MOUNTAINEER FLEXIBLE BENEFITS
FBMC BENEFITS MANAGEMENT, INC.

WEST VIRGINIA PEIA PUBLIC EMPLOYEE INSURANCE AGENCY

2026 WEST VIRGINIA FLEXIBLE BENEFITS GUIDE

RETIRED EMPLOYEES

mountaineer.fbmcbenefits.com

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IMPORTANT DATES

OPEN ENROLLMENT PERIOD	**APR 2 -THRU- MAY 15**
PERIOD OF COVERAGE	**7/1/25 -THRU- 6/30/26**
BENEFITS FAIRS	**APR 7 -THRU- APR 24**

MONDAY APR 7	VIRTUAL ENROLLMENT UPDATE SESSION	+1 (443) 584-3915 PIN: 887318316	meet.google.com/ rxx-hrih-zoy	3:00-4:00 PM
TUESDAY APR 8	CHARLESTON: Toyota Hall, Bridge Valley Community & Tech College 1201 Science Park Drive, South Charleston, WV 25303			3:00-6:00 PM
WEDNESDAY APR 9	BECKLEY: Tamarack Conference Center 1 Tamarack Park, Beckley, WV 25801			3:00-7:00 PM
THURSDAY APR 10	HUNTINGTON: Delta Hotels Huntington-Downtown 800 3rd Ave, Huntington, WV 25701			3:00-6:00 PM
TUESDAY APR 15	WHEELING: WV Northern Community College 1704 Market Street, Wheeling, WV 26003			3:00-7:00 PM
WEDNESDAY APR 16	MORGANTOWN: Holiday Inn-University Area 1188 Pineview Drive, Morgantown, WV 26508			3:00-7:00 PM
THURSDAY APR 17	MARTINSBURG: Holiday Inn 301 Foxcroft Avenue, Martinsburg, WV 25401			3:00-7:00 PM
TUESDAY APR 22	MINERAL WELLS: Comfort Suites 167 Elizabeth Pike, Mineral Wells, WV 26150			3:00-7:00 PM
THURSDAY APR 24	VIRTUAL ENROLLMENT UPDATE SESSION	+1 (929) 276-1122 PIN: 529113552	meet.google.com/ mnv-ssmb-hij	9:00-10:00 AM

GETTING STARTED

- This is a changes-only enrollment. If you do not make changes during open enrollment, your benefits will roll over and you will continue to be liable for all premiums due.
- If you wish to keep your current benefits you do not need to complete an enrollment form.
- Retirees who would like to add or change benefits during open enrollment must complete an enrollment form in its entirety and return it to FBMC Retiree and Direct Bill Department by mail.
- **Newly-eligible retirees will have the month of and two months following from the date of their retirement to return the enrollment form. Benefits do not automatically roll over from active employment into retirement.**
- Please keep this benefits guide and the yellow copy of your enrollment form for reference during the plan year.

WHAT'S NEW IN 2026

- **GREAT NEWS!** There are no rate or plan design changes for your Dental, Vision, Legal, or Hearing plans.

HOW TO ENROLL

WHO IS AN ELIGIBLE RETIREE?

A retired employee (or his/her surviving spouse) of the State of West Virginia, a County Board of Education, or a non-state agency who currently receives income from the WV Consolidated Public Retirement Board (CPRB) or a TIAA-CREF retirement plan.

Upon certain qualifying events, spouses, children and retirees may be eligible to continue for group health plan coverage under COBRA law.

HOW TO ENROLL DURING THE PLAN YEAR

Your coverage will be effective the first day of the month following your retirement & you will be billed accordingly. If you do not enroll during this time, you must wait until the next open enrollment period to participate.

CPRB

Any State of West Virginia Retiree who receives income from the Consolidated Public Retirement Board (CPRB) can choose to have their premium payments deducted from their CPRB retirement check by electing this option on the Retiree Enrollment Form, unless costs are greater than the total amount of your check. In this instance, payment must be made directly to FBMC as directed on the monthly billing statement you will receive. The Benefit Enrollment Confirmation letter will include where to submit your premium payment(s).

RETIREE AND BILLING - If you are electing CPRB pension deductions, be advised of the following:

- Review your pension statement or bank account each month to ensure that deductions have been taken.
- **TIAA-CREF Retirees** - Payment must be sent to FBMC once you receive your Enrollment Summary Report. Payments must be made by the due date specified.

WHERE TO SEND YOUR PAYMENTS

- Please send the WHITE COPY of your enrollment form to the address below. (Keep the yellow copy for your records.)

FBMC Benefits Management, Inc.
ATTN: Retiree Direct Bill
PO Box 10789
Tallahassee, Florida 32302-2789

IMPORTANT NOTE:

Until your CPRB deductions or ACH (electronic) payments begin, payment by personal check or money order is required. You will receive an Enrollment Summary Report upon enrolling, which will include where to submit your monthly premium until deductions begin.

LEARN MORE

Scan the QR code for full plan documents & details.

provided by: **Sun Life**

DENTAL

Good health starts with your teeth. Annual preventive care alone can help prevent health problems such as heart disease and diabetes. Sun Life, your dental insurance provider, helps protect your teeth for a lifetime.

PLAN # 959860 1 (844) 583-5036

RATES (COST PER MONTH)	ASSISTANCE		BASIC		ENHANCED		PREMIER	
	In-Net	Out	In-Net	Out	In-Net	Out	In-Net	Out
RETIREE ONLY	$10.95		$16.58		$27.98		$36.80	
RT + SPOUSE	$24.49		$37.01		$65.04		$86.18	
RT + CHILD(REN)	$21.95		$33.21		$56.01		$73.98	
RT + FAMILY	$35.55		$53.67		$92.90		$123.21	
PLAN YEAR DEDUCTIBLES								
• Per Person	$25 (Type II & III services only)		$25 (Type II & III services only)		$50 (Type II & III services only)		$75 (Type II & III services only)	
• Per Family Max	$75		$75		$150		$225	
PLAN YEAR MAX BENEFIT*	$750	$500	$1,000	$500	$1,500	$1,000	$2,500	$1,500
OTHER MAXIMUMS								
• Ortho Lifetime Max ▸ Paid over 2 Plan Years	Not Covered		Not Covered		$1,250	$500	$2,500	$1,000
• TMJ Lifetime Max	Not Covered		Not Covered		$1,000	$1,000	$1,000	$1,000
BENEFITS								
TYPE I: PREVENTIVE	100%	80%	100%	80%	100%	80%	100%	80%
TYPE II: BASIC DENTAL	40%	25%	75%	50%	80%	60%	90%	70%
TYPE III: MAJOR DENTAL	25%	10%	40%	25%	60%	40%	75%	50%
TYPE IV: ORTHODONTIC ▸ No age limit	Not Covered		Not Covered		40%	25%	50%	50%
TMJ DISORDER	Not Covered		Not Covered		60%	40%	75%	50%
• Non-Surgical treatment Lifetime Maximum	Not Covered		Not Covered		$1,000		$1,000	
REIMBURSEMENT TYPE	Maximum Allowable Charge		Maximum Allowable Charge		Maximum Allowable Charge		Usual & Customary	
WAITING PERIODS**								
• Type I & II	None		None		None		None	
• Type III & IV	6 Months		6 Months		6 Months		6 Months	

* Once the Per Person Non-Network Maximum Benefit has been paid for Network and Non-Network Expenses combined, no additional benefits are payable for the remainder of the Benefit Year for Non[1]Network Expenses. The benefits paid for Network Expenses and Non-Network Expenses combined will never exceed the Maximum Benefit for Network Expenses shown in the Benefit Highlights.

**For a complete description of services and waiting periods, please review your certificate of insurance. If you were covered under your employer's prior plan the wait will be waived for any type of service covered under the prior plan and this plan.

NEW DENTAL APP NOW AVAILABLE!

Scan the QR code & download today!

provided by: **Humana / EyeMed**

VISION

Your vision health is an important part of complete wellness. Vision benefits are designed to give you and your covered family members the care, value, and service to help maintain good vision and overall health.

PLAN # 855933 1 (877) 398-2980

RATES (COST PER MONTH)	EXAM PLUS PLAN		FULL SERVICE PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
RETIREE ONLY	$1.13		$6.60	
RT + FAMILY	$2.58		$16.78	
EXAM WT DILATION	$10	≤ $40	$20	≤ $40
• Retinal imaging [1]	≤ $39	Not Covered	≤ $39	Not Covered
CONTACT LENS EXAM [2]				
• Standard fitting & follow-up	≤ $40	Not Covered	≤ $40	Not Covered
• Premium fitting & follow-up	10% Discount	Not Covered	$60	Not Covered
FRAMES[3]	35% off retail Discount	Not Covered	$150 allowance + 20% off balance	$75 allowance
STANDARD PLASTIC LENSES[4]				
• Single Vision	$50	Not Covered	$20	≤ $30
• Bifocal	$70	Not Covered	$20	≤ $50
• Trifocal	$105	Not Covered	$20	≤ $70
• Lenticular	20% Discount	Not Covered	$20	≤ $80
FREQUENCIES				
• Exam	1 per Plan Year		1 per Plan Year	
• Glasses/Contact Lenses[5]	Not Covered		1 per Plan Year	
• Frames	Not Covered		1 per 2 Plan Years	
DIABETIC EYE CARE & TESTING:	Not Covered		$0	≤ $15 - 77

1 Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.

2 Standard contact premium contact lens exam and fit and follow-up cost may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.

3 Discounts may be available on all frames except when prohibited by the manufacturer.

4 Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.

5 Plan covers contact lenses, in lieu of frames, but not both.

LEARN MORE

Scan the QR code for full plan documents & details.

HEARING

1 (866) 956-5400

RATES
(COST PER PAY PERIOD)

RETIREE ONLY	$1.82
RT + SPOUSE	$3.61
RT + CHILD(REN)	$2.67
RT + FAMILY	$4.45

FEATURE	BENEFIT	FREQUENCY
HEARING EXAMINATION		
• Adults & Children	$70	1 per Year
HEARING AID DEVICE BENEFIT		
• Adults	$500 per Ear	1 every 5 Years
• Children	$500 per Ear	1 every 2 Years

GETTING STARTED

1. Visit EPICHearing.com/FBMC or call EPIC at **1 (866) 956-5400** to request an appointment. Reference hearing plan name: **State of West Virginia Retirees.**
2. Have eligibility validated, discuss product and service options, receive provider consult letter.
3. Visit an EPIC provider for hearing exam and consultation.
4. Your provider will help you choose from a broad array of hearing aids based on your unique hearing needs.
5. Receive hearing aids, fitting and follow-up care.

*Hearing aids purchased in the Silver technology level will receive 1 follow-up visit.

**One-time professional fee may apply.

***These are discounted items and are not insured benefits.

[1]Center for Hearing and Communication. Statistics and facts about hearing loss. chchearing.org/facts-about-hearing-loss/. Accessed February 2025.

WHY HAVE A HEARING INSURANCE PLAN?

Hearing loss is more common than you may think – in fact, 48 million Americans have some degree of hearing loss[1]. Your coverage through Fidelity Security Life Insurance Company® can help you save on hearing exams, hearing aids, and follow-up care. Visit EPICHearing.com/read to learn more about the connections between hearing and overall health.

WITH EPIC, YOU'LL HAVE ACCESS TO:

- Expansive network with 6,500+ hearing care professional locations nationwide.
- A range of options, from high-value Relate® prescription hearing aids to the latest technology and newest features from other major hearing aid brands.
- A wide selection of advanced technology, including recharging capabilities, remote adjustments, connection to 2 Bluetooth® devices, tap control and other advanced features.
- Charging case or extra batteries included with purchase.***
- 3 in-person follow-up visits included after hearing aid purchase.*
- 60-day trial period.
- 3-year extended warranty covers repair and 1-time loss/damage replacement.**/***

Fully Insured Exclusions: No benefits will be paid for services or materials: provided free of charge in the absence of insurance; payable under any Workers' Compensation law or similar statutory authority; payable under any governmental plan or program whether Federal, state or subdivisions thereof, except for medical assistance benefits under Title XIX of the Social Security Act (Medicaid); for the medical and/or surgical treatment of the internal or external structures of the ear(s); provided by a Hearing Aid Dispenser; required by an employer as a condition of employment; not prescribed by a Physician or Audiologist; for Hearing Aid batteries, cleaning supplies or accessories; for ear protection devices or plugs; for Assistive Listening Devices; or for replacement due to loss, theft of or damage to the Hearing Aid.

Termination of Coverage: The Insured's insurance coverage will cease on the earliest of the following dates: on the date the Policy ends; the end of the last period for which any required premium has been made; or the date the Insured is no longer eligible for insurance.

Underwritten by Fidelity Security Life Insurance Company®, Kansas City, MO Policy Form #M-9091. Policy Number HC-111.

provided by: ARAG

LEGAL

Legal troubles can happen to anyone. We've all been there – you get caught speeding, a contractor ghosts you mid-remodel or true love doesn't work out. And when trouble happens, ARAG® legal insurance protects. Work with a network attorney and attorney fees are 100% paid in full for most covered matters.

PLAN # 18387 1 (800) 247-4184

RATES (COST PER MONTH)	ULTIMATEADVISOR®	ULTIMATEADVISOR PLUS ™
RETIREE + FAMILY	$9.50	$13.90

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% paid in full when you work with a network attorney. That means you'll avoid paying high-cost attorney fees, which currently average $341 an hour.*

*$341 is the average hourly billable rate for attorneys in 2024 according to Clio's "2024 Legal Trends Report."

PRE-EXISTING LEGAL MATTERS

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

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 of knowledgeable attorneys who average more than 20 years of experience. They can review or prepare documents, make follow-up calls or write letters on your behalf, provide legal advice and consultation and represent you, even in court, if necessary. 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 **18387ret** to learn more about what these plans offer, research specific legal topics and more.

LEARN MORE ABOUT YOUR LEGAL BENEFIT!

Scan the QR code for full plan documents & details.

HOW TO:
CHANGE YOUR COVERAGE

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:
  - 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 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). 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. 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.

It is important that you carefully consider your benefit elections during your initial enrollment as a retiree or during any annual open enrollment. Coverage you select will remain in effect the entire plan year, except under limited circumstances as described below.

CHANGES TO COVERAGE

Once you elect coverage, you may only change your coverage mid-plan-year due to marriage, divorce, birth or death. You may increase or decrease coverage only for the individual(s) involved. You may also decrease or cancel coverage if your spouse or a dependent becomes ineligible for coverage under your plan, or becomes eligible for coverage under another employer's plan, a state CHIP program or Medicare/Medicaid.

Coverage you cancel cannot be reinstated until the next annual open enrollment period.

Please send your written requests for changes to:

FBMC Benefits Management, Inc.
ATTN: Retiree Direct Bill
PO Box 10789
Tallahassee, Florida 32302-2789

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 FBMC. 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 FBMC. For more information, email the FBMC Benefits Service Center to request a CIS form.

HOW DO I MAKE A CHANGE?

You will need to submit a written request for processing to FBMC Retiree & Direct Bill Department at directbill@fbmc.com with your change information. Any changes to your retiree benefits will require your written authorization. Premium changes will be promptly initiated after your request has been received and will become effective the first of the following month after receipt of all processable data. Changes will not be made retroactively. However, if you are having premium payments deducted from your retirement check, any required refunds will be completed as soon as verification is received that your deduction has changed. Refunds are processed one time each month and are mailed no later than the 15th of the following month.

NOTICES

COBRA

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. However, due to COVID-19, certain COBRA deadlines have been extended, including the timeframe to elect COBRA coverage, the date for making COBRA premiums, and the date to notify the plan of a qualifying event or disability determination. Please ask your COBRA administrator for more information.

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.
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, the request must be made within the month of and two months following the qualifying event.

To request special enrollment or obtain more information, consult your benefit coordinator.

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.

LEARN MORE

Scan the QR code for full plan documents & details.

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.

HIPAA PRIVACY

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (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, the request must be made within the month of and two months following the qualifying event.

To request special enrollment or obtain more information, consult your benefit coordinator.

BENEFITS DIRECTORY

SUN LIFE
DENTAL
PLAN #: 959860
1 (844) 583-5036
http://www.SunLife.com/wvpeia

HUMANA/EYEMED
VISION
PLAN #: 855933
1 (877) 398-2980
http://www.Humana.com

ARAG
LEGAL INSURANCE
PLAN #: 18387
1 (800) 247-4184
ARAGlegal.com/myinfo / Access Code: 18387ret

EPIC
HEARING
PLAN NAME: State of West Virginia Retirees
1 (866) 956-5400
EPICHearing.com/FBMC

INSPIRA FINANCIAL
COBRA
1 (800) 359-3921
Inspirafinancial.com

FBMC BENEFITS MANAGEMENT

Contract Administrator

ATTN: **Mail Slot 32,** PO Box 1878,
Tallahassee, FL 32302-2789

MyFBMC.com

This guide does not contain a complete listing of all terms, conditions, or exclusions of the benefits listed herein. Please refer to the policy and/or certificate of coverage for more information. 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.

LEARN MORE

Scan the QR code for full plan documents & details.

2026 WEST VIRGINIA
FLEXIBLE BENEFITS GUIDE
RETIRED EMPLOYEES
mountaineer.fbmcbenefits.com

WV PEIA
601 57th Street, SE Suite 2
Charleston, WV 25304-2345

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Important:

Benefits Open Enrollment information inside