electrical and mechanical contractor

B.J. Baldwin Electric

EMPLOYEE BENEFITS GUIDE

January 1, 2024 – December 31, 2024

CONTENTS

B.J. Baldwin Electric strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of our benefits – that's why we've put together this Open Enrollment Guide.

Open Enrollment is a short period each year when you are permitted to make changes to your annual benefit elections. This guide will outline all the different benefit options, so you can identify which offerings are best for you and your family.

Benefit elections you make during open enrollment will become effective on 1/1/2024. If you have questions about any of the benefits stated in this guide, please do not hesitate to reach out to Human Resources, or The Graham Company Service Line at 1-888-842-1488.

HIGHLIGHTS

- The dental insurance carrier has changed from Delta Dental to **Lincoln Financial**. Both plans, the PPO Base Plan and PPO Buy-Up Plan, will continue to offer the same level of benefits.
- There will continue to be two medical plan options: Base Plan and Buy-Up Plan. Both plans will continue to be administered by Trustmark/ELAP.

OPEN ENROLLMENT CONSIDERATIONS

Open Enrollment begins on **11/15/23** and runs through **12/1/23**. The benefits you choose during Open Enrollment will become effective on 1/1/2024.

ENROLLMENT CONSIDERATIONS

If you have questions about any of the benefits stated in this guide, please do not hesitate to reach out to Sharon Lockwood, or The Graham Company Service Line at 1-888-842-1488.

WHO IS ELIGIBLE?

All full-time employees working 30 or more hours per week are eligible for health, dental, vision, and the FSA.

DEPENDENT COVERAGE

In addition to electing coverage for yourself, you can elect to cover your eligible dependents. Your eligible dependents include your spouse, your children up to age 26 regardless of student status, and your children of any age who are mentally or physically disabled and depend upon you for support.

QUALIFIED CHANGE OF STATUS

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period.

Qualifying events include (but are not limited to):

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

HOW TO ENROLL?

Please complete the enrollment form by December 1st if you wish to make changes to your current elections and/or enroll in the Flexible Spending Account. If you do not complete an enrollment form, your current elections will rollover into 2024.

MEDICAL PLANS

There will continue to be two medical plan options: Base Plan & Buy-Up Plan. Administered by Trustmark/ELAP.

	Base Plan	Buy-Up Plan
Medical Deductible *(Single/Family)*	$2,000/$4,000	$0/$0
Benefit Level *(Coinsurance)*	90%	100%
Out-of-Pocket Max *(Single/Family)* ***UPenn***	$7,150/$14,300 $5,500/$11,000	$7,150/$14,300 $5,500/$11,000
Lifetime Maximum	Unlimited	Unlimited
OFFICE VISITS		
Primary Doctor Visit **UPenn**	$20 Copay $15 Copay	$20 Copay $15 Copay
Specialist Visit **UPenn**	$40 Copay $30 Copay	$40 Copay $30 Copay
Telehealth	$0	$0
Preventive Care	100%	100%
HOSPITAL CARE		
Inpatient Hospital Care **UPenn**	90% after deductible	$500/day up to 5 days $385/day up to 5 days
Outpatient Surgery **UPenn**	90% after deductible	$250 Copay $190 Copay
Emergency Room	$500 Copay	$500 Copay
OTHER SERVICES		
Complex Imaging **UPenn**	$250 Copay $190 Copay	$250 Copay $190 Copay
Lab/Radiology **UPenn**	$0/$40 Copay $0 Copay	$0/$40 Copay $0 Copay
Urgent Care **UPenn**	$80 Copay $60 Copay	$80 Copay $60 Copay
PRESCRIPTION DRUG *Retail (30-day supply)*		
Generic	$10 Copay	$10 Copay
Formulary	$30 Copay	$30 Copay
Non-Formulary	$50 Copay	$50 Copay
Specialty	80% Coinsurance	80% Coinsurance
Mail Order	2.5x Retail Copay	2.5x Retail Copay

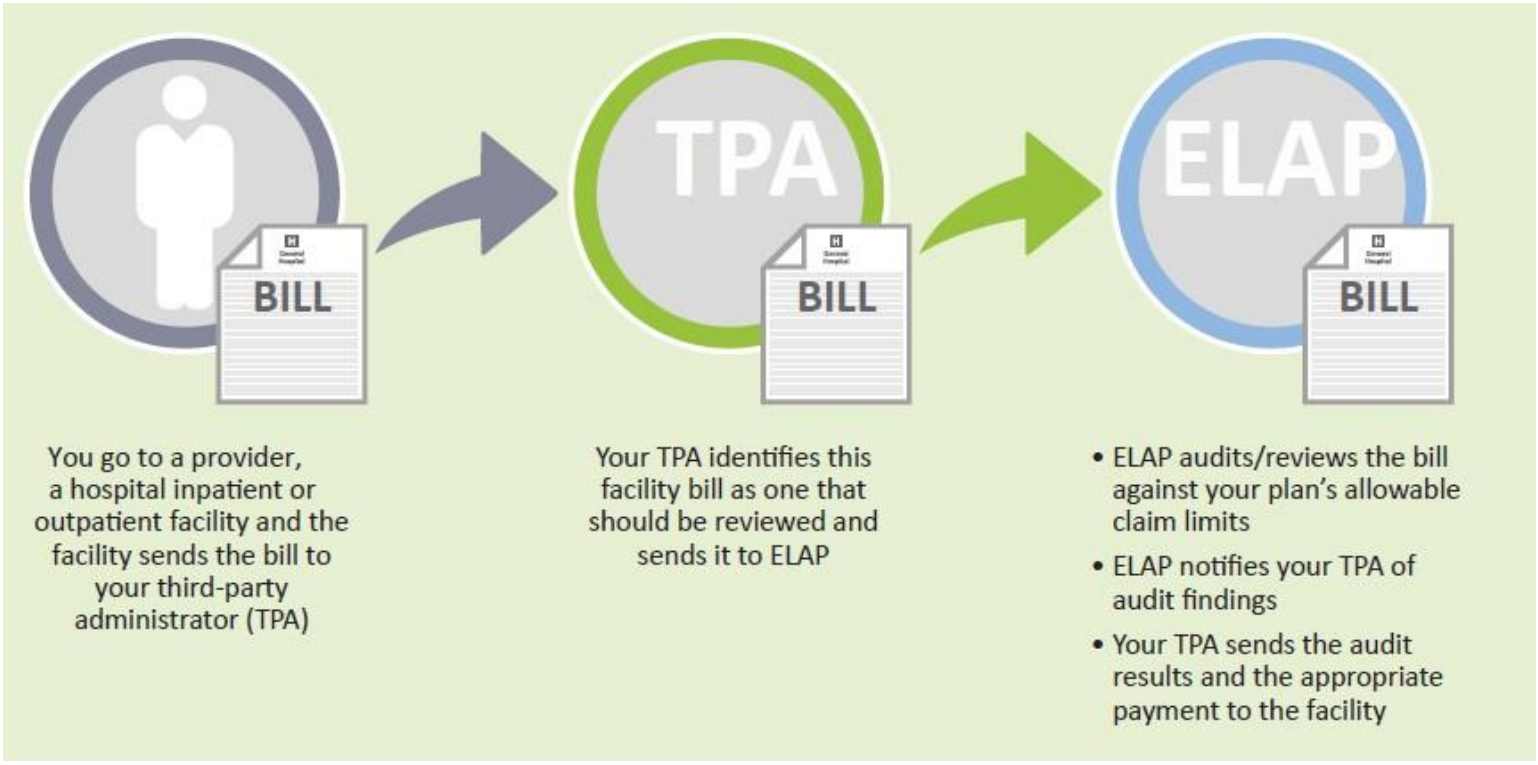
EMPLOYEE CONTRIBUTIONS (weekly)	Base Plan	Buy-Up Plan
Employee Only	$67.09	$87.69
Employee/Spouse	$135.69	$177.37
Employee/Child(ren)	$120.02	$156.89
Family	$136.79	$178.82

IMPORTANT INFORMATION: *Plan provisions are for illustrative purposes only. Please see plan documents for a full listing of plan coverage, exclusions, and limitations. The plan document will provide the final determination of benefits.

ELAP 101: How it Works

In order to keep hospital/facility care affordable, ELAP partners with your health plan to establish and enforce fair limits on what it will pay for health care services. Our goal is to ensure fair and accurate payment that save you money.

ELAP manages the medical plan by auditing all provider/hospital/facility claims line-by-line. When they identify charges that exceed the plan's allowable claim limits, ELAP will notify the member and the facility.



BALANCE BILLING

And How ELAP Helps

If ELAP discovers the plan is overcharged for care, they will send a notification letter informing the plan member that they are reducing payment and to look out for any balance bills.

ELAP will advise plan members to look out for balance billing in the following ways:

- Compare the amount owed according to the Explanation of Benefits (EOB) statement to the bill you receive from your healthcare provider.

- If the bill(s) from the provider exceed(s) the amount owed as shown on your EOB, ELAP will work to resolve the issue

In the event you receive a balance bill, it's extremely important that you take action with ELAP **immediately**.

- Members should review and send all balance bills, collection notices, and any other related correspondence received to ELAP right away

- ELAP's expert team will work on behalf of you and request that 2 forms be signed and returned:
  Signed HIPAA form for medical records release
  Signed Attorney-Client Representation Agreement

- An ELAP member Service Advocate will work closely with you throughout the entire process. ELAP's legal experts will help work on resolving the balance billing issue.

ELAP Member Services: 1-800-977-7381

balancebills@elapservices.com

TELEHEALTH

MEET OUR DOCTORS

Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 20 years experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & Flu symptoms
- Allergies
- Sinus problems
- Sore Throat
- Respiratory infection
- Skin problems
- And more!

WHEN CAN I USE TELADOC

Teladoc does not replace your primary physician it is a convenient and affordable option for quality care

- You need care now
- If you're considering the ER or urgent care for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short term prescription refills

Teladoc.com

Available on the iPhone App Store

ANDROID APP ON Google play

1.800.TELADOC (835-2362)

FLEXIBLE SPENDING ACCOUNTS (FSA)

As an employee of BJ Baldwin, you have the opportunity to contribute to a Flexible Spending Account (FSA). Ameriflex administers the FSA for BJ Baldwin.

- FSAs allow employees to reduce taxable income by setting aside pre-tax dollars to pay for qualified healthcare and dependent care expenses.

- Healthcare FSA: **$3,200 maximum annual contribution (2024)**
  - Eligible expenses include health plan deductibles and coinsurance, medical, dental, vision, prescriptions, and limited over-the-counter products.
- Dependent Care FSA: **$5,000 maximum annual contribution** ($2,500 if married and filing separate tax returns)
  - Eligible expenses include after school programs, nursery/preschool tuition, daycare, etc.
- Contributed through payroll deductions
- Visit fsastore.com for an easy way to shop online for FSA eligible products.

- **FSAs have a "use it or lose it" provision.**
- **Employees may only carry over $640 of unused healthcare FSA funds into the next plan year**

CONVENIENCE CARD

If you choose to participate in the health care flexible spending account, you will receive an Ameriflex Convenience Card. The card gives you easy access to the funds in your employee-benefit account. You cannot use it at an ATM or to obtain "cash back" when making a purchase. You can use the card at Healthcare-related merchants, such as physician and dentist offices, vision care providers and hospitals.

HEALTH CARE FSA

The Health Care FSA allows you to use pre-tax dollars to pay for eligible healthcare expenses incurred by you or any other person whom you claim as a dependent on your federal income tax return. Set aside monies in your Health Care FSA for anticipated medical, prescription drug, dental and vision care expenses that are not covered at 100% by the health insurance plan.

DEPENDENT CARE FSA

If you have children, a disabled spouse, or elderly relatives, you know how important it is to have reliable and affordable care for them while you are at work. As long as you use dependent care services on a regular basis, you can take advantage of the Dependent Care FSA to help you pay for these expenses and get a tax break at the same time.

For an itemized list of eligible expenses that are reimbursable through your FSA account, visit www.irs.gov

DENTAL PLANS

(NEW!) Lincoln Financial

New for 2024, BJ Baldwin is offering dental through a new insurance carrier – **Lincoln Financial.** All members will have access to the Lincoln DentalConnect PPO network with the same two plan options offered in 2023: The PPO Base Plan or The PPO Buy-Up Plan

With these plans, you have the flexibility to receive dental treatment from any dentist you choose, either participating or non-participating. However, you will experience cost savings by utilizing in-network dentists.

	LINCOLN DENTAL BASE PLAN		LINCOLN DENTAL BUY-UP PLAN	
BENEFIT OVERVIEW	**IN-NETWORK (PPO)**	**OUT-OF-NETWORK**	**IN-NETWORK (PPO)**	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE (single/family)	$50 / $150		$50 / $150	
ANNUAL MAXIMUM	$1,500 / $1,000		$1,500 / $1,000	
COVERED SERVICES **PREVENTATIVE:** Exams, X-rays, Cleanings, Fluoride Treatment	100%	100%	100%	100%
BASIC: X-rays, Fillings, Emergency palliative treatment, Simple Extractions	100%	80%	100%	80%
MAJOR: Crowns, Bridges, Dentures, Prosthetics, Inlays/Onlays	Not Covered	Not Covered	60%	50%
ORTHODONTIA	Not Offered		50% up to a Lifetime Maximum of $1,000	
EMPLOYEE CONTRIBUTIONS (weekly) **EMPLOYEE ONLY**	$1.56		$3.46	
EMPLOYEE/SPOUSE	$3.46		$7.28	
EMPLOYEE/CHILD(REN)	$3.78		$9.96	
FAMILY	$5.80		$14.60	

*Out-of-network payments are made at the 90th percentile of Usual and Customary Charges.

The above is a brief description of the most commonly used benefits. It does not include all benefits, maximums, and/or limitations. Please refer to the carrier plan documents for more detail. The insurance company and Certificate of Coverage/Plan Documents will provide the final determination of benefits. Any discrepancies, the carrier plan document prevails.

VISION PLAN

NVA

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems. BJ Baldwin's vision insurance thru NVA entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

BENEFIT OVERVIEW		PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
VISION EXAM (every 12 months)		Covered 100%	Reimbursement up to $32
FRAMES (every 24 months)		Retail allowance up to $110; 20% discount off balance	Reimbursement up to $30
LENSES (every 12 months)	Single	Covered 100%	Reimbursement up to $24
	Bifocal	Covered 100%	Reimbursement up to $36
	Trifocal	Covered 100%	Reimbursement up to $46
	Progressive	Covered 100%	Reimbursement up to $50
MEDICALLY REQUIRED CONTACTS		Covered 100%	Reimbursement up to $225
CONTACTS IN LIEU OF GLASSES		Up to $110 Retail; 15% discount conventional or 10% discount disposable balance	Reimbursement up to $85
EMPLOYEE CONTRIBUTIONS (weekly)	Employee Only	$1.71	
	Employee/Spouse	$3.08	
	Employee/Child(ren)	$3.08	
	Family	$4.44	

The above is a brief description of the most commonly used benefits. It does not include all benefits, maximums, and/or limitations. Please refer to the carrier plan documents for more detail. The insurance company and Certificate of Coverage/Plan Documents will provide the final determination of benefits. Any discrepancies, the carrier plan document prevails.

BASIC LIFE AND DISABILITY

BASIC LIFE INSURANCE:

Life insurance can help provide for your loved ones if something were to happen to you. BJ Baldwin provides full-time employees with $10,000 in group life and accidental death and dismemberment (AD&D) insurance.

LONG TERM DISABILITY:

One of the most important assets you can protect is your income. What would you do if a sickness or injury left you unable to come to work and earn your paycheck? In the event that you become disabled from an injury or sickness, disability income benefits will provide a partial replacement of lost income.

1in8	2.8	12.6%
workers will be disabled for five or more years during their working careers	years is about the average long-term disability absence	of the American population is classified as disabled (39.7 million)

	VOLUNTARY LONG-TERM DISABILITY
EMPLOYEE CONTRIBUTION REQUIRED	100% Employee Paid
ELIMINATION PERIOD	180 Days
BENEFIT DURATION	The calendar month when you reach normal retirement age as determined by Social Security.
BENEFIT AMOUNT	60% of monthly pre-disability earnings to a max of $6,000

The above is a brief description of the most commonly used benefits. It does not include all benefits, maximums, and/or limitations. Please refer to the carrier plan documents for more detail. The insurance company and Certificate of Coverage/Plan Documents will provide the final determination of benefits. Any discrepancies, the carrier plan document prevails.

SHORT-TERM DISABILITY BUY-UP

STD BUY-UP:

B.J. Baldwin will continue to provide eligible employees the option to enroll in a voluntary short-term disability buy-up benefit:

	SHORT-TERM DISABILITY BUY-UP
BENEFIT	60% of weekly earnings up to a maximum of $750/week
ELIMINATION PERIOD	7 days
BENEFIT DURATION	25 weeks

PLEASE NOTE:

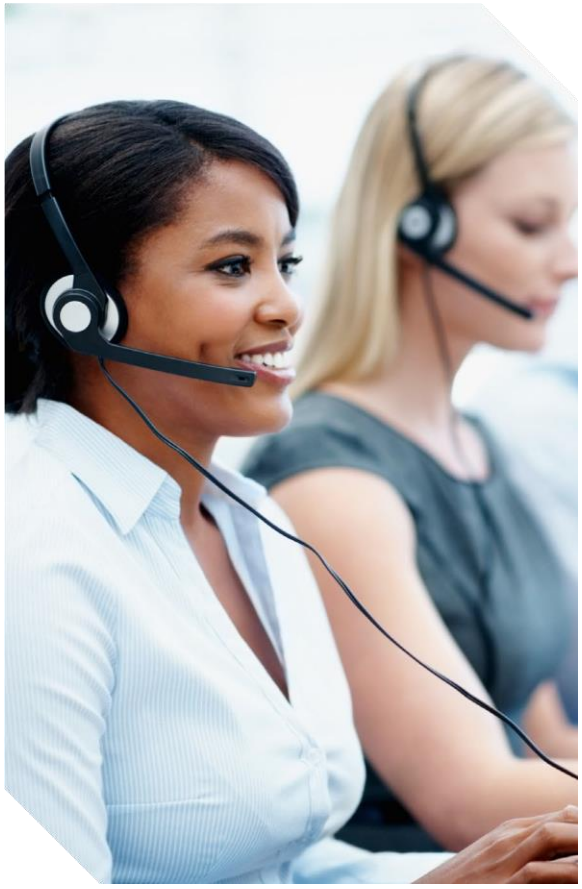
- This benefit will be 100% employee paid
- The current employer-paid Short-Term Disability benefit is $350/week

The above is a brief description of the most commonly used benefits. It does not include all benefits, maximums, and/or limitations. Please refer to the carrier plan documents for more detail. The insurance company and Certificate of Coverage/Plan Documents will provide the final determination of benefits. Any discrepancies, the carrier plan document prevails.

CARRIER CONTACTS

CARRIER NAME	CONTACT #	WEBSITE
Carrier Name	**Contact #**	**Website**
Trustmark	800-848-3012	www.mytrustmarkbenefits.com
ELAP	800-977-7381	www.ELAPservices.com Balancebills@elapservices.com
Express Scripts (RxBenefits)	800-334-8134	RxHelp@rxbenefits.com www.rxbenefits.com
Teladoc	800-835-2362	www.teladoc.com
Lincoln	800-423-2765	www.lincolnfinancial.com
NVA	800-672-7723	www.e-nva.com
Ameriflex	888-868-3539	www.myameriflex.com
The Hartford	800-523-2233	www.thehartford.com

CUSTOMER SERVICE RESOURCES



EMPLOYEE BENEFIT SERVICE LINE

Employees that have inquiries related to claim payment, coverage explanations and eligibility are encouraged to call the insurance company as a first step to resolve the inquiry. If you feel that you still need assistance after contacting the insurance company, The Graham Company, BJ Baldwin's insurance broker, provides a call center to assist employees with inquiries related to claim payment, coverage explanations and eligibility. The Graham Company Employee Benefits Service Line can answer inquiries related to Medical Insurance, Dental Insurance, Life and Disability Insurance.

The service line is staffed Monday through Friday from 9:00 AM to 5:00 PM EST. (Bilingual representative available.)

1.888.842.1488 (toll free)

BenefitsAssist@grahamco.com

GRAHAM COMPANY®

A Marsh & McLennan Agency LLC Company

YOUR PLAN RIGHTS

NEW HEALTH INSURANCE MARKETPLACE COVERAGE NOTICE

OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

Due to the Affordable Care Act, there is another 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 Marketplace and employment-based health coverage offered by BJ Baldwin Electric, Inc.

1. 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. Open enrollment for health insurance coverage through the Marketplace typically begins in October for coverage starting as early as January the following year.

2. 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 you are not offered coverage by BJ Baldwin Electric, Inc. The savings on your premium that you're eligible for depends on your household income.

3. Does BJ Baldwin Electric, Inc Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you are eligible for the BJ Baldwin Electric, Inc Health Plan, it meets the standards required under the law. You will not be eligible for a tax credit through the Marketplace and may wish to enroll in the BJ Baldwin Electric, Inc Plan.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by BJ Baldwin Electric, Inc then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after - tax basis.

How Can I Get More Information?

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.

PART B: Information About Health Coverage Offered by BJ Baldwin Electric, Inc

This section contains information about any health coverage offered by BJ Baldwin Electric, Inc. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

If you are not eligible for health insurance coverage through you and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

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.

3. EMPLOYER NAME	**B.J. Baldwin Electric**		4. EMPLOYER IDENTIFICATION NUMBER		
5. EMPLOYER ADDRESS	7060 Division HWY		6. EM PLOYER PHONE NUMBER	717-354-4651	
7. CITY	Narvon	8. STATE PA		9. ZIP CODE	17555
10. WHO CAN WE CONTACT ABOUT EMPLOYEE HEALTH COVERAGE AT THIS JOB?				Sharon Lockwood	
11. PHONE NUMBER	717-354-4651		12. EMPLOYER NAME	**B.J. Baldwin Electric**	

YOUR PLAN RIGHTS

Here is some basic information about health coverage offered by this employer:

1. As your employer, we offer a health plan to:
   - ❑ All employees. Eligible employees are:

   - ❑ Some employees. Eligible employees are:
   - ➢ Employees regularly working 30 hours or more a week are benefit eligible after a 90-day waiting period

   - ❑ With respect to dependents:
   - ➢ We do offer coverage. Eligible dependents are:
   - ➢ Your eligible dependents include your spouse, your children up to age 26 regardless of student status, and your children of any age who are mentally or physically disabled and depend upon you for support

   - ❑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

WOMEN'S RIGHTS AND CANCER ACT NOTICE

Special Rights Following Mastectomy. A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and treatment of physical complications of mastectomy.

Our Plan complies with these requirements. Benefits for these items generally are comparable to those provided under our Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.
Contact Sharon Lockwood for more information.

NEWBORNS AND MOTHER'S HEALTH PROTECTION ACT

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).

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2009

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:

The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA):

The Genetic Information Nondiscrimination Act of 2008 (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 a 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.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA):

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets.

NOTICE OF PATIENT PROTECTIONS:

Trustmark generally requires 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 information on how to select primary care provider, and for a list of participating primary care providers, contact Trustmark at **800-848-3012.**

For children, you may designate a pediatrician as the primary care provider for the Trustmark Medical Plan.

You do not need prior authorization from Trustmark or from any other person(including a primary care provider) in order to obtain access to obstetrical or gynecological care from health care professional in our network who specializes in obstetrics and gynecology. The health care professional, however, may be required to comply with certain procedure, including obtaining prior authorization for certain services, following a pre-approved treatment plan , or procedures for making referrals. For a listing of participating healthcare professionals who specialize in obstetrics or gynecology, contact Trustmark at **800-848-3012**.

NOTICE REGARDING SPECIAL ENROLLMENT

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

LOSS OF OTHER COVERAGE

If you are declining coverage 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 after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

MARRIAGE, BIRTH OR ADOPTION

If you have a new dependent as a result of a 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 after the marriage, birth, or placement for adoption.
Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.
Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

FOR MORE INFORMATION OR ASSISTANCE

To request special enrollment or obtain more information, please contact:

NAME	Sharon Lockwood
ADDRESS	7060 Division HWY
CITY, STATE	Narvon, PA
TELEPHONE	717-354-4651

HIPAA PRIVACY NOTICE

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.

PRIVACY OBLIGATIONS OF THE PLAN

The Plan is required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of the Plan's legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following are the different ways the Plan may use and disclose your PHI:

- For Treatment. The Plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise emergency room physicians about the types of prescription drugs you currently take.
- For Payment. The plan may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Plan's terms. For example, the Plan may receive and maintain information about surgery you received to enable the Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.
- To the Plan Sponsor. The Plan may disclose your PHI to designated personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to designated HR personnel so that they can carry out related administrative functions. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the Plan to any other employee or department and (2) will not be used for any employment related actions and decisions or in connection with any other sponsored employee benefit plan.
- To a Business Associate. Certain services are provided to the Plan by third party administrators known as "business associates." For example, we may forward information about your health care treatment to our broker to assist with the claim processing. In doing so, we will disclose your PHI to the broker so he/she can perform their claim payment function. However, we will require its business associates to appropriately safeguard your health information.
- Health-Related Benefits and Services. The Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.
- Personal Representative Involved in Your Care. The Plan may also advise a family member or close friend about your condition, your location (for example that you are in the hospital) or death.
- As Required by Law. The Plan will disclose your PHI when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.

SPECIAL USE AND DISCLOSURE SITUATIONS

The Plan may also use or disclose your PHI under the following circumstances:

- Lawsuits and Disputes. The Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful process.
- Law Enforcement. The Plan may release your PHI if asked to do so by a law enforcement official (for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime).
- Workers' Compensation. The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

The plan is required to obtain plan participants' authorization to use or disclose psychotherapy notes, to use PHI for marketing purposes, to sell PHI, or to use or disclose PHI for any purpose not described in the notice. The Plan Administrator must obtain this authorization from the plan participant in writing. The plan participant my revoke this authorization anytime in writing by contacting the Plan Administrator at the address below:

Sharon Lockwood

7060 DIVISION HWY NARVON PA 17555

717-354-4651

HIPAA PRIVACY NOTICE (CONTINUED)

PROHIBITED USE OF PHI

The plan is prohibited from using PHI that is genetic information for underwriting purposes

YOUR RIGHTS REGARDING YOUR PHI

Your rights regarding PHI the Plan maintains about you are as follows:

- Right to Inspect and Copy. You have the right to inspect and copy PHI maintained by the Plan. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not included psychotherapy notes. To inspect and copy PHI maintained by the Plan, you must submit your request in writing to the Plan Administrator. The Plan may charge a fee for the cost of copying, mailing, or other costs associated with your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

- Right to Request Restrictions. You have the right to request a restriction on the health information the Plan uses or discloses about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan disclosed about you to someone who is involved in your care, like a family member or friend. (For example, you could ask that the Plan not use or disclose information about a surgery you had.) To request restrictions, you must make your request in writing to the Plan Administrator. You must advise us: (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply. Note: The Plan is not required to agree to your request.

- Right to be Notified of a Breach. You have the right to receive notice if there has been a breach of your unsecured protected health information.

- Right to Amendments to Your PHI. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be submitted in writing to the person listed below.

- Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures. Your request to for an accounting must be submitted in writing to the person listed below.

- Right to Request Confidential Communications. You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger.

- Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may write to the Plan Administrator to request a written copy of this notice at any time.

If you wish to make any of the above-listed requests, you may write to the Plan Administrator at the address listed below in the Contact Information section.

Changes to this Notice: The Plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Plan already has about you, as well as any information the Plan receives in the future. The Plan will post a copy of the current notice on the Intranet.

Complaints: If you believe your privacy rights under this policy have been violated, you may file a written complaint with Human Resources at the address listed below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, generally, within 180 days of when the act or omission occurred.

HIPAA PRIVACY NOTICE (CONTINUED)

Other Uses and Disclosures of Health Information: Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plan will be made only with your written authorization. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization, however, the Plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information:

If you have any questions about this notice, please contact:

SHARON LOCKWOOD

7060 DIVISION HWY NARVON PA 17555

717-354-4651

Notice Effective Date: 1/1/2022

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

INTRODUCTION

You are receiving 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 generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

Read this notice carefully to help understand your COBRA rights. Keep in mind that 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice does not fully describe COBRA continuation coverage or other rights under the Plan. For additional and more complete 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 does not 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 known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage.

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or You become divorced or legally separated from your spouse. In the event your spouse, who is the employee, reduces or terminates your coverage under the Plan in anticipation of a divorce or legal separation that later occurs, the divorce or legal separation may be considered a qualifying event even though the coverage was reduced or terminated before the divorce or separation.

DEPENDENT CHILDREN Your dependent children (including any child born to or placed for adoption with you during the period of COBRA coverage who is properly enrolled in the Plan and any child of yours who is receiving benefits under the Plan pursuant to a qualified medical child support order) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- 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."

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS (CONTINUED)

RETIREE COVERAGE

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Company, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. 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;
- COMMENCEMENT OF A PROCEEDING IN BANKRUPTCY WITH RESPECT TO THE COMPANY;] OR
- The employee's becoming entitled to Medicare benefits (under Part A, Part B or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Sharon Lockwood. The Plan procedures for this notice, including a description of any required information or documentation, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, you will lose your right to elect COBRA continuation coverage.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives timely 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. If COBRA continuation coverage is not elected within the 60-day election period, a qualified beneficiary will lose the right to elect COBRA continuation coverage. COBRA continuation coverage is a temporary continuation of coverage.

- When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of 36 months.
- When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Also, when the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

DISABILITY EXTENSION

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, there will be no disability extension of COBRA continuation coverage. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS (CONTINUED)

SECOND QUALIFYING EVENT EXTENSION

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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both) or gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. 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.

The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, there will be no extension of COBRA continuation coverage due to a second qualifying event.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA?

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 contact or contacts identified below. For more information about your rights under 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.

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

[NAME] has determined that the prescription drug coverage offered by [NAME] is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current NAAA coverage may (or may not) be affected. Please contact us for more information about what happens to your coverage if you decide to enroll in a Medicare Part D program. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will (or will not) be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with UnitedHealthcare and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility

ALABAMA – Medicaid
http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Website:
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
CHP+ Customer Service: 855-692-6442

FLORIDA – Medicaid
Website:https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website:https://medicaid.georgia.gov/healthinsurancepremiumpayment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Website: https://dhs.iowa.gov/ime/members
Phone:1-800-338-8366
Hawki Website: http://dhs.iowa.gov/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

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program(KI-HIPP)
Website:https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207(Medicaid hotline) or 1-855-6185488(LaHIPP)

MAINE – Medicaid
http://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

Continued on next page

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

MASSACHUSETTS – Medicaid and CHIP

Website:http://www.mass.gov/info-details/masshealth-premium-assistance-pa

Phone: 1-800-862-4840

MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MINNESOTA – Medicaid
http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: https://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/ombp/nhhpp/
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website:http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4247, or 401-462-0311 (Direct Rite Share line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.org/en/famis-select
https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website:https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA– Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website:https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021 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

1(888) 842-1488
www.grahamco.com
benefitsassist@grahamco.com