SALEM VA
HUMAN RESOURCES

City of Salem

Benefit Enrollment Guide

2026

Table of Contents

This brochure summarizes the benefit plans that are available to City of Salem & Salem City Schools eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. The information provided in this brochure is not a guarantee of benefits.

A Message to Our Employees

The Benefits Open Enrollment Period Is Here!

As healthcare costs continue to rise due to inflation and increased government regulation, the cost to provide healthcare coverage has also increased. City of Salem has seen an increase in the occurrence as well as the severity of claims. This has been a common scenario across the market as costs continue to increase. In an effort to keep pace with healthcare trends and provide you with the best coverage options available, City of Salem has decided to make some changes to the Anthem medical plans and there will also be a change in employee contributions for the 2026 plan year. We appreciate the understanding of these challenging decisions and are committed to continue to provide a comprehensive benefits package to employees and their dependents.

Benefits for You & Your Family

City of Salem is pleased to announce our 2026 benefits program, which is designed to help you stay healthy, feel secure, and maintain a work/life balance. Offering a competitive benefits package is just one way we strive to provide our employees with a rewarding workplace. Please read the information provided in this guide carefully. For full details about our plans, please refer to the summary plan descriptions. Listed below are the City of Salem benefits available during Open Enrollment:

- Medical
- Dental
- Vision
- Health Savings Account
- Flexible Spending Account
- Voluntary Benefits

For more benefits information, please visit the Salem HR Intranet.

Who is Eligible?

Full-time employees actively working a minimum of 40 hours per week and their eligible dependents may participate in the City of Salem benefits program.

Generally, dependents are defined as:

- Your legal spouse
- Dependent “child” up to age 26. (Child means the employee’s natural child or adopted child and any other child as defined in the certificate of coverage)

When and How Do I Enroll?

Open enrollment will be conducted **Wednesday, November 12, 2025 – Wednesday, November 26, 2025.**

All eligible employees are required to complete the enrollment process, even if you do not wish to make any changes to your benefits. You must also re-enroll in the FSA and/or HSA every plan year.

All employees must make their elections or waive their benefits through our new benefit administration system: **UKG Ready at** https://secure10.saashr.com/ta/6104242.login.

When is My Coverage Effective?

The effective date for your benefits is **January 1, 2026 – December 31st, 2026**

Changing Coverage During the Year

You can change your coverage during the year when you experience a qualified change in status, such as marriage, divorce, birth, adoption, placement for adoption, or loss of coverage**.**

The change must be reported to the Human Resources Department within 30 days of the event. The change must be consistent with the event. For example, if your dependent child no longer meets eligibility requirements, you can drop coverage only for that dependent.

Key Information for 2026:

- The Anthem medical plans will be moving from the KeyCare PPO network to the HealthKeepers POS network for the 2026 calendar year. More details on this transition is outlined in this benefit guide.
- The orthodontia maximum on the Delta Dental plan has increased to $1,500.
- Our wellness vendor is moving from Synergy Health to Care ATC.
- There is a new benefit administration system: Ready UKG
- The 2026 HSA Calendar year contribution limits have increased for both individual and family coverages:
    - Individual increased from $4,300 to $4,400
    - Family increased from $8,550 to $8,750
- The Healthcare FSA Calendar year contribution limit for 2026 has increased from $3,300 to $3,400. The Dependent FSA limit is also increasing to $7,500 or $3,750 if married but filing separately.

Medical Insurance

City of Salem will continue to offer medical coverage through Anthem. The chart on the following page is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

Wellness Program

The City of Salem will continue to offer employees the opportunity to pay lower health insurance premiums by completing the requirements of the Wellness Program through Care ATC. In order to qualify, you must:

1. Complete your Health Risk Assessment
2. Complete one follow-up visit for a chronic condition or a preventive care screening either at the onsite clinic or at your primary care physician's office
    - Examples of preventive care screenings include: annual physical exams, eye exam, prostate specific antigen test/PSA (males), colonoscopy, osteoporosis screen (bone density), well women/PAP exam, mammogram, etc. For a full list please discuss with your provider or visit Anthem.com.

Send documentation of both steps to Care ATC by October 31, 2026, in order to earn the incentive for 2027. **Dates of service must be between 11/1/2025 – 10/31/2026**.

Spouses on the City of Salem medical insurance are also a part of the Wellness Program with the same program requirements to complete a health risk assessment and one follow-up visit. **Both the employee and covered spouse must complete the program to get the Wellness rate.** All activities must be completed by October 31, 2026, and recorded by Care ATC in order to be eligible for the Wellness rate that will be effective January 1, 2027.

Medical Benefits Overview

Benefit Coverage	Anthem Health Plans of Virginia HealthKeepers OA 30 2000/20% Embedded		Anthem Health Plans of Virginia HealthKeepers OA HSA 3500/0% Embedded	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Annual Deductible				
Individual	$2,000	$3,000	$3,500	$3,500
Family	$4,000	$6,000	$7,000	$7,000
Coinsurance	20%	40%	0%	20%
Maximum Out-of-Pocket*				
Individual	$5,000	$7,250	$4,000	$6,000
Family	$10,000	$14,500	$8,000	$12,000
Physician Office Visit				
Primary Care	$30 copay per visit	40% AD	0% AD	20% AD
Specialty Care	$50 copay per visit	40% AD	0% AD	20% AD
Preventive Care				
Adult Periodic Exams	0%	40% AD	0%	20% AD
Well-Child Care	0%	40% AD	0%	20% AD
Diagnostic Services				
X-ray and Lab Tests	20% AD	40% AD	0% AD	20% AD
Complex Radiology	20% AD	40% AD	0% AD	20% AD
Urgent Care Facility	$30 copay per visit - PCP; $50 copay per visit - SPC	40% AD	0% AD	20% AD
Emergency Room Facility Charges*	20% AD	20% AD	0% AD	0% AD
Inpatient Facility Charges	20% AD	40% AD	0% AD	20% AD
Outpatient Facility and Surgical Charges	20% AD	40% AD	0% AD	20% AD
Mental Health				
Inpatient	20% AD	40% AD	0% AD	20% AD
Outpatient	20% AD	40% AD	0% AD	20% AD
Substance Abuse				
Inpatient	20% AD	40% AD	0% AD	20% AD
Outpatient	20% AD	40% AD	0% AD	20% AD
Other Services				
Chiropractic	20% AD; 30 visits per year	40% AD; 30 visits per year	0% AD	20% AD

Benefit Coverage	Anthem Health Plans of Virginia HealthKeepers OA 30 2000/20% Embedded		Anthem Health Plans of Virginia HealthKeepers OA HSA 3500/0% Embedded	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Retail Pharmacy (30 Day Supply)				
Generic (Tier 1)	$15 copay	$15 copay	$10 copay AD	$10 copay AD
Preferred (Tier 2)	$40 copay	$40 copay	$30 copay AD	$30 copay AD
Non-Preferred (Tier 3)	$75 copay	$75 copay	$50 copay AD	$50 copay AD
Preferred Specialty (Tier 4)	20% up to $200	N/A	20% up to $200 AD	N/A
Mail Order Pharmacy (90 Day Supply				
Generic (Tier 1)	$38 copay	Not covered	$25 copay AD	Not covered
Preferred (Tier 2)	$100 copay	Not covered	$75 copay AD	Not covered
Non-Preferred (Tier 3)	$188 copay	Not covered	$125 copay AD	Not covered
Preferred Specialty (Tier 4)	20% up to $400	N/A	20% up to $200 AD	N/A

*AD = After Deductible

Employee Contributions (Monthly)		
Anthem HealthKeepers OA 30 2000/20%	**Wellness**	**Non-Wellness**
Employee	$73.50	$128.50
Employee & One Child	$266.00	$321.00
Employee & Spouse	$735.28	$790.28
Employee & Children	$808.90	$863.90
Employee & Family	$918.24	$973.24

Employee Contributions (Monthly)		
Anthem HealthKeepers OA HSA 3500/0%	**Wellness**	**Non-Wellness**
Employee	$23.66	$78.66
Employee & Child	$154.32	$209.32
Employee & Spouse	$399.58	$454.58
Employee & Children	$450.56	$505.56
Employee & Family	$515.38	$570.38

Anthem HealthKeepers Out-of-State

Access healthcare wherever you need it

At Anthem, we're committed to helping people access quality healthcare when and where they need it. That's why our HealthKeepers network includes access to BlueCard® preferred provider organization (PPO) doctors and other healthcare professionals nationwide.

HealthKeepers uses our national BlueCard PPO network (including more than 1.7 million doctors and hospitals in all 50 states*) for care received outside of Virginia. This includes care received at Duke University Hospital, The Johns Hopkins Hospital, Memorial Sloan Kettering Cancer Center, and Cleveland Clinic. In addition, the plan:

- Provides healthcare access outside of the Virginia service area through participating BlueCard PPO care providers. Individuals should continue using the HealthKeepers network when accessing care within the Virginia service area.
- Extends in-network benefits to all healthcare services covered by the plan, not just urgent or emergency care. Covered services will still be subject to benefit and medical guidelines.
- Adds flexibility to use participating BlueCard PPO labs outside of the Virginia service area. When seeking care in Virginia, we have expanded in-network access to lab providers, including Quest Diagnostics, Labcorp and participating hospital reference labs.
- Sends HealthKeepers health plan ID cards that show the PPO "suitcase" icon, indicating access to out-of-area coverage, to everyone who enrolls in the plan.

How to access out-of-state care

- Call 911 or go to the nearest hospital in an emergency.
- Log in to anthem.com and use the Find Care tool to search for a doctor or hospital in the BlueCard PPO program.
- Use our Sydney℠ Health app to search for a BlueCard PPO program doctor or hospital. Get directions to the nearest doctor, urgent care center, or emergency room.
- Call Member Services at the number on your health plan ID card.

Remember to show the doctor or hospital the PPO suitcase icon on your ID card. This indicates that you have BlueCard PPO network coverage.

For more information

If you have questions, please call the Member Services number on your ID card.

As a reminder, you must live or work in our Virginia service area in order to enroll in a HealthKeepers plan. For a definition of covered services, please see your evidence of coverage (EOC).

Anthem

Use your preventive care benefits

Stay healthy and catch problems early for easier treatment

Our health plans offer all the preventive care services and immunizations below at no cost to you.[1] As long as you use a doctor, pharmacy, or lab in your plan's network, you won't have to pay anything. If you go to doctors or facilities that are not in your plan, you may have to pay out of pocket.

If you are not sure which exams, tests, or shots are right for you, talk to your doctor.

Preventive care vs. diagnostic care: Knowing the difference

Preventive care helps protect you from getting sick. If your doctor recommends services when you have no symptoms, that's preventive care. **Diagnostic care** is when you have symptoms, and your doctor recommends services to determine what's causing those symptoms.

Adult preventive care

General preventive physical exams, screenings, and tests (all adults):

- Alcohol and drug misuse: related screening and behavioral counseling
- Anxiety, depression, and suicide risk screenings
- Aortic aneurysm screening (for men who have smoked)
- Behavioral counseling to promote a healthy diet and physical activity
- High blood pressure (hypertension) screening
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) levels screening
- Colorectal cancer screenings, including fecal occult blood test, barium enema, flexible sigmoidoscopy (exam of the large intestine), screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)[2]
- Diabetes screening (type 2)[3]
- Exercise interventions to prevent falls in adults over age 65

- Hepatitis B virus (HBV) screening for people at increased risk of infection
- Hepatitis C virus (HCV) screening
- Hearing screening
- Height, weight, and body mass index (BMI) measurements
- Human immunodeficiency virus (HIV): screening and counseling
- Interpersonal and domestic violence: screening and counseling
- Lung cancer screening for adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years[2]
- Obesity: related screening and counseling[3]
- Prostate cancer screenings, including digital rectal exam and prostate-specific antigen (PSA) test
- Sexually transmitted infections: related screening and counseling
- Syphilis infection screening for persons who are at increased risk
- Tobacco use: related screening and behavioral counseling
- Tuberculosis screening

Women's preventive care:

- Breast cancer screenings, including exam, mammogram, and genetic testing for BRCA1 and BRCA2 when certain criteria are met[5]
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies, and counseling[6,7,8,9]
- Chlamydia and gonorrhea screening
- Contraceptive (birth control) counseling
- Counseling related to chemoprevention for those at high risk for breast cancer
- Counseling related to genetic testing for those with a family history of ovarian or breast cancer
- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Human papillomavirus (HPV) screening[7]
- Pelvic exam and Pap test, including screening for cervical cancer
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, HIV, healthy weight, preeclampsia, and depression[7]
- Urinary incontinence screening
- Well-woman visits

Immunizations:

- Diphtheria, tetanus, and pertussis (whooping cough)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps, and rubella (MMR)
- Meningococcal (meningitis)
- Monkeypox and/or smallpox (at risk)
- Pneumococcal (pneumonia)
- Respiratory syncytial virus (RSV)
- Severe acute respiratory syndrome coronavirus 2 (SARS CoV 2)(COVID-19)
- Varicella (chickenpox)
- Zoster (shingles)

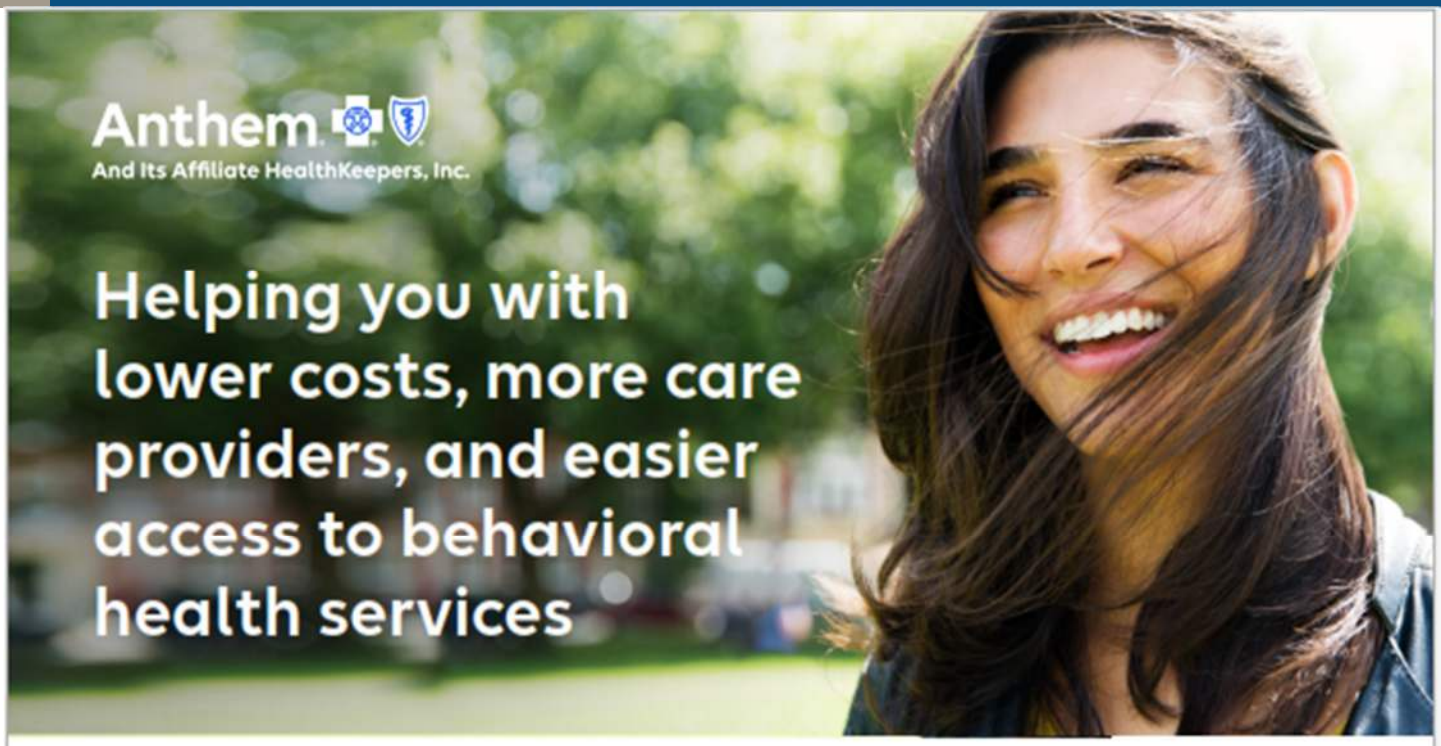
Child preventive care

Preventive physical exams, screenings, and tests:

- Anemia screening
- Anxiety, depression, and suicide risk screenings
- Autism Spectrum Disorder (ASD) screening
- Blood pressure screening
- Cervical dysplasia (abnormal cell growth on the cervix) screening
- Cholesterol and lipid (fat) levels screening
- Development and behavior screening
- Diabetes screening (type 2)
- Hearing screening
- Height, weight, and BMI measurements
- Hemoglobin or hematocrit (blood count) screening
- Hepatitis B screening
- HIV screening
- Lead testing
- Newborn screening
- Obesity: related screening and counseling
- Ocular prophylaxis for Gonococcal Ophthalmia Neonatorium: Preventive medication: newborns
- Oral (dental health) assessment, when done as part of a preventive care visit
- Sexually transmitted infections: related screening and counseling
- Skin cancer counseling for those ages 6 months to 24 years with fair skin
- Sudden cardiac arrest/death risk assessment
- Tobacco, alcohol, and drug use assessments
- Vision screening for those ages 6 months to 5 years

Immunizations:

- Chickenpox
- Flu
- Haemophilus influenza type B (HIB)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Meningitis
- Measles, mumps, and rubella (MMR)
- Pneumonia
- Polio
- Respiratory syncytial virus (RSV)
- Rotavirus
- Severe acute respiratory syndrome coronavirus 2 (SARS CoV 2)(COVID-19)
- Whooping cough



Mental health is part of your overall well-being

It's important to get the right support for behavioral health concerns.

Youth suicide rates

Suicide is the second leading cause of death for children between 10 and 14 years old in the U.S., and 11th overall.[1]

Complex needs

21.5 million U.S. adults experience both mental illness and a substance use disorder.[2]

Whole-health impact

Adults experiencing depression are at higher risk of chronic diseases, including heart disease, diabetes, and stroke.[3]

We're here to help

If you or a loved one needs help with a mental health or substance use concern, you're not alone. Through your Anthem Blue Cross and Blue Shield benefits, you can quickly find expert, compassionate, and confidential care — often at low or no extra cost. You have access to a wide range of programs and services online, on the phone, in person, or through video — whatever is most convenient for you.

Virtual visits

You can schedule virtual visits with psychologists and therapists within seven days using our Sydney℠ Health app — half the time needed for scheduling in-person appointments.[4]

90% of individuals were able to find all the behavioral health services they needed.[5]

Enhancing behavioral health support in Virginia

Reduced copays
Providing lower copays for virtual and in-person office visits.

Expanded networks
Using larger networks with more than 100 care providers added through Carelon Behavioral Health and more LiveHealth Online virtual care providers.[6]

Support options
Offering innovative whole-health programs and services that provide support to children, teens, and adults — with virtual or in-person options.

Specialized benefits
Including:

- Eating disorder treatment
- Autism spectrum disorder family outreach
- Behavioral health case management
- Emotional Well-being Resources
- Virtual care through LiveHealth Online
- Outreach for children, adolescents, families, and guardians

Our caring team helps you find the right support

If you have questions about your benefits or need help finding a behavioral health professional or program, chat with us live on the Sydney Health app or at anthem.com, or call Member Services at the number on your member ID card.

Visit anthem.com/va/behavioralhealth to view more available programs. Scan the QR code using your phone's camera.

For help with ...	This program is available.	How to access[7]
General behavioral health and severe anxiety, depression, trauma, and substance use	Aspire365 brings personalized, at-home mental health and substance use treatment to people ages 13 and older over a 12-month period. The program works around your schedule, providing 24/7 clinical support, telehealth and in-person visits, and access to community group sessions.	**Aspire365: virtual and in home** Visit **Find Care** at anthem.com. Learn more at aspire-365.com.
Substance use disorders such as opioid and alcohol	Aware Recovery Care provides long-term substance use treatment, including withdrawal management, medication-assisted treatment, and care and support in the privacy and security of your home.	**Aware Recovery Care: virtual** Visit **Find Care** at anthem.com. Learn more at awarerecoverycare.com.
Young people and family crisis support, including treatments for anxiety, depression, mood disorders, substance use disorders, and self-harm in ages 11 to 34	Charlie Health treats high-acuity mental health conditions with hyperpersonalized care. Treatment programs, including virtual Intensive Outpatient Program (IOP), combine personalized care with peer connection to foster long-term healing.	**Charlie Health: virtual** Visit charliehealth.com.
General behavioral health and medication management for ages 1 and older	Headway matches individuals with therapists based on their needs. Offering an easy-to-use scheduling platform on their website, the average new-patient appointment is available in less than five days.	**Headway: virtual and in person** Visit **Find Care** at anthem.com. Learn more at headway.co.
General mental and behavioral health concerns	Talkspace offers video, text, and phone sessions for individuals, teens, and couples to connect with a licensed therapist through live sessions, ongoing messaging, or both.	**Talkspace: virtual** Visit talkspace.com/anthem.
General behavioral health, psychiatric care, medication management for ages 5 and older	Rula offers services for individual therapy, medication management, couples therapy, family therapy, and psychiatric care. They offer an easy-to-use online scheduling platform.	**Rula: virtual** Visit rula.com.

1 National Institute of Mental Health. Suicide (February 2021). nimh.nih.gov.
2 Substance Abuse and Mental Health Services Administration. Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health (December 2022). https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022 nsduh nnr.pdf.
3 National Institute of Mental Health. Understanding the Link Between Chronic Disease and Depression (2018). nimh.nih.gov.
4 Appointments subject to availability. Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please text, chat, or call 988 (Suicide and Crisis Lifeline), or 911 for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.
5 Internal data: Behavioral Health Care Management Member Satisfaction Survey, Q1-Q3 2022.
6 Internal data: Carelon Behavioral Health, 2022.
7 Access to these providers may change based on the status of provider participation. To verify provider availability is you as a member, please contact member services. In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You also may receive a bill for any charges not covered by your health plan.

Virtual visit and video visits powered by LiveHealth Online. LiveHealth Online is offered through an arrangement with Teladoc, a separate company, providing telehealth services on behalf of your health plan. Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company, offering mobile application services on behalf of your health plan.

Anthem Blue Cross and Blue Shield is the trade name of Anthem HealthPlans of Virginia, Inc. Anthem Blue Cross and Blue Shield, and its affiliate HealthKeepers, Inc., serving all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123, are independent licensees of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Vision

Your Anthem Medical Plan comes with valuable vision benefits and discounts to help you take care of your eyes. Below is an overview of basic in-network benefits included in the Blue View Vision Network. Please refer to the summary plan description for complete benefit details.

Benefit Coverage	Anthem Health Plan Blue View Vision Benefit
	In-Network Benefits
Eye Exam	$15 Copay
Eyeglass Lenses	Single Vision - $50 Copay
	Bi-focal - $70 Copay
	Tri-Focal - $105 Copay
	Standard Progressive (add on to Bi-focal) - $65 copay
Frames	35% Coinsurance
Contact Lenses	Conventional (Non-Disposable) – 15% coinsurance

One eye exam per member per calendar year is eligible for coverage.

Benefits through the Blue View Vision Network for your calendar year eye exam are for routine services only. If you need medical treatment for your eyes, select a participating eye care physician specialist from your medical network. Your out-of-pocket expenses related to the vision benefits do not count toward your annual out-of-pocket limit and are never waived, even if your annual out-of-pocket limit is reached. These vision services are not subject to an out-of-plan deductible.

Health Savings Account (HSA)

When you are enrolled in a Qualified High Deductible Health Plan (QHDHP) and meet the eligibility requirements, the IRS allows you to open and contribute to an HSA Account.

2026 HSA Administration

City of Salem continues to partner with Flexible Benefit Administrators (FBA) to administer our HSA. If you currently participate in Flexible Benefits, please make sure to hold onto your current FBA Benefits card so that you can access your HSA funds once they are available.

Please note that a Health Savings Account is your own personal savings account so you may receive communication requesting you to agree to HSA disclosures and the Customer Identification Program (CIP) check process will initiate in accordance with USA Patriot Act, which typically takes 1-2 business days to complete. If the bank requires any additional information for the CIP check, an email will be sent to you requesting specific documentation.

What is a Health Savings Account (HSA)?

An HSA is a tax-sheltered bank account that you own to pay for eligible health care expenses for you and/or your eligible dependents for current or future healthcare expenses. The Health Savings Account (HSA) is yours to keep, even if you change jobs or medical plans. There is no “use it or lose it” rule; your balance carries over year to year.

Plus, you get extra tax advantages with an HSA because:

- Money you deposit into an HSA is exempt from federal income taxes
  Interest in your account grows tax free; and
- You don’t pay income taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes and penalties apply).
- You also have a choice of investment options which earn competitive interest rates, so your unused funds grow over time.

Are you eligible to open a Health Savings Account (HSA)?

- Although everyone can enroll in the Qualified High Deductible Health Plan, not everyone is eligible to open and contribute to an HSA. If you do not meet these requirements, you cannot open an HSA.
  - You must be enrolled in a Qualified High Deductible Health Plan (QHDHP)
  - You must not be covered by another non-QHDHP health plan, such as a spouse’s PPO plan.
  - You are not enrolled in Medicare.
  - You are not in the TRICARE or TRICARE for Life military benefits program.
  - You have not received Veterans Administration (VA) benefits within the past three months.
  - You are not claimed as a dependent on another person’s tax return.
  - You are not covered by a traditional health care flexible spending account (FSA). This includes your spouse’s FSA. (Enrollment in a limited purpose health care FSA is allowed).

2026 HSA Contributions

You are able to contribute to your Health Savings Account on a pre-tax basis through payroll deductions up to the IRS statutory maximums. The IRS has established the following maximum HSA contributions:

For the 2026 Tax Year:

- **$4,400 Individual**
- **$8,750 Family**
- **If you are age 55 and over, you may contribute an extra $1,000 catch up contribution.**

How do I get reimbursed for my eligible expenses?

The easiest way to use your HSA dollars is by using your HSA Debit Card at the time you incur an eligible expense. Or you can withdraw money from an ATM. But keep your receipts! You must be able to prove that you were reimbursing yourself for an eligible expense in the event that you are audited by the IRS. If you use your HSA funds for non-eligible expenses, you will be charged a 20% penalty tax (if under age 65) as well as federal income taxes. You can manage your HSA through Flexible Benefit Administrators. For additional guidelines, please go online or call Flexible Benefit Administrators, Inc.

Flexible Spending Accounts (FSA)

The City of Salem will continue to partner with FBA to administer the FSAs.

What is a Flexible Spending Account (FSA)?

Flexible Spending Accounts allow employees to pay for IRS-approved expenses with pre-tax dollars. Eligible Expenses include all expenses outlined in the IRS Publication 503. You can obtain a copy of this publication from the Internet at https://www.irs.gov/pub/irs-pdf/p503.pdf or by calling 1-800-TAX-FORM. There are three FSA options: Healthcare FSA (KeyCare 30 Plans), Limited Benefit FSA (for HSA enrollees), this plan covers dental and vision out-of-pocket expenses), and Dependent Care FSA. Your health care and limited benefit FSAs are pre-funded accounts. This means the amount you elect for the plan year will be in your account on the first day of the plan year and available for reimbursement of eligible health care expenses. You will pay each pay period to cover those funds. The dependent care account, on the other hand, is not pre-funded. The amount you contribute per pay period is the amount that is in the account and available for reimbursement.

Unlike an HSA, an FSA Account is a “Use it or Lose it” account. Only put money into your FSA for expenses that you know you will incur during the year because money not used during the calendar year or the grace period that follows will be forfeited. There is a 2 ½ month grace period for incurring expenses so if you have money left over at the end of the calendar year, you can use expenses incurred up to March 15, 2027 against your 2026 balance. Please note that the grace period is not available on a dependent care FSA.

Are you eligible to open a Flexible Spending Accounts (FSA)?

There are three FSA options. If you are enrolled in the KeyCare plans, you may enroll in the Health Care FSA and file for reimbursement of any IRS-approved health expenses. If you are enrolled in the HDHP plan, you are NOT eligible for the healthcare FSA. However, if you are expecting to have out of pocket expenses for vision or dental, you can enroll in the limited benefit FSA.

If you pay for dependent care expenses for children up to age 13, a disabled dependent of any age, or a disabled spouse, you may enroll in the dependent care FSA and reimburse yourself for out-of-pocket dependent care expenses with pre-tax dollars. A debit card is provided if you enroll in the health care or limited benefit FSA. This card is a convenient way to pay for your eligible out-of-pocket expenses at the time of service. You must re-enroll each year if you would like to participate in the FSA.

2026 FSA Contributions

The 2026 FSA Contribution Limits:

- Health Care FSA - **$3,400**
- Dependent Care FSA - **$7,500** ($3,750 if married filing separately)

How do I get reimbursed for my eligible expenses?

The easiest way to use your FSA dollars is by using your FSA Debit Card at the time you incur an eligible expense. Make sure to keep receipts! Your administrator may request a receipt as proof that the expense was incurred and, if you are audited by the IRS, you may need receipts as well. If you do not use your debit card, you can file for reimbursement directly with FBA. All requests for reimbursement must be submitted to FBA no later than March 30, 2026, in order to avoid any forfeiture of funds remaining in the account.

Dental Insurance

City of Salem will continue to offer a dental program through Delta Dental. The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

Benefit Coverage	Delta Dental of Virginia Dental PPO	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	$25	$25
Family	$75	$75
Waived for Preventive Care	Yes	Yes
Annual Maximum		
Per Person / Family	$1,000	$1,000
MaxOver™ Carryover	Your plan allows a portion of an enrollee's annual maximum to be carried over to the next year.	
Preventive	100%	100%
Basic	80%	80%
Major	50%	50%
Orthodontia		
Benefit Percentage	50%	50%
Adult (and Covered Full-Time Students, if Eligible)	Not covered	Not covered
Dependent Child(ren)	Covered	Covered
Lifetime Maximum	$1,000	$1,000
Benefit Waiting Periods	N/A	N/A

Employee Contributions (Monthly)	
Dental PPO	
Employee	$0.00
Employee & 1 Dep	$24.40
Employee & 2+ Deps	$59.50

DELTA DENTAL

Prevention First

HELPING YOUR PREVENTIVE BENEFITS GO FARTHER

Preventive care helps lead to good oral health. Delta Dental of Virginia's Prevention First benefit helps you stretch your plan benefits when you receive preventive care each plan year.

With Prevention First, your preventive care and diagnostic services, typically X-rays, exams and cleanings, do not count against your annual maximum. This leaves your entire annual maximum available for other services, such as fillings or crowns, throughout the plan year.

Delta Dental handles all of the details. Just visit your dentist for regular checkups to be included in the program.

THE VALUE OF PREVENTION FIRST

- Cleanings and preventive visits are covered at the plan's current level.
- Prevention First does not affect any other benefits in your dental plan.
- Prevention First leaves your annual maximum available for other procedures, such as crowns.

Continued on back page

DELTA DENTAL HANDLES THE DETAILS

STRETCHES THE ANNUAL MAXIMUM FARTHER

GET REWARDED FOR GOOD ORAL HEALTH HABITS

▲ **Delta Dental of Virginia** | 5415 Airport Road, Roanoke, VA 24012 | 800.237.6060 | DeltaDentalVA.com

Voluntary Benefits

The City also offers the following voluntary benefits for employees through payroll deduction:

- 457 Defined Contribution Plan
- Accident
- Cancer
- Intensive Care/Critical Care
- Hospital Insurance
- Short Term Disability
- Long Term Disability

For more information, please feel free to contact any of our vendors for enrollment information. Some of these pre-tax benefits must be selected within 30 days from hire or during our Annual Open Enrollment Period (AOEP). Others may be elected anytime. Direct contact information for voluntary benefits can be found on on the Salem HR Intranet.

Resources

Benefit Related Questions?

"Services denied?"

"Why won't they pay my claim?"

"How can my claim still be in process? It's been two months!"

"I called my insurance carrier, but now I'm just more confused."

"Do I have mail-order prescription benefits?"

Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution
- Medicare basics with your employer plan
- Coordination of benefits
- Finding in-network providers
- Access to care issues
- Obtaining case management services
- Group disability claims

Benefits Resource Center

BRCEast@usi.com | Toll Free: 855-874-6699 | Monday – Friday • 8am – 5pm EST & CST

Additional information regarding benefit plans can be found on the Salem HR Intranet. Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

Carrier Customer Service

BENEFITS PLAN	CARRIER	PHONE NUMBER	WEBSITE
Medical PPO	Anthem Health Plans of Virginia	(866) 868-9963	www.anthem.com
Dental PPO	Delta Dental of Virginia	(800) 237-6060	www.deltadental.com
Health Savings Account	Flexible Benefit Administrators, Inc.	(800) 437-3539	https://fba.wealthcareportal.com/Authentication/Handshake
Flexible Spending Account			
Voluntary Benefits	Aflac	Kevin Martin (540) 556-9494 k1_martin@us.aflac.com	www.aflac.com
	Mission Square Retirement	Trey Sizemore (866) 328-4671 tsizemore@missionsq.org	www.missionsq.org
	WorkSite Strategies	Don Lopez (540) 580-1499	www.worksitestrategies.com

For further Open Enrollment questions, please contact your HR Representative listed below:

Human Resources
humanresources@salemva.gov
P.O. Box 869
Salem, Virginia 24153

REQUIRED NOTIFICATIONS

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

NEWBORNS ACT DISCLOSURE – FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

ADA NOTICE REGARDING WELLNESS PROGRAMS

The Care ATC Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a voluntary health risk assessment or “HRA” that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g. cancer, diabetes, or heart disease). You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of discounted health insurance premiums for completing a follow up visit either at the onsite clinic or their primary care physician’s office. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive discounted health insurance premiums.

The information from your HRA will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and City of Salem may use aggregate information it collects to design a program based on identified health risks in the workplace, Care ATC Healthcare Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at humanresources@salemva.gov.

HIPAA 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 the person at the end of this summary 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.

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

Important Notice from City of Salem 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 City of Salem and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. City of Salem has determined that the prescription drug coverage offered by the Anthem for the plan year 2026 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, the following options may apply:

- You may stay in the City of Salem and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose Anthem creditable coverage.

- You may stay in the Anthem plan and also enroll in a Medicare prescription drug plan. The Anthem plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Anthem plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Anthem plan, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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 City of Salem 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 City of Salem 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:	01/01/2026
Name/Entity of Sender:	Beth Rodgers
Contact Position/Office:	Human Resources
Address:	P.O. Box 869, Salem, VA 24153
Phone Number:	540-375-3060

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 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+)

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/fssa/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:
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

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: 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

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: 1-800-657-3739

MISSOURI – Medicaid

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

MONTANA – Medicaid

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

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

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

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: 1-800-356-1561
Medicaid 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

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: Children's Health Insurance Program (CHIP) (pa.gov)
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: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
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: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

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

WASHINGTON – Medicaid

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

WEST VIRGINIA – Medicaid and CHIP

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

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

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

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)

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.[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

[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.

standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all these factors in determining whether to purchase a health plan through the Marketplace.

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender:	Beth Rodgers
Contact--Position/Office:	Human Resources
Address:	P.O. Box 869, Salem, VA 24153
Phone Number:	540-375-3060

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 City of Salem		4. Employer Identification Number (EIN) 54-6001593
5. Employer address P.O. Box 869		6. Employer phone number 540-375-3060
7. City Salem	8. State VA	9. ZIP code 24153
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	12. Email address humanresources@salemva.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:

    All full time employees who have me the group waiting period.

  - ☐ Some employees. Eligible employees are:

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

  - ☐ 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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?
(mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

---

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly