



EMPLOYEE BENEFIT HIGHLIGHTS

2024 Plan Year



Medical | Dental | Vision | Life & AD&D | Supplemental Plans

INTRODUCTION

Welcome to the Lucid Staffing Solutions Benefits Program! We remain committed to providing our employees with flexible comprehensive benefits and at an affordable cost. Our goal is to empower you with the resources and flexibility you need to enjoy success on the job and to live a healthy life.

This guide provides an overview of the benefits available to you and your family for the 2024 plan year, which begins May 1, 2024. We encourage you to take the time to explore and learn about your options so you can choose the coverage that's right for you and your family.

If you have any questions about your benefits, eligibility and/ or how to enroll, contact Human Resources.

BENEFITS OVERVIEW

- HEALTH & WELFARE BENEFITS
- INCOME PROTECTION & SECURITY
- ANTHEM MEDICAL
- PRINCIPAL VOLUNTARY LIFE
- PRINCIPAL DENTAL
- PRINCIPAL VISION
- ACCIDENT
- CRITICAL ILLNESS
- HOSPITAL INDEMNITY



ELIGIBILITY

Your company provides an array of benefits that can help you enjoy increased well-being, deal with an unexpected illness or accident, build and protect your financial security, balance your person and professional life and meet everyday needs. These benefits are affordable, comprehensive and competitive.

This booklet provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions set forth in each insurance carrier of provider's contract

You may enroll for coverage if you are a regular full-time salaried or hourly employee.

You may also cover eligible dependents as follows:

- Your spouse
- Your registered domestic partner (same and opposite sex)
- Your children up to age 26, including natural and adopted children, stepchildren who you support and who live with you in a parent-child relationship, and any other children you support for whom you are the legal guardian or for whom you are required to provide coverage as the result of a qualified medical child support order
- Your child(ren) of any age who are incapable of self-sustaining employment by reason of mental or physical disability and supported primarily by you

Making Changes During the Year

The choices you make during enrollment will remain in effect for the entire year and cannot be changed unless you experience a qualifying life event. These include:

- Marriage, divorce or legal separation
- Birth or adoption of a child, or placement for adoption
- Death of a covered dependent
- Change in your spouse's employment that affects your benefits
- Dependent's loss of eligibility due to age or student status change
- Gain/loss of group insurance coverage
- Medicare or State Assistance
- Family Medical Leave

To make changes during the plan year, notify Human Resources and complete Changes within 30 days of the qualifying life event. Otherwise, you must wait until the next Open Enrollment period.

It is your responsibility to notify Human Resources within 30 days of any qualifying event.

For more information about making changes during the year, contact Human Resources.

WHEN YOU CAN ENROLL

When You Can Enroll

You can enroll for benefits at any of the following times:

- On date of hire
- During the annual open enrollment period
- Within 30 days of a qualifying life event
(see previous page for qualifying life events)

If you do not enroll during the time frames noted above, you must wait for the next annual open enrollment period.

Before You Enroll

Be sure to take time to review the information in this guide as well as the Summary of Benefits and Coverage provided by the medical carrier. It will help you understand your benefit choices. You should also share this information with your family.

How to Enroll

Your enrollment packet includes instructions for enrolling for coverage. The Elections you make will be in effect through April 30, 2025.

If you have any questions With regard to completing any of the enrollment forms, please contact Human Resources.



MEDICAL BENEFITS

PPO PLANS

Lucid Staffing offers medical benefits through Anthem. Rates are shown on a per pay period basis.

For more information on coverage, limitations and exclusions, refer to the Carrier benefit summaries on the benefits administrative system.

	ULTIMATE-AMRJ	PREMIUM-AMQV
NETWORK	PPO	PPO
ANNUAL DEDUCTIBLE	\$0/\$0	\$2,500/\$5,000
ANNUAL MAXIMUM	\$7,000/\$14,000	\$5,000/\$10,000
PREVENTIVE CARE	No Charge	No Charge
DIAGNOSTIC LAB & X-RAY	\$60 copay	\$50 copay
PRIMARY CARE COPAY	\$25 copay	\$25 copay
SPECIALIST COPAY	\$60 copay	\$50 copay
URGENT CARE	\$50 copay	\$40 copay
EMERGENCY ROOM	\$1,000 copay per visit	\$1,000 copay per visit after ded
CO-INSURANCE	100%	100%
PHARMACY	\$10/\$60/\$125/\$500	\$10/\$60/\$125/\$500
EMPLOYEE	\$76.58	\$67.22
EMPLOYEE + SPOUSE	\$168.50	\$147.89
EMPLOYEE + CHILD(REN)	\$137.86	\$121
FAMILY	\$237.43	\$208.39

Your coverage under the benefits plans will end if you no longer meet the eligibility requirements, your contributions are discontinued or the Group Insurance Policy is terminated.

MEDICAL BENEFITS

PPO PLANS

Lucid Staffing offers medical benefits through Anthem. Rates are shown on a per pay period basis.

For more information on coverage, limitations and exclusions, refer to the Carrier benefit summaries on the benefits administrative system.

	ENHANCED-AMS7	ESSENTIAL-AMS6
NETWORK	PPO	PPO
ANNUAL DEDUCTIBLE	\$3,500/\$7,000	\$5,000/\$10,000
ANNUAL MAXIMUM	\$9,450/\$18,900	\$8,700/\$17,400
PREVENTIVE CARE	No Charge	No Charge
DIAGNOSTIC LAB & X-RAY	\$85 copay	\$100 copay
PRIMARY CARE COPAY	\$40 copay	\$50 copay
SPECIALIST COPAY	\$85 copay	\$100 copay
URGENT CARE	\$75 copay	\$80 copay
EMERGENCY ROOM	\$1,000 per visit after ded	\$1,000 copay per visit after ded
CO-INSURANCE	100%	100%
PHARMACY	\$10/\$60/\$125/\$500	\$10/\$60/\$125/\$500
EMPLOYEE	\$57.10	\$55.04
EMPLOYEE + SPOUSE	\$125.63	\$121.09
EMPLOYEE + CHILD(REN)	\$102.78	\$99.07
FAMILY	\$177.02	\$170.62

Your coverage under the benefits plans will end if you no longer meet the eligibility requirements, your contributions are discontinued or the Group Insurance Policy is terminated.

DENTAL BENEFITS

DENTAL PLANS

Lucid Staffing offers dental benefits through Principal.

For more information on coverage, limitations and exclusions, refer to the Carrier benefit summaries on the benefits administrative system.

	LOW PLAN	HIGH PLAN
NETWORK	PPO	PPO
ANNUAL MAX	\$1,000 per person	\$2,000 per person
ANNUAL DEDUCTIBLE	\$50/\$150 basic and major only	\$50/\$150 basic and major only
PREVENTIVE SERVICES	100%	100%
BASIC SERVICES	80%	90%
MAJOR SERVICES	50%	60%
ORHODONTIA	N/A	50% \$2,000 max
EXAMS	Twice per year	Twice per year
CLEANINGS	Four per year	Four per year
EMPLOYEE	\$2.91	\$4.80
EMPLOYEE + SPOUSE	\$5.70	\$9.01
EMPLOYEE + CHILD(REN)	\$7.23	\$13.27
FAMILY	\$10.54	\$18.49

Your coverage under the benefits plans will end if you no longer meet the eligibility requirements, your contributions are discontinued or the Group Insurance Policy is terminated.

VISION BENEFITS

VISION PLANS

Lucid Staffing offers vision benefits through Principal.

For more information on coverage, limitations and exclusions, refer to the Carrier benefit summaries on the benefits administrative system.

	VISION
NETWORK	VSP
EXAMS	\$0 copay every 12 months
PERScription GLASSES	\$10 copay
LENS ENCHANCEMENTS	\$0 copay covered every 12 months
FRAMES	\$250 allowance
ELECTIVE CONTACTS	\$250 allowance
CONTACT FITTING	Up to \$60 copay
NECESSARY CONTACTS	\$10 copay every 12 months
EMPLOYEE	\$1.39
EMPLOYEE + SPOUSE	\$2.64
EMPLOYEE + CHILD(REN)	\$2.73
FAMILY	\$4.26

Your coverage under the benefits plans will end if you no longer meet the eligibility requirements, your contributions are discontinued or the Group Insurance Policy is terminated.

ADDITIONAL BENEFITS

VOLUNTARY LIFE

Lucid Staffing offers voluntary life insurance through Principal. Rates are show per pay period.

For more information on coverage, limitations and exclusions, refer to the Carrier benefit summaries on the benefits administrative system.

BENEFIT	Select in increments of \$10k
GUARANTEED ISSUE	\$150k under age 70/\$10k over age 70

Benefit amount	29 & under	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
\$10,000	\$0.26	\$0.30	\$0.43	\$0.64	\$0.96	\$1.52	\$2.37	\$3.59	\$5.96
\$20,000	\$0.54	\$0.60	\$0.88	\$1.28	\$1.93	\$3.06	\$4.75	\$7.19	\$11.94
\$30,000	\$0.80	\$0.90	\$1.31	\$1.92	\$2.89	\$4.58	\$7.12	\$10.77	\$17.90
\$40,000	\$1.07	\$1.20	\$1.74	\$2.55	\$3.85	\$6.11	\$9.50	\$14.36	\$23.87
\$50,000	\$1.34	\$1.50	\$2.19	\$3.20	\$4.82	\$7.64	\$11.88	\$17.96	\$29.84
\$60,000	\$1.61	\$1.80	\$2.62	\$3.84	\$5.78	\$9.17	\$14.25	\$21.55	\$35.81
\$70,000	\$1.87	\$2.10	\$3.05	\$4.47	\$6.73	\$10.69	\$16.62	\$25.13	\$41.77
\$80,000	\$2.14	\$2.40	\$3.48	\$5.11	\$7.69	\$12.22	\$18.99	\$28.72	\$47.74
\$90,000	\$2.41	\$2.70	\$3.93	\$5.76	\$8.66	\$13.75	\$21.37	\$32.32	\$53.71
\$100,000	\$2.68	\$3.00	\$4.36	\$6.39	\$9.62	\$15.28	\$23.75	\$35.91	\$59.68
\$110,000	\$2.94	\$3.30	\$4.79	\$7.03	\$10.58	\$16.80	\$26.12	\$39.49	\$65.64
\$120,000	\$3.22	\$3.60	\$5.24	\$7.67	\$11.55	\$18.34	\$28.50	\$43.09	\$71.62
\$130,000	\$3.48	\$3.90	\$5.67	\$8.31	\$12.51	\$19.86	\$30.87	\$46.68	\$77.58
\$140,000	\$3.74	\$4.20	\$6.10	\$8.95	\$13.47	\$21.38	\$33.24	\$50.27	\$83.54
\$150,000	\$4.02	\$4.50	\$6.55	\$9.59	\$14.44	\$22.92	\$35.62	\$53.87	\$89.52
\$160,000	\$4.28	\$4.80	\$6.98	\$10.23	\$15.40	\$24.44	\$37.99	\$57.45	\$95.48
\$170,000	\$4.55	\$5.10	\$7.41	\$10.86	\$16.36	\$25.97	\$40.37	\$61.04	\$101.45
\$180,000	\$4.82	\$5.40	\$7.86	\$11.51	\$17.33	\$27.50	\$42.75	\$64.64	\$107.42
\$190,000	\$5.09	\$5.70	\$8.29	\$12.15	\$18.29	\$29.03	\$45.12	\$68.23	\$113.39
\$200,000	\$5.35	\$6.00	\$8.72	\$12.78	\$19.24	\$30.55	\$47.49	\$71.81	\$119.35
\$210,000	\$5.62	\$6.30	\$9.15	\$13.42	\$20.20	\$32.08	\$49.86	\$75.40	\$125.32
\$220,000	\$5.89	\$6.60	\$9.60	\$14.07	\$21.17	\$33.61	\$52.24	\$79.00	\$131.29
\$230,000	\$6.16	\$6.90	\$10.03	\$14.70	\$22.13	\$35.14	\$54.62	\$82.59	\$137.26
\$240,000	\$6.42	\$7.20	\$10.46	\$15.34	\$23.09	\$36.66	\$56.99	\$86.17	\$143.22
\$250,000	\$6.70	\$7.50	\$10.91	\$15.98	\$24.06	\$38.20	\$59.37	\$89.77	\$149.20
\$260,000	\$6.96	\$7.80	\$11.34	\$16.62	\$25.02	\$39.72	\$61.74	\$93.36	\$155.16
\$270,000	\$7.22	\$8.10	\$11.77	\$17.26	\$25.98	\$41.24	\$64.11	\$96.95	\$161.12
\$280,000	\$7.50	\$8.40	\$12.22	\$17.90	\$26.95	\$42.78	\$66.49	\$100.55	\$167.10
\$290,000	\$7.76	\$8.70	\$12.65	\$18.54	\$27.91	\$44.30	\$68.86	\$104.13	\$173.06
\$300,000	\$8.03	\$9.00	\$13.08	\$19.17	\$28.87	\$45.83	\$71.24	\$107.72	\$179.03
\$310,000	\$8.30	\$9.30	\$13.53	\$19.82	\$29.84	\$47.36	\$73.62	\$111.32	\$185.00
\$320,000	\$8.57	\$9.60	\$13.96	\$20.46	\$30.80	\$48.89	\$75.99	\$114.91	\$190.97
\$330,000	\$8.83	\$9.90	\$14.39	\$21.09	\$31.75	\$50.41	\$78.36	\$118.49	\$196.93
\$340,000	\$9.10	\$10.20	\$14.82	\$21.73	\$32.71	\$51.94	\$80.73	\$122.08	\$202.90
\$350,000	\$9.37	\$10.50	\$15.27	\$22.38	\$33.68	\$53.47	\$83.11	\$125.68	\$208.87
\$360,000	\$9.64	\$10.80	\$15.70	\$23.01	\$34.64	\$55.00	\$85.49	\$129.27	\$214.84
\$370,000	\$9.90	\$11.10	\$16.13	\$23.65	\$35.60	\$56.52	\$87.86	\$132.85	\$220.80
\$380,000	\$10.18	\$11.40	\$16.58	\$24.29	\$36.57	\$58.06	\$90.24	\$136.45	\$226.78
\$390,000	\$10.44	\$11.70	\$17.01	\$24.93	\$37.53	\$59.58	\$92.61	\$140.04	\$232.74
\$400,000	\$10.70	\$12.00	\$17.44	\$25.57	\$38.49	\$61.10	\$94.98	\$143.63	\$238.70
\$410,000	\$10.98	\$12.30	\$17.89	\$26.21	\$39.46	\$62.64	\$97.36	\$147.23	\$244.68

ADDITIONAL BENEFITS

VOL CRITICAL ILLNESS

Lucid Staffing offers voluntary critical illness through Principal.

Critical illness will give you a cash payout for illness such as but not limited to cancer, loss of sight, brain tumor, organ failure etc. For more information on coverage, limitations and exclusions, refer to the Carrier benefit summaries on the benefits administrative system.

BENEFIT	Select in increments of \$5k max of \$50k
GUARANTEED ISSUE	\$20k

Age	Employee	Spouse
24 & under	\$.457	\$.457
25 - 29	\$.648	\$.648
30 - 34	\$.726	\$.726
35 - 39	\$.826	\$.826
40 - 44	\$1.092	\$1.092
45 - 49	\$1.499	\$1.499
50 - 54	\$2.119	\$2.119
55 - 59	\$2.863	\$2.863
60 - 64	\$4.035	\$4.035
65 - 69	\$5.627	\$5.627
70 & over	\$8.154	\$8.154

ADDITIONAL BENEFITS

VOL OFF THE JOB ACCIDENT

Lucid Staffing offers voluntary accident through Principal. Rates are show monthly.

Off the job accident will give you a cash payout for injuries such as but not limited to burns, concussions, dislocations, fractures etc. For more information on coverage, limitations and exclusions, refer to the Carrier benefit summaries on the benefits administrative system.

BENEFIT	Ranges from \$500 to \$15k cash payout on various injuries
GUARANTEED ISSUE	No medical underwriting

	Monthly rate
Employee	\$8.06
Employee & spouse	\$13.24
Employee & child(ren)	\$14.89
Family	\$23.38

ADDITIONAL BENEFITS

VOL HOSPITAL INDEMNITY

Lucid Staffing offers voluntary hospital indemnity with Principal. Rates are show monthly.

Hospital indemnity will give you a cash payout for various hospital and ICU stays. The idea is to help supplement your medical deductible, so you are not paying fully out of pocket. For more information on coverage, limitations and exclusions, refer to the Carrier benefit summaries on the benefits administrative system.

BENEFIT	Ranges from \$100 to \$1k on various hospital and ICU visits
GUARANTEED ISSUE	No medical underwriting

	Monthly rate
Employee	\$15.87
Employee & spouse	\$33.49
Employee & child(ren)	\$25.69
Family	\$45.15

ENROLLMENT

When You Can Enroll

You can enroll for benefits at any of the following times:

- After completing the initial eligibility period
- During the annual open enrollment period
- Within 30 days of a qualifying life event (see previous page for qualifying life events) If you do not enroll during the time frames noted above, you must wait for the next annual open enrollment period.

Before You Enroll

Be sure to take time to review the information in this guide as well as the Summary of Benefits and Coverage provided by the medical carrier. It will help you understand your benefit choices.

You should also share this information with your family.

How to Enroll

Your enrollment packet includes instructions for enrolling for coverage. The elections you make will be in effect through April 30, 2025.

If you have any questions with regard to completing any of the enrollment forms, please contact your HR Administrator Ruth Winstel (rwinstel@stafflucid.com).

What is changing for the coming year?

What do I need to do?

There are three things you need to do to complete your annual enrollment this year:

- 1. Review this benefits guide.** This will help you to choose your benefits for the coming year.
- 2. Complete your elections on Ease.** You will have access to the Ease online enrollment portal **10 days** following the on-site enrollment meeting. You must complete the enrollment process at <https://.ease.com> regardless of whether you are continuing coverage, making changes, or waiving benefits.
- 3. Record your payroll deductions on the worksheet through DocuSign.** This form, which replaces the PDF and paper deduction worksheets used in the past, will be sent to you by email.

Again, you must complete this form whether you are continuing coverage, making changes, or waiving benefits.



Enrollment Guide at a Glance

1. Log in to Ease per the instructions you have received from your HR administrator or Broker.





For optimal performance it is recommended that you use
Chrome  or Firefox  as your browser.


2. Click  to begin your enrollment.

3. Follow the prompts on each page to complete your benefit enrollment 

information.

4. If requested during the enrollment process, provide any emergency contacts.

6. Please Select  your benefit by selecting  or 
Click  to proceed to the next benefit.

7. You will then be prompted to provide any missing data. Once you have done this, you will be able to review and sign your forms using your mouse or 

8. Before you review your forms



type your name.

THEN

Sign your signature



and follow the prompts to finish

9. If you have questions, reach out to your HR administrator or Broker.

PLAN NOTICES & DISCLOSURES

Hereinafter, Lucid Staffing Solutions will be referred to as “The Company” and Anthem “The Carrier”.
For more information regarding any of these notices, please contact your Plan Administrator:

Name: _____

Phone: _____

Title: _____

Email: _____

Address: _____

Street

City

State

Zip

ACA Section 1557 Nondiscrimination Notice

Discrimination is Against the Law

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - ☐ Qualified sign language interpreters
 - ☐ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - ☐ Qualified interpreters
 - ☐ Information written in other languages

If you need these services, contact the Plan Administrator.

[THE FOLLOWING APPLIES ONLY TO EMPLOYERS WITH 15 OR MORE EMPLOYEES]

If you believe that The Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Plan Administrator in person or by mail, fax, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Genetic Information Nondiscrimination Act Of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Grandfather Notice

The Company believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator.

Mental Health Parity & Addiction Equity Act Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Michelle's Law Notice

Pursuant to Michelle's Law, you are being provided with the following notice because The Company's group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

When a dependent child loses student status for purposes of The Company's group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, The Company's group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under The Company's group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

- The Company's group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.

Newborns' And Mothers' Health Protection Act Notice

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

Notice of Patient Protections

The Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from The Company or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact The Company.

Notice of Special Enrollment Rights

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **30 days (varies by carrier)** after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Plan Administrator.

Women's Health and Cancer Rights Act Notices

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.

Wellness Program Disclosure

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

General Notice of COBRA Rights

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 and other members of your family when group health coverage would otherwise end. For more 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. 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 it would otherwise end because of a life event. This is also called 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'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 continuation 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. 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.

How is COBRA continuation 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.

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. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. 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.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the plan administrator. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the 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.

Plan contact information

If you have questions, please contact your Plan Administrator.

Initial Notice of Cal-COBRA Rights (California)

You are receiving this notice because you have recently become covered under The Company plan.

This notice contains important information about your right to Cal-COBRA continuation coverage; which is a temporary extension of coverage under the plan. The right to Cal-COBRA continuation coverage was created by state law in conjunction with a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Cal-COBRA continuation coverage can become available to you and to other members of your family who are covered under the plan when you would otherwise lose your group health coverage. This notice generally explains Cal-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. This notice gives only a summary of your Cal-COBRA continuation coverage rights. For more information about your rights and obligations under the plan and federal law, you should either review the plans summary plan description or get a copy of the plan document from the Plan Administrator.

Cal-COBRA Continuation Coverage

Cal-COBRA continuation coverage is a continuation plan Coverage when coverage would otherwise and because of the life event known as a “qualifying event”. Specific qualifying events are listed later in this notice. Cal-COBRA continuation coverage must be offered to each person who is a “qualified beneficiary”. A qualified beneficiary is someone who will lose coverage under the plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees and dependent children of employees may be qualified beneficiaries.

Under the plan qualified beneficiaries who elect Cal-COBRA continuation coverage must pay for Cal-COBRA continuation coverage.

If you are an *employee*, you will become a qualified beneficiary if you lose your coverage under the plan for either one of the following two qualifying events:

- 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 for any of the following qualifying events:

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

Your *dependent children* will become beneficiaries if they lose coverage under the plan for any of the qualifying events:

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

Additional plan procedures for this notice and required information documentation, if any, are as follows:

Once the Plan Administrator receives notice that a qualifying event has occurred, Cal-COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects Cal-COBRA continuation coverage, Cal-COBRA continuation coverage will begin:

- On the date of the qualifying event; or
- On the date the plan coverage would otherwise have been lost.

Cal-COBRA continuation coverage is temporary continuation of coverage. When the qualifying event is death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation or a dependent child losing eligibility as a dependent child, Cal-COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, Cal-COBRA continuation coverage last for up to 18 months.

Extension of Continuation Coverage

There are two ways in which this 18-month period of Cal-COBRA continuation coverage can be extended.

Disability

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of Cal-COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your retired family can receive up to 11 months of Cal-COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of Cal-COBRA continuation coverage.

Second Qualifying Event

If your family experiences another qualifying event while receiving Cal-COBRA continuation coverage, the spouse and dependent children in your family can get additional months of Cal-COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when the child stops being eligible under the plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.

Extended Coverage for California Employees

Your group health plan must offer any qualified beneficiary who has exhausted continuation coverage under Cal-COBRA the opportunity to continue coverage for up to 36 months from the date of the qualified beneficiary's continuation coverage began, if the qualified beneficiary is entitled to less than 36 months of continuation coverage under Cal-COBRA.

A qualified beneficiary electing such further continuation coverage shall pay to the group plan, on or before the due date of each payment but not more frequently than on a monthly basis, not more than 110 percent of the applicable rate charged for a covered employee, or in the case of dependent coverage, not more than 110 percent of the applicable rate charged to a similarly situated individual under the group benefit plan being continued under the group contract.

In the case of a qualified beneficiary who is determined to be disabled by SSA (see "disability" above) the qualified beneficiary shall be required to pay to the group health plan an amount no greater than 150 percent of the group rate after the 1st 18 months of continuation coverage.

Keep Your Plan Informed of Addressed 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 sent to the Plan Administrator.

Health Insurance Exchange Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than **8.39%** of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact our employer directly. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you.

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 January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	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
ARKANSAS – Medicaid	FLORIDA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplecovery.com/flmedicaidtplecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
INDIANA – Medicaid	MINNESOTA – 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	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
IOWA – Medicaid and CHIP (Hawki)	MISSOURI – Medicaid
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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	MONTANA – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov
KENTUCKY – Medicaid	NEBRASKA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	NEVADA – 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)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	NEW HAMPSHIRE – 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: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	TEXAS – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	UTAH – Medicaid and CHIP
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	VERMONT– Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
OREGON – Medicaid	WASHINGTON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	WYOMING – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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 January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it

displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebesa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires
1/31/2026)



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