. Ask your supervisor for a current list of observed holidays)	✓	✓	
HEALTH BENEFITS			
Health Care (Eligibility is the 1st of the month after 60 days of employment)	✓		
Dental Care (Eligibility is the 1st of the month after 60 days of employment)	✓		
Life Insurance (Eligibility is the 1st of the month after 60 days of employment)	✓		
Optional Life Insurance (Eligibility is the 1st of the month after 60 days of employment)	✓		
Short-Term Disability (Eligible to apply after 3 months of employment)	✓	✓	✓
Long-Term Disability (Eligibility is the 1st of the month after 60 days of employment)	✓		
Worker's Compensation (Eligible to apply immediately)	✓	✓	✓

Making Plan Changes

Unless you experience a Qualifying Life Event, you cannot make changes to your benefits until the next Open Enrollment period. Qualifying Life Events include:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan.

You must notify Human Resources within 30 days of experiencing a Qualifying Life Event.

Medical & Prescription Benefits

AETNA

HeartShare offers the following medical plan options administered by Aetna. If you are enrolled in one of the medical plans, you are automatically enrolled in the corresponding prescription drug plan through Aetna. Don't forget that preventive care services are covered 100% in-network! **The Garner HRA will cover your entire deductible! See page 12 for more details on Garner Health**.

	Aetna Whole Health + $4,000 Garner HRA	Open Access Elect Choice EPO $3,000 + $3,000 Garner HRA
IN-NETWORK BENEFITS		
Annual Deductible Individual/Family	$4,000/$8,000	$3,000/$6,000
Garner HRA	$4,000/$8,000	$3,000/$6,000
Out-of-Pocket Maximum Individual/Family	$8,500/$17,000	$7,000/$14,000
Coinsurance (% Member Pays)	40% after deductible	30% after deductible
Preventive Care Services	Covered 100%	Covered 100%
PCP Office Visit	$50 copay	$50 copay
Specialist Office Visit	$70 copay	$70 copay
Emergency Room	$250 copay	$250 copay
Inpatient Hospital	$500 copay, then 40% after deductible	30% after deductible
Outpatient Surgery	40% after deductible	30% after deductible
Outpatient Lab & X-Ray	Lab: 40%, no deductible / X-Ray: 40% after deductible	Lab: Covered 100% / X-Ray: 30% after deductible
Urgent Care	$100 copay	Covered 100%
OUT-OF-NETWORK BENEFITS		
Deductible Individual/Family	Not Covered	Not Covered
Out-of-Pocket Maximum Individual/Family	Not Covered	Not Covered
Coinsurance (% Member Pays)	Not Covered	Not Covered
RETAIL PHARMACY (UP TO A 30-DAY SUPPLY)		
Generic **Preferred Brand** **Non-Preferred Brand** **Specialty Medications**	$25 copay $50 copay $75 copay $75 copay	$20 copay $40 copay $80 copay $80 copay
MAIL ORDER (UP TO A 90-DAY SUPPLY)		
Generic **Preferred Brand** **Non-Preferred Brand** **Specialty Medications**	$62.50 copay $125 copay $187.50 copay $187.50 copay	$50 copay $100 copay $200 copay $200 copay

The single deductible is embedded in the family deductible, so no one family member can contribute more than the individual deductible amount during the plan year. Once the member meets their single deductible, they will start paying copays and/or coinsurance until they have reached their out-of-pocket maximum.

Find an In-Network Provider

AETNA

- To search for a provider, visit: **www.aetna.com/individuals-families/find-a-doctor.html**
- Click on **Plan From an Employer**
- Type in your zip code
- For **Aetna Whole Health**, search the **Aetna Whole Health - Open Access Elect Choice** network
  - If you are NY, you will see a 'NY' indicator. Similarly, if you are in 'NJ', you will see a 'NJ' indicator.
  - **The Whole Health network is not nationwide**. Members with this plan outside of the Aetna Whole Health footprint will only have emergency coverage.
- For the **Aetna $3k/$6k EPO**, search for **Aetna Elect Choice EPO (Open Access)**.
  - This is a national network

REMINDER: Neither plan as out-of-network coverage. However, members can use the CVS Virtual Health benefit anywhere in the country.

Preventive Care

Good News! Your health benefits and insurance plan covers the services listed on this page with *no cost share as part of your Preventive Care benefit*.

The information provided on the next couple pages is not all inclusive and HeartShare recommends consulting with your physician if you believe any of these services apply to you. Many services listed are covered as part of physical exams. These include regular checkups and routine gynecological and well-child exams. You won't have to pay out-of-pocket for these preventive visits, when provided in-network, but these services are generally not preventive if you get them as part of a visit to diagnose, monitor, or treat an illness or injury. If part of a diagnostic visit, then copays, coinsurance, and deductibles may apply. Aetna follows the recommendations of national medical societies about how often children, women, and men, need these services. Be sure to talk with your doctor about which services are right for your age, gender, and health status.

Covered Preventive Services for Adults Generally Include:

- **Annual Physical**
- **Screenings for:**
  - Abdominal aortic aneurysm
  - Alcohol misuse
  - Blood pressure
  - Cholesterol
  - Colorectal Cancer (for adults over age 50)
  - Cervical Cancer screening
  - Type 2 Diabetes
  - Human papillomavirus (HPV)
  - Obesity counseling
  - Tobacco Use
  - Shingles vaccine
  - Prostate Cancer screening (men ages 55 to 69)
  - Lung Cancer (for adults over age 55 with a history of smoking)

Covered Preventive Services for Adults (cont.):

- **Medications and Supplements**
  - Aspirin up to 325 for men and women age 45 and older with certain cardiovascular risk factors
  - Vitamin D supplements for adults aged 65 and older with certain conditions
  - Tobacco cessation programs when prescribed by a health care provider and filled at a participating pharmacy
- **Immunizations**
  - Diphtheria, pertussis, tetanus (DPT)
  - Hepatitis A & B
  - Human Papillomavirus (HPV)
  - Influenza
  - Measles
  - Chickenpox
  - Meningitis

Preventive Care (cont.)

Below are additional preventive screenings, services, and counseling available for women:

- BRCA (counseling and genetic testing for women at a high risk with no personal history of breast and/or ovarian cancer)
- Breast cancer chemoprevention (for woman at high risk)
- Breast cancer mammography every one (1) or two (2) years for women over age 40
- Cervical cancer
- Interpersonal or domestic violence
- Osteoporosis for women age 60+ depending on risk factors
- Women have access to FDA approved contraception products and services. Women can get two (2) visit per year for patient education and counseling on contraceptives.

Below are other preventive services available to pregnant women:

- Routine prenatal visits
- Anemia screenings
- Diabetic screenings
- Breastfeeding interventions to support and promote breastfeeding after delivery, including up to six (6) visits with a lactation consultant
- Breastfeeding pumps

Below are preventive services and screenings for children and infants:

- Anemia screenings
- Body mass index (BMI)
- Chickenpox
- Hearing and vision screening
- Influenza vaccine
- Obesity screening and counseling
- Oral fluoride
- Tetanus, diphtheria, pertussis (TDAP) vaccine
- Human Papillomavirus (HPV) vaccine
- Hepatitis A and Hepatitis B

CVS Health Virtual Visits

When to use CVS Health and the cost difference compared to ER and Urgent Care:

- CVS Health Virtual Care is the most cost effective solution for minor ailments
- For non life-threatening conditions that require a prompt response and an in-person consultation, CVS Minute Clinics and Urgent Care will be the best option
- For the most severe conditions that may be life threatening, Emergency Care is available

	CVS Health Virtual Care	Primary Care Provider (PCP)	Walk-In Clinic (i.e. CVS MinuteClinic)	Urgent Care	Emergency Room
When to Use Each Service?	Minor cuts, Sprains, Flu Symptoms, Allergies, Rash, Fever, Stomachache, Headache, Medication Refills, Mental Health*	Sprains, Joint or lower back pain, Urinary tract infection	Sprains, Joint or lower back pain, Urinary tract infection	More severe sprains, Flu Symptoms, Minor Burn, Joint or lower back pain, Urinary tract infection	Broken bones, Chest pain, Severe shortness of breath, Deep wounds, Unconsciousness, Uncontrolled bleeding
Average Out-of-Pocket Cost to Member based on the Aetna Whole Health 2025/26 plan design	$0	$50 copay (Preventive Visits are available at no cost)	$50 copay	$100 copay	$250 copay
Availability	24/7 care for minor illnesses from phone or laptop	A PCP can sometimes have long wait times. Therefore it is important to know where to go if your PCP is not available for urgent needs	CVS MinuteClinic walk-in appointments can be made very easily and generally have shorter wait time than the Urgent Care or Emergency Room	In-network Urgent care offices are available for non-life threatening injuries or illnesses that required a prompt response	The ER should be used for more severe conditions that may be life threatening

* Mental Health services are available through CVS Health Virtual Care for members aged 13 and older. Members aged 18+ can receive Health Medication Management and Psychiatry services while members younger than 18 can receive counseling only.

Get Started Today!

Scan the QR code or visit **www.cvs.com/virtual-care** to register and schedule an appointment.

Insurance Terminology

Deductible

How much you pay before your health insurance starts to cover a larger portion of the cost.

- The deductible **resets** on January 1st each year
- You **must** first meet the deductible before the plan begins paying benefits, unless otherwise noted on the plan summary
- Many preventive care services are covered before meeting the deductible

Copay

A predetermined rate you pay the time of care. That rate can vary based on the service and provider.

- On the Aetna Whole Health Plan, a Primary Care Physician (PCP) copay is $50, while a Specialist copay is $70

Coinsurance

The percentage of a medical charge that you pay after your deductible has been met for the year.

- The Aetna Whole Health Plan coinsurance is 60%. This means that once the deductible is met, the plan will pay 60% of the costs and you pay 40%

Out-of-Pocket Maximum

The most you must pay for your healthcare expenses before your insurance covers 100% of the cost.

- The out-of-pocket maximum **resets** on January 1st each year
- The Aetna Whole Health Plan out-of-pocket maximum is $8,500 for an individual, and $17,000 for a family
- Pharmacy expenses, coinsurance/copays, and deductible expenses all count toward hitting your out-of-pocket maximum

What is Garner?

Garner is a free healthcare benefit that helps you find the best medical providers, then reimburses you for qualifying out-of-pocket medical costs. Garner will automatically reimburse members for out-of-pocket medical costs!

Get access to the top 20% of doctors! You'll get reimbursed for your out-of-pocket medical costs when you see them.

Create a Garner account. Then, use the Garner Health app or website to search for the very best doctors in your area. These Top Providers are automatically added to your list of approved providers as soon as they are visible on your screen. Once Top Providers are on your list of approved providers, you can get reimbursed for qualifying* out-of-pocket costs.

Top Providers have shown to:

- Practice based on the latest medical research
- Successfully diagnose problems
- Get the highest patient satisfaction ratings
- Produce the best patient outcomes

***Your out-of-pocket medical costs will qualify for reimbursement if:**

- You have created a Garner account and added the provider to your list of approved providers prior to the date of service.
- Your provider is in-network and the cost was covered by your health insurance plan. (Check your health insurance plan.)
- Emergency services will be covered along with Prescription Drugs that are prescribed from a Garner participating provider.

Create an Account and Start Using Your Garner Benefit

Download the Garner Health app or go to: **https://garner.guide/oe**

STEP 1: Choose **HeartShare**

STEP 2: Enter your full legal name

STEP 3: Verify your identity: enter your personal information correctly

Questions?

Message the Concierge through the Garner Health mobile app, online at **getgarner.com** or email **concierge@getgarner.com**.

Recommendations are based solely on independent analysis, not commissions or fees. Garner has no financial relationships with doctors.

Garner FAQ's

What does it mean to grandfather a provider?

If a member is seeing a Primary Care Provider (PCP) that is not on the Garner list of preferred providers, the member may add the PCP to their account. This will allow Garner to reimburse out of pocket medical expenses incurred from services with the listed PCP. PCP's include primary care providers, gynecologists, therapists, & pediatricians.

How long do members have to grandfather their healthcare providers once Garner is active?

We recommend members add PCPs immediately. Until a member adds their existing PCPs, claims from those providers are not eligible for reimbursement. Each provider must be added to the member's list of providers before the date they receive care. However, there is no deadline for adding existing PCPs in the plan year.

If I grandfather in my PCP, does that mean other HeartShare members can go to that provider and it will be Garner approved?

Each HeartShare employee must add their own providers to their account. However, if a provider has been added to an account, all dependents on the primary's health plan will have that provider approved for claims reimbursements.

What are Garner's concierge hours?

8am - 8pm ET, Monday—Friday

If I pay at the doctor's office with my FSA card, can I still be reimbursed through Garner?

No. You may not be reimbursed by the Garner HRA for an out-of-pocket medical cost that will also be paid using your FSA. This is often referred to as double-dipping and is prohibited by the IRS.

Do Prescription medications prescribed by a grandfathered provider get covered for reimbursement?

Yes

Are Mental Health costs reimbursed by Garner?

Yes. Therapists and psychologists are considered PCPs and should be added by the member.

What are other examples of reimbursable expenses:

Office visits, prescriptions, Physical Therapy, Imaging and lab work, Urgent Care, Hospital bills. All of these expenses can be reimbursed as long as a Garner provider is utilized.

How will I be reimbursed?

Garner will automatically see your claim and reimburse you for eligible out of pocket medical expenses so long as you use the Garner network of providers. Members do not have to submit for reimbursement. Garner will reimburse you via check.

EMPLOYEE CONTRIBUTIONS

BI-WEEKLY RATES

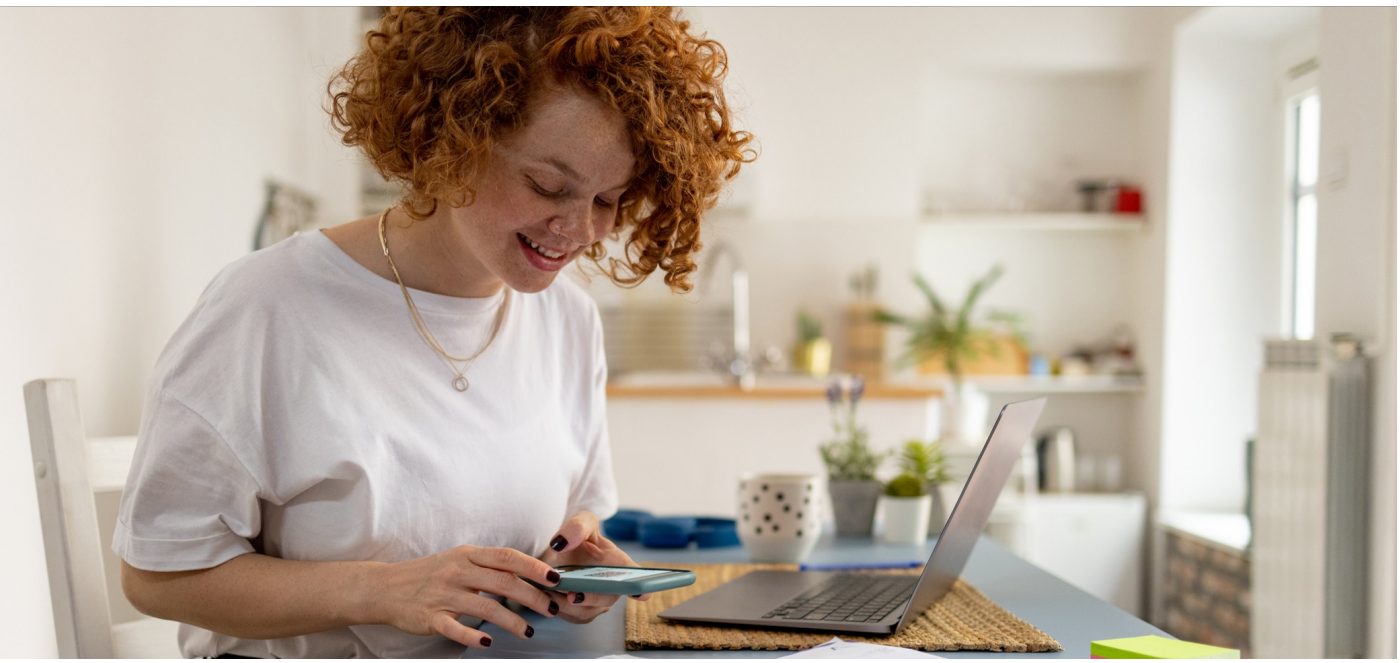
Medical & Prescription Drug Bi-Weekly Contributions

COVERAGE LEVEL	AETNA WHOLE HEALTH PLAN	OPEN ACCESS ELECT CHOICE $3,000
Employee	$31.98	$133.55
Employee + Spouse	$203.02	$406.16
Employee + Child(ren)	$182.71	$365.54
Family	$456.78	$761.50

Dental Bi-Weekly Contributions

COVERAGE LEVEL	DPPO
Employee	$8.80
Employee + Spouse	$18.64
Employee + Child(ren)	$20.73
Family	$30.60

* Members that enroll in the dental plan will automatically get the vision plan.



Understanding Your Prescription Benefits

AETNA

Generic Drugs

Safe. Effective. FDA-Approved

A generic drug is identical (or bioequivalent) to a brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. Although generic drugs are chemically identical to their branded counterparts, they are typically sold at substantial discounts from the branded price.

Ask your healthcare provider if there is a generic equivalent for your brand-name drug or visit **www.fda.com** for a catalogue of FDA-approved drug products.

GoodRx

Use GoodRx to compare drug prices at local and mail-order pharmacies and discover free coupons and savings tips. Find huge savings on drugs not covered by your insurance plan - you may even find savings versus your typical copayment. With GoodRx you can:

- Instantly access to the lowest prices for prescription drugs at more than 75,000 pharmacies
- Receive coupons and savings tips that can cut your prescription costs by 50% or more
- Review side effects, pharmacy hours and locations, pills images and much more!

Visit **https://connerstrong.goodrx.com** or download the GoodRx mobile app to get started today!

Mail Order

Members can use mail order for maintenance medications. Using the mail order program through Aetna for your maintenance medications will **SAVE YOU MONEY**. You will receive up to a 90-day supply for two and half retail copays. In addition to the savings, you will receive, your prescriptions will be delivered right to your home.

How much can you save when you use Mail Order? *Compare for yourself...*

RETAIL PHARMACY OPEN ACCESS ELECT CHOICE $3,000 (30-DAY SUPPLY)	MAIL ORDER OPEN ACCESS ELECT CHOICE $3,000 (90-DAY SUPPLY)	ANNUAL SAVINGS
Preferred Brand Copay $40	Preferred Brand Copay $100	$80
Annual cost *($35 per month x 12 fills)* $480	Annual cost *($87 per order x 4 fills per year)* $400	

These costs will be reimbursed when using your Garner HRA.

Vision Benefits

AETNA

Take care of your vision and overall health while saving on your eye care and eyewear needs with our vision plan administered by Aetna. Vision insurance can help you maintain your vision as well as detect various health problems. Health conditions such as diabetes and high blood pressure can be detected early through a comprehensive eye exam. **Members that enroll in the dental plan will automatically get the vision plan**.

	AETNA VISION PLAN	
BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Exam	$10 copay	Up to $50
Frames	$180 allowance; 20% off any remaining balance	Up to $48
Lenses		
Single Vision Lenses	$20 copay	Up to $48
Bifocal Lenses	$20 copay	Up to $67
Trifocal Lenses	$20 copay	Up to $86
Lenticular Lenses	$20 copay	Up to $126
Contact Lenses (in lieu of eyeglasses)	$180 allowance; 15% off any remaining balance	Up to $105
Frequency		
Vision Exam	Once every calendar year	Once every calendar year
Lenses	Once every calendar year	Once every calendar year
Frames	Once every calendar year	Once every calendar year

Dental Benefits

AETNA

Eligible employees and their eligible family members may enroll in the Aetna dental plan, which includes 100% coverage for preventative services such as routine dental exams, cleanings and X-rays. Dental hygiene and health are directly linked to health in other areas of the body. Good dental care is a crucial part of your overall physical health because other systems can be affected by your oral health. For example proper gum care can actually help prevent heart disease.

	DPPO PLAN	
BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Calendar Year Deductible Individual/Family	$50/3x Individual	$50/3x Individual
Calendar Year Maximum (per patient)	$2,500	$2,500
Preventive & Diagnostic Services Exams, Cleanings, Bitewing X-rays (each twice in a calendar year), Fluoride Treatment (once in a calendar year, children to age 19)	100%	100%
Basic Services Fillings, Extractions, Endodontics (root canal), Periodontics, Oral Surgery, Sealants	90%	80%
Major Services Crowns, Gold Restorations, Bridgework, Full and Partial Dentures	70%	60%
Orthodontia Benefits	50% with $1,500 Lifetime Maximum	Not Covered

Flexible Spending Accounts

BENEFIT RESOURCE, INC.

Flexible Spending Accounts (FSAs) provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pre-tax bases. By anticipating your family's health care and dependent care costs for the next plan year, you can lower your taxable income.

Healthcare FSA

The Healthcare FSA allows you to set aside pre-tax dollars via payroll deductions to pay for qualified healthcare expenses for you and your dependents. The annual maximum amount you may contribute is **$3,300** per calendar year. The Healthcare FSA can be used for:

- Doctor office copays
- Non-cosmetic dental procedures (crowns, dentures, orthodontics)
- Prescription contact lenses, glasses and sunglasses
- LASIK eye surgery

CARES Act and Qualifying Medical Expenses

Under the CARES Act, the definition of a qualifying medical expense now includes certain over-the-counter medications and products. Specifically, the act treats additional over-the-counter medications, along with menstrual care products, as qualified expenses that may be paid for using FSAs or other tax-advantaged accounts.

Healthcare FSA $660 Carryover

HeartShare allows up to $660 of unused Healthcare FSA funds to carry over into the next plan year. Amounts over $660 will be forfeited.

Claims Submission Deadline

All eligible claims for FSA expenses incurred between March 1, 2025 through February 29, 2026 must be submitted to Benefit Resource, Inc. by May 14, 2026.

Dependent Care FSA

The Dependent Care FSA lets you use pre-tax dollars toward qualified dependent care expenses. The annual maximum amount you may contribute is **$5,000** (or **$2,500** if married and filing separately) per calendar year. The Dependent Care FSA can be used for:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)
- Au Pair
- After school programs
- Baby-sitting/dependent care to allow you to work or actively seek employment
- Day camps
- Adult/eldercare for adult dependents

Contact Benefit Resource, Inc.

- Call: **800.473.9595**
- Website: **www.benefitresource.com**
- Email: **participantservices@benefitresource.com**
- Mobile App: **BRiMobile**

FSA FAQ's

Am I eligible to participate in the Healthcare FSA?

You are eligible to participate in the Healthcare FSA regardless of your medical plan election.

Is the Healthcare FSA the same as the Dependent Care FSA?

No, the are separate and require separate elections. The Healthcare FSA allows you to use pre-tax funds for qualified medical expenses, while the Dependent Care FSA allows you to use pre-tax funds on childcare expenses.

How much can I contribute to my FSA?

For the 2025 calendar year, you ca contribute up to $3,300. Those that are age 55 and older can contribute an additional $1,000.

How do the tax advantages work for the FSA?

Members can fund their FSA with pre-tax dollars. The funds can then be spent on qualified medical expenses on a pre-tax basis. In this way the member can save an estimate 20%-30% depending on their tax rate.

Do I forfeit unused funds at the end of the year?

You can carry over up to $660 into the following plan year. Unused amounts above $660 will be forfeited unless spent down by the end of the year.

Will I get a debit card to spend down my FSA?

Yes, you will get a debit card from BRI.

What can I use my FSA for?

- BRI, our FSA plan administrator, has a tool to use to confirm if an item or service is FSA eligible, visit: www.benefitresource.com/resources/eligible
- In general, you can use the FSA for Medical, Prescription, Dental, and Vision out-of-pocket expenses
- You can also purchase items with your FSA card at the Amazon FSA store

Are the funds available at the beginning of the year?

Yes, the funds that you elect will be available on your card on the first day of the plan year. You will then be payroll deducted throughout the year. As an example, if you elected to contribute $1,000 in 2025, you will have access to the $1,000 on your FSA card on March 1, 2025. You will then have a payroll deduction of $28.46 per paycheck (assuming 26 paychecks) to fund the $1,000.

Is the FSA portable and can I take the funds with me if I leave HeartShare?

The FSA is not portable, meaning you cannot take if with you if you leave the organization.

Can I use my FSA and Garner HRA on the same service?

No. You may not be reimbursed by the Garner HRA team and the FSA for the same service. The IRS does not allow for it.

Commuter Benefits

BENEFIT RESOURCE, INC.

HeartShare is pleased to provide our employees with the opportunity to enroll a spending account specific to work-related transit expenses. Commuter Benefits allow you to pay for eligible work-related transit and parking expenses through pre-tax payroll deductions from your paycheck.

You are able to make changes to your pre-tax election amount on a month-to-month basis. Once you make your election, you will receive a debit care that can be used to pay for work-related transit and parking expenses. Your debit card is loaded with your pre-tax deductions each time a deduction is taken from your paycheck. Each time you use your debit card to pay for transit purchases, the funds are automatically debited from your transit account.

Carryover & Eligible Expenses

There is no annual "use-it-or-lose-it" rule for Commuter Benefits. While unused amounts cannot be cashed out, they can be carried over to provide transit benefits in subsequent years.

Maximum Monthly Contributions

For the 2025 plan year you may contribute:

- **TRANSIT:** Up to $325 per month for transportation (mass transit, train, subway, bus fares, ferry rides). Transit requires payment with the Benefit Resource, Inc. debit card only.
- **PARKING:** Up to $325 per month for parking expenses incurred at or near your work location or near a location from which you commute using mass transit.

At the end of the plan year, any balances in either account will remain in your account and be available for you use in the next plan year, unless your employment with HeartShare is terminated.

Questions?

If you need additional information or have questions, please contact Benefit Resource, Inc. at **800.473.9595** or by visiting **www.benefitresource.com**. You may also visit **www.irs.gov** for more information about qualified expenses.

Employee Assistance Program (EAP)

COMPSYCH

There are times when you cannot go it alone. With HeartShare, you don't have to.

Sometimes we experience difficulties that cannot be resolved without the assistance of a trained professional. Unresolved issues with substance abuse, stress, anxiety, home life, and work life can affect or undermined our quality of living.

With an EAP, you and your family household members have access to free, confidential resources to help handle life's everyday— and not so every day—challenges.

How the EAP Works

The Compsych Employee Assistance Program provides eligible employees and their families assistance with behavioral healthcare services that can help being the process of resolving emotional or substance abuse issues. You and the members of your household are entitled to three (3) face-to-face or telephonic meetings per year. The encounter with the counselor through the EAP is completely confidential.

The EAP can assist with topics such as:

- Emotional Difficulties/ Depression
- Family/Relationship Problems
- Stress/Anxiety Issues
- Grief and Loss Issues
- Alcohol/Drug Abuse or Addiction
- Anger/Rage Issues
- Eating Disorders
- Life Transition Problems
- Gambling Problems
- Other Behavioral Addictions

Contact Information

For personal and confidential assistance you may contact Compsych any of the following ways:

- Call: 800.272.7255 (TDD: 800.697.0353)
- Online: www.guidanceresources.com
- App: GuidanceResources Now
- Web ID: COM589

Life & Disability Benefits

PRUDENTIAL

Basic Life Insurance

Life Insurance can help provide for your loved ones if something were to happen to you. HeartShare provides part-time and full-time employees working a minimum of 30 hours per week Group Life and Accidental Death and Dismemberment Insurance (AD&D). HeartShare pays for the full cost of the benefit.

BASIC LIFE AND AD&D INSURANCE	
Basic Life/AD&D Benefit	$25,000 Reduces to 35% at age 60 and then to 50% at age 70

Voluntary Life Insurance

While HeartShare offers basic life insurance some employees may be interested in additional coverage based off their personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? Depending on your needs, you may want to consider buying supplemental coverage. With voluntary life insurance, you are responsible for paying the full cost of coverage through payroll deductions. You can purchase coverage for yourself or for your spouse or your dependent child(ren) as outlined below.

VOLUNTARY LIFE INSURANCE	
Employee Optional Term Life	Increments of $25,000 up to a maximum of $300,000, not to exceed 5 times your covered annual earnings.
Spouse Optional Term Life	Purchase coverage for your spouse for $12,500, $25,000, $37,500 or $50,000 **NOTE:** The coverage amount on your spouse may not exceed 50% of your Optional Term Life coverage amount
Dependent Child Term Life	Birth to age 6 months: $500 Over 6 months of age: $2,500, $5,000, $7,500, $10,000 **NOTE:** The coverage amount on your children may not exceed 50% of your Optional Term Life coverage amount
GUARANTEED ISSUE AMOUNTS*	
Employee	$150,000
Spouse	$50,000

* Guaranteed issue amounts are only available to employees/spouses in their initial eligibility period or after and eligible life event.

Short-Term Disability

Short-Term Disability (STD) is a type of disability insurance coverage that can help you remain financially stable should you become injured or ill and cannot work.

SHORT-TERM DISABILITY	
Benefit	50%
Maximum Weekly Benefit	$170
Elimination Period	7 days
Duration of Benefits	26 weeks

Long-Term Disability

Long-Term Disability (LTD) insurance protects workers in the event they become disabled for a prolonged period prior to retirement. HeartShare LTD provides you with the opportunity for income continuation in the event your illness or injury lasts beyond 180 days. This helps ensure you have a continued income if you are unable to work due to a covered sickness or injury.

LONG-TERM DISABILITY	
Benefit	60%
Maximum Monthly Benefit	$7,000

Voluntary Benefits

AETNA

Critical Illness

Critical Illness Insurance coverage can keep you focused on your health when it matters the most. This extra coverage can help ease come financial worries during a difficult time. The Aetna Critical Illness Plan pays benefits when a doctor diagnoses you with a covered serious illness or condition, like heart attack, stroke, cancer and more.

Hospital Plan

Maybe you are expecting to have a hospital stay - or maybe not. Either way, you can plan ahead to give yourself an extra financial cushion. The Aetna Hospital Indemnity Plan pays benefits directly to you when you have a planned, or unplanned hospital stay for an illness, injury, surgery, or birth of a child.

Accident Plan

Accidents are just that - accidents. You can't plan for them, but you can protect yourself financial as much as possible. The Aetna Accident Plan pays benefits when you get treatment for an accidental injury. The insurance plan pays for a long list of covered minor and serious injuries.

Contact Aetna

- Call: **888.772.9682**
- Website: **www.myaetnasupplemental.com**

Would you be financially ready if you had an accidental injury or a serious illness? What about a hospital stay - expected or unexpected?

You can help fill in the gaps with the Aetna Accident, Critical Illness, and Hospital Indemnity Plans to supplement your medical coverage.

How are these plans different from a major medical plan?

Medical plans pay doctors and hospitals directly for costs related to your care. Unfortunately, medical plans don't cover 100% of the cost, leaving you to come up with the rest. They also don't cover other expenses that health events might impact, like daycare, rent, and more if you're out of work.

However, the Aetna Accident, Critical Illness, and Hospital Indemnity Plans pay benefits directly to **YOU**, giving you extra cash when you need it the most. They can help fill the gaps, making them a great companion to your major medical plan.

How can you use the cash benefits?

It's completely up to you. You can use the money for anything you want, like:

- Deductibles or copays
- Mortgage or rent
- Groceries or utility bills

*And so much more! You can use the benefits any way **YOU** choose.*

Voluntary Benefits

COLONIAL LIFE

Term Life Insurance

If something happened to you, the last thing your family should have to worry about is a financial burden. Funeral expenses, medical bills, and taxes could be just the beginning. How would they cover ongoing living expenses, such as mortgage, utilities and health care? Term Life Insurance from The Paul Revere Life Insurance Company can help with that.

Plan features include:

- You can convert your policy to a Paul Revere cash value life insurance policy any time through age 75 with no evidence of insurability.
- An accelerated death benefit option is available.
- Coverage options are available for your spouse and children.
- A waiver of premium benefit ride is available allowing you to waive all premiums in the instance that you become totally and permanently disabled before the age of 65.
- An accidental death benefit ride is available which provides an additional benefit to the beneficiary if the insured dies as a result of an accident before age 70.

Group Disability Insurance

You never know when a disability could impact your way of life. Fortunately, there is a way to help protect your income. If a covered injury or sickness prevents you from earning a paycheck, disability insurance can provide a monthly benefit to help you cover your ongoing expenses.

Plan features include:

- Coverage is available for both total disabilities and partial disabilities.
- Premium payments are waived after 90 consecutive days of a covered disability.
- If you are disabled while outside of the United States, you may receive benefits for up to 60 days before you have to return to the U.S.
- Coverage is available from ages 17 to 74.
- Coverage is portable - meaning you can take your policy with you if you change jobs or retire.
- Your premium is based on your age when you purchase coverage and the amount of coverage you purchase. Your premium will not change as you age.

Contact Colonial Life

- Call: **866.896.1600**
- Website: **www.coloniallife.com**

403(b) Retirement Savings Plan

BPAS

Make the Most of Your 403(b)

Are you saving for retirement? In your early working years, saving for a goal that's decades away may be easy to postpone. However, attaining that goal through your HeartShare 403(b) plan is easier than you think and the sooner you get started, the more secure your retirement years will be!

Convenient

You decide how much you would like to contribute and that amount is automatically deducted from your paycheck. You can change your contribution amount at any time. **403(b) participation is eligible for employer match.**

Inexpensive

A small contribution each paycheck can really add up over the course of your career. On top of this, there are tax savings when you contribute to your 403(b).

Profitable

You choose investments for your 403(b) funds and can take advantage of compounding growth. Allowing your money to grow over time can produce exponential growth.

How to Enroll

When you're ready to enroll, register online by vising **https://u.bpas.com**. For more information, please contact BPAS directly at **866.401.5272**.

- The Plan Code is: **HEAHUM4221**
- You'll receive enrollment instructions from BPAS shortly after you begin employment. If you try to enroll before receiving those communications, please contact BPAS
  OR
- Human Resources Department to ensure your contact information has been added to the system.

COVERAGE LEVEL	AMOUNT PER PAY $	PAY REDUCED BY	ANNUAL CONTRIBUTION
1%	$17	$14	$450
3%	$52	$41	$1,350
5%	$87	$68	$2,250
8%	$138	$108	$3,600

Benefit Resources

CONNER STRONG & BUCKELEW

Benefits Member Advocacy Center

Don't get lost in a sea of benefits confusion! With just one call or click, the Benefits MAC can help guide the way!

The Benefits Member Advocacy Center (Benefits MAC). Provided by Conner Strong & Buckelew, can help you and your covered family members navigate your benefits. Contact the Benefits MAC to:

- Find answers to your benefits questions
- Search for participating network providers
- Clarify information received from a provider or your insurance company, such as a bill, claim, or explanation of benefits (EOB)
- Rescue you from a benefits problem you've been working on
- Discover all that your benefit plans have to offer!

Member Advocates are available Monday through Friday, 8:30am to 5:00pm (Eastern Time). After hours, you will be able to leave a message with a live representative and receive a response by phone or email during business hours within 24 to 48 hours of your inquiry.

Contact the Benefits MAC

You may contact the Benefits Member Advocacy Center in any of the following ways:

- Via phone: **800.563.9929**, Monday through Friday, 8:30 am to 5:00 pm (Eastern Time)
- Via the web: **www.connerstrong.com/memberadvocacy**
- Via email: **cssteam@connerstrong.com**
- Via fax: **856.685.2253**

BenePortal

Your benefits information in one place!

BenePortal is a valuable online resource that houses all of our benefit information. It's your One-Stop-Shop for all benefits-related information and downloads, quick links to carrier websites, enrollment forms and wellness forms, and much more!

You and your family can access BenePortal anytime at: **www.heartsharebenefits.com**.

Wellness Resources

Wellhub

The world's largest network for employee fitness, health, and wellbeing; all with one membership!

Through our new partnership with Wellhub, a corporate wellbeing program, you'll have access to:

- 15,000 gyms, studios and fitness clubs in the U.S.
- 35+ top-rated wellbeing apps for self-care
  - Mental Health (meditation, preventing burnout, sleep)
  - Physical (fitness, nutrition)
  - Health habits
  - Financial
- 1:1 virtual wellness coach sessions
- Live & on-demand classes from popular gym partners

Scan the QR Code fore more information!

Benefit Perks

This feature provides a broad array of services, discounts and special deals on a consumer services, travel services, recreational services and much more. Simply access the site and register and you can begin using it now.

Learn more at:
https://connerstrong.corestream.com

HUSK Gym Discount Program

HUSK offers discounts at more than 10,000 gyms nationwide. Members also get exclusive savings on home health and fitness products from top brands nationwide.

Learn more about HUSK by visiting
https://huskwellness.com/connerstrong

HealthyLearn

This resource covers over a thousand health and wellness topics in a simple, straight-forward manner. The HealthyLearn On-Demand Library features all the health information you need to be well and stay well.

Learn more at:
www.healthylearn.com/connerstrong

Carrier Contacts

Below is a list of important contacts for all of your employee benefits needs.

CARRIER/PROGRAM	PHONE NUMBER	WEBSITE
AETNA Medical/Prescription Drug Dental Plans Vision Plan	833.380.0788	www.aetna.com
AETNA (VOLUNTARY) Critical Illness Hospital Accident	888.772.9682	www.myaetnasupplemental.com
BENEFIT RESOURCE, INC. Flexible Spending Accounts Commuter Benefits	800.473.9595	www.benefitresource.com
BPAS 403(b)	866.401.5272	u.bpas.com
COLONIAL LIFE Term Life Insurance Group Disability Insurance	866.896.1600	www.coloniallife.com
COMPSYCH Employee Assistance Program	800.437.0911	www.myliferesource.com
CONNER STRONG & BUCKELEW Member Advocacy	800.563.9929	www.connerstrong.com/memberadvocacy
GARNER HRA	866.761.9586	www.getgarner.com
PRUDENTIAL Life/AD&D Short-Term Disability Long-Term Disability	Client Operations Service Center: 888.598.5671 Disability/Absence Claims: 800.842.1718 Waiver of Premiums & Life Claims: 800.524.0542 Life Conversion: 877.889.2070 Life Portability: 800.778.3827 Medical Underwriting: 888.257.0412	Employee Portal: www.prudential.com/mybenefits Employee Forms: www.prudential.com/giemployeeforms

Glossary of Terms

After-tax contributions: These are dollars that have been contributed to health and/or retirement benefits after they have been taxed via payroll.

Carryover Savings: HSA balances belong to the employee, therefore, any money left at the end of 2023 is available to carry over into 2024.\

Coinsurance: After reaching your deductible, you and the plan share the cost of covered health expenses. This cost sharing is called coinsurance.

Contribution: A contribution to benefits is your share of the cost towards any health or welfare benefits offered by HeartShare. Contributions may be made on a pre- or post-tax basis depending on the benefit.

Copay: A copay is a fixed out-of-pocket amount paid by you for covered healthcare services.

Cost for Care: This is the amount paid out-of-pocket for a health plan relative to another. Cost sharing and taxation: Some of the benefits offered by HeartShare are paid entirely by HeartShare, while others are paid for entirely by you, the employee. There are also some benefits where the cost is shared between you and HeartShare, such as medical, dental, and the 401(k) retirement plan. Depending on the benefit, your share of the cost may be contributed on a pre- or post-tax basis.

Cost Up Front: This is what you will contribute for your choice of health plan in pre-tax payroll contributions which varies by plan.

Deductible: The deductible is the amount you pay out of your pocket for non-preventive care each year before the plan begins to pay a portion of your claims.

Diagnostic: Care you receive when you have symptoms or risk factors and your doctor wants to diagnose them.

Eligible children: Children eligible to qualify as your dependent include natural children, adopted children, stepchildren, children of your domestic partner, or children of whom you are legal guardian. Your child(ren) may maintain dependent status until they reach the age of 26, or 30 if unmarried and called to active duty.

Formulary Drugs: These are brand-name drugs that go through a thorough review process and are chosen based on their safety, cost and how well they work. The cost for formulary drugs is usually lower than non-formulary drugs.

Generic Drugs: Generic drugs are equivalent to brand name drugs in terms of safety, quality, performance, strength, dosage form, route of administration, performance characteristics and intended use, but typically cost less than brand-name drugs.

HSA Plan: The HSA medical plan is unique in that you may contribute pre-tax dollars to an account dedicated to qualified medical expenses. Pre-tax contributions towards this health plan are lower than the PPO plan but higher than the Minimum PPO plan.

Glossary of Terms

Mail order: A mail order prescription means that you don't have to pick up your medications from a pharmacy. Instead, your medications are delivered to your doorstep. To add convenience, you may order up to a 90-day supply, as opposed to retail prescriptions which only allow up to a 30-day supply.

Minimum PPO Plan: The Minimum PPO plan is brand new and has the lowest payroll contributions. You will have the ability to see your primary care physician and other specialists by simply paying a copay, rather than paying the deductible up-front.

Non-Formulary Drugs: Non-formulary drugs are brand name drugs and are typically more expensive than formulary drugs.

Out-of-Pocket Cost: Your out-of-pocket cost for all healthcare services is the sum of your deductible, copays, and coinsurance.

Out-of-Pocket Maximum: The out-of-pocket maximum is the limit to how much you have to pay out of your pocket in a year for covered health expenses (including the amounts you pay for your deductible and coinsurance). If you reach this limit, the plan pays 100% of your costs for the rest of the year.

Post-tax: Unlike tax-favored pre-tax benefits, post-tax benefits such as basic life insurance or disability are paid for using dollars that have already been taxed.

PPO Plan: Although this plan requires the highest elective contribution, you will pay the least amount out-of-pocket for healthcare services.

Pre-tax: Pre-tax benefits favor you, the employee, because they may be paid for using dollars that have not yet been taxed via payroll. Pre-tax contributions: These are dollars that have been contributed to health and/or retirement benefits before they have been taxed via payroll.

Preventive: Routine healthcare that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Retail: Retail prescriptions are those that are filled in person at a participating pharmacy. These prescriptions provide you with 31-day supplies of your needed drug.

SBC: The Summary of Benefits and Coverage (SBC) is an easy-to-read summary that lets you make comparisons of costs and coverage between health plans. You can compare options based on price, benefits, and other features that may be important to you.

SPD: The Summary Plan Description (SPD) is the main vehicle for communicating health plan rights and obligations to participants.

Legal Notices

Notice Regarding Special Enrollment

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

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

New dependent by marriage, birth, adoption, or placement for adoption
If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you request a change due to a special enrollment event within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment.

Newborns' and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act

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

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other benefits. If you have any questions, please speak with Human Resources.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

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

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - MEDICAID
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

Legal Notices

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid Website: https://www.in.gov/medicaid/
http://www.in.gov/fss/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: www.mymaineconnection.gob/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: 800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-495-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 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)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

Legal Notices

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – 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: https://www.pa.gov/en/agencies/dhs/resources/chip.html
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA - Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS - Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-562-3022

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: http://mywvhipp.com/ and https://dhhr.wv.gov/bms/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, 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

Insurance Marketplace Notice

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the insurance carrier's customer service number located on your ID card. 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. To get information about the Marketplace coverage, you can call the government's 24/7 Help-Line at 1-800-318-2596 or go to https://www.healthcare.gov/marketplace/individual/.

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 HeartShare Human Services of New York		4. Employer Identification Number 11-1633549
5. Employer Address 12 MetroTech Center		6. Employer phone number 718-422-3221
7. City Brooklyn	8. State NY	9. Zip Code 11201
10. Who can we contact about employee health coverage at this job? Elizabeth Roden		
11. Phone number (if different from above) 718-422-3202	12. Email address Elizabeth.Roden@heartshare.org	

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

HeartShare

HeartShare reserves the right to modify, amend, suspend or terminate any plan, in whole or in part, at any time. The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. If you have any questions about your Guide, contact Human Resources.