2023

GUIDE TO YOUR BENEFITS

MAKE YOUR WEST MARINE BENEFITS WORK FOR YOU

BE READY FOR ENROLLMENT

West Marine is committed to providing our Crew Members with a benefits program that is both comprehensive and competitive. Our benefits program offers health care, dental and vision coverage, as well as financial security to our Crew Members and their families. This guide provides a general overview of your benefit choices and enrollment information to help you select the coverage that is right for you.

BENEFITS OVERVIEW

If you are a full-time Crew Member working at least 30 hours per week, you are eligible for all benefits offered by West Marine. Part-time Crew Members working at least 16 hours per week are eligible for voluntary supplemental health benefits (Critical Illness, Accident, and Hospital Indemnity) through West Marine.

DEPENDENT ELIGIBILITY

You can enroll your dependents in plans that offer dependent coverage. Eligible dependents are defined as your legal spouse or domestic partner and eligible children who depend primarily on you for support. This includes: your own children, legally adopted children, stepchildren, a child for whom you have been appointed legal guardian, and/or a child for whom the court has issued a Qualified Medical Child Support Order (QMCSO) requiring you or your spouse or domestic partner to provide coverage.

MEDICAL, DENTAL, AND VISION PLAN DEPENDENT COVERAGE

You may cover your eligible dependent children up to age 26, regardless of marital or student status (this does not include spouses or domestic partners of adult children).

Dependent coverage will cease for your covered dependent children at the end of the month in which an eligible dependent reaches age 26.

DOMESTIC PARTNER COVERAGE

Domestic partners are eligible to enroll as dependents in the benefit plans. You and your partner must meet specific criteria to qualify for domestic partner coverage. A domestic partnership is different than a marriage with an individual of the same-sex. A same-sex spouse is a federal tax dependent for group health plan purposes; whereas, a domestic partner often is not. If you cover a domestic partner, a domestic partner's child or another person who is not considered an IRS tax dependent for group health plan purposes, West Marine is required to report income for you that reflects the value of coverage for tax-reporting purposes. This is known as imputed income. You will receive a W-2 annually for the value of coverage for any dependent who is not an IRS tax dependent.

ENROLLMENT PERIODS

New Crew Members

As a new Crew Member of West Marine, you become eligible for benefits 30 days after your date of hire. Our benefits plan year runs from January 1st through December 31st.

Open Enrollment

As a benefits-eligible Crew Member, you have the opportunity to enroll in or make changes to your benefit plans during our annual open enrollment period. Open Enrollment is usually held in November with benefit elections effective January 1st.

MAKE YOUR WEST MARINE BENEFITS WORK FOR YOU

MAKING CHANGES DURING THE YEAR

Choose your benefits carefully. Medical, dental, vision, and flexible spending account contributions are made on a pre-tax basis and IRS regulations state that you cannot change your pre-tax benefit options during the year unless you have a qualified life event. Qualified life events include:

- Marriage or divorce;
- Death of your spouse, domestic partner, or dependent;
- Birth or adoption of a child;
- Your spouse or domestic partner terminating or obtaining new employment (that affects eligibility for coverage);
- You or your spouse or domestic partner switching employment status from full-time to part-time or vice versa (that affects eligibility for coverage);
- Significant cost or coverage changes; or
- Your dependent no longer qualifies as an eligible dependent.

You must notify and submit any applicable forms and/or documentation to West Marine within 30 days of the event. West Marine will review your request and determine whether the change you are requesting is allowed. Only benefit changes which are consistent with the qualified life event are permitted.

PAYING FOR YOUR BENEFITS

Some benefits are provided to you at no cost. The cost of other benefits, such as medical and dental, is shared by you and West Marine. Additional benefits, such as vision and Supplemental Life Insurance are paid for by you at discounted group rates. Having benefit options available means you can build a benefits program that meets your needs and your lifestyle.

BENEFIT	WHO CONTRIBUTES?	TAX BASIS
Medical & Prescription Drug	West Marine & You	Pre-Tax
Dental	West Marine & You	Pre-Tax
Vision	You	Pre-Tax
Basic Life & Accidental Death and Dismemberment	West Marine	Pre-Tax
Supplemental Life	You	Post-Tax
Long-Term Disability	West Marine	Pre-Tax
Flexible Spending Accounts	You	Pre-Tax
Health Savings Account	West Marine & You	Pre-Tax
Hospital Indemnity	You	Post-Tax
Accident Insurance	You	Post-Tax
Critical Illness	You	Post-Tax
Retirement 401(k) Savings Plan	West Marine & You	Pre-Tax

WHAT'S NEW FOR 2023:

- Slight Changes to Medical Plan Designs
- Slight Changes to Medical, Dental, and Vision Premiums

WHY WEST MARINE OFFERS SUPPLEMENTAL MEDICAL BENEFITS:

Medical insurance does not prevent all of the financial strain of a major illness or injury. Many families don't have enough in their savings to cover the deductible and coinsurance of a major medical event. Supplemental medical benefits can help cover this out-of-pocket financial exposure for a reasonable cost.

These benefits are paid directly to you, allowing you to use the funds how ever you choose. You receive the full benefit even if you have other insurance. West Marine offers, Critical Illness Insurance, Accident Insurance, and Hospital Indemnity Insurance.

MEDICAL BENEFITS

West Marine seeks to provide the best possible medical benefits at a reasonable cost. Crew Members are provided with two medical plans through Anthem and Prescription Drug coverage through Express Scripts. If you live in California, you have an additional plan option available through Kaiser.

Please refer to the chart on the next page for a comparison of medical plan benefits.

IN-NETWORK ADVANTAGE

Within some of the medical, dental and vision plans, you have the freedom to use any provider. However, when you use an in-network provider, the percentage you pay out-of-pocket will be based on a negotiated fee, which is usually lower than the actual charges. If you use a provider who is outside of the network, you may be responsible for paying for the difference between the Usual, Customary and Reasonable (UCR) charges and what the provider charges. You also may need to submit claim forms.

MEDICAL AND PRESCRIPTION DRUG COVERAGE

MEDICAL AND PRESCRIPTION DRUG BENEFITS

The information below is a summary of medical coverage only. Please contact Anthem at **anthem.com**, for plan summaries detailing coverage information, limitations, and exclusions.

Any deductibles and copays shown in the chart below are amounts for which **you** are responsible.

COST OF COVERAGE

BENEFIT	ANTHEM BLUE CROSS HSA PLAN		ANTHEM BLUE CROSS PPO PLAN		KAISER HMO PLAN (CALIFORNIA ONLY)	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Employer HSA Contribution	$250 Per Quarter (If activities are completed)		None	None	None	None
Annual/Calendar Year Deductible (Individual/Family)	$2,200/$4,400	$5,720/$11,440	$1,350/$2,700	$3,510/$7,020	$0/$0	Not Covered
Out-of-Pocket Maximum (Individual/Family)	$5,500/$11,000	$11,000/$33,000	$4,320/$8,640	$8,640/$25,920	$3,000/$6,000	Not Covered
Coinsurance	20% after deductible	50% after deductible	20% after deductible	50% after deductible	0% after deductible	Not Covered
Physician Services						
Doctor's Office Visit	20% after deductible	50% after deductible	$30 Copay	50% after deductible	$30 Copay	Not Covered
Specialist Office Visit	20% after deductible	50% after deductible	$50 Copay	50% after deductible	$30 Copay	Not Covered
Preventive Care	No Charge	50% after deductible	No Charge	50% after deductible	No Charge	Not Covered
Lab & X-ray Services	20% after deductible	50% after deductible	20% after deductible	50% after deductible	$10 Copay Diagnostics $100 Copay Imaging	Not Covered
Hospital Services						
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible	$500 Copay	Not Covered
Outpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible	$250 Copay	Not Covered
Urgent Care	20% after deductible	50% after deductible	$75 Copay	50% after deductible	$30 Copay	$30 Copay
Emergency Care	20% after deductible		$150 Copay then 20% (deductible does not apply)		$150 Copay	
PRESCRIPTION DRUGS						
Retail (30-day Supply)						
Generic	20% after deductible	50% after deductible	$10 Copay	50% after deductible	$15 Copay	Not Covered
Preferred Brand	25% after deductible	50% after deductible	$35 Copay	50% after deductible	$35 Copay	Not Covered
Non-preferred Brand	50% after deductible	50% after deductible	$60 Copay	50% after deductible	$35 Copay	Not Covered
Mail Order (90-day Supply)						
Generic	20% after deductible	50% after deductible	$25 Copay	50% after deductible	$30 Copay	Not Covered
Preferred Brand	25% after deductible	50% after deductible	$88 Copay	50% after deductible	$70 Copay	Not Covered
Non-preferred Brand	50% after deductible	50% after deductible	$150 Copay	50% after deductible	$70 Copay	Not Covered
BI-WEEKLY PAYCHECK DEDUCTIONS						
Crew Member Only	$88.45		$109.06		$112.48	
Crew Member + Spouse/ Domestic Partner	$194.79		$240.12		$247.47	
Crew Member + Child(ren)	$123.89		$152.75		$157.48	
Family	$230.24		$283.81		$292.46	

NOTE: Deductibles, copays, and coinsurance accumulate toward the out-of-pocket maximums. Usual, Customary, and Reasonable charges apply for all out-of-network benefits.

DENTAL AND VISION COVERAGE

DENTAL BENEFITS

Dental coverage is key to your overall health. West Marine offers Crew Members two dental plan options through Delta Dental. Review the details about each plan carefully so you can determine which plan meets your needs. Your dental plans offer choices that cover four main types of expenses:

- Preventive and diagnostic services like routine exams and cleanings, fluoride treatments, sealants, and x-rays
- Basic services such as simple fillings and extractions, root canals, oral surgery, and gum disease treatment
- Major services such as crowns and dentures
- Orthodontia available to all ages

COST OF COVERAGE

BENEFIT	BASIC DENTAL	ENHANCED DENTAL
Annual/Calendar Year Maximum	$2,000 Per Person	$2,500 Per Person
Annual/Calendar Year Deductible (Individual/Family)	$50/$100	$50/$100
Preventive Services	100% Covered	100% Covered
Basic Services	80% Covered after deductible	80% Covered after deductible
Major Services	50% Covered after deductible	50% Covered after deductible
Orthodontia Lifetime Maximum	No Orthodontia Benefit	$1,500 Per Person
BI-WEEKLY PAYCHECK DEDUCTIONS		
Crew Member Only	$7.84	$10.73
Crew Member + Spouse/Domestic Partner	$18.31	$25.14
Crew Member + Child(ren)	$17.48	$24.36
Family	$27.95	$36.66

VISION BENEFITS

West Marine offers Crew Members one vision plan through VSP that includes coverage for eye exams and eyeglasses or contact lenses.

COST OF COVERAGE

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Exam (Every Year)	$20 Copay	$45 Reimbursement
Lenses (Every Year)	$25 Copay	$25 Copay $30 - $100 Reimbursement (depending on lens type)
Frames (Every Other Year)	$150 Allowance	$70 Reimbursement
Contact Lenses Instead of Glasses		
Conventional/Disposable	$150 Allowance	$105 Reimbursement
Medically Necessary	$150 Allowance	$210 Reimbursement
BI-WEEKLY PAYCHECK DEDUCTIONS		
Crew Member Only	$1.98	
Crew Member + Spouse/Domestic Partner	$3.96	
Crew Member + Child(ren)	$4.25	
Family	$6.78	

NOTE: ID Card not required for vision services.

GUARD YOUR FINANCES

INCOME PROTECTION BENEFITS

BASIC LIFE & ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

West Marine provides full-time Crew Members with Basic Life Insurance and AD&D coverage in the amount of 1X Annual Earnings up to a maximum of $150,000 at no cost to you.

SUPPLEMENTAL LIFE AND AD&D

Full-time Crew Members can purchase supplemental life coverage for you and your family. You can elect additional life insurance for:

YOURSELF:	**Life:** $10,000 increments up to 3X Annual Earnings or $300,000, whichever is less **AD&D:** $25,000 increments up to $500,000 maximum
YOUR SPOUSE/ DOMESTIC PARTNER:	**Life:** $5,000 increments up to $150,000 maximum **AD&D:** $5,000 increments up to $150,000 maximum
YOUR CHILD(REN):	**Life:** $500 (Birth to 6-months), then $2,000 increments up to $10,000 maximum **AD&D:** $2,000 increments up to $10,000 maximum

To purchase coverage for your spouse, domestic partner, or child(ren), you must enroll yourself for coverage. You pay 100% of the cost for this coverage. Please refer to the plan summaries for the low-cost, age-related rates. Statement of Health application may be required if you elect coverage over the guaranteed issue amount or if you enroll after your initial eligibility period. Age reductions may apply to life insurance amounts.

WHAT DOES GUARANTEED ISSUE MEAN?

Guaranteed issue refers to the amount of insurance you may buy without the insurance company requiring you to provide evidence of insurability (EOI), or a Statement of Health.

LONG-TERM DISABILITY (LTD)

West Marine provides LTD Insurance which pays a monthly benefit in the event you cannot work because of a long-term illness or injury. LTD benefits provide you with 50% of your monthly salary, up to a $5,000 monthly maximum after 90 consecutive days of a qualified non-work related illness or injury.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

FSAs help you save money by allowing you to pay for certain types of health care and dependent care expenses on a pre-tax basis. You decide how much money to put aside each payday to cover these expenses up to the maximum.

This amount is then deducted from your pay before taxes and deposited into your FSA. When you need money to cover an eligible expense, you can get reimbursed using a variety of reimbursement methods. Remember to always keep your receipts.

HEALTH CARE SPENDING ACCOUNT	
Use For:	Copays, deductibles, orthodontia, over-the-counter medications, etc.
Annual Contribution Limit:	$2,850
DEPENDENT CARE SPENDING ACCOUNT	
Use For:	Daycare, nursery school, elder care expenses, etc.
Annual Contribution Limit:	$2,500 for single taxpayer or $5,000 for married couples filing jointly

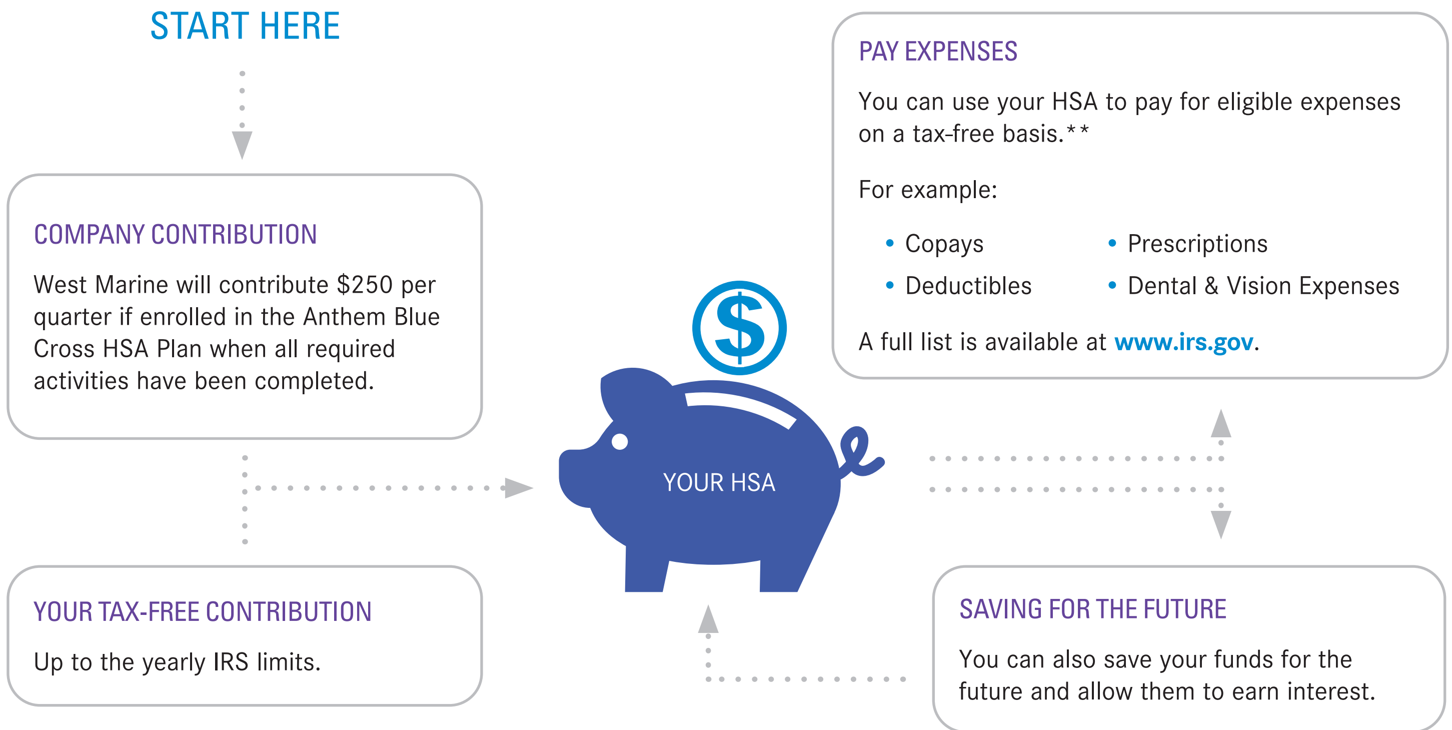
IMPORTANT: USE IT OR LOSE IT!

According to IRS rules, any money remaining in a Health Care or Dependent Care Spending Account after the deadline for filing claims will be forfeited. It will NOT roll over into the next plan year. If you have money left in your Health Care FSA at the end of 2022, you may carry over up to $570 for use in 2023. The money you carry over doesn't count against the IRS annual contribution maximum, which means you can start the year with an amount $570 greater than the IRS limit in your Health Care FSA. You can use the amount throughout the 2023 plan year. This rule applies each subsequent calendar year. This does not apply to the Dependent Care FSA.

ROLLOVER YOUR SAVINGS

HEALTH SAVINGS ACCOUNT (HSA)

If you enroll in West Marine's Anthem Blue Cross HDHP Plan, you'll have access to a HSA. You can think of your HSA as a personal savings account for your health care expenses, with some impressive tax advantages. The account even includes a contribution from West Marine that can be a big help throughout the year.



HOW MUCH CAN YOU CONTRIBUTE?	2023 IRS CONTRIBUTION LIMIT	MAXIMUM WEST MARINE CONTRIBUTION	YOUR MAXIMUM CONTRIBUTION AMOUNT
Crew Member Only Coverage	$3,850	$1,000	$2,850
Family Coverage	$7,750	$1,000	$6,750

* If an individual reaches age 55 by the end of the calendar year, he or she can contribute an additional $1,000.

LET'S BREAK IT DOWN

- You can add funds into the HSA that are not subject to federal income taxes** up to the IRS limits.
- The HSA allows you to pay for qualified medical expenses with these tax-free funds.
- The account can earn interest on a tax-free basis, and you are allowed to roll funds over year after year.
- If you leave West Marine, or retire, you can take your HSA with you.

**Any reference to taxes is at the federal level. State tax rules may vary.

PREPARE FOR THE FUTURE

VOLUNTARY BENEFITS

CRITICAL ILLNESS INSURANCE

Full-time and part-time Crew Members can protect themselves from the unexpected costs of a serious illness.

Even the most generous medical plan does not cover all of the expenses of a serious medical condition like a heart attack or cancer. Critical Illness Insurance pays a full lump sum benefit directly to you if you are diagnosed with a covered illness that meets the plan criteria. The benefit is paid in addition to any other insurance coverage you may have.

Covered illnesses include but are not limited to:

- Heart Attack
- Stroke
- Cancer
- Major Organ Transplant
- End Stage Renal (Kidney) Failure
- Coronary Artery Bypass Surgery**

PLAN FEATURES

Guaranteed Acceptance: There are no health questions or physical exams required.

Family Coverage: You can elect to cover your spouse and children.

Payroll Deduction: Premiums are paid through convenient payroll deductions.

Portable Coverage: You can take your policy with you if you change jobs or retire.

** The coverage pays 25% of the face amount of the policy once per lifetime for coronary bypass surgery.

ACCIDENT INSURANCE

Major injuries are painful. But the financial impact of the medical treatment doesn't have to be.

Accident Insurance pays benefits directly to you if you suffer a covered injury such as a fracture, burn, ligament damage, or concussion. Benefits are paid even if you have other coverage. The benefit amount is calculated based on the type of injury, its severity, and what medical services are required in treatment and recovery. The plan covers a wide variety of injuries and accident-related expenses, including:

- Injury Treatment (fractures, dislocations, concussions, burns, lacerations, etc.)
- Hospitalization
- Physical Therapy
- Emergency Room Treatment
- Transportation and more!

PLAN FEATURES

Guaranteed Acceptance: There are no health questions or physical exams required.

Family Coverage: You can elect to cover your spouse and children.

Payroll Deduction: Premiums are paid through convenient payroll deductions.

Portable Coverage: You can take your policy with you if you change jobs or retire.

HOSPITAL INDEMNITY INSURANCE

Receive payments to help cover the cost of a hospital stay. If you are admitted into a hospital, it doesn't take long for the out-of-pocket costs to add up. Hospital Indemnity Insurance pays benefits directly to you if you are admitted into a hospital for care or childbirth. Benefits are paid even if you have other coverage.

You receive a benefit as soon as you are admitted and then an additional benefit based on the number of days you are confined to the hospital. The benefit increases if you are admitted and confined to an intensive care unit or inpatient rehabilitation.

PLAN FEATURES

Guaranteed Acceptance: There are no health questions or physical exams required.

Family Coverage: You can elect to cover your spouse and children.

Payroll Deduction: Premiums are paid through convenient payroll deductions.

Portable Coverage: You can take your policy with you if you change jobs or retire.

MORE BENEFITS AND RESOURCES

RETIREMENT 401(k) SAVINGS PLAN

All full-time Crew Members that have completed 1 month of service and part-time Crew Members that have completed 1 year of service in which they worked 1,000 hours, are eligible to participate in our 401(k) Plan. Participants may enroll in the plan at any time once the eligibility requirements are met.

The 401(k) Plan allows you to invest up to 75% of your compensation through pre-tax, Roth, or after-tax deferrals through automatic payroll deductions. In addition, contributions up to 5% of pay is matched at 33%.

For additional information regarding any of the plan provisions, please consult the 401(k) page on the West Marine Cloud: **westmarine.sabacloud.com**. Our 401(k) Plan administrator is Aon PEP. You can contact them at **1-833-266-9737** or visit their website at **my.voya.com**.

COMING SOON! - DISCOUNT SITE

When you use BenefitHub, you can save money on wellness products and services, as well as other day-to-day and specialty items. By leveraging the buying power of our colleagues along with employees of other companies, BenefitHub can offer products and services from nationally recognized retailers, restaurants, hotels and more. Some of the things you can save on include:

- Car rentals, parts and service
- Beauty items and services
- Entertainments: books, DVDs, games, event & theme park tickets
- Pet Insurance and care
- Travel and leisure items and services, and more!

BENEFITS ADMINISTRATOR INFORMATION

If you have any questions regarding eligibility, benefit plans or enrollment periods or would like additional information, contact the person responsible for benefits at your facility.

GET MORE INFORMATION

BENEFIT	WHO TO CALL	WEBSITE	PHONE NUMBER
Medical & Prescription Drug	Anthem	anthem.com/ca	1-877-230-0278/1-877-826-5690
	Kaiser Permanente	Kp.org	1-800-464-4000
Dental	Delta Dental	deltadentalins.com	1-888-335-8227
Vision	VSP	vsp.com	1-800-877-7195
Life & Accidental Death & Dismemberment Claims	The Hartford	thehartford.com/employee-benefits	1-888-563-1124
Long-Term Disability	The Hartford	thehartford.com/mybenefits	1-800-549-6514
Critical Illness, Accident, and Hospital Indemnity	The Hartford	thehartford.com/benefits/myclaim	1-866-547-4205
Flexible Spending Accounts	Anthem ActWise	anthem.com/ca	1-877-230-0278
Health Savings Account	Anthem ActWise	anthem.com/ca	1-877-230-0278
Employee Assistance Program	Anthem EAP	anthem.com/ca	1-877-230-0278
Retirement 401(k) Savings Plan	Aon PEP (Voya)	aonpep.voya.com	1-833-266-9737
Human Resources	West Marine Human Resources	https://mybenefits.ops.aon.com/Microsites_OPS/West-Marine/2022/Home	1-954-833-2732
Discount Site	BenefitHub		

ABOUT THIS GUIDE: This guide highlights all employee benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual Summary Plan Description (SPD), plan document or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail.

Updated 11/2022

IMPORTANT NOTICES

ABOUT THIS GUIDE

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan descriptions (SPDs), plan document, or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail. West Marine reserves the right to make changes at any time to the benefits, costs, and other provisions relative to benefits.

REMINDER OF AVAILABILITY OF PRIVACY NOTICE

This is to remind plan participants and beneficiaries of the West Marine Health and Welfare Plan (the "Plan") that the Plan has issued a Health Plan Privacy Notice that describes how the Plan uses and discloses protected health information (PHI). You can obtain a copy of the West Marine Health and Welfare Plan Privacy Notice upon your written request to the Human Resources Department, at the following address:

West Marine, Human Resources
1 East Broward Blvd, Suite 200 Fort Lauderdale, FL 33301

If you have any questions, please contact the West Marine Human Resources Office at **1-954-833-2732**.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:$2,000 single and $4,000 family on HSA plan, $1,250 single and $2,500 family on PPO plan and $0 on Kaiser plan. If you would like more information on WHCRA benefits, call your plan administrator at **1-954-833-2732**.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT DISCLOSURE

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

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted and you will continue to pay the same amount as if you were not absent. If the absence is for more than 31 days and not more than 24 months, you may continue to maintain your coverage under the Plan by paying up to 102% of the full amount of premiums. You and your dependents may also have the opportunity to elect COBRA coverage. Contact West Marine for more information.

Also, if you elect not to continue your health plan coverage during your military service, you have the right to be reinstated in the Plan upon your return to work, generally without any waiting periods or pre-existing condition exclusions, except for service connected illnesses or injuries, as applicable.

This guide contains important information about the Medicare Part D creditable status of your prescription drug coverage on page 11.

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

YOUR OPTIONS

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with West Marine 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. West Marine has determined that the prescription drug coverage offered by the West Marine Plan through Anthem and Kaiser 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 through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current West Marine coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current West Marine coverage, be aware that you and your dependents may not be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with West Marine 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 West Marine 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 for personalized help. See the inside back cover of your copy of the "Medicare & You" handbook for their telephone number.
- 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: **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: 1/1/2023
Name of Entity/Sender: West Marine Products, Inc.
Contact: Human Resources
Address: 1 East Broward Blvd, Suite 200 Fort Lauderdale, FL 33301
Phone Number: **1-954-833-2732**

YOUR ERISA RIGHTS

As a participant in the West Marine benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan participants shall be entitled to receive information about their plan and benefits, continue group health plan coverage, and enforce their rights. ERISA also requires that plan fiduciaries act in a prudent manner.

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

You are entitled to:

- Examine, without charge, at the plan administrator's office, all plan documents—including pertinent insurance contracts, trust agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the plan's administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary report of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

CONTINUED GROUP HEALTH PLAN COVERAGE

You are entitled to:

- Continued health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have credible coverage from another plan. You should be provided a certificate of credible coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the plan;
  - You become entitled to elect COBRA continuation coverage;
  - You request it up to 24 months after losing coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plans. The people who operate your plans are called "fiduciaries," and they have a duty to act prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to:

- Know why this was done;
- Obtain copies of documents relating to the decision without charge; and
- Appeal any denial.

All of these actions must occur within certain time schedules. Under ERISA, there are steps you can take to enforce your rights. For instance, you may file suit in a federal court if:

- You request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator;
- You have followed all the procedures for filing and appealing a claim (as outlined earlier in this summary) and your claim for benefits is denied or ignored, in whole or in part. You may also file suit in a state court.
- You disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order; or
- The plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. This should occur if the court finds your claim frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have questions about how your plan works, contact the Human Resources Department. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office listed on EBSA's website: **https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/regional-offices**.

Or you may write to the:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee and Employer Hotline of the Employee Benefits Security Administration at: **1-866-444-3272**. You may also visit the EBSA's web site on the Internet at: **https://www.dol.gov/agencies/ebsa**.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage.

It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happen:

- 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 COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is 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), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the 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: West Marine Human Resources or COBRA administrator.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Any qualified beneficiary who does not elect COBRA within the 60-day election period specified in the election notice **will lose his or her right to elect COBRA.**

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of the date of the Social Security Administration's disability determination; the date of the covered employee's termination of employment or reduction in hours; and the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction in hours. You must also provide this notice within 18 months after the covered employee's termination or reduction in hours in order to be entitled to this extension.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

OTHER COVERAGE OPTIONS

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 **www.healthcare.gov**.

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit **https://www.medicare.gov/medicare-and-you**.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **https://www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator 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 the Plan Administrator.

PLAN CONTACT INFORMATION

For further information regarding the plan and COBRA continuation, please contact:

West Marine Benefits Supervisor
1 East Broward Blvd, Suite 200 Fort Lauderdale, FL 33301
1-954-833-2732

SUMMARIES OF BENEFITS AND COVERAGE (SBCs)

As required by the Affordable Care Act, Summaries of Benefits and Coverage (SBCs) are available on the West Marine website at **westmarine.sabacloud.com**. If you would like a paper copy of the SBCs (free of charge), you may also call West Marine at **1-954-833-2732**.

West Marine is required to make SBCs available that summarize important information about health benefit plan options in a standard format, to help you compare across plans and make an informed choice. The health benefits available to you provide important protection for you and your family and choosing a health benefit option is an important decision.

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, 2022. Contact your state for more information on eligibility –

1. ALABAMA – Medicaid
   Website: http://myalhipp.com/
   Phone: 1-855-692-5447
2. ALASKA – Medicaid
   The AK Health Insurance Premium Payment Program
   Website: http://myakhipp.com/
   Phone: 1-866-251-4861
   Email: CustomerService@MyAKHIPP.com
   Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
3. ARKANSAS – Medicaid
   Website: http://myarhipp.com/
   Phone: 1-855-MyARHIPP (1-855-692-7447)
4. CALIFORNIA – Medicaid
   Health Insurance Premium Payment (HIPP) Program
   Website: http://dhcs.ca.gov/hipp
   Phone: 1-916-445-8322
   Fax: 1-916-440-5676
   Email: hipp@dhcs.ca.gov
5. 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://www.colorado.gov/pacific/hcpf/child-health-plan-plus
   CHP+ Customer Service: 1-800-359-1991/ State Relay 711
   Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
   HIBI Customer Service: 1-855-692-6442
6. FLORIDA – Medicaid
   Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
   Phone: 1-877-357-3268
7. GEORGIA – Medicaid
   GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
   Phone: 1-678-564-1162, Press 1
   GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra
   Phone: 1-678-564-1162, Press 2
8. INDIANA – Medicaid
   Healthy Indiana Plan for low-income adults 19-64
   Website: http://www.in.gov/fssa/hip/
   Phone: 1-877-438-4479
   All other Medicaid
   Website: https://www.in.gov/medicaid/
   Phone 1-800-457-4584
9. IOWA – Medicaid and CHIP (Hawki)
   Medicaid Website: https://dhs.iowa.gov/ime/members
   Medicaid Phone: 1-800-338-8366
   Hawki Website: http://dhs.iowa.gov/Hawki
   Hawki Phone: 1-800-257-8563
   HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
   HIPP Phone: 1-888-346-9562
10. KANSAS – Medicaid
    Website: https://www.kancare.ks.gov/
    Phone: 1-800-792-4884
11. 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://kidshealth.ky.gov/Pages/index.aspx
    Phone: 1-877-524-4718
    Kentucky Medicaid Website: https://chfs.ky.gov
12. 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)
13. MAINE – Medicaid
    Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
    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
14. MASSACHUSETTS – Medicaid and CHIP
    Website: https://www.mass.gov/masshealth/pa
    Phone: 1-800-862-4840 TTY: 1-617- 886-8102
15. MINNESOTA – Medicaid
    Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
    Phone: 1-800-657-3739
16. MISSOURI – Medicaid
    Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
    Phone: 1-573-751-2005
17. MONTANA – Medicaid
    Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
    Phone: 1-800-694-3084
    Email: HHSHIPPProgram@mt.gov
18. NEBRASKA – Medicaid
    Website: http://www.ACCESSNebraska.ne.gov
    Phone: 1-855-632-7633
    Lincoln: 1-402-473-7000
    Omaha: 1-402-595-1178
19. NEVADA – Medicaid
    Medicaid Website: http://dhcfp.nv.gov
    Medicaid Phone: 1-800-992-0900
20. NEW HAMPSHIRE – Medicaid
    Website: : https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
    Phone: 1-603-271-5218
    Toll free number for the HIPP program: 1-800-852-3345, ext 5218
21. NEW JERSEY – Medicaid and CHIP
    Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
    Medicaid Phone: 1-609-631-2392
    CHIP Website: http://www.njfamilycare.org/index.html
    CHIP Phone: 1-800-701-0710
22. NEW YORK – Medicaid
    Website: https://www.health.ny.gov/health_care/medicaid/
    Phone: 1-800-541-2831
23. NORTH CAROLINA – Medicaid
    Website: https://medicaid.ncdhhs.gov/
    Phone: 1-919-855-4100
24. NORTH DAKOTA – Medicaid
    Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
    Phone: 1-844-854-4825
25. OKLAHOMA – Medicaid and CHIP
    Website: http://www.insureoklahoma.org
    Phone: 1-888-365-3742
26. OREGON – Medicaid
    Website: http://healthcare.oregon.gov/Pages/index.aspx
    http://www.oregonhealthcare.gov/index-es.html
    Phone: 1-800-699-9075
27. PENNSYLVANIA – Medicaid
    Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
    Phone: 1-800-692-7462
28. RHODE ISLAND – Medicaid and CHIP
    Website: http://www.eohhs.ri.gov/
    Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)
29. SOUTH CAROLINA – Medicaid
    Website: https://www.scdhhs.gov
    Phone: 1-888-549-0820
30. SOUTH DAKOTA – Medicaid
    Website: http://dss.sd.gov
    Phone: 1-888-828-0059
31. TEXAS – Medicaid
    Website: http://gethipptexas.com/
    Phone: 1-800-440-0493
32. UTAH – Medicaid and CHIP
    Medicaid Website: https://medicaid.utah.gov/
    CHIP Website: http://health.utah.gov/chip
    Phone: 1-877-543-7669
33. VERMONT – Medicaid
    Website: http://www.greenmountaincare.org/
    Phone: 1-800-250-8427
34. VIRGINIA – Medicaid and CHIP
    Website: https://www.coverva.org/en/famis-select
    https://www.coverva.org/en/hipp
    Medicaid Phone: 1-800-432-5924
    CHIP Phone: 1-800-432-5924
35. WASHINGTON – Medicaid
    Website: https://www.hca.wa.gov/
    Phone: 1-800-562-3022
36. WEST VIRGINIA – Medicaid and CHIP
    Website: https://dhhr.wv.gov/bms/
    http://mywvhipp.com/
    Medicaid Phone: 1-304-558-1700
    CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699- 8447)
37. WISCONSIN – Medicaid and CHIP
    Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
    Phone: 1-800-362-3002
38. 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, 2022, 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

GLOSSARY

AFFORDABLE CARE ACT AND PATIENT PROTECTION (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, reduced FSA contributions, covering preventive care without cost-sharing, etc, among other requirements.

BRAND NAME DRUG

The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

COINSURANCE

A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

COPAYMENT (COPAY)

A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

DEDUCTIBLE

The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

EMPLOYER CONTRIBUTION

Each quarter, the company provides you with an amount of money that you can apply toward the cost of your health care premiums. The amount of the employer contribution depends on who you cover. You can see the amount you'll receive when you enroll. If you're enrolling as a new hire, the employer contribution amount will be prorated based on your date of hire.

GENERIC DRUG

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

HIGH-DEDUCTIBLE HEALTH PLAN (HDHP)

High-Deductible Health Plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a Health Savings Account (HSA).

HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. You must be enrolled in a High-Deductible Health Plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

OUT-OF-POCKET MAXIMUM

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

PLAN YEAR

The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

PREVENTIVE CARE

Health care services you receive when you are not sick or injured—so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

West Marine