



2020 Employee Flexible Benefits Guide

What You Should Know Before & After Enrollment

When can I enroll?

What is an HSA?

Can I add a new family member after Open Enrollment?

What does my vision plan cover?



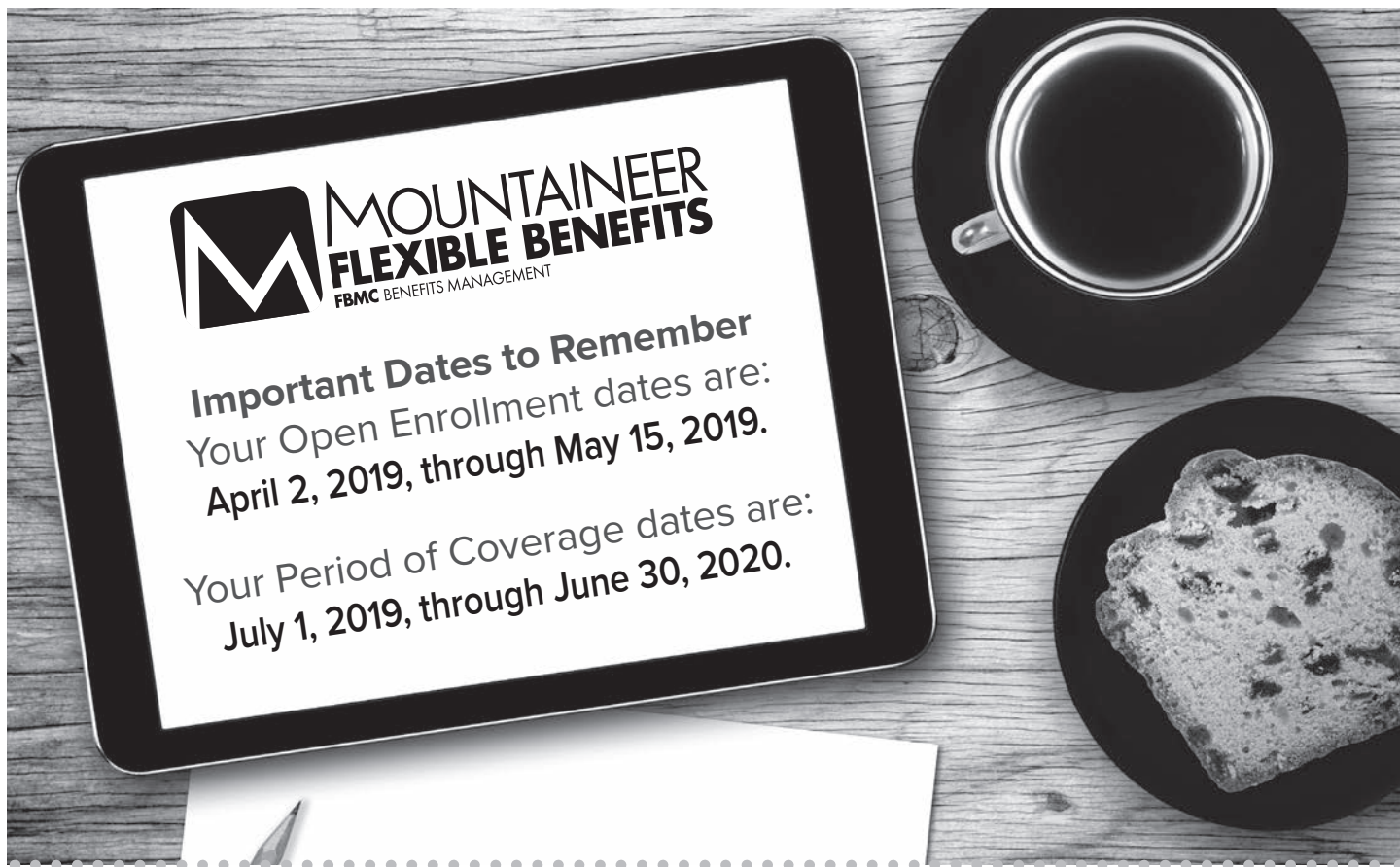
**MOUNTAINEER
FLEXIBLE BENEFITS**
FBMC BENEFITS MANAGEMENT, INC.

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Key Things To Know



What's New?

Get ready for benefits open enrollment! Here's what's changing for your upcoming Mountaineer Flexible Benefits Plan Open Enrollment:

- The maximum Healthcare FSA contribution increased to \$2,700 – a \$50 increase from 2018. See page 20 for details.
- The 2019 annual HSA contribution limit for individuals will be \$3,500 – a \$50 increase from 2018.
- The 2019 annual HSA contribution limit for individuals with family will be \$7,000 – a \$150 increase from 2018.
- Healthcare FSA card transactions under \$150 will no longer require supporting documentation to be approved.
- Healthcare FSA card transactions for dental claims will no longer require supporting documentation to be approved.

Important Enrollment Information

- You can visit **myFBMC.com** and enroll online or complete and return your signed and dated enrollment form to your benefits coordinator by May 15, 2019, to enroll for or make changes to your benefits.
- For more information, go to **myFBMC.com**, or call 1-844-55-WVA4U (1-844-559-8248), 7 a.m. – 7 p.m. ET, Monday through Friday.

Benefit Fairs

Benefit Fairs will take place from April 11, 2019, through April 25, 2019. Benefit Fairs allow you access to specific information on each of your benefits. You're invited to ask questions, share your concerns and gain more knowledge about the coverages you select.

Mountaineer Flexible Benefits Representatives will be available at the Benefit Fairs to:

- Provide you with detailed benefit information
- Answer any benefit questions, and
- Help you complete your enrollment form.

See the Benefit Fairs schedule on the back of this benefits guide for times and locations.

How to Enroll

Enroll Online

Employees may choose to enroll at **myFBMC.com**. You must be registered to access the web enrollment. If you have not already, you will need to register following the first-time user link provided.



Registering Online

Your first step is to register, using your name, mailing ZIP code, email address and one of the following: FBMC ID or Social Security number (current users will continue to use your existing login credentials).

Fill out the registration form, enter the random image string into the text box, read the user acceptance agreement and then click the, "I agree. Complete my registration" button. You will receive an email shortly to finalize the registration. Follow the instructions within the email.

If you previously registered an email address and password on FBMC's website, you may continue using this information.

Accessing Your Online Benefits

Once registered, you may access the web enrollment instructions at the "Resources" tab.

Accessing the online enrollment website:

- Log in to **myFBMC.com**.
- Follow the instructions to set up your own username and password.
- Click the "Web Enrollment" link.
- Verify your demographic information.
- Add or update any dependent or beneficiary information.
- Begin the enrollment process.
- For each benefit, choose your coverage level or election amounts and then go to the next benefit.
- Continue until your enrollment is complete.
- Print out your confirmation statement containing all your benefit elections for you and your family.

Enroll by Paper

You may only enroll by paper form, if you:

- Are a new hire after March 1, 2019.
- Currently do not participate.
- Work for a non-state agency or a County Board of Education.
- If FBMC does not have your annual salary amount, you must enroll via paper application.



Note: This is a changes only enrollment. If you have no changes, you do not have to do anything and your benefits will remain the same.

For each benefit you are adding, changing or canceling, you must check the appropriate box next to the corresponding benefit.

For the benefit selections you are not altering, check the "Keep Coverage" box. If you complete an enrollment form, but do not indicate your desire to cancel or change an existing benefit, that benefit will continue regardless of other benefits which may or may not be indicated on the enrollment form.

If you are selecting "Employee & Children," "Employee & Spouse" or "Employee & Family" coverage, you must complete the dependent information in Section 4 on the enrollment form. Use an additional sheet of paper as needed for additional dependents.

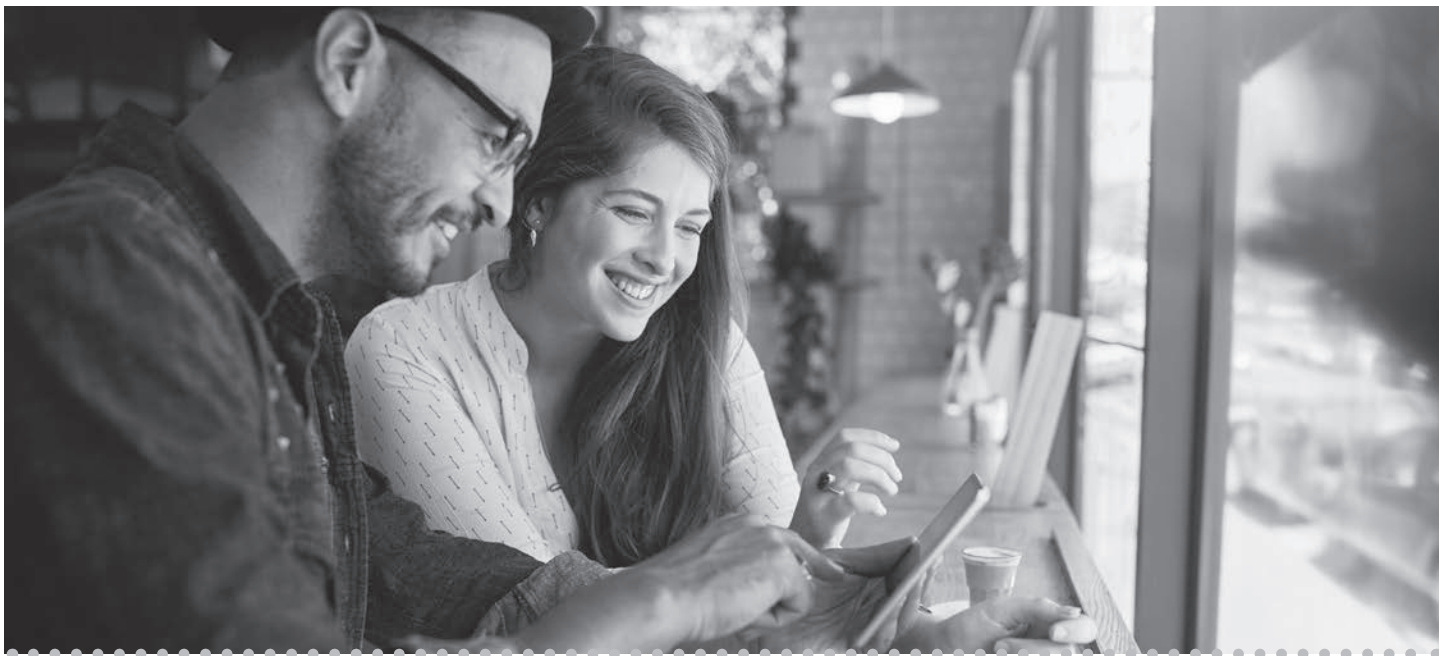
Your cost per pay period is based on your number of payrolls per plan year. Please check with your benefits coordinator if you have questions.

Sign and date the form at the bottom. Return your completed enrollment form to your benefits coordinator no later than May 15, 2019.

Keep Your Address Updated

In order to protect your family's rights, you should keep your employer and FBMC Benefits Management, Inc. informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices you send to your employer and FBMC. Please see your benefits coordinator to complete the FBMC Demographic Change Form. The Demographic Change Form can also be found on the PEIA website (www.peia.wv.gov).

How to Enroll



Enrollment Options

- **Enrolling for the first time?** Enroll online or complete an enrollment form and make your benefit selections by checking the “Add Coverage” box.
- **Changing your benefits?** Make changes online or complete an enrollment form and change your selections by checking the “Change Coverage” box. Complete the line with the new coverage information.
- **Adding a new benefit?** Enroll online or complete an enrollment form and make your selections by checking the “Add Coverage” box. Complete the line with the new coverage information.
- **Keeping all of your current benefits?** All benefits will continue as currently enrolled.
- **Canceling current benefits?** Make changes online or complete an enrollment form and check the “Cancel Coverage” box for the benefit you want to cancel; otherwise, it will automatically continue for the 2020 plan year.
- **Transferring to a new agency?** If you transfer from one agency to another, your benefits must remain the same. Complete an enrollment form, check the “Transfer” box and turn the form in to your new benefits coordinator.

When an employee transfers, it is the employee’s responsibility to provide their current benefits to the new agency. In the event that the new employee is unsure of his or her current benefits, the employee needs to contact the old agency to confirm coverage.

If an employee transfers from an agency that did not participate to an agency that does participate, they will be treated as a “new hire.”

Filing an Enrollment Appeal

If you have an enrollment change or request for a mid-plan year election change, you have the right to appeal the decision by sending a written request for review within 30 days of the initial denial.

Your appeal must include:

- The name of your employer
- Your contact information, including an email address so that you may be contacted easily and timely
- Why you believe your request for a variance should be considered
- Any additional documents, information or comments you think may have a bearing on your appeal

Your appeal and supporting documentation will be reviewed upon receipt. You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

IMPORTANT NOTE: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer’s, insurance provider’s and IRS regulations governing the plan.

For appeals involving your enrollment elections or mid-year changes, mail to:

FBMC Benefits Management
Attn: Enrollment Appeal; Mail Slot 51
PO Box 1878
Tallahassee, FL 32302-1878

Eligibility + Coverage

Who is Eligible?

All active, benefit-eligible employees of state agencies, colleges and universities and participating County Boards of Education are eligible to participate in this program. This program is also offered to some non-state agencies. Please check with your benefits department to see if you are eligible.

Upon certain qualifying events, spouses, children and employees may be eligible to continue for group health plan coverage under COBRA law. Please contact the FBMC Service Center at 1-844-55-WVA4U (1-844-559-8248) for more information.

A provision in the Patient Protection and Affordable Care Act (PPACA) allows for an employee's adult child to be covered under the employee's healthcare plan through the end of the month in which the adult child turns age 26. Coverage is in effect whether the adult child is/is not married or is/is not a student. For more information, please read the FAQs at myFBMC.com.

Period of Coverage

Your period of coverage begins on July 1, 2019, and continues until June 30, 2020, unless you:

- Terminate employment
- Go on an unpaid leave of absence or
- Change your benefit elections in limited circumstances as further discussed under "Changing Your Coverage"

Retiree Coverage

During the 90 days prior to your anticipated retirement date, contact FBMC for your retiree enrollment packet. When you retire, the benefits that are currently offered are dental, vision, hearing and legal. Flexible Spending Accounts and disability income protection are not offered to retirees and the coverage will end at the end of the month in which you end employment. If you are retiring, you have the option to meet with a benefits coordinator to discuss retiree benefits available and complete your enrollment form.

HIPAA Privacy

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of (HIPAA). These requirements are described in a Notice of Privacy that was previously given to you. A copy of this notice is available upon request.

HIPAA Special Enrollment Notice

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 62 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 62 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, call the FBMC Service Center at 1-844-55-WVA4U (1-844-559-8248).

Employees on Leave

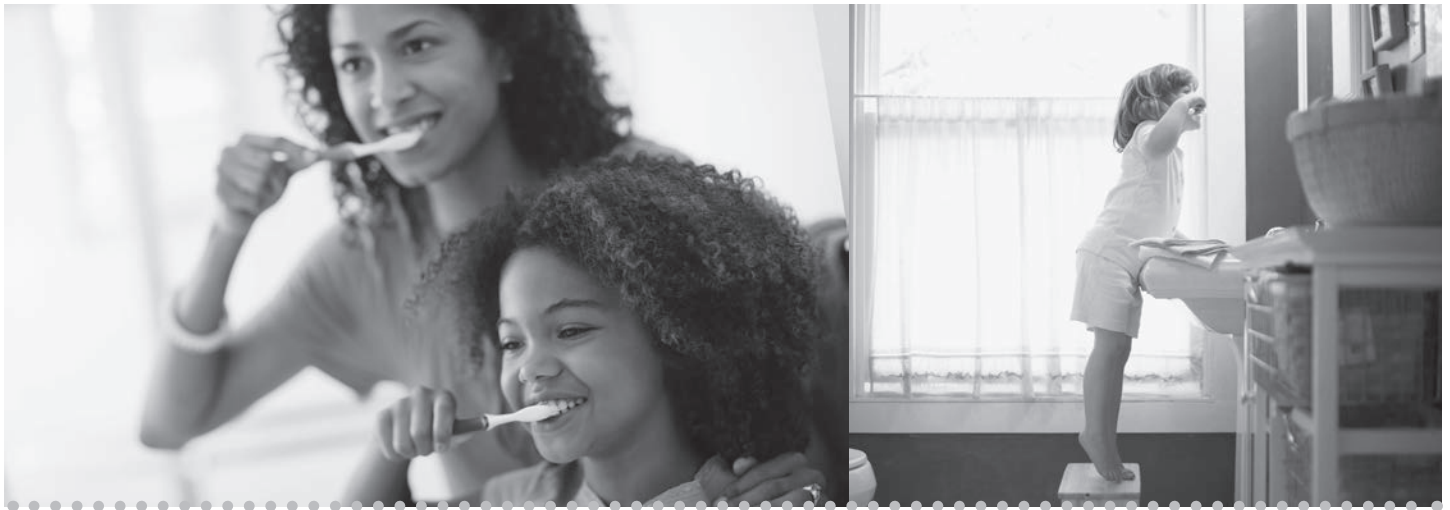
Approved Medical Leave: If you go on medical leave because of your own disability (which includes pregnancy and disabilities resulting from pregnancy complications), your premium deductions will continue through the Mountaineer Flexible Benefits Plan as long as you receive a salary. The Family and Medical Leave Act may affect your rights concerning the continuation of your health benefits while on unpaid leave. Contact your benefits coordinator or call FBMC at 1-844-55-WVA4U (1-844-559-8248).

Approved Unpaid Leave: You can continue to receive coverage for certain benefits for the duration of your leave if you pay your premium to FBMC on an after-tax basis.

If you have not maintained a current premium status while on leave, you will be required to re-satisfy eligibility requirements when you return to active status, except as otherwise provided by law. Call the FBMC Service Center at 1-844-55-WVA4U (1-844-559-8248) for further information on billing if you go on approved, unpaid leave.

If you are planning on a leave of absence, you will need to contact your benefits coordinator to advise. To remit payment while on leave, you will need to send your payment to your benefits coordinator. The benefits coordinator will submit the payment with the Mt. Flex personal pay summary form to FBMC.

Dental



You may choose from the following dental plans:

- Routine Plan
- Assistance Plan
- Basic Plan
- Enhanced Plan

With Delta Dental, you have complete freedom of choice in selecting a dentist. You can choose a dentist from the Delta Dental Premier® or Delta Dental PPOSM networks, or a dentist who does not participate in either network. Your choice of dentist can determine your cost savings.

Save on out-of-pocket costs

PPO dentists have agreed to reduced fees that are often lower than Premier fees. This helps you cover more services under your annual maximum. As with your Premier network dentist's plan, you won't get charged more than your expected share of the bill when you visit a PPO dentist. You won't have to submit any claim paperwork when you visit a Delta Dental dentist.

How can I tell if my dentist is Premier or PPO?

Your dentist might already be a PPO dentist. To find out, enter your dentist's name in the Find a Dentist search at deltadentalins.com. You can also call your dental office to confirm. Ask whether your dentist is a "contracted Delta Dental PPO dentist."

Online Services

Get information about your plan anytime, anywhere by signing up for an Online Services account. Available once your coverage kicks in, this free service lets you find a network dentist, view or print your ID card and more. The one-time registration process takes only a minute. Receive an email when a new dental benefits statement is available. Save time, reduce clutter and preserve environmental resources. To enroll, log in to Online Services and update your settings at deltadentalins.com.

Further Information

Eligible employees may cover your eligible dependent children to age 26, and spouses.

See the chart on page 11 for a partial list of covered services. Call Delta Dental for more information concerning your benefits, to view a list of exclusions or to request a claim form. **Certificates of Coverage** can be found at myFBMC.com.

There are no ID cards distributed with these plans.

Submit claim forms to:

Delta Dental of West Virginia Plan #01058

PO Box 2105

Mechanicsburg, PA 17055-2105

Customer Service: 1-800-932-0783

TTY/TDD: 1-888-373-3582

How to Print your ID card

1. Go to deltadentalins.com
2. Log in to Online Services with your username and password. (If you don't already have a username or password, click "Register Today" link to complete the quick registration process.)
3. Once you've logged in, click the "Eligibility & Benefits" tab.
4. Select "Print ID card" on the left-hand side of the page. (If you do not see this option, in some instances you may also need to click on the "Eligibility & Benefits" link on the left-hand side of the page before you have the option to select "Print an ID card.")
5. Click "Print."

NOTE: The card is not required to obtain services.

Dental

YOUR TAX-FREE DENTAL RATES

ROUTINE	10 PAY	12 PAY	18 PAY	20 PAY	21 PAY	22 PAY	24 PAY	26 PAY
Employee Only	\$13.40	\$11.17	\$7.45	\$6.70	\$6.38	\$6.09	\$5.59	\$5.16
Employee & Children	\$26.88	\$22.40	\$14.93	\$13.44	\$12.80	\$12.22	\$11.20	\$10.34
Employee & Spouse	\$29.99	\$24.99	\$16.66	\$14.99	\$14.28	\$13.63	\$12.50	\$11.53
Employee & Family	\$43.54	\$36.28	\$24.19	\$21.77	\$20.73	\$19.79	\$18.14	\$16.74
ASSISTANCE	10 PAY	12 PAY	18 PAY	20 PAY	21 PAY	22 PAY	24 PAY	26 PAY
Employee Only	\$14.48	\$12.07	\$8.05	\$7.24	\$6.90	\$6.58	\$6.04	\$5.57
Employee & Children	\$29.04	\$24.20	\$16.13	\$14.52	\$13.83	\$13.20	\$12.10	\$11.17
Employee & Spouse	\$32.40	\$27.00	\$18.00	\$16.20	\$15.43	\$14.73	\$13.50	\$12.46
Employee & Family	\$47.03	\$39.19	\$26.13	\$23.51	\$22.39	\$21.38	\$19.60	\$18.09
BASIC	10 PAY	12 PAY	18 PAY	20 PAY	21 PAY	22 PAY	24 PAY	26 PAY
Employee Only	\$20.72	\$17.27	\$11.51	\$10.36	\$9.87	\$9.42	\$8.64	\$7.97
Employee & Children	\$41.50	\$34.58	\$23.05	\$20.75	\$19.76	\$18.86	\$17.29	\$15.96
Employee & Spouse	\$46.25	\$38.54	\$25.69	\$23.12	\$22.02	\$21.02	\$19.27	\$17.79
Employee & Family	\$67.07	\$55.89	\$37.26	\$33.53	\$31.94	\$30.49	\$27.95	\$25.80
ENHANCED	10 PAY	12 PAY	18 PAY	20 PAY	21 PAY	22 PAY	24 PAY	26 PAY
Employee Only	\$34.46	\$28.72	\$19.15	\$17.23	\$16.41	\$15.67	\$14.36	\$13.26
Employee & Children	\$68.93	\$57.44	\$38.29	\$34.46	\$32.82	\$31.33	\$28.72	\$26.51
Employee & Spouse	\$80.04	\$66.70	\$44.47	\$40.02	\$38.11	\$36.38	\$33.35	\$30.78
Employee & Family	\$114.34	\$95.28	\$63.52	\$57.17	\$54.45	\$51.97	\$47.64	\$43.98

DENTAL TIPS:

- Twice-a-year dental cleanings are an important part of maintaining your oral and overall health. Call your dentist for an appointment today.
- Your toothbrush won't last forever. Three months is a typical lifespan, but whenever the bristles start to become bent, it's time to go shopping.



Visit mysmilecoverage.com
 – a one-stop-shop for oral
 health tools and tips, including
 videos, recipes and Grin!,
 our free oral wellness e-magazine.

Dental

Call Delta Dental for more information concerning your benefits, to request a list of exclusions or to request a claim form. Certificates of Coverage can be found at **myFBMC.com**. This is not a full list of the terms and conditions applicable to the benefits outlined below.

	ROUTINE PLAN	ASSISTANCE PLAN	BASIC PLAN	ENHANCED PLAN
Deductible (Per Person Per Plan Year) - Maximum total family deductible	No deductible	You pay \$25 (applies to all services)* \$75	You pay \$25 (applies to all services)* \$75	You pay \$50 (diagnostic, preventive and ortho are exempt) \$150
Plan Year Max (Per Person) - Delta Dental network dentist - Non-participating dentist	\$500 \$500	\$750 \$500	\$750 \$500	\$1,250 \$1,000
Other Maximums - Ortho Lifetime Max (Paid over two plan years) - TMJ Disorder	N/A N/A	N/A N/A	N/A N/A	\$1,000 \$500
BENEFIT	PLAN PAYS	PLAN PAYS	PLAN PAYS	PLAN PAYS
Diagnostic/Preventive Services*** Visits/Exams (twice in a plan year) - Routine cleaning (twice in a plan year) - Fluoride treatments (to age 19, twice in a plan year) - Bitewing X-rays (twice in a plan year) - Space maintainers (to age 14) - Sealants (to age 14, once in any 36-month period on unfilled permanent first and second molars)	100%*	100%*	80%*	100%*
Basic Restorative** - Amalgam ("silver") and composite ("white") on anterior teeth and the facial surface of bicusps	N/A	25%*	80%*	80%*
Oral Surgery - Extractions - Oral surgery procedures (Medical is primary for impactions) - General anesthesia and IV sedation are benefitted with all covered oral surgery procedures and with select endodontic and periodontic surgeries.	N/A	25%*	80%*	80%*
Endodontics - Pulpal therapy - Root canal therapy	N/A	25%*	80%*	80%*
Periodontics*** - Treatment for gums and supporting structures	N/A	25%*	80%*	80%*
Major Restorative** - Inlays, onlays, crowns (crowns for natural teeth, not implants)	N/A	NOT COVERED	NOT COVERED	50%*
Prosthodontic** - Bridges, Full and partial dentures, Denture adjustments/relining	N/A	NOT COVERED	NOT COVERED	50%*
Orthodontia** - For eligible dependent children to age 26, employees and spouses	N/A	NOT COVERED	NOT COVERED	50%*
TMJ	N/A	NOT COVERED	NOT COVERED	50%*

* Deductible waived for diagnostic/preventive procedures at Delta Dental PPO Provider. Deductible applies to all services rendered by Delta Dental Premier and non-participating dentists.

* Percentage is based on Delta Dental's applicable Maximum Plan Allowance or the dentist's fee, whichever is less (the Allowed Amount). The Delta Dental payment under the program, plus the patient payment, equals the Allowed Amount, which is accepted by Delta Dental participating dentists as full payment. Participating dentists are paid directly by Delta Dental, and by agreement cannot bill you more than the applicable Copayment, deductible or charges where maximums have been exceeded for covered services. By selecting a participating dentist, you always limit your out-of-pocket costs. For services performed by non-participating dentists, Delta Dental sends the benefit payment directly to you. You are responsible for paying the non-participating dentist's total fee, which may include amounts in addition to your share of Delta Dental's Allowed Amount. Out-of-pocket costs may also include applicable Copayments, deductibles, charges where maximums have been exceeded, and services not covered by the Group Dental Service Contract. Maximum Plan Allowance is an amount, determined by Delta Dental, from claim charges submitted on a regional basis for a given service by dentists of similar training within the same geographical area. These charges are blended by Delta Dental with dentist fee information from a number of other sources, using various factors, subject to regulatory limitations and adjustment for extraordinary circumstances, such as extreme difficulty or unusual circumstances.

** Basic Restorative have a 30-day exclusion. Major Restorative, Prosthodontics, and Orthodontics require six month plan participation.

*** Enhanced benefits for pregnancy, which include an additional oral evaluation and a choice of an additional periodontal scaling, root planing or prophylaxis, or additional periodontal maintenance procedure are covered.

Vision



You may choose from the following vision plans:

- Full Service Vision Plan
- Exam Plus Vision Plan

MetLife Vision Plan continues to be your vision plan provider. You may choose to cover your family by selecting the “Employee & Family” rates. You may cover your spouse and any children, stepchildren or foster children up to age 26.

Value-Added Benefit

Diabetic Eyecare Program – Provides additional coverage through medical diagnosis and procedure codes specifically targeted toward members with Type 1 diabetes.

How To Use These Plans

To obtain vision care benefits, call a MetLife Vision member doctor, identify yourself as a MetLife Vision patient and make an appointment. The doctor’s office will verify the patient’s eligibility and plan coverage and obtain authorization from MetLife Vision. There are no ID cards distributed with these plans.

The doctor will explain any additional charges. After you pay your Copayment, the doctor will take care of all the paperwork.

If you prefer, you can visit a non-member doctor and pay the doctor’s normal charges. Save your itemized receipt and mail it, along with the MetLife Vision Member Reimbursement Form, within six months of service date to:

MetLife Vision Claims
PO Box 385018
Birmingham, AL 35238-5018

Claim forms with the correct address can be downloaded from mybenefits.metlife.com/westvirginia. For more information, contact MetLife Vision’s Customer Service Line at 1-855-638-7339 (855-MET-SEE9).

MyBenefits – MetLife’s Self-Service Website

Logging on to the MyBenefits:

1. Go to the MyBenefits website at mybenefits.metlife.com/westvirginia
2. Complete the Account sign-in process by entering your username and password or
3. If you are a first-time user, click on the “Register Now” button
 - Provide your first name, last name, date of birth, Social Security number and email address
 - Create your own username and password
 - Select three security questions and provide your answers, in the event you forget your username or password in the future
4. Read and agree to the MyBenefits website’s terms of use
5. You will see a “Thank You” page and a registration confirmation email will be sent to the email address you provided while registering

Find a participating eye care professional

1. Click on the Find a Vision Provider near you link at: mybenefits.metlife.com/westvirginia
2. Enter your ZIP code or address
3. Add additional information to refine your search for a vision provider
4. Select your plan: Full Service Vision or Exam Plus Vision Plan

You can also call MetLife Vision at 1-855-MET-SEE9 (1-855-638-7339) for access to the 24/7 Interactive Voice Response system.

Print a personalized Vision ID card

- **A Vision ID card is not required to obtain services.**
 - Please note you will not be able to obtain an ID card until you are enrolled in the MetLife Vision Plan.
1. Click on Get My Vision ID card (located on right side of the landing page)
 2. Select the state where you reside
 3. The vision identification card will be displayed
 4. Using the printer icon located on top right of page – print your card

YOUR TAX-FREE VISION RATES

FULL SERVICE PLAN	10 PAY	12 PAY	18 PAY	20 PAY	21 PAY	22 PAY	24 PAY	26 PAY
Employee Only	\$10.13	\$8.44	\$5.63	\$5.06	\$4.82	\$4.60	\$4.22	\$3.90
Employee & Family	\$26.18	\$21.82	\$14.55	\$13.09	\$12.47	\$11.90	\$10.91	\$10.07
EXAM PLUS PLAN	10 PAY	12 PAY	18 PAY	20 PAY	21 PAY	22 PAY	24 PAY	26 PAY
Employee Only	\$1.70	\$1.42	\$0.95	\$0.85	\$0.81	\$0.77	\$0.71	\$0.66
Employee & Family	\$3.85	\$3.21	\$2.14	\$1.93	\$1.83	\$1.75	\$1.61	\$1.48

Vision

This is not a full list of the terms and conditions applicable to the benefits outlined below. Please contact 1-855-MET-SEE9 (1-855-638-7339) or review the certificate of coverage for more information.

	FULL SERVICE VISION PLAN		EXAM PLUS VISION PLAN	
	METLIFE MEMBER DOCTOR	NON-MEMBER DOCTOR	METLIFE MEMBER DOCTOR	NON-MEMBER DOCTOR
Copayments[†] Exam Copay Exam Frequency Prescription Glasses	\$20 Once per year \$20	Covered up to \$35 allowance Once per year \$0	\$10 Once per year Not covered	Covered up to \$35 allowance Once per year Not covered
Vision Examination (every plan year)	Covered in full after copay	\$35	Covered in full after copay	\$35
Lenses (every plan year) ^{***} Single Vision Lenses ^{**} Bifocal Lenses - (including progressive lenses) ^{**} Trifocal Lenses Lenticular Lenses ^{**}	Covered in full Covered in full Covered in full Covered in full	Covered up to \$25 Covered up to \$40 Covered up to \$55 Covered up to \$80	20% Savings at private practice locations only (Does NOT apply to Walmart/Sams Club)	Not covered
Frames (every other plan year) (Up to \$150 allowance) Sams Club/Walmart \$85.00 allowance	Covered in full*	Covered up to \$45	20% Savings at private practice locations only (Does NOT apply to Walmart/Sams Club)	Not covered
Contact Lenses^{**} (in place of lenses & frames) Necessary ¹ Elective Fitting and evaluation	Covered in full ^{***} \$150 Allowance Services are covered in full once every plan year, after a maximum \$60.00 copayment ^{****}	Exam & \$210 Exam & \$105 \$0	15% Savings at private practice locations is for Fitting and Evaluation only. Necessary and Elective for contact lenses are not covered.	Not covered
Prescription Glasses Discount	20% - Savings on additional pairs of prescription glasses, non-prescription sunglasses and lens enhancements from a MetLife vision member doctor.	- Single vision \$25 allowance - Lined bifocal \$40 allowance - Lined trifocal \$55 allowance - Lenticular \$80 allowance	20% - Savings on additional pairs of prescription glasses, non-prescription sunglasses and lens enhancements from a MetLife vision member doctor.	None
Prescription Contact Lenses Discount	Standard or premium fit covered in full with a copay not to exceed \$60	Applied to the allowance for contact lenses	15% Savings is for the fitting and evaluation only at private practice locations only (Does NOT apply to Walmart/Sams Club)	Not covered
Laser Vision Care Program Discount	15%	None	15%	None
	Average 15 percent off the regular price or five percent off a promotional offer for laser surgery, including LASIK, Custom LASIK and PRK surgeries. This offer is only available at MetLife participating locations.			

¹ These are patients who cannot have their vision corrected with standard glasses/lenses. They HAVE to have contact lenses which makes them necessary.

[†] Copayments apply in-network (MetLife Vision Member Doctor) at the time of service.

* Within Plan Limitations. If you select a frame that costs more than your plan allowance, there will be an additional charge you will pay out of pocket. When you visit a MetLife Vision member doctor, ask him/her which frames are covered in full. The allowance is very competitive and ensures a good choice with little or no out-of-pocket cost.

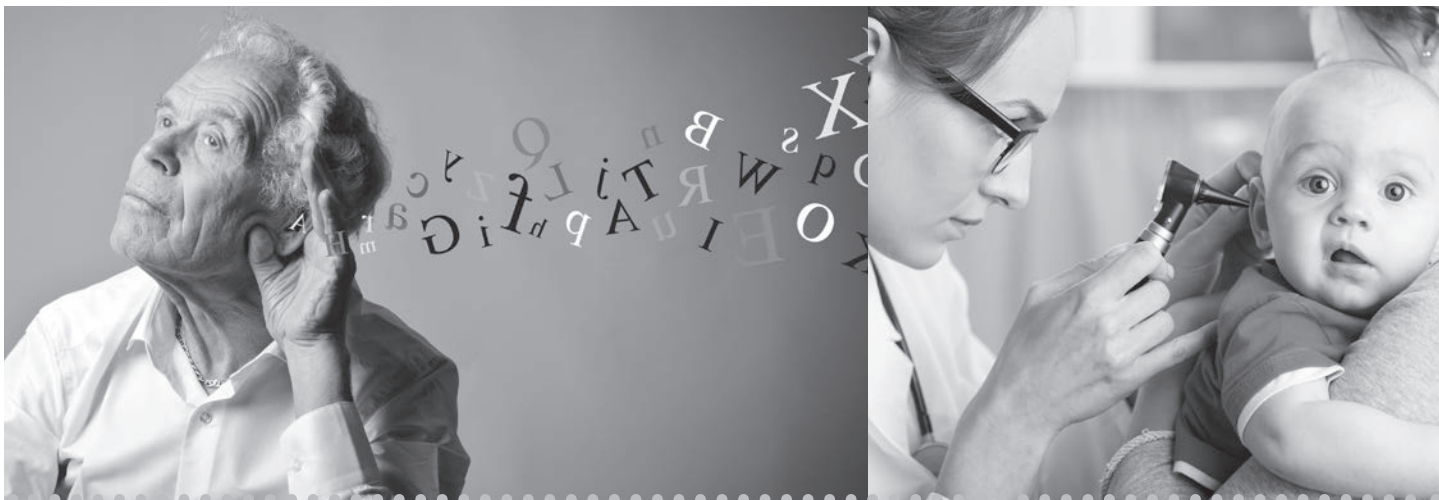
There will be an extra cost if you select materials or services that are elective or cosmetic in nature, such as tints and scratch coatings.

** Exam and contact lenses are also covered once every plan year, if necessary, provided you have not received spectacle lenses in the same plan year. You may receive eyeglass frames every other plan year. You may receive either spectacle lenses or contact lenses in the plan year, but not both.

*** There is a single materials Copayment of \$20 on lenses and frames or medically necessary contact lenses.

**** Fifteen percent discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

Hearing



Why have a Hearing Plan?

Hearing is one of the five natural senses that allow us to enjoy life and the world around us. Music, radio, television, movies and theater all become less accessible and enjoyable without the benefit of hearing. And the loss of sounds, like sirens and alarms can actually endanger your life.

Hearing is a valued life asset that can be protected, treated and assisted through a program for hearing healthcare. The EPIC Hearing Service Plan provides easy access to hearing health professionals – primarily physicians and audiologists who can help you achieve your maximum hearing potential throughout your life.

EPIC's Five-Step Plan

The EPIC Hearing Service Plan starts with an evaluation of your ears and hearing. Diagnostic tests and measures will determine the course of treatment most likely to help you hear better. The EPIC Hearing Plan's five basic steps to good hearing include:

1. Pure Tone Hearing Test – to determine if a hearing problem exists
2. Functional Assessment – to define the magnitude of the problem and the technology best suited to treat it
3. Hearing Aid Evaluation – to determine your ability to wear a hearing aid and select the best model and make
4. Fitting and Programming your hearing aid
5. Therapy and Training – to fine tune your device and maximize the benefits you receive

How the EPIC Plan Works

1. Call EPIC at 866-956-5400.
2. A hearing counselor will register you and assist in determining your healthcare needs.
3. You will receive a Hearing Service Plan booklet outlining all plan benefits, services and pricing.
4. A hearing counselor will coordinate a referral to a provider location near your home or work.
5. Contact the provider; follow through with an appointment, examination and treatment.
6. EPIC will coordinate and manage the provider network, provider fee schedule, provider referral, customer service, account management and client reporting.
7. EPIC will assist you in coordinating any insurance benefits or coverages, when applicable.
8. Contact EPIC at any time for assistance, advice or additional information at 866-956-5400.

When to call EPIC

If you or a family member experience any of the following, you may have a hearing problem that could be helped by a hearing health professional:

- Difficulty understanding voices and words (especially those of women and children)
- Occasional ringing in one or both ears
- Itching in the ear canals
- Difficulty understanding in noisy situations
- Turning up the television volume to understand the dialogue

In addition, some more serious symptoms merit immediate attention by a physician:

- A sudden hearing loss
- Spinning and dizziness with vomiting
- Persistent ringing in one ear
- Blood or fluid draining from one or both ears
- Persistent pain in one or both ears

Underwritten by Fidelity Security Life Insurance Company, Kansas City, MO Policy Form #M-9091.

Hearing

YOUR HEARING RATES

	10 PAY	12 PAY	18 PAY	20 PAY	21 PAY	22 PAY	24 PAY	26 PAY
Employee Only:	\$2.35	\$1.96	\$1.31	\$1.18	\$1.12	\$1.07	\$0.98	\$0.90
Employee + Children:	\$3.46	\$2.88	\$1.92	\$1.73	\$1.65	\$1.57	\$1.44	\$1.33
Employee + Spouse:	\$4.67	\$3.89	\$2.59	\$2.33	\$2.22	\$2.12	\$1.95	\$1.80
Employee + Family:	\$5.76	\$4.80	\$3.20	\$2.88	\$2.74	\$2.62	\$2.40	\$2.22

FEATURE	BENEFIT AMOUNT	FREQUENCY
Examination • Adults • Children	\$70 \$70	Adults: Once every 2 years Children: Once every year
Hearing Aid Device • Adults • Children	\$500 per ear device benefit \$500 per ear device benefit	Adults: Once every 5 years Children: Once every 2 years

SUMMARY OF ADDITIONAL HEARING PRODUCTS AT DISCOUNTED PRICES*

- Hearing Device Batteries – Discount battery program provides savings up to 40 percent off MSRP on name brand batteries. Orders are shipped direct with no shipping fees. EPIC will provide a one-year supply of batteries for any hearing aid(s) purchased in-network at the completion of the trial period.
- Product Warranties - EPIC provides an extended 3-year warranty on all hearing aid purchases at no additional cost to you.

Call EPIC to order or for more information, 1-866-956-5400.

* These are discounted items and are not insured benefits.

Long-Term Disability

Long-Term Disability (LTD) insurance can help safeguard your family's lifestyle and provide some peace of mind in the event you become disabled and are unable to work.

Because the State of West Virginia's retirement plan may not provide you adequate protection in the event you become disabled, you should consider enrolling in one of the two Long-Term Disability insurance plans offered by Standard Insurance Company.

When am I considered disabled?

During the benefit waiting period and the next 24 months you are considered disabled if, due to injury, physical disease, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of your own occupation, or you are unable to earn more than 80 percent of your pre-disability earnings while working in your own occupation.

Thereafter, you are considered disabled if, due to an injury, physical disease, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience, or you are unable to earn more than 60 percent of your pre-disability earnings while working in your own or any other occupation.

What is the LTD benefit?

The monthly LTD benefit is based on your earnings from your public employer. The group insurance policy refers to these earnings as pre-disability earnings. The group policy has an actively-at-work requirement you must meet before your insurance will become effective.

You may apply for coverage under either Plan 1 or Plan 2. The monthly benefit under each plan is determined as follows:

- **Plan 1:** 50 percent of the first \$6,000 of your monthly pre-disability earnings, reduced by deductible income. The maximum monthly benefit is \$3,000.
- **Plan 2:** 70 percent of the first \$8,571 of your monthly pre-disability earnings, reduced by deductible income. The maximum monthly benefit is \$6,000.

Both plans have a minimum monthly LTD benefit of \$100.

What is deductible income?

Deductible Income is income you receive or are eligible to receive from other sources. It includes, but is not limited to: sick pay or other salary continuation, workers' compensation benefits, Social Security benefits, disability benefits from any other group insurance, 50 percent of earnings from work activity while you are disabled (after the first 12 months of your disability), and disability or retirement benefits you receive any amount you receive by compromise, settlement, or other method as a result of a claim for any of the above, whether disputed or undisputed.

When do LTD benefits become payable?

If your LTD claim is approved by The Standard Insurance Company, LTD benefits become payable at the end of the 180-day benefit waiting period. Refer to the Beyond Your Benefits section for information on taxes you may have to pay on insurance payments you receive.

How long can LTD benefits continue?

If you become continuously disabled before age 62, LTD benefits can continue during disability until age 65, or three years and six months if longer. If you become continuously disabled at age 62 or older, LTD benefits can continue during disability for a limited time. See the chart below.

How long are benefits payable?

Your benefits are payable according to the following schedule:

AGE	MAXIMUM BENEFIT PERIOD
age 61 or younger	to age 65 (or 3 years, 6 months, if longer)
age 62	3 years, 6 months
age 63	3 years
age 64	2 years, 6 months
age 65	2 years
age 66	1 year, 9 months
age 67	1 year, 6 months
age 68	1 year, 3 months
age 69 +	1 year

Benefits are limited to 24 months for each period of continuous disability caused or contributed by a mental disorder. This limitation will not apply if you are continuously confined in a hospital at the end of the 24 months.

This description is designed to answer some common questions about the Long-term Disability coverage. It is not intended to provide a detailed description of the plans. If you become insured, a more detailed description will be available in group insurance certificates provided to you. The controlling provisions are in the master group insurance policies. This description and the certificates do not modify the group policies or the insurance in any way. For rules governing the taxes on the insurance payments you may receive, please read the Beyond Your Benefits section in the back of this benefits guide.

Long-Term Disability

What are the exclusions and limitations?

You are not covered for a disability caused or contributed to by:

- 1) a pre-existing condition (except as provided in your Certificate),
- 2) an intentionally self-inflicted injury or 3) war or any act of war.

Benefits are not payable for more than 24 months for each period of disability caused or contributed to by a mental disorder, or for any period when you are not under the ongoing care of a physician.

What is the definition of a pre-existing condition?

If your disability results, directly or indirectly, from a pre-existing sickness or injury for which you received medical treatment or services, took prescribed drugs or medicines, or consulted a Physician within three (3) months before the most recent effective date of your insurance, you will receive no monthly benefit for that condition. However, this exclusion does not apply to a period of Disability that begins after you have been insured under the plan for 12 consecutive months.

The Pre-existing Condition Exclusion will apply to any added benefits or increases in benefits.

What are some of the features of this coverage?

- Coverage for disabilities occurring 24 hours a day both on or off the job.
- Insurance continues without premium payments while LTD benefits are payable.
- A survivors' benefit may be applicable if you die while LTD benefits are payable.

Assisted Living Benefit:

This benefit is available when LTD benefits are payable. It provides additional income replacement if you become disabled and cannot perform two of six activities of Daily Living or suffer a Severe Cognitive Impairment, and the condition is expected to last 90 days or more. It increases the income replacement to 80 percent of your pre-disability earnings. The additional benefits paid under the Assisted Living Benefit are not reduced by deductible income. The maximum benefit amount for the Assisted Living Benefit cannot exceed \$1,800 for Plan 1 or \$857 for Plan 2. This benefit is available on both Plan 1 and Plan 2.

Lifetime Security Benefit:

This benefit provides a lifetime income to severely disabled employees, extending LTD benefits indefinitely by continuing to pay benefits, beyond the regular Maximum Benefit Period of age 65, until death at the original 70 percent level. Severely disabled means you cannot perform two of six activities of Daily Living or suffer a Severe Cognitive Impairment, and the condition is expected to last 90 days or more. Benefits paid under the Lifetime Security Benefit are reduced by deductible income. This benefit is available on Plan 2. If you have a lifetime security benefit and it continues after age 65, you will no longer be eligible for the survivor benefit.

Policy Provider

Standard Insurance Company underwrites this plan. The A.M. Best Company, an organization that rates the financial strength and performance of insurance companies, rates Standard Insurance Company "A" Excellent.

West Virginia Public Employees Insurance Agency

Policy #611506-A

Standard Insurance Company
Mon – Fri, 10 a.m. – 9 p.m. ET
1-800-368-2859

Long-Term Disability

PRETAX RATES FOR PLAN 1 (50% COVERAGE LEVEL)

Age*	Monthly Premium Rate per \$100 of Salary
to 29	\$.14
30-34	\$.16
35-39	\$.20
40-44	\$.29
45-49	\$.42
50-54	\$.61
55-59	\$.86
60-64	\$.97
65-69	\$1.23
70 and over	\$1.58

* Age as of July 1, 2019. Disability Income Plan premiums are adjusted on an annual basis according to the employee's age and salary.

DISABILITY INCOME PROTECTION FORMULA:

1. Enter your monthly salary
(maximum \$6,000) _____
2. Divide by 100 _____
3. Find your age on the chart above and
enter the figure from the "Rate" column _____
4. Multiply the amount in Line 2 by the
amount in Line 3 to get your monthly
premium (based on 12 months) _____
Monthly Premium

**IF YOU ARE PAID MORE THAN 12 TIMES A YEAR, YOU CAN
CALCULATE THE AMOUNT TO BE DEDUCTED FROM YOUR
PAYCHECK BY COMPLETING THE FOLLOWING CHART.**

5. Enter the monthly premium
amount from Line 4 _____
6. Multiply by 12 _____
7. This is your annual premium _____
8. Divide by the number of regular
paychecks you receive annually _____
**Per Paycheck
Deduction**

PRETAX RATES FOR PLAN 2 (70% COVERAGE LEVEL)

Age*	Monthly Premium Rate per \$100 of Salary
to 29	\$.24
30-34	\$.29
35-39	\$.37
40-44	\$.52
45-49	\$.76
50-54	\$1.12
55-59	\$1.47
60-64	\$1.57
65-69	\$1.76
70 and over	\$1.88

* Age as of July 1, 2019. Disability Income Plan premiums are adjusted on an annual basis according to the employee's age and salary.

DISABILITY INCOME PROTECTION FORMULA:

1. Enter your monthly salary
(maximum \$8,571) _____
2. Divide by 100 _____
3. Find your age on the chart above and
enter the figure from the "Rate" column _____
4. Multiply the amount in Line 2 by the
amount in Line 3 to get your monthly
premium (based on 12 months) _____
Monthly Premium

**IF YOU ARE PAID MORE THAN 12 TIMES A YEAR, YOU CAN
CALCULATE THE AMOUNT TO BE DEDUCTED FROM YOUR
PAYCHECK BY COMPLETING THE FOLLOWING CHART.**

5. Enter the monthly premium
amount from Line 4 _____
6. Multiply by 12 _____
7. This is your annual premium _____
8. Divide by the number of regular
paychecks you receive annually _____
**Per Paycheck
Deduction**

Short-Term Disability

When am I considered disabled?

You are considered disabled if, due to sickness, injury or pregnancy, you are unable to perform with reasonable continuity the material duties of your own occupation or you are unable to earn more than 60 percent of your pre-disability earnings while working in your own occupation.

What is the STD benefit?

The weekly Short-Term Disability (STD) benefit is based on your earnings from your public employer. The group insurance policy refers to these earnings as pre-disability earnings.

The weekly benefit is 70 percent of your pre-disability earnings, reduced by deductible income. The maximum weekly benefit is \$750. The minimum weekly benefit is \$15.

What is deductible income?

Deductible income includes 50 percent of earnings from work activity while you are disabled, and disability benefits you receive or are eligible to receive because of your disability under any state disability benefit law or similar law. Any amount you receive by compromise, settlement, or other method as a result of a claim for any of the above, whether disputed or undisputed.

When do STD benefits become payable?

If your STD claim is approved by The Standard Insurance Company, STD benefits become payable at the end of the 30-day benefit waiting period. During this 30-day period, no STD benefits are payable. The Group Policy has an actively-at-work requirement you must meet before your insurance will become effective.

How long can STD benefits continue?

STD benefits can continue during the disability until no longer disabled, but no longer than the 180th day of disability.

What are the exclusions and limitations?

You are not covered for a disability caused or contributed to by: 1) a work-related injury, 2) an intentionally self-inflicted injury or 3) war or any act of war. Benefits are not payable for any period when you 1) receive or are eligible to receive sick leave, 2) are working for any employer other than the State of West Virginia or your public employer, 3) are eligible for any benefits under a workers' compensation act or similar law or 4) are not under the ongoing care of a physician.

This description is designed to answer some common questions about the Short-Term Disability coverage. It is not intended to provide a detailed description of the plan. If you become insured, a more detailed description will be available in group insurance certificates provided to you. The controlling provisions are in the master group insurance policies. This description and the certificates do not modify the group policies or the insurance in any way.

For rules governing the taxes on the insurance payments you may receive, please read the Beyond Your Benefits section in the back of this benefits guide.

Policy Provider

Standard Insurance Company underwrites this plan. The A.M. Best Company, an organization that rates the financial strength and performance of insurance companies rates Standard Insurance Company "A" Excellent.

YOUR PRETAX RATES

Example: If your weekly salary is \$350, your monthly premium would be calculated:
 $\$350 \times \$0.0315 = \$11.02$ per month.

Worksheet:

1. Your weekly salary _____
(maximum \$1071.00) X \$0.0315
2. This is your monthly premium _____
If you are paid more than 12 times a year, you can calculate the amount to be deducted from your paycheck by completing the following chart.
3. Enter the monthly premium amount from Line 2 _____
4. Multiply by 12 _____
5. This is your annual premium _____
6. Divide by the number of regular paychecks you receive annually _____
Per Paycheck Deduction

West Virginia Public Employees Insurance Agency Policy #611506-B

Standard Insurance Company
Mon – Fri, 10 a.m. – 9 p.m. ET
1-800-368-2859

Group Legal Insurance

Affordable Legal Protection with Access to Network Attorneys

We're excited to provide you with valuable legal protection from ARAG®. It's affordable legal counsel for everyday life matters – like a dispute with a contractor, buying or selling a home or the need for estate planning. The plan provides you with the peace of mind knowing that attorney fees for most covered legal matters are 100 percent paid in full when you work with a network attorney. That means you'll avoid paying high-cost attorney fees, which currently average \$368 an hour*.

Resolve Your Legal Issues with a Network Attorney by Your Side

When a life event turns into a legal issue, ARAG will be there for you, backed by a nationwide network update to more than 14,000 knowledgeable attorneys. They can review or prepare documents, make follow-up calls or write letters on your behalf, provide legal advice and consultation, and represent you in court. Rely on legal help and protection with a wide range of covered services. For additional details regarding your plan's specifically-covered services, visit ARAGLegal.com/myinfo and enter **Access Code 18387wv** to learn more about what these plans offer, research specific legal topics and more.

Pre-existing Legal Matters

For any legal matters not covered and not excluded, you may be eligible to receive a minimum 25 percent reduced fee off a network attorney's normal hourly rate.

Call for Questions or Legal Assistance

You can also get assistance from our award-winning Customer Care Center with dedicated specialists who will help you navigate your legal issues. Call 800-247-4184 to speak with an ARAG Customer Care Specialist.

Visit ARAGLegal.com/myinfo and enter Access Code 18387wv to learn more about your legal benefit! See the plan options on the following page.

YOUR POST-TAX GROUP LEGAL RATES

ULTIMATEADVISOR®	10 PAY	12 PAY	18 PAY	20 PAY	21 PAY	22 PAY	24 PAY	26 PAY
EMPLOYEE & FAMILY	\$13.80	\$11.50	\$7.67	\$6.90	\$6.57	\$6.27	\$5.75	\$5.31

* Average attorney rates in the United States of \$368 per hour for attorneys with 11-15 years of experience, Survey of Law Firm Economics, The National Law Journal and ALM Legal Intelligence, November 2018.

Group Legal Insurance

Legal Insurance from ARAG®



Count on a wide range of coverage and services, like the examples shown below, that address the legal matters you encounter in life:

For your organization's complete list of covered matters and coverage levels, visit ARAGlegal.com/myinfo, Access Code 18387wv.

Plan Options	Ultimate Advisor®
Consumer Protection	
Auto Repairs, Buy/Sell a Car, Consumer Fraud, Contractors and More	•
Insurance Disputes	•
Estate Planning	
Wills and Powers of Attorney	•
Estate Administration & Closing (9 Hours)	•
Family	
Adoption	•
Contested Divorce (20 Hours)	•
Uncontested Divorce	•
Elder Law	•
Guardianship/Conservatorship	•
Name Change	•
Prenuptial Agreements	•
Domestic Violence Protection	•
Mental Incompetency or Infirmary	•
School Administrative Hearings	•
Real Estate	
Buy/Sell - Primary Residence	•
Home Equity Loan - Primary Residence	•
Refinance - Primary Residence	•
Real Estate Disputes - Primary Residence	•
Neighbor Disputes - Primary Residence	•
Easement	•
Zoning and Variances	•
Building Codes	•
Disputes with a Landlord - Contracts, Lease, Eviction, Deposits	•
Traffic and Vehicle	
Minor Traffic (Excluding DWI)	•
Driving Privilege Restoration	•
Driving Privilege Protection (Excluding DWI)	•
Immigration	
Immigration Services	•
Benefits	
Social Security/Veterans/Medicare	•
Identity Theft	
Identity Theft Services	•
Taxes	
IRS Audit Protection	•
IRS Collection Defense	•
State and Local Tax Audit	•
State and Local Tax Collection Defense	•
Property Tax - Primary Residence	•
Debt	
Bankruptcy	•
Defense of Debt Collection	•
Foreclosure	•
Defense of Garnishment	•

Plan Options	Ultimate Advisor®
Criminal	
Criminal Misdemeanor Defense	•
Habeas Corpus	•
Parental Responsibilities	•
Juvenile Court	•
Civil Damage Defense	
Libel/Slander, Pet-Related Matters and More	•
General Coverages	
Credit Record Correction	•
Small Claims Court	•
Document Preparation and Review	•
Personal Property Protection	•

Top Plan Uses:

- Estate Planning**
Meet with a network attorney to protect everything you've worked so hard for with a will, living will or the appropriate powers of attorney.
- Family Law**
When you face challenges like child custody or child support issues, our network attorneys can provide assistance.
- Traffic Tickets**
Our network attorneys will provide resources and assistance to help you defend a traffic offense and can even represent you in court.
- Property Protection**
Our network attorneys can help you address neighbor disputes, boundary disagreements and personal loans.
- Consumer Protection**
Get advice from a network attorney for issues/problems with auto repairs, contractors, buying a car or addressing other types of fraud.

You may be eligible to receive a minimum **25% reduced fee** off a Network Attorney's normal hourly rate for any other non-covered, non-excluded issues.



800-247-4184

ARAGlegal.com/myinfo, access code 18387wv

Limitations and exclusions apply. Depending upon a state's regulations, ARAG's legal insurance plan may be considered an insurance product or a service product. Insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa, GuideOne® Mutual Insurance Company of West Des Moines, Iowa or GuideOne Specialty Mutual Insurance Company of West Des Moines, Iowa. Service products are provided by ARAG Services, LLC. This material is for illustrative purposes only and is not a contract. For terms, benefits or exclusions, call our toll-free number.

(Cannot be used by spouses against policyholder) Rev 3/19 200277

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Flexible Spending Accounts



Flexible Spending Accounts

A Flexible Spending Account (FSA) lets you pay for eligible expenses with tax-free money. You contribute to an FSA with pretax money from your paycheck. This, in turn, may help lower your taxable income. There are two types of FSAs – Healthcare FSA and Dependent Care FSA.

Healthcare FSA

A Healthcare FSA is used to pay for eligible medical expenses which are not covered by your insurance or other plan. These expenses can be incurred by you, your spouse, a qualifying child or relative. Your full annual contribution amount is available at the beginning of the plan year, so you don't have to wait for the money to accumulate.

Dependent Care FSA

The Dependent Care FSA is a great way to pay for eligible dependent care expenses, such as: before and after school care, day time baby-sitting fees, elder care services, nursery and preschool costs. Eligible dependents include your qualifying child up to age 13, your spouse and/or relative unable to care for him or herself.

Once you pay for dependent care services for your eligible dependent(s), you can request reimbursement from your Dependent Care FSA. Please note that you are only able to submit a claim for the amount that is available in your account at the time of your reimbursement request. Unlike the Healthcare FSA, your full annual contribution is not available at the beginning of the plan year.

New for Plan Year 2020

- Healthcare FSA card transactions under \$150 will no longer require supporting documentation to be approved.
- Healthcare FSA card transactions for Dental claims will no longer require supporting documentation to be approved.

Annual Contribution Limits For Healthcare FSA:

- Minimum Annual Contribution: \$150
- Maximum Annual Contribution: \$2,700*

For Dependent Care FSA:

- Minimum Annual Contribution: \$150
- The maximum contribution depends on your tax filing status.
- If you are married and filing separately, your maximum annual contribution is \$2,500*.
- If you are single and head of household, your maximum annual contribution is \$5,000*.
- If you are married and filing jointly, your maximum annual contribution is \$5,000*.
- If either you or your spouse earn less than \$5,000* a year, your maximum annual contribution is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual contribution is \$3,000* a year for one dependent and \$5,000 a year for two or more dependents.

*Including administrative fees

Grace Period and Run Out Period

You have a 120-day run-out period (ending October 31, 2020) after your 2020 plan year ends to submit reimbursement requests for all eligible FSA expenses incurred DURING your plan year.

You may, however, continue using only your Healthcare FSA during the grace period (ending September 15, 2020), which is two months and 15 days after the end of your 2020 plan year. Be sure to submit your grace period claims before the end of your 120-day run-out period.

Flexible Spending Accounts

FSA Appeals and Managing Your FSA Online Appeals Process

If you have an FSA reimbursement claim denied, in full or in part, you have the right to appeal the decision by sending a written request within 30 days of the denial for review by mail to:

PayFlex Systems USA, Inc.
Flex Department
PO Box 981158
El Paso, TX 79998-1158

or Fax to: 1-855-703-5305

Your appeal must include:

- The name of your employer;
- The date of the services for which your request was denied;
- A copy of the denied request;
- The denial letter you received;
- Why you think your request should not have been denied; and
- Any additional documents, information or comments you think may have a bearing on your appeal.

Your appeal and supporting documentation will be reviewed upon receipt. You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

NOTE: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and the IRS regulations governing the plan.



Use your PayFlex Card®, your account debit card

The PayFlex debit card is a convenient way to pay for eligible Healthcare expenses. The card knows

when the expense is eligible and whether you have funds available. When you use the card, save your Explanation of Benefits, itemized statements and detailed receipts. There may be times when PayFlex asks you to provide documentation to verify you used your card for an eligible expense. If you're a new Healthcare FSA member, you'll automatically receive one card in the mail before the beginning of the plan year. The card is not available for the dependent care FSA. Additional cards may be requested by calling the PayFlex customer service at 1-844-PAYFLEX (1-844-729-3539).

Filing a Claim with PayFlex

If you pay for an eligible expense with cash, check or personal credit card, you can file a claim online at **payflex.com** or through the PayFlex Mobile® app to pay yourself back for your out of pocket expenses. Or you can fill out a paper claim form and mail it to PayFlex at:

PayFlex Systems USA, Inc.
Flex Department
PO Box 981158
El Paso, TX 79998-1158

or Fax to: 1-855-703-5305

This form can be found in the Resource Center at **payflex.com** or you may call PayFlex at 844-PAYFLEX to request a form.

After you log in to **payflex.com**, click on the **Financial Center** tab and select your account from the drop down. Click on **File a Spending Account Claim** to get started. When you submit a claim or validate a card swipe, you need to include supporting documentation that shows the following required items for approval.

Five Required Items for FSA Claim Approval:

- **Merchant or service provider name**
- **Name of patient (if applicable)**
- **Date of service**
- **Amount you were required to pay**
- **Description of item or service**

How to Register Online

- Go to **payflex.com**.
- Click on **Create Your Profile** and follow the online instructions.
- After successfully registering your account, My Dashboard will be displayed and you will be able to access your account information.
- To receive electronic account notifications, select **My Settings** at the top of the page and
 - Select the notifications link,
 - Enter your email address and then re-enter to confirm, and
 - Then select the notifications you wish to receive and click Submit.

Enroll in Direct Deposit

To receive your claim payments quickly, sign up for direct deposit through the PayFlex member website. Log in to **payflex.com**. Click on the **Financial Center** tab. Select your account from the drop down menu and click on **Enroll in Direct Deposit** to get started.

Health Savings Account

What is a Health Savings Account?

Providing economical Healthcare while costs are rising is a major issue facing the nation. To deal with this issue and help you plan for future health expenses, you will have the choice of enrolling in a Health Savings Account (HSA). This option allows you and your family to take greater responsibility for your medical care to reduce your insurance premiums and save money for future health expenses.

A Health Savings Account (HSA) is a tax-free account that can be used to pay Healthcare expenses. Unlike money in a Flexible Spending Account, the funds do not have to be spent in the plan year they are deposited. Money in the account, including interest or investment earnings, accumulates tax-free, so the funds can be used to pay qualified medical expenses in the future¹. An important advantage of an HSA is that it is owned by the employee. If you leave your job, you can take the account with you and continue to use it for qualified medical expenses.

Who is eligible to contribute to an HSA?

- Employees must be covered by an eligible, high deductible health plan (PEIA Plan C).
- Employees cannot be covered by any other health plan that is not a qualified high deductible health plan, including Medicare. However, they may be covered for specific injuries, accidents, disability, dental care, vision care and long-term care.
- Participants cannot be claimed as a dependent on another person's tax return.

How much can I contribute to my HSA?

If you enroll in an HSA and elect to make contributions, your contributions are deducted on a pretax basis. The 2019 annual HSA contribution limit for individuals with self-only HDHP coverage will be \$3,500 – a \$50 increase from 2018. The 2019 limit for individuals with family HDHP coverage will be \$7,000 – a \$150 increase from 2018. Please visit irs.gov/pub/irs-pdf/p969.pdf for updates. These limits, established by the federal government and subject to change, are tied to the rate of inflation. An individual age 55 and older may make “catch-up” contributions of up to \$1,000 above the limits shown above in 2020.

You may also make after-tax contributions, which apply toward the maximum annual limit(s). You will receive additional information when you enroll.

Can I transfer funds from my IRA to my HSA?

A one-time irrevocable trustee-to-trustee transfer of IRA funds to an HSA will be allowed as long as the transferred amount does not exceed the annual HSA contribution limits³. Any transfer from an IRA to an HSA will reduce the maximum amount that may be contributed to an HSA during a calendar year.

¹ Please consult your tax advisor or IRS Publication 502 with questions regarding these expenses, qualified health plans, and tax information. Accounts opened prior to March 1, 2020 will continue their current fee structure of \$2 per month maintenance fee waived with an average daily balance of \$2,500 and a \$0.50 per check written fee. Other fees may apply, including fees for insufficient funds. Refer to the PayFlex Fees and Charges for more information.

² The “catch-up” contribution rule applies to employees who are or become age 55 prior to 12/31 of the election year.

³ Please consult a tax advisor. Certain restrictions apply.

How do I access the funds in my HSA account?

After electing the HSA, your information and account is established. Please go to payflex.com to open your account. You will receive a MasterCard with instructions on how to go to payflex.com and create your profile. You can link your bank account and set up for alerts. You may order additional cards at no charge online or by calling customer service at 844-729-3539. You may use your MasterCard to pay for eligible expenses. However, if you withdraw funds for ineligible expenses, you may have to pay taxes and penalties on those funds, unless you reimburse your HSA for the ineligible expense.

Will I be charged any banking or custodian fees?

The custodian will charge you \$2.50 per month for your HSA. This fee includes the MasterCard® debit card, all transaction fees associated with the card. To make an HSA payment, use the online payment tool to pay your provider directly from your HSA. A check will be mailed to your provider at no additional cost. Other fees may apply, including fees for insufficient funds and account closure fees. Refer to the PayFlex Fees and Charges for more information.

PRETAX BENEFITS SAVINGS EXAMPLE*

(With HSA)		(Without HSA)
\$31,000	Annual Gross Income	\$31,000
- 5,000	HSA Deposit for Recurring Expenses	- 0
\$26,000	Taxable Gross Income	\$31,000
- 5,369	Federal, Social Security Taxes	-6,401
\$20,631	Annual Net Income	\$24,599
- 0	Cost of Recurring Expenses	-5,000
\$20,631	Spendable Income	\$19,599

By using an HSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of

\$1,032!

* Based upon a 20.65% tax rate (15% federal and 7.65% Social Security) calculated on a calendar year.

Remember, Limited Healthcare FSAs are available to HSA participants. Dependent Care Spending Account eligibility is not affected by your HSA participation. Limited Healthcare FSAs are ONLY available to HSA participants.

Limited Healthcare FSA

MINIMUM ANNUAL DEPOSIT:	\$150
MAXIMUM ANNUAL DEPOSIT:	\$2,700

Limited Healthcare FSA (LPFSA) is offered in conjunction with your Health Savings Account, should you elect. LPFSA funds can only be used for dental and vision. You are not allowed to contribute to both a health savings account as well as a standard (non-limited) healthcare FSA.

Whose expenses are eligible?

Your LPFSA may be used to reimburse eligible expenses incurred by yourself, your spouse, your qualifying child or your qualifying relative.

When are my funds available?

Funds are available on day one of the plan. Once you sign up for a LPFSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible expenses will be available throughout your period of coverage.

Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible expenses at the start of your plan year, which is July 1, 2019.

FSA Grace Period and Run-Out Period Dates

Your FSA grace period ends two months and 15 days after the end of your plan year. During the FSA grace period, you may incur expenses and submit claims for those expenses. The grace period does not apply to Dependent Care FSAs. **Your grace period ends September 15, 2020.**

Your FSA run out period is a 120-day run-out period after your plan year ends to submit reimbursement requests for all eligible FSA expenses (for both Healthcare or Dependent Care FSAs) incurred DURING your plan year. Be sure to submit your grace period claims before the end of your 120-day run-out period. **Your run-out period ends October 31, 2020.**

Changing Your Coverage

Changing Your Benefits During The Plan Year

You will have the month of and two months following a qualifying event to submit an election form and supporting documentation to your benefits coordinator. Upon the approval of your election change request, your existing benefit elections will be stopped or modified (as appropriate). However, if your benefit election change request is denied, you have the month of and two months following from the date of a qualifying event, to file an appeal with your employer. For more information, contact FBMC Service Center or your benefits coordinator. Visit myFBMC.com for information on rules governing periods of coverage and IRS Special Consistency Rules.

Changes In Status:

Marital Status	A change in marital status includes marriage, death of a spouse, divorce or annulment (legal separation is not recognized in all states).
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid Change In Status (CIS) event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital, employment or tax dependent status.
Change in Residence*	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.

Some Other Permitted Changes:

Coverage and Cost Changes*	Your employer's plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Care FSA benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.
Open Enrollment Under Other Employer's Plan*	You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and: <ul style="list-style-type: none">• The other employer's plan has a different period of coverage (usually a plan year) or• The other employer's plan permits mid-plan year election changes under this event.
Judgment/Decree/Order†	If a judgment, decree or order from a divorce, legal separation (if recognized by state law), annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Medicare/Medicaid†	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pretax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within 30 days of one of the following CIS events: birth, adoption or placement for adoption. Note that a Healthcare FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.
Family and Medical Leave Act (FMLA) Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.

* Does not apply to a Healthcare FSA plan.

† Does not apply to a Dependent Care FSA plan.

Notices

COBRA Q&A

Overview

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event, also called a “qualifying event.” After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

When is COBRA available?

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

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

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

Options Besides COBRA

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

More Information

This COBRA Q&A section does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from your employer.

Keep Address Updated

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

This is not an exhaustive account of your right under, or the conditions of, COBRA. Complete information will be provided in separate notices as appropriate.

TAXABLE BENEFITS AND THE IRS

Certain benefits may be taxed if you become disabled, depending on how the premiums were paid during the year of the disabling event. Payments, such as disability, from coverages purchased with pretax premiums and/or nontaxable employer credits, will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pretax and after-tax dollars, then any payments received under the plan will be taxed on a pro-rata basis. If premiums were paid on a post-tax basis, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages. Consult your personal tax adviser for additional information.

In addition, FICA and Medicare taxes will be withheld from any disability payments paid through six calendar months following the last calendar month in which you worked prior to becoming disabled. Thereafter no FICA or Medicare tax will be withheld.

You will be required by the IRS to pay FICA, Medicare, and federal income taxes on certain other benefit payments, such as those from Hospital Indemnity Insurance, Personal Cancer Expense Insurance and Hospital Intensive Care Insurance, that exceed the actual Healthcare expenses you incur, if these premiums were paid with pretax dollars and/or nontaxable employer credits. If you have questions, consult your personal tax adviser.

SOCIAL SECURITY

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors’ and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.

However, the tax savings realized through a cafeteria plan may generally outweigh the Social Security reduction. Call 1-844-55-WVA4U (1-844-559-8248) for an approximation.

DISCLAIMER - HEALTH INSURANCE BENEFITS PROVIDED UNDER HEALTH INSURANCE PLAN(S)

Health Insurance benefits will be provided not by your employer’s flexible benefits plan, but by the health insurance plan(s). The types and amounts of health insurance benefits available under the health insurance plan(s), the requirements for participating in the health insurance plan(s) and the other terms and conditions of coverage and benefits of the health insurance plan(s) are set forth from time to time in the health insurance plan(s). All claims to receive benefits under the health insurance plan(s) shall be subject to and governed by the terms and conditions of the health insurance plan(s) and the rules, regulations, policies and procedures from time to time adopted.

NOTICE OF FBMC’S CAPACITY

FBMC Benefits Management, Inc. (FBMC) has been authorized by your employer to provide certain administrative services for some of the insurance plans offered within your employer’s benefit program. Importantly, FBMC is not the policyholder or an insurance company. The policyholder is the entity to whom the insurance policy has been issued; the employer is the policyholder for group insurance products and the employee is the policyholder for individual products. The policyholder is identified on either the face page or schedule page of the policy or certificate. The insurance companies noted in this guide have been selected by your employer and are liable for the funds to pay your insurance claims.

Benefits Directory

FBMC Benefits Management, Inc. (Contract Administrator)

FBMC Service Center
Monday – Friday, 7 a.m. – 7 p.m. ET
1-844-55-WVA4U (1-844-559-8248)
myFBMC.com

EPIC Hearing Service Plan (Hearing Benefits)

Monday – Friday, 9 a.m. – 9 p.m. ET
1-866-956-5400
epichearing.com

Delta Dental of West Virginia (Dental) Plan #01058

Customer Service
Monday – Friday, 8 a.m. – 8 p.m. ET
1-800-932-0783
deltadentalins.com

MetLife (Vision)

Customer Service
Monday – Friday, 8 a.m. – 11 p.m. ET
Saturday, 10 a.m. – 11 p.m. ET
Sunday, 10 a.m. – 10 p.m. ET
1-855-638-7339 (855-MET-SEE9)
mybenefits.metlife.com/westvirginia

ARAG (Legal)

Customer Care Number:
Monday – Friday, 7 a.m. – 7 p.m. CT
1-800-247-4184
1-800-383-4184 for TTY
ARAGlegal.com/myinfo, Access code: 18387wv

Standard Insurance Company (STD/LTD Claims)

(STD) Policy #611506-B
(LTD) Policy #611506-A
Monday – Friday, 10 a.m. – 9 p.m. ET
1-800-368-2859
standard.com

Trustmark Insurance Company* (LifeEvents®)

Customer Care
Monday – Thursday, 7 a.m. – 7 p.m.
Friday, 7 a.m. – 6 p.m.
1-800-918-8877
trustmarksolutions.com

PayFlex (Flexible Spending Accounts) (Health Savings Accounts)

Customer Service
Monday – Friday, 7 a.m. – 7 p.m. CT
Saturday, 9 a.m. – 2 p.m. CT
1-844-PAYFLEX (1-844-729-3539)
Toll-Free Claims Fax
1-888-238-3539
payflex.com

PayFlex Card (Lost or Stolen Card)

Customer Service
Monday – Friday, 7 a.m. – 7 p.m. CT
1-844-PAYFLEX (1-844-729-3539)
payflex.com

PayFlex Systems USA, Inc. (COBRA)

State of West Virginia Mountaineer
Flexible
Benefits Call Center at
1-844-559-8248
Monday – Friday, 7 a.m. – 7 p.m. ET
payflex.com

*Trustmark no longer offers new LifeEvents® policies. Employees who currently have LifeEvents® may continue coverage.

2019 Benefit Fair Schedule

Date	Location	Time
Thursday, April 11	Courtyard by Marriott 100 Kanawha Blvd Charleston, WV 25301	3 p.m. – 6 p.m.
Tuesday, April 16	Tamarack Conference Center 1 Tamarack Park Beckley, WV 25801	3 p.m. – 7 p.m.
Wednesday, April 17	Holiday Inn 800 3rd Ave Huntington, WV 25701	3 p.m. – 7 p.m.
Thursday, April 18	Comfort Suites of Parkersburg 167 Elizabeth Pike Mineral Wells, WV 26150	3 p.m. – 7 p.m.
Tuesday, April 23	WV Northern Community College 1704 Market Street Wheeling, WV 26003	3 p.m. – 7 p.m.
Wednesday, April 24	University Holiday Inn 1188 Pineview Drive Morgantown, WV 26508	3 p.m. – 7 p.m.
Thursday, April 25	Holiday Inn Express 301 Foxcroft Avenue Martinsburg, WV 25401	3 p.m. – 7 p.m.



Contract Administrator
FBMC Benefits Management, Inc.
PO Box 1878 • Tallahassee, Florida 32302-1878
FBMC Service Center 1-844-55-WVA4U (1-844-559-8248)
Mon. - Fri., 7 a.m. - 7 p.m. ET
myFBMC.com

Information contained herein does not constitute an insurance certificate or policy.
Certificates or policies will be provided to participants following the start of the plan year, if applicable.