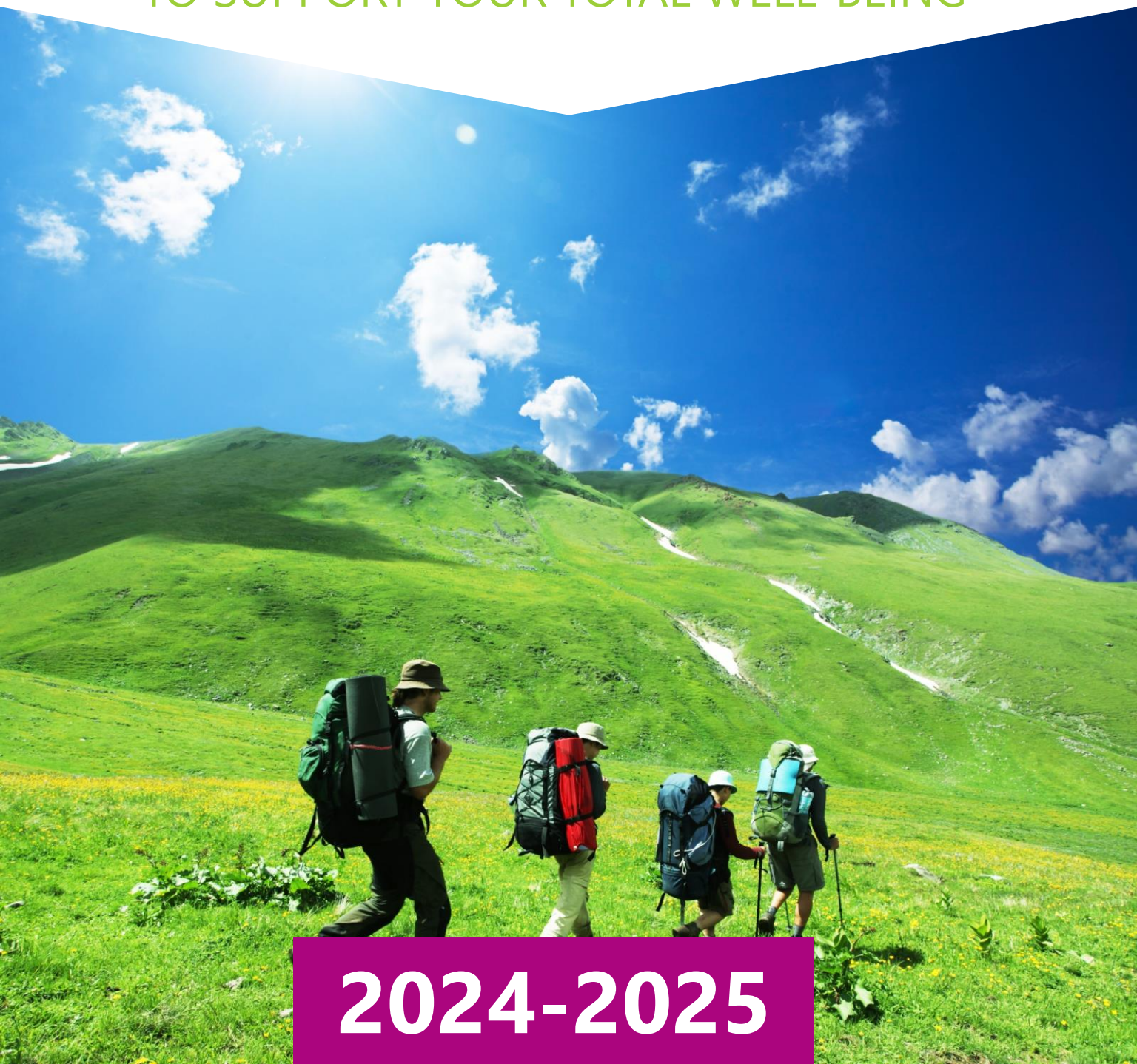
Health SOLUTIONS

Hope. Health. Together

EMPLOYEE BENEFITS GUIDE

MAKE THE MOST OF BENEFITS TO SUPPORT YOUR TOTAL WELL-BEING



2024-2025

Health Solutions Benefits

YOUR BENEFITS

YOUR HEALTH PLANS

ADDITIONAL BENEFITS

ADDITIONAL INFORMATION

At **Health Solutions**, we know our dedicated employees—YOU—are key to our overall success as an organization. We recognize that offering a quality, comprehensive benefit program is an important way to show you how valuable you are to the organization. We understand that navigating the world of employee benefits is challenging and no two employees are alike, which is why we offer this benefits guide to explain the multiple benefit options to improve your physical, financial and mental well-being.

About Us

Health Solutions is a comprehensive, non-profit community medical and behavioral health treatment provider with centers in Pueblo, Huerfano and Las Animas counties. Health Solutions is licensed by the State of Colorado and governed by a citizens' board of directors.

Our Mission

Our mission is to make available a comprehensive range of affordable and quality community-based medical and behavioral health services.

Health Solutions exists to assist those in need of healthcare services who require expert care to support recovery and to successfully achieve their healthcare goals.

We are committed to offering exceptional quality services that set the standard for healthcare in Colorado. This care is provided through service excellence, innovation, compassion and promotion of self-determination.

Our Services

- Diagnostic Evaluation
- Individual Therapy
- Couples Therapy
- Youth & Family Therapy
- Medications
- Recovery Treatment Services
- Emergency Crisis Services
- Acute Care
- Care Coordination
- School-based Therapy
- Early Childhood Services
- Ancillary Services

Management Team

Leadership With Heart

Health Solutions leaders work with a servant's heart knowing they are stewards to our local community and a life changing resource for those we serve.

With that powerful knowledge behind what they do, our Health Solutions leaders manage resources, people and the brand of our organization with gratitude and inspiration.

Developed as life-long learners our seasoned executives are well informed, strong decision makers, who are respected leaders in our community.

Our Values

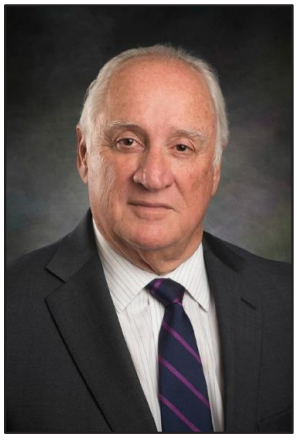
- We believe that individuals in need of our services are our highest priority. They are the reason why Health Solutions exists.
- We believe in the preservation of human dignity, self-respect and individual rights in a caring environment that results in enabling individuals to live, work and contribute in their chosen community.
- We believe in the person-centered approach to care in which the total healthcare needs of the individual are addressed. We encourage families to become involved in their loved one's treatment efforts.
- We believe our employees are our most valuable asset and we promote a healthy work environment, open communications, teamwork, trust, honesty, and ethical behavior which allows us to be accountable to each other, to the individuals we serve, and to our community.
- We believe that Health Solutions should be responsive to the healthcare needs of the communities it serves and direct its resources to meet those needs.
- We believe in being a good corporate citizen of the community, maintaining communications with the various publics we serve, and participating actively in community affairs, particularly those related to healthcare.

Strategic Objectives

- Be renowned for providing an exceptional patient experience that results in unabashed patient loyalty.
- Routinely meet patient expectations for our core business services while consistently exceeding expectations for the patient experience.
- Improve the health and/or quality of life of those we serve.
- Maintain financial sustainability by increasing market share, maximizing efficiencies, and expanding into profitable lines of business while improving the quality and diversity of care we provide.
- Consistently recognize demonstrated behaviors of staff members who engage in quality excellence, human kindness and financial efficacies.

HEALTH SOLUTIONS EXECUTIVE STAFF

Jason Chippeaux, MSW, LCSW
Chief Executive Officer



Rob Kepplinger, MA, LPC
Deputy Chief Executive Officer

Dana Brown, BS
Chief Technology Officer

Paige Oldham, CPA, CMA Chief Financial Officer

Heather Hankins, RN, APN Chief Operations/ Chief Medical Officer

Chet Phelps, BS Chief Information Officer

Your Benefits

Eligibility

Full-time employees

Employees working 24 hours or more per week are eligible for all health benefits with no waiting period.

PRN employees

Employees working fewer than 24 hours per week may become eligible based on Affordable Care Act guidelines.

When coverage begins

- Immediate for employees hired on the first day of the month.
- The first day of the following month for employees whose date of hire is not on the first of the month.

When coverage ends.

If your employment with Health Solutions terminates (voluntarily or otherwise), your benefits will end on the last day of the month of your termination.

Adding a family member

Prior to electing benefits, employees should verify that Human Resources has proof of dependent status for any dependent who are being added. This is not required if your dependents have previously been covered through the **Health Solutions** insurance plan. The following can be used as proof:

- Marriage license for spouse
- Birth certificate, adoption, or placement documents for children
- Signed domestic partner affidavit

Covering your family members

Many of the plans offer coverage for your eligible family members, including:

- Your spouse, including your legally married same- or opposite-sex spouse, common law spouse, civil union partner, or same- or opposite-sex domestic partner
- Your dependent children, including your stepchildren, legally-adopted children, and children placed with you for adoption
  - Dependent children are eligible for medical, dental, and vision insurance up to the end of the month in which they turn age 26 (regardless of student or marital status)
  - Dependent children of any age may remain eligible if they are physically or mentally incapable of self-support.

Benefits Enrollment

New employees

As a new employee, you must enroll in benefits within 31 days of your date of hire. If you do not enroll within 31 days, you will need to wait until the next open enrollment period to enroll.

Current employees

Open enrollment is the only time during the year that you can change your benefits unless you experience a qualifying life event. During the open enrollment period, you can newly enroll in coverage or make changes to your current coverage.

If you wish to contribute pre-tax dollars to a flexible spending account in 2025, you must make a new election during the FSA open enrollment. FSA elections do not carry over from year to year.

At Health Solutions, open enrollment for benefits is typically held in October. The FSA open enrollment is held in November.

Any changes you make during benefits open enrollment become effective November 1. Elections made during FSA Open Enrollment become effective January 1.

Changing Your Benefits During the Year

As stated above, you cannot change your benefits during the year unless you experience a qualifying life event. The most common qualifying life events are:

- Marriage, legal separation, or divorce.
- Birth of a child (including adoption).
- Loss of other coverage (e.g., child turns 26 and loses coverage through parent's plan).

There are other, less common, life events that allow you to change your benefits. Please contact Human Resources for a complete list of qualifying life events.

If you experience a qualifying life event and wish to change your benefits, you must log into the Paycom portal within 30 days of the life event. You will be required to provide proof of your life event, such as a birth certificate or marriage license. You can only change benefits that were impacted by the life event (e.g., if you get married, you can add your new spouse to the medical plan, but you cannot change medical plans).

How to Enroll

Benefits enrollment is completed online through the **Paycom Self-Service Portal** website at **www.paycomonline.net**.

In order to complete your enrollment, you need:

- Dates of birth and social security numbers for yourself as well as any family members you are enrolling.
- Proof of eligibility for your spouse and dependent children (e.g., marriage license, birth certificate).

Need to Know Updates and Info

- Ask Charlie is your new benefit advocacy team
- Base Plan Deductible increasing to $1,500/$3,000
- Long-term disability has increased to 60% of your monthly salary with a max of $7,500
- Consider what is new with you. Did you have a baby, get married, etc.?
- Online Enrollment dates:
  - **9/23/2024 – 10/11/2024**
- Open enrollment will be passive enrollment: except for FSA, all elections will carryover if no changes are made.

Health SOLUTIONS
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Advocating for Your Benefits Support Needs

Discover How Charlie Can Help You Today!

Charlie's personalized benefits support provides a team of dedicated advocates to help you and your covered family members maximize your benefits, alleviating the overwhelming process of navigating the complex world of employee benefits.

A Line of Support at Your Fingertips

At Charlie, our team of licensed experts are available to answer benefit questions you may have, from:

+ Medical, Dental and Vision
+ Voluntary Benefits, Life & Disability
+ HSAs, FSAs & EAPs
+ And more!

ASK Charlie

Let us help!

Ask Charlie Advocacy Center

M-F 8AM to 6PM CST

EMAIL: **healthsolutions.benefits@imacorp.com**

PHONE: **833.543.8695**

Our Benefits Experts

+ Explain the value and functionality of your benefits
+ Help locate in-network providers
+ Navigate your billing issues and assist in resolving insurance claims
+ Facilitate your pre-authorizations and support appeal options

...and other benefits-related concerns!

PROVIDED BY IMA

Cigna Medical – PPO Open Access Plus (Base Plan)

Health Solutions offers two medical insurance plans through Cigna. Please take the time to understand the features and differences of each plan so that you choose the coverage that is best for you and your family.

Both medical plans include in- and out-of-network benefits, which means you can choose any provider that you would like. However, you will pay less out of your pocket when you choose a **Cigna** provider. Locate a Cigna network provider at **www.mycigna.com.**

The table below summarizes the key features of the PPO Base plan. Please refer to the official pan documents for additional information on coverage and exclusions.

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible	$1,500 individual $3,000 family	$5,000 individual $10,000 family
Coinsurance	Plan pays 80%	Plan pays 60%
Out-of-Pocket Limit (Includes deductible and office copays)	$4,000 individual $8,000 family	$9,000 individual $18,000 family
Preventive Care	Plan pays 100%	Plan pays 60% after deductible
Office Visit	PCP: $35 copay Specialist: $50 copay	Plan pays 60% after deductible
Emergency Services	$300 copay per visit	
Diagnostics a) X-Ray and Lab Services b) MRI/nuclear medicine/high-tech	a) Plan pays 100% b) Plan pays 80% after deductible	a) and b) Plan pays 60% after deductible
Urgent Care	$50 copay per visit	Plan pays 60% after deductible
Inpatient Hospital	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient Hospital	Plan pay 80% after deductible	Plan pays 60% after deductible
Chiropractic Therapy (20 visits each per calendar year)	$50 copay per visit	Plan pays 60% after deductible
Prescription Drugs – 30-day supply Tier 1/Tier 2/Tier 3/Tier 4 Specialty	$15/$40/$70/20% up to $200	Not covered
Prescription Drugs – 90-day supply (retail and home delivery) ***excludes tier 4 Specialty***	2x Retail Copay	

Cigna Medical – PPO Open Access Plus (Buy Up Plan)

Health Solutions offers two medical insurance plans through Cigna. Please take the time to understand the features and differences of each plan so that you choose the coverage that is best for you and your family.

Both medical plans include in- and out-of-network benefits, which means you can choose any provider that you would like. However, you will pay less out of your pocket when you choose a **Cigna** provider. Locate a Cigna network provider at **www.mycigna.com**.

The table below summarizes the key features of the PPO Buy-Up plan. Please refer to the official pan documents for additional information on coverage and exclusions.

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible	$750 individual $1,500 family	$4,000 individual $8,000 family
Coinsurance	Plan pays 80%	Plan pays 60%
Out-of-Pocket Limit (Includes deductible and office copays)	$3,250 individual $6,500 family	$8,000 individual $16,000 family
Preventive Care	Plan pays 100%	Plan pays 60% after deductible
Office Visit	PCP: $25 copay Specialist: $40 copay	Plan pays 60% after deductible
Emergency Services	$300 copay per visit	
Diagnostics a) X-Ray and Lab Services b) MRI/nuclear medicine/high-tech	a) Plan pays 100% b) Plan pays 80% after deductible	a) and b) Plan pays 60% after deductible
Urgent Care	$40 copay per visit	Plan pays 60% after deductible
Inpatient Hospital	Plan pays 80% after deductible	$100 per visit, Plan pays 60% after deductible
Outpatient Hospital	Plan pays 80% after deductible	$100 per visit, Plan pays 60% after deductible
Chiropractic Therapy (20 visits each per calendar year)	$40 copay per visit	Plan pays 60% after deductible
Prescription Drugs – 30-day supply Tier 1/Tier 2/Tier 3/Tier 4 Specialty **Prescription Drugs – 90-day supply (retail and home delivery) *excludes tier 4 Specialty***	$15/$40/$70/20% up to $200 2x Retail Copay	Plan pays 50%

Member Choice Cigna 90 – New for 2024

A pharmacy network designed to boost engagement and avoid surprises.

Member Choice Cigna 90 Now puts customers in control of where they fill their 30- and 90-day medications. Members can choose the pharmacy location and pharmacist care team that works best for them. With pharmacists playing an increasingly important role on the care team, there's opportunity to drive better patient adherence, clinical outcomes, satisfaction and overall health care savings.

A Team Based Approach

Having a pharmacist on your care team may drive better patient adherence, clinical outcomes and satisfaction. It's part of Cigna's Healthcare's whole-person, value-based care approach.

Anchor Option 1	Anchor Option 2
Walgreens	**CVS Pharmacy**
30-day supply: 55,000 pharmacies 90-day supply: 30,000 pharmacies	30-day supply: 55,000 pharmacies 90-day supply: 30,000 pharmacies
Voluntary or Exclusive 90-day supply benefit design available at one of the 30,000 pharmacies. **Network excludes CVS**	Voluntary or Exclusive 90-day supply benefit design available at one of the 30,000 pharmacies. **Network excludes Walgreens**

FAQ.

1. **How are networks determined?** Network determined by anchor pharmacy. Walgreens will act as Health Solutions' anchor meaning that you will automatically be enrolled in the Walgreens anchor if you do not have pharmacy history with Cigna.
2. **How does it work?** Customers have access to more than 55,000 retail pharmacies - including Walgreens, grocery chains, local, and independent retail pharmacies.
   - **30-day network**: Access to more than 55,000 in-network regional and independent pharmacies.
   - **90-day network**: Access to more than 30,000 in-network regional and independent pharmacies.
3. **Can a customer change the assigned network?** After the plan effective date, customers can change their network chain one time per calendar year to CVS Pharmacy by calling Cigna Healthcare or by visiting MyCigna.com. Customers can also change their network chain upon certain events, such as relocation by calling Cigna Healthcare.
4. **Are network selections made at the subscriber level, or the individual level?** Every covered member in the household can choose the pharmacy network that works best for them.
5. **When can customers switch networks?** Customers have the option to change anchors once during the plan year and at other certain events, such as relocation.
6. **Are 90-day benefit designs available?** Yes, members can elect either a voluntary or exclusive benefit design for 90-day maintenance medications. This plan design feature determines whether filling the 90-day supply is required at one of the 30,000 pharmacies in the network.
   - **In-store and home delivery options**: Customers can fill 90-day maintenance medications at an in-network retail 90-day pharmacy, including Express Scripts Pharmacy.
   - **Opportunities for savings**: Moving to 90-day fills for maintenance medications can drive cost savings for customers and improved prescription adherence.

Flexible Spending Account

Health Solutions offers two flexible spending account (FSA) options through **EBC Flex**. The money that you put into an FSA is collected from your paycheck before taxes are withheld, which means you don't pay taxes on those dollars. **A few very important rules apply to FSAs. Please read this page carefully before you make your FSA elections!**

IMPORTANT INFORMATION REGARDING YOUR FSA ACCOUNTS

- FSA elections must be made every year during the FSA open enrollment. Your current year election WILL NOT carry over to next year.
- You will be issued a prepaid debit card from **EBC Flex** with the balance of your election. This Smart Card can be used to pay for out-of-pocket eligible health care FSA expenses and can verify eligibility of purchases at many locations on the spot.
- All manual requests for reimbursement must be submitted to **EBC Flex** by December 31.
- A full list of eligible expenses is available at **www.ebcflex.com**

Health Care FSA

Health care FSA dollars can be used to pay for eligible out-of-pocket expenses such as deductibles, copays, and other health-related expenses that are not reimbursed by the medical, dental, or vision plans.

- Over-the-counter (OTC) medications require a prescription in order to be reimbursed.
- You may contribute up to the IRS maximum for your health care FSA for the January 1 plan year. The entire amount you elect is available to you on January 1 (or if you are a new hire, on date benefits become effective).
- Some reimbursement examples include:
- Medical copays and coinsurance
- Prescription copays and coinsurance
- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations and eyeglasses
- Dental services and orthodontia
- Chiropractic services and acupuncture
- Mental health care

Dependent Care FSA

- Dependent care FSA dollars can be used to pay for eligible dependent care expenses that allow you and your spouse to work or attend school full time.
- Eligible expenses include day care, preschool, summer camp, before- and after-school care, and elder care.
- Funds can be used for care for your:
  - Children under 13 years of age;
  - Child over 13, spouse, and/or elderly parent who lives with you and is unable to care for themselves
- You may contribute up **to $5,000** to the dependent care FSA if you are married and file a joint return or if you file a single or head of household return. If you are married and file separate returns, you can each elect $2,500.
- Dependent care contributions are deposited each pay period. You can only be reimbursed for amounts up to what is currently in your account.

Dental Insurance

Health Solutions offers dental insurance through **Cigna.** Be sure to use CIGNA Dental PPO Network providers in order to receive your best benefit and avoid out-of-pocket expense. Providers can be located at www.mycigna.com.

The table below summarizes the key features of the dental plans. The coinsurance amounts listed reflect the amount you pay for services. Please refer to the official plan documents for additional information on coverage and exclusions.

Do I need to see a dentist?

A visit to the dentist is about more than just a teeth cleaning. By looking in your mouth, your dentist can tell a lot about your overall health. In fact, he or she may be able to identify early signs of disease, such as diabetes, heart disease, kidney disease, and even some forms of cancer, before you even notice symptoms.

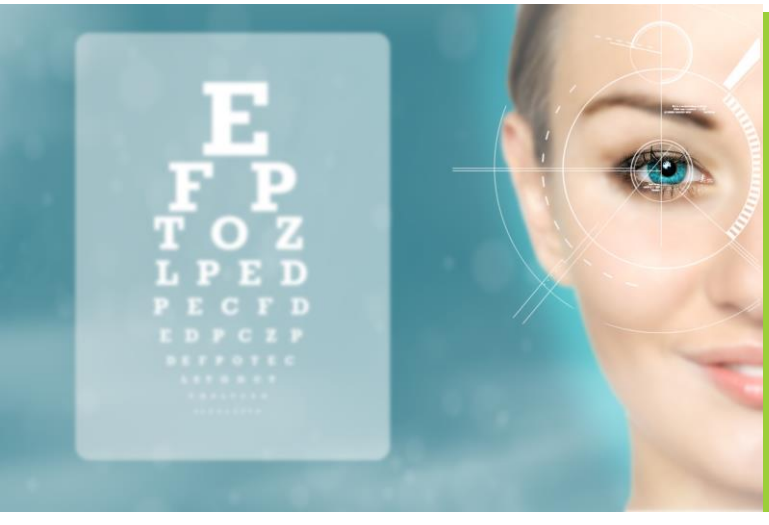
PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Individual Deductible	$50	
Family Deductible	$100	
Annual Maximum	$2,000 per calendar year for each member enrolled in the plan	
Preventive Service	Paid 100%, deductible waived	Paid 100%, deductible waived
Basic Services	Paid 80% after deductible	Paid 80% after deductible
Major Services	Paid 50% after deductible	Paid 50% after deductible
Adult & Child Orthodontia	50%, no deductible	50%, no deductible
Adult & Child Orthodontia Lifetime Max	$1,500	$1,500

Vision Insurance

Health Solutions offers a vision insurance plan through **Ameritas**. This plan allows you to choose any eye care provider. However, you will maximize the plan benefits when you choose a network provider through the Ameritas VSP network. Locate an **Ameritas** network provider at **www.ameritas.com**.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Exam Copay	$10 copay	Reimbursed up to $45
Materials Copay	$25 copay	Reimbursement schedule based on lens type
Contact Lenses a) Medically Necessary b) Elective	a) $25 copay b) Up to $130 allowance	a) Reimbursed up to $210 b) Reimbursed up to $105
Frame Retail Allowance	Up to $130 per frequency	Up to $70 per frequency
Lens Benefit, Single	$25 copay	Reimbursed up to $30
Lens Benefit, Bifocals	$25 copay	Reimbursed up to $50
Lens Benefit, Trifocals	$25 copay	Reimbursed up to $65
Frequency of Services	Exams, Lenses and Contacts – every 12 months Frames – every 24 months	
Laser Vision Correction	15% Discount off regular price or 5% off promotional price	No discount available



Do I need an annual eye exam if I have perfect vision?

Your eyes are your windows to the world. They are also your eye doctor's windows into your body. Just by looking in your eyes, a doctor can find warning signs of serious diseases and conditions like high blood pressure, high cholesterol, thyroid diseases, and certain types of cancer. In fact, eye doctors are frequently the first to detect signs of abnormal health conditions.

Long-Term Disability Insurance

Health Solutions offers benefits-eligible employees Long Term Disability insurance through **New York Life**. If you are unable to work (perform your job) for a continuous 90-day period due to illness or injury, your Long-Term Disability (LTD) benefit will take effect. LTD benefits are subject to pre-existing condition limits, and benefit duration is shortened if the disability begins after age 60.

Long-Term Disability Insurance

Benefits Begin	After 90 days of disability
Maximum Benefit Payable to Employee	Up to $7,500 per month
Percentage of Income Replaced	60% of salary
Benefits End	When no longer disabled or at retirement age

If you experience an injury that keeps you from working, be sure to contact HR to begin your paperwork as soon as you are able.

Life and Accidental Death and Dismemberment Insurance

Life and accidental death and dismemberment (AD&D) insurance provides financial protection for those who depend on you for financial support. Upon your death, your designated beneficiary will receive the life benefit. If you die as the result of an accident, you beneficiary will receive both the life and AD&D benefits. The carrier for basic, voluntary life and AD&D insurance is **New York Life**.

Basic Life and AD&D Insurance

All eligible employees (full-time employees regularly working at least 24 hours per week) will receive 1x their annual salary up to $150,000 in Life and AD&D coverage. Employees are asked to designate a beneficiary at the time of enrollment. Health Solutions pays 100% of this premium.

If you are eligible for $50,000 or more in basic life insurance, you are required to pay income tax on the value of the coverage in excess of $50,000.

Designate a Beneficiary

In the event of your death NY Life would pay your Life and/or AD&D policy to your beneficiaries. Designate your beneficiary for your Basic Life and AD&D insurance, as well as any Voluntary Life insurance.

You may change this designation at any time. You are automatically the beneficiary on your Spouse and/or Child Life policy.

*Evidence of Insurability

If you purchase Life and AD&D insurance for yourself or your spouse and/or children when you are first eligible to enroll, you may purchase up to the guarantee issue amounts without completing a statement of health (evidence of insurability). If you do not enroll when first eligible, and choose to enroll during a future open enrollment period, you will be required to submit evidence of insurability for any amount of coverage. Coverage will not take effect until approved by **New York Life**

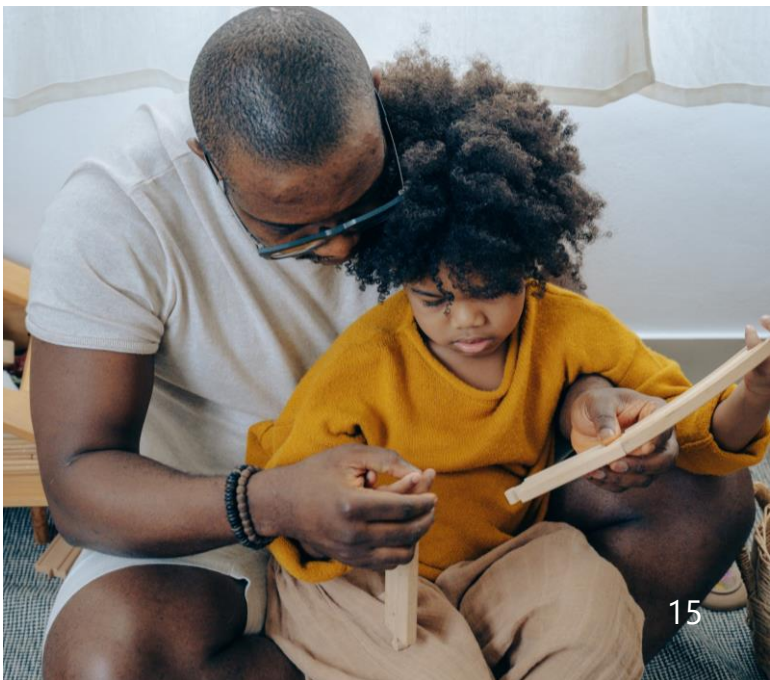
Voluntary Life Insurance

Employees may purchase additional life insurance for themselves and dependents. Employee benefits will be available in increments of **$10,000** up to **$500,000** or 5 times your annual salary (whichever is less) with medical underwriting over **$150,000*.** Spouse benefits will be available in increments of **$5,000** up to **$250,000** (not to exceed 50 % of the employee benefit amount), with medical underwriting over **$50,000*.** Child benefits will be available in values of **$5,000** or **$10,000** per child. Rates are age-based, and employees pay 100% of the premium.

Voluntary AD&D Insurance

Employees may purchase additional AD&D insurance for themselves and dependents. Employee benefits will be available in increments of $10,000 up to $500,000 or 5 times your annual salary (whichever is less).

Spouse benefits will be available in increments of $5,000 up to $250,000 (not to exceed 50 % of the employee benefit amount), Child benefits are available up to $10,000. Monthly cost is $.026 per $1,000 of coverage. Employees pay 100% of the premium.



Benefits from Allstate

Allstate BENEFITS

Hospital stays, major illness diagnosis and unexpected accident treatment can be very expensive, even with medical insurance. These plans are designed to help you pay your medical bills and protect your finances. Benefits are paid directly as cash payments to you, regardless of any other coverage, to use however you see fit. All plans can be taken with you if you leave the company for any reason.

Accident Insurance

- $1,000 initial hospital benefit, $200 daily hospital benefit.
- Up to $4,000 for fractures or dislocations.
- Up to $40,000 for accidental death.
- Up To $200 for ER treatment, X-rays and physician treatment plus many more benefits.
- Outpatient physician treatment benefit of two $50 benefits for going to see a doctor outside a hospital, a dentist, a chiropractor or getting an eye exam for ANY reason. This goes to four total benefits with covered dependents.

Critical Illness Insurance

Critical illness insurance is a policy that provides a lump-sum, cash benefit if you are diagnosed with a covered illness (e.g., heart attack, stroke, cancer). These diagnoses can cause significant financial burden, especially if you are unable work while receiving treatment. You can use the money you receive however you would like, including to help you pay your mortgage, pay your deductible, seek experimental treatment, or for any other expenses.

- You can elect a $10,000 or $20,000 benefit on yourself that will pay if you are diagnosed with a covered illness.
- Covered dependents get 50 % of your amount.
- This product is a Guarantee Issue for all who sign up during initial enrollment, so no health questions to qualify.
- Covered illnesses include heart attack, stroke, invasive cancer, major organ transplant, benign brain tumor and complete loss of hearing, sight or speech plus many more.
- This plan includes a $50 wellness benefit that you can collect on you and your covered spouse each calendar year.
- The plan is issue-aged meaning you are locked in at your age banded rate for life, unless you change your policy.

Short-Term Disability Income Protection

Most of us insure our home, car, etc., but neglect to insure our most important asset — our ability to earn income. This plan pays you a specific dollar amount when you are sick or injured and cannot work and provides income when you need it most. (Pregnancies are covered after nine months).

- Benefits start after 14 days for a sickness or injury and can pay for a maximum three-month benefit period.
- You can choose in $100 monthly benefit increments up to 60 % of your salary to a max of $5,000.

Hospital Indemnity Plan

- A few days in the hospital can hit your out-of-pocket max on your medical plan.
- This plan is Guarantee Issue during initial enrollment, so no health questions to qualify.
- It pays a $1,000 or $2,000 initial hospital benefit for any sickness or injury related stay in the hospital.
- It also pays $150 or $250 for each day thereafter that you are still in the hospital.

Employee Assistance Program

Profile EAP is available to you and your household family members with an employee assistance program (EAP) at no cost to you. The EAP is a valuable resource that can help you identify and resolve many workplace, family, social, economic, and mental health issues.

For all employees of Health Solutions — Full-Time, Part-Time and PRN

Talk to a counselor about:	Connect to local resources for:	Get tips for staying healthy:
• Improving relationships	• Childcare needs	• Sleep practices
• Managing life changes	• Caring for an elder	• Eating well
• Improving esteem and confidence	• School success	• Finding a gym
• Achieving work-life harmony	• Legal resources	

EAP Benefits

- Completely confidential. Health Solutions does not receive any information about who contacts the EAP.
- Available 24/7/365.
- Includes eight in-person therapy sessions.
- Online resources.
- Unlimited phone consultations.

Call or go online for help with:

- Depression
- Conflict resolution
- Drug or alcohol abuse
- Marital or family difficulties
- Legal concerns
- Help finding child and elder care
- Wills and estate planning
- Financial counseling

EXAMPLE:

Jim has recently been struggling to balance his responsibilities at work with his responsibilities at home. At times, he struggles to find childcare and finds that this impacts his performance on the job.

Jim contacted the EAP to talk through these struggles, and they were also able to provide trusted childcare resources that he now uses regularly!

Call: 719-634-1825 (800-645-6571)
Website: www.profileeap.org (Company Code: SPHCS)

EAP resources are available for free to you and your household family members up to age 26.

Telemedicine
Virtual Healthcare

Health Solutions is committed to your physical and mental well-being, offering several program options with you in mind. Virtual doctor's visits allow you to see and speak to a doctor online, anytime.

When Virtual Healthcare is Appropriate	When Virtual Healthcare is Not Appropriate
Virtual healthcare is good for routine issues such as: • Cold and flu symptoms • Allergies • Pink eye • Urinary tract infections • Rash • Sinus problems • Quick assessment for severity • Stomach aches	Virtual healthcare is not good for diagnoses that require a hands-on exam and lab test, emergencies or for injuries such as sprains and broken bones

EXAMPLE

Over the weekend, Linda's daughter begins itching her eye excessively. Knowing her primary care physician is not in the office, Linda utilizes virtual healthcare. She simply speaks with a doctor virtually, sends in photos of her child's eye, and the doctor can prescribe an antibiotic for pink eye.

Rather than waiting in an urgent care, Linda can stay home and care for her daughter!

Online: Visit www.Teladoc.com and log in to your account then complete the My Medical History section.

Call 1-800-Teladoc: Teladoc can help you complete your medical history disclosure over the phone.

Use Teladoc:

On vacation | After Hours | On a business trip | For non-emergent medical assistance | For behavioral health services | For dermatology services

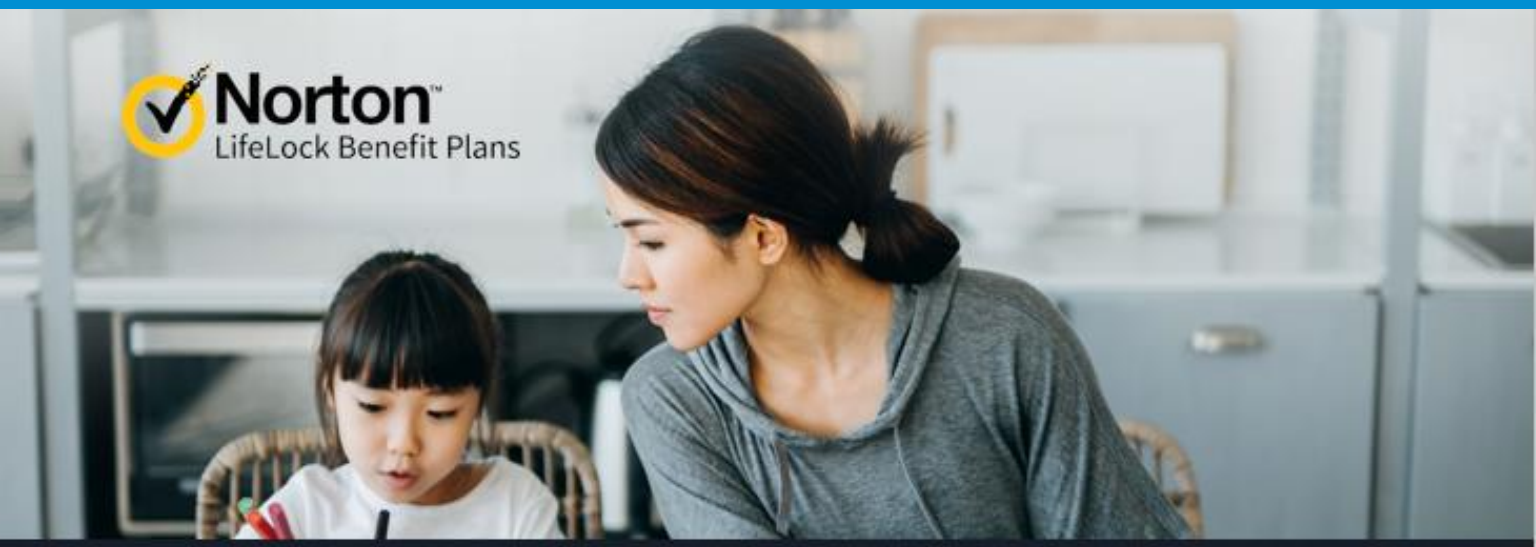
Teladoc is easy to use!

- Book an appointment from anywhere, anytime at www.Teladoc.com
- Video chat with a board-certified doctor from your phone, tablet, or computer
- A prescription can be sent to the pharmacy nearest you

It's easy to set up your account:

1. Visit teladoc.com
2. Click "set up account"
3. Provide required info

ID Theft Protection



Opt-in to Cyber Safety

Health Solutions

No one intends to be unsafe online. Help protect your identity and devices with Norton LifeLock Benefit Plans. Let us help empower you and your family to live your digital lives safely.

Device Security

Anti-virus software and multi-layered, advanced security helps protect devices against existing and emerging threats, including malware and ransomware.

Online Privacy

Norton Secure VPN protects devices and helps keep online activity and browsing history private. Privacy Monitor scans common public people-search websites to help you opt-out. And SafeCam alerts you and blocks attempts to access your webcam.[1]

Screen modified for demonstration purposes. Features may differ depending on plan.

Identity

We monitor for fraudulent use of personal information, and send alerts when a potential threat is detected.[†]

Home & Family

Take action to monitor your child's online activity with easy-to-use tools to set screen time limits, block unsuitable sites, and monitor search terms and activity history.

Norton™
LifeLock Benefit Plans

	Benefit Premier
Identity	
LifeLock Identity Alert™ System†	
• Identity Verification Monitoring†,**	
• Telecom & Cable Applications for New Service	
• Payday - Online Lending Alerts†	
• Credit Alerts & Social Security Alerts†	
Dark Web Monitoring**	
Home Title Monitoring	
USPS Address Change Verification	
Stolen Wallet Protection	
Social Media Monitoring*	
Data Breach Notifications	
Bank & Credit Card Activity Alerts†,**	
Checking & Savings Account Application Alerts†,**	
Bank Account Takeover Alerts†,**	
401k & Investment Account Activity Alerts†,**	
Prior Identity Theft Remediation∂ This feature is separate from our Million Dollar Protection™ Package and does not provide coverage for lawyers and experts, reimbursement of stolen funds or compensation for personal expenses for events occurring during the 12 months prior to enrollment. See disclaimer for details.	
U.S.-based Identity Restoration Specialists	
24/7 Live Member Support	
Million Dollar Protection™ Package†††	*Up to $1 Million each*
• Stolen Funds Reimbursement	
• Personal Expense Compensation	
• Coverage for Lawyers and Experts	
Credit Application Alerts[2],**	*One-Bureau[1]*
Credit Monitoring[1],**	*Three-Bureau[1]*
Annual Credit Reports & Credit Scores[1],** The credit scores provided are VantageScore 3.0 credit scores based on data from Equifax, Experian and TransUnion respectively. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.	***On Demand –*** *Three-Bureau[1]*
• Identity Lock [1,5]	
Monthly Credit Score Tracking[1],** The credit score provided is a VantageScore 3.0 credit score based on Equifax data. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.	*One-Bureau[1]*
Credit, Bank & Utility Account Freezes**	
Device Security	
Secures PCs, Mac & mobile devices**	*Up to 5 devices (Family gets 10 devices)*
Online Threat Protection**	
Password Manager**	
Smart Firewall**	
Cloud Backup[3],**	*50 GB*
Home & Family	
Parental Control[4],**	
Online Privacy	
Norton Secure VPN**	
Privacy Monitor	
SafeCam[3],**	

Benefit Plan - Monthly Rates	Benefit Premier
Employee Only (18+ Years Old)--employee benefit paid by Health Solutions	
Employee + Family—can be purchased by employee for $5.30 bi-weekly	

Health SOLUTIONS
Hope. Health. Together

Advocating for Your Benefits Support Needs

Discover How Charlie Can Help You Today!

Charlie's personalized benefits support provides a team of dedicated advocates to help you and your covered family members maximize your benefits, alleviating the overwhelming process of navigating the complex world of employee benefits.

A Line of Support at Your Fingertips

At Charlie, our team of licensed experts are available to answer benefit questions you may have, from:

+ Medical, Dental and Vision
+ Voluntary Benefits, Life & Disability
+ HSAs, FSAs & EAPs
+ And more!

Our Benefits Experts

+ Explain the value and functionality of your benefits
+ Help locate in-network providers
+ Navigate your billing issues and assist in resolving insurance claims
+ Facilitate your pre-authorizations and support appeal options

...and other benefits-related concerns!

ASK Charlie

Let us help!

Ask Charlie Advocacy Center

M-F 8AM to 6PM CST

EMAIL: **healthsolutions.benefits@imacorp.com**

PHONE: **833.543.8695**

PROVIDED BY IMA

Rates

Bi-weekly Employee Medical Cost

Cigna PPO Base Plan	Tobacco Use Bi-weekly	Non-Tobacco Use Bi-weekly
Employee Only	$109.03	$83.44
Employee + Spouse	$218.58	$167.39
Employee + Child(ren)	$249.81	$190.94
Employee + Family	$272.84	$208.86
Cigna PPO Buy Up Plan	**Tobacco Use Bi-weekly**	**Non-Tobacco Use Bi-weekly**
Employee Only	$126.95	$101.36
Employee + Spouse	$253.39	$202.20
Employee + Child(ren)	$290.25	$231.38
Employee + Family	$316.87	$252.88

Bi-weekly Employee Dental Cost

Cigna PPO Plan	
Employee Only	$4.77
Employee + Spouse	$9.72
Employee + Child(ren)	$10.81
Employee + Family	$12.05

Bi-weekly Employee Vision Cost

Ameritas Vision	
Employee Only	$3.45
Employee + Spouse	$6.26
Employee + Child(ren)	$6.31
Employee + Family	$9.67

Rates

Employee Monthly Voluntary Life and AD&D Cost

MONTHLY RATES PER $1,000 (Unless otherwise stated)	UNISEX RATES (Rates are based on employee age for spouse)	UNISEX SMOKER RATES (Rates are based on employee age for spouse)
Under age 20	$0.06	$0.06
20-24	$0.06	$0.06
25-29	$0.06	$0.06
30-34	$0.08	$0.08
35-39	$0.11	$0.11
40-44	$0.16	$0.16
45-49	$0.27	$0.27
50-54	$0.44	$0.44
55-59	$0.69	$0.69
60-64	$0.92	$0.92
65-69	$1.48	$1.48
70-74	$2.61	$2.61
Child Life	Units of $5,000 or $10,000 per child $0.146 per $1,000	
AD&D	$0.026 per $1,000 of coverage	

Bi-weekly Allstate Plans

Accident	
Employee Only	$4.28
Employee + Spouse	$7.38
Employee + Child(ren)	$9.08
Employee + Family	$11.80

Hospital Indemnity	**Base Plan**	**Buy Up Plan**
Employee Only	$6.30	$12.12
Employee + Spouse	$17.46	$33.90
Employee + Child(ren)	$10.92	$21.00
Employee + Family	$18.72	$36.36
Disability	**Age-banded rates based on monthly benefit amount. See HR for rate table.**	

Critical Illness	**Age-banded rates based on plan election and tobacco usage. See HR for rate table.**

Additional Information

Resources and Contact Information

Do you have a question about your benefits?

All Cigna members should create their MyCigna profile at www.mycigna.com.

Information on all plans can be obtained at the contact information below.

Benefit	Carrier & Phone	Website
Medical and Dental	**Cigna** 1-866-494-2111	www.cigna.com www.mycigna.com
Vision	**Ameritas** 1-800-877-7195	www.ameritas.com
Telehealth	**Teladoc** 1-800-835-2362	www.teladoc.com/bsc
Flexible Spending Accounts, Dependent Care Accounts	**Employee Benefits Corp (EBC)** 800-346-2126 Participantservices@ebcflex.com	www.ebcflex.com
Life and Disability	**New York Life** 1-800-225-5695	www.newyorklife.com
Profile EAP - Employee Assistance Program	719-634-1825 (800-645-6571 toll free)	www.profileeap.org
Allstate - Disability, Accident, Hospital Indemnity, Critical Illness	(888) 282-2550	mybenefits.allstate.com
Ask Charlie Benefits Advocacy Center	**Ask Charlie** (833) 543-8695	Healthsolutions.benefits@imacorp.com
Identity Theft Protection	**NortonLifeLock**	Direct enrollment: www.Norton.com/EBsetup

To obtain a copy of your benefit plan documents, contact Human Resources.

Notices

Health Solutions
41 Montebello Road Suite 202
Pueblo, CO
81001
719-545-2746

The following pages provide employee benefit plan notices. Please read them carefully as we generally provide these once a year during annual open enrollment. You may see some of these notices in other documents as well, but we consolidate the following notices here for your convenience:

- MEDICARE PART D PRESCRIPTION DRUG CREDITABILITY/NON-CREDITABILITY
- OUR PLAN PAYS SECONDARY TO DISABILITY-BASED MEDICARE AFTER BEING SOCIAL SECURITY DISABLED FOR 24 MONTHS
- PROVIDER CHOICE WHEN PLAN REQUIRES A PRIMARY CARE PHYSICIAN
- NON-GRANDFATHERED MEDICAL PLAN APPEALS PROCESSES
- WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)
- PUBLIC HEALTH INSURANCE MARKETPLACE
- WELLNESS PLAN
- SPECIAL MEDICAL ENROLLMENT RIGHTS AND RESPONSIBILITIES UNDER HIPAA
- PREMIUM ASSISTANCE UNDER MEDICAID OR THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you (and/or your dependents) have Medicare or will be eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 2 for more details.

Throughout these pages you are invited to "contact HR" for assistance. For any questions or requests you may have about the pages below, including a request for a paper copy of this notice packet, contact Marne Autobee in human resources (HR) at 719-423-1234.

Before we get into the notices, some basic rules governing our plan are summarized below:

- You may only enroll when first eligible or during our annual open enrollment each year in October.
- **Your election is locked** for the entire plan year, November 1 to October 31.
- You can generally submit a benefit change **within 30 days of a qualifying life event** during the plan year. We will require substantiating documentation of the event, and we may determine the event does not qualify to make the requested change.
- At any time, we may audit dependent status and require current substantiating documentation.
- **Please update address or beneficiary changes in Paycom.**
- When first enrolling in health coverage, a **general notice of rights and responsibilities to continue health coverage under COBRA** is mailed to the home. It explains that when certain life events make an enrolled individual no longer eligible to stay on the plan, coverage might be able to continue for a limited time under COBRA so long as you or your spouse follow our procedures to notify us within 30 days of the qualifying life event.
- Your rights and responsibilities under the FMLA and our company-specific FMLA policies are discussed in our employee handbook.

Notices

MEDICARE PART D PRESCRIPTION DRUG CREDITABILITY/NON-CREDITABILITY

When you or a family member becomes eligible for Part D (Medicare's prescription drug benefit), it is important to understand when to enroll in Part D. You can wait as long as you maintain "creditable" coverage (i.e., coverage which on average pays at least as well as Part D pays on average). But if you do not have creditable coverage, you need to enroll in Part D at the earliest opportunity.

Below are highlights to note:

- A continuous break in creditable coverage of 63 or more days will trigger a late enrollment penalty payable for life.
- The longer you go without creditable coverage, the higher the penalty. For the rest of your life, you would be charged an additional 1% of Part D base premium for each month you are late.
- When creditable coverage ends, a special enrollment period of two (2) months may be provided to enroll in Part D (but note that this is only available when normal coverage ends, not when retiree or COBRA coverage ends).
- The Part D annual open enrollment occurs each year from October 15th through December 7th for coverage to begin January 1st.

The information below indicates whether prescription drug coverage under our plan is creditable.

Creditable Coverage	Non-Creditable Coverage
PPO Base Plan **PPO Buy-Up Plan**	**None (all plans are creditable)**

Anyone needing to learn more about Medicare should contact a Medicare-approved counselor in their state at *https://www.medicare.gov/Contacts/#resources/ships*.

OUR PLAN PAYS SECONDARY TO DISABILITY-BASED MEDICARE AFTER BEING SOCIAL SECURITY DISABLED FOR 24 MONTHS

When you or a dependent are determined disabled by the Social Security Administration, it is imperative such individual have Medicare begin immediately after 24 months of Social Security disability. Regardless whether the individual is enrolled in Medicare or not, our plan will calculate how much Medicare would have paid and then pay secondary (meaning it will pay very little or nothing).

If we employ 100 or more full- and part-time employees during 50% or more of business days during the previous calendar year, then we will give everyone an update that our plan will begin paying primary (not secondary) to disability-based Medicare.

Anyone needing to learn more about Medicare should contact a Medicare-approved counselor in their state at *https://www.medicare.gov/Contacts/#resources/ships*.

Notices

NON-GRANDFATHERED MEDICAL PLAN APPEALS PROCESSES

Your medical plan booklet will explain how to appeal a claim denial through the plan, through a government-authorized third party, and with the help of a consumer assistance office.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

Enrolled individuals may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For 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 co-insurance applicable to other medical and surgical benefits provided under the medical plan. If you would like more information on WHCRA benefits, please contact HR.

PUBLIC HEALTH INSURANCE MARKETPLACE

For individuals needing to purchase health insurance on their own, the Affordable Care Act (ACA) created a new public Health Insurance Marketplace. This website and call center helps individuals shop for private health insurance, helps individuals enroll in Medicaid or the Children's Health Insurance Program (CHIP), and evaluates eligibility for new tax credits. Open enrollment for public Marketplace coverage occurs each fall for coverage starting January 1, but special enrollment periods may be available for certain life events. Learn more or request assistance at *www.healthcare.gov*.

Please note that insurance companies are not required to participate in the public Marketplace, so you are unlikely to see all plans available in the community when shopping the public Marketplace.

The public Marketplace can help you determine whether you may be eligible for tax credits under section 36B of the Internal Revenue Code for Marketplace coverage. One tax credit can lower your monthly premium, and the other can lower your cost sharing (such as your deductible). Since tax credits are based on your projected household income and typically paid in advance to the insurance company, there is a chance you may have to repay some or all tax credits on your tax return if your income for the year ends up higher than anticipated.

Tax credits are not available to those eligible for "affordable, minimum value" medical coverage. "Minimum value" means our plan is intended to pay, on average, at least 60% of the costs of medical care received. "Affordable" means our lowest-cost minimum value plan costs you no more than 9.5% (indexed annually) of your household income to be enrolled in single (not family) coverage.

Notices

PUBLIC HEALTH INSURANCE MARKETPLACE *(Continued)*

Our plan is intended to be affordable and minimum value. As a result, if you or someone in your family wanted to compare your health insurance options in the public Marketplace to the insurance offered through us, you'll need to remember that:

- You might pay full retail price for public Marketplace insurance (without the new tax credits)
  a) You would no longer be paying for insurance on a pre-tax basis
  b) You would no longer have an employer contribution toward your insurance (note that employer contributions are typically excludable from income for federal income tax)
- You would navigate any questions you have directly with the insurance company you choose…HR will not be able to assist you with your public Marketplace plan
- Should you desire to come back to our plan in the future, you will either need to:
  a) experience a "qualifying event" recognized by our plan as a mid-year election change, or
  b) wait until our next annual open enrollment

WELLNESS SCREENING PLAN

We sponsor a voluntary wellness screening for employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act (HIPAA), as applicable, among others.

If you choose to participate in the wellness screening, you will be asked to complete a voluntary health risk assessment that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test, and a follow-up meeting with a health coach. You are not required to complete the assessment, blood test, or other medical examinations.

However, employees who choose to participate in the wellness screening will receive an incentive of 10% medical premium reduction for completing the biometric screening, health risk assessment, and health consultation. Although you are not required to complete the assessment or biometric screening, only employees who do so will receive the incentive.

The information from your assessment and biometric screening will be used to provide you with information to help you understand your current health and potential risks.

Notices

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

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

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

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

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness screening, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact HR.

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of1995 (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 (0MB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by 0MB under the PRA, and displays a currently valid 0MB control number, and the public is not required to respond to a collection of information unless it displays a currently valid 0MB 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 0MB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email *ebsa.opr@dol.gov* and reference the 0MB Control Number 1210-0137.

Notices

SPECIAL MEDICAL ENROLLMENT RIGHTS AND RESPONSIBILITIES UNDER HIPAA

When you are eligible to participate in our group medical plan, you may have to enroll and agree to pay part of the premium through payroll deduction in order to actually participate.

A federal law called the Health Insurance Portability and Accountability Act (HIPAA) requires that we notify you of your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

SPECIAL ENROLLMENT PROVISION

- **Loss of Eligibility under Medicaid or a State Children's Health Insurance Program (CHIP).** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while coverage under Medicaid or CHIP is in effect, you may be able to enroll yourself and your dependents in this plan **if eligibility is lost for the other coverage**. However, **you must request enrollment within 60 days** after the other coverage ends.
- **Loss of Eligibility for Other Coverage.** If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other medical coverage is in effect, you may be able to enroll yourself and your dependents in this plan if eligibility is lost for the other coverage (or if the employer stops contributing toward it). However, **you must request enrollment within 30 days** after the other coverage ends (or after the employer stops contributing toward it).
- **New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.** If you have a new dependent as a result of marriage, birth, adoption, or placement with you for adoption, you may be able to enroll yourself and your new dependents. However, **you must request enrollment within 30 days** after the marriage, birth, adoption, or placement for adoption.
- **Eligibility for Medicaid or CHIP State Premium Assistance Subsidy.** If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through CHIP with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, **you must request enrollment within 60 days** after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact HR.

Notices

PREMIUM ASSISTANCE UNDER MEDICAID OR THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	Indiana – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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 (1-866-444-3272)

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