Davis
STAFFING, INC.

Navigating Your 2019 Benefits

Contents

WELCOME!

Welcome to your 2019 benefits! Use this benefits guide as a resource to compare plans and learn more about the coverages available to you.

If you have questions about your benefits, SISCO is available to help and can be reached at (844) 631-6104.

ELIGIBILITY

You're eligible for benefits on the first of the month following 60 days of employment if you are scheduled to work 30 hours or more per week.

You may enroll your eligible dependents in the same plans you choose for yourself. Eligible dependents include your legal spouse and your children up to age 26.

WHEN TO ENROLL

You can enroll for coverage within 30 days of your eligibility date or during the annual Open Enrollment period.

If you don't enroll for coverage within 30 days of your eligibility date, you won't receive health coverage during the plan year, unless you have a qualified change in family status (see Making Changes for details).

MAKING CHANGES

The choices you make when you are first eligible are in effect for the remainder of the plan year which ends on December 31. Once you enroll, you must wait until the next Open Enrollment period to change your benefits or add or remove coverage for dependents, unless you have a qualified change in family status as defined by the IRS. The following are a few examples:

- Marriage, divorce, legal separation, annulment or death of spouse
- Birth, adoption or placement for adoption
- Change in your residence or workplace (if your benefit options change)
- Loss of other health coverage
- Change in your dependent's eligibility status because of age, student status or any similar circumstance

MEDICAL COVERAGE YOU CAN COUNT ON

Take great care of your health through annual preventive care visits with your doctor. Review the medical plan options below to choose the plan that's best for you based on your medical needs and expenses in the upcoming plan year.

Plan Features	**MVP**
	In-Network Only
Network	Cigna Choice Fund PPO
Deductible	
Individual	$3,000
Family	$6,000
Out-of-Pocket Maximum	(Includes deductible)
Individual	$6,350
Family	$12,700
Coinsurance	60% / Not Covered
Preventive Care	Covered in full
Primary Care Visit	60% after deductible
Specialist Visit	60% after deductible
Emergency Room	60% after deductible
Diagnostic Lab & X-ray	60% after deductible
Advanced Imaging	60% after deductible
Inpatient Hospital Services / Surgery	60% after deductible
Prescription Drugs: Retail (up to a 30-day supply)	
Generic	$10 after deductible
Brand Formulary	$35 after deductible
Non-Formulary	$70 after deductible
Prescription Drugs: Mail Order (up to a 90-day supply)	
Generic	$20 after deductible
Brand Formulary	$70 after deductible
Non-Formulary	$150 after deductible

MEC Basic

In-Network Only

Covers *only in-network* preventive care. All in-network preventive care is paid at 100%.

Take great care of your health through annual preventive care visits with your doctor. Review the medical plan options below to choose the plan that's best for you based on your medical needs and expenses in the upcoming plan year.

This is only a brief summary of the plans. For more details, including limitations and exclusions, please contact Human Resources for a Summary Plan Description.

MEDICAL INDEMNITY PLANS*

Unexpected accidents or illness can happen at any time. For employees and their families interested in supplementing their medical coverage to protect against expenses for covered accidents or illnesses, enroll in one of the medical indemnity plans listed below.

Plan Features	Medical Indemnity Plan 1	Medical Indemnity Plan 2	Medical Indemnity Plan 3
Hospital Admission 1st Day	$500 per day, 1 day per year	$1,000 per day, 1 day per year	$1,500 per day, 1 day per year
Hospital Inpatient	$300 per day, 30 days per year	$500 per day, 30 days per year	$700 per day, 30 days per year
Intensive Care Unit	Hospital inpatient Benefit applies	Hospital inpatient benefit applies	Hospital inpatient benefit applies
Emergency Room Visit	$250 per day, 1 day per year	$300 per day, 1 day per year	$500 per day, 1 day per year
Doctor's Office Visits	$70 per day, 6 days per year	$80 per day, 6 days per year	$100 per day, 6 days per year
Outpatient Lab & X-ray	$50 per day, 1 day per year	$75 per day, 1 day per year	$100 per day, 1 day per year
Outpatient Advance Studies	$150 per day, 3 days per year	$200 per day, 3 days per year	$300 per day, 3 days per year
Inpatient Surgical	$1,000 per day, 1 day per year	$1,500 per day, 1 day per year	$2,000 per day, 1 day per year
Inpatient Surgical Anesthesia	$250 per day, 1 day per year	$375 per day, 1 day per year	$500 per day, 1 day per year
Outpatient Surgical	$500 per day, 1 day per year	$750 per day, 1 day per year	$1,000 per day, 1 day per year
Outpatient Minor Surgical	$75 per day, 1 day per year	$100 per day, 1 day per year	$150 per day, 1 day per year
Outpatient Surgical Anesthesia	$125 per day, 1 day per year	$188 per day, 1 day per year	$250 per day, 1 day per year

*These products are not qualifying health coverage ("Minimum Essential Coverage") that satisfies the health coverage requirement of the Affordable Care Act. The termination or loss of this policy does not entitle you to a special enrollment period to purchase a health benefit plan that qualifies as minimum essential coverage outside of an open enrollment period. These products may include a pre-existing condition exclusion provision.

About Independence American Insurance Company

Independence American Insurance Company is domiciled in Delaware and licensed to write property and/or casualty insurance in all 50 states and the District of Columbia. Its products include short-term medical, hospital indemnity, fixed indemnity limited benefit, group and individual dental, and pet insurance. Independence American is rated A- (Excellent) for financial strength by A.M. Best Company, a widely recognized rating agency that rates insurance companies on their relative financial strength and ability to meet policyholder obligations (an A++ rating from A.M. Best is its highest rating).

HOW TO FIND AN IN-NETWORK PROVIDER

MVP (TRUE COMPREHENSIVE MAJOR MEDICAL)

This is a major medical plan with comprehensive services including surgical benefits and hospitalization. Listed preventative care services are covered at 100%. For other services, including routine office visits, procedures, lab work, prescription drugs, etc., no benefits will be paid until you meet your annual deductible.
Search for a PPO provider under the Choice Fund PPO at https://ifphcpdir.cigna.com/web/public/ifpproviders.

MEC BASIC (PREVENTIVE CARE SERVICES ONLY)

The MEC basic plan provides In-Network preventive care services. Listed preventive care services are covered at 100% as long as your physician bills your visit as preventive.

Choose from a wide variety of doctor and hospitals at www.multiplan.com

TELADOC SERVICES SAVE YOU TIME AND MONEY

Teladoc's U.S. board-certified doctors are available 24/7/365 to resolve medical issues through phone or video consults (this service does not replace your primary care physician). Teladoc is a convenient and affordable option for quality health care. Some conditions Teladoc doctors can treat include, but are not limited to, cold and flu, allergies, bronchitis, urinary tract infection, respiratory infection, sinus problems and more!
After signing up for Teladoc, you will receive a welcome kit with instructions for setting up your account, completing your medical history, and requesting a consult.

	Enrolled in a medical plan	NOT enrolled in a medical plan
How to Enroll	Call (844) 631-6104 to activate or select the coverage when enrolling via BenefitElect	You must be enrolled in at least one voluntary plan: Dental or Short-Term Disability
Copay per Televisit	**MVP Plan Participants:** $45 copay per televisit	$0 copay per televisit
Weekly Cost per Employee	No charge (Included in your medical deduction)	$5.00

PRESCRIPTION DRUG CHANGES FOR 2019

WALGREENS 90-DAY MAINTENANCE PROGRAM & CASTIARX HOME ADVANTAGE SELECT (MAIL ORDER)

You have two options to fill your 90-day maintenance medications. You are allowed two 30-day fills at your retail pharmacy, then subsequent fills must be obtained either through the Exclusive Walgreens 90-day Maintenance Program at a Walgreens retail pharmacy or through CastiaRx's mail order pharmacy.

To obtain a prescription through the Exclusive Walgreens 90-day Maintenance Program, follow these steps:

1. Have your doctor write a 90-day prescription with refills and take it to a Walgreens retail pharmacy.
2. Take your ID card to your Walgreens pharmacy to ensure proper coverage and processing of your prescriptions.
3. Pay the appropriate copayment.

Save time and money through CastiaRx Home Advantage with three easy steps:

1. **Enroll:** Contact CastiaRx at (866) 516-2121 to register for mail order. After completion of the registration process, CastiaRx will contact your physician for a 90-day prescription with refills.
2. **Order:** Place your order or enroll in CastiaRx's auto refill program. Orders take 5-7 business days or more.
3. **Payment:** Payment must be received prior to prescriptions being released. For optimal results, agree to have a payment method remain on file.

NON-COVERED DRUGS: PROTON PUMP INHIBITORS (PPIS)

PPIs are a group of drugs used for the prevention and treatment of acid-related conditions. All PPI medications are available over-the-counter and will no longer be covered under the benefit plan.

VARIABLE SPECIALTY COPAY PROGRAM (VSCP)

For specialty medications dispensed by CastiaRx Specialty Pharmacy, CastiaRx will help you apply for copay assistance programs offered for your therapy to cover your out-of-pocket costs. If you qualify, the plan will cover the full cost of the medication and you will have a $0 copay for the calendar year. For specialty drugs not dispensed by the CastiaRx Specialty Pharmacy or if the copay assistance program is not available, you are responsible for the full applicable copayment or coinsurance.

STEP THERAPY FOR MEDICATIONS TO TREAT DIABETES

Save money by choosing generic and preferred brand medications to treat your diabetes condition. CastiaRx's Step Therapy Program helps you take advantage of the most cost-effective medication by requiring lower cost medications be tried first before more expensive drugs are covered. Ask your pharmacy to contact CastiaRx to start the step therapy process.

CASTIARX PREMIUM FORMULARY (NO CHANGES FOR 2019)

There will be no changes to the drug formulary (also known as a Preferred Drug List or PDL) for 2019. Be sure to visit the PDL at www.CastiaRx.com to help you and your doctor choose the most cost-effective medication(s) covered under your plan. For questions, contact Customer Service at 866-516-3121 or visit www.CastiaRx.com.

VOLUNTARY DENTAL COVERAGE WORTH SMILING ABOUT

Your voluntary dental insurance uses the DenteMax network of providers. Choose in-network dentists for the best coverage at the lowest rate. Find a DenteMax provider at www.dentemax.com or by calling (800) 753-0404. Employees are responsible for 100% of dental insurance premiums.

Plan Features	**Companion Life** (DenteMax Network)
	PPO Plan B
	In-Network
Calendar Year Deductible	$50
Calendar Year Maximum	$750
Diagnostic and Preventive Services (e.g., x-rays, cleanings, exams) *No waiting period*	Covered in full
Basic and Restorative Services (e.g., fillings, root canals) *3 month waiting period*	80%
Major Services (e.g., dentures, extractions, crowns, bridges) *12 month waiting period*	50%

***Note:** If you visit an out-of-network provider, you are responsible for charges above usual, customary, and reasonable (UCR) limits.

VOLUNTARY VISION COVERAGE FOR A CLEAR FUTURE

Your voluntary vision coverage uses the EyeMed vision network. Choose an in-network optometrist for the highest level of coverage for annual exams and glasses or contacts. Find an in-network provider at www.eyemed.com or by calling (866) 939-3633. Employees are responsible for 100% of vision insurance premiums.

Plan Features	**Companion Life** (EyeMed Vision Network)	
	In-Network	**Out-of-Network**
	You pay:	*Plan reimburses you:*
Exam (every 12 months)	$10 copay	Up to $35 reimbursement
Materials (every 12 months)	$10 copay	Varies depending on lens type
Frames (every 24 months)	Covered	Up to $45 reimbursement
Contact Lenses – in lieu of frames (every 12 months)	Covered	Up to $64 reimbursement

LIFE AND AD&D INSURANCE COVERAGE FOR PEACE OF MIND

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

Basic Life and AD&D insurance through Companion Life offers peace of mind and protects your family financially in the event of death or serious accident. **When you choose MVP plan option, you'll receive $10,000 of employee only Basic Life and AD&D coverage at no extra cost. This benefit is not included in the MEC or Hospital Indemnity coverage.**

VOLUNTARY BENEFITS

VOLUNTARY LIFE AND AD&D INSURANCE

You can buy additional Life insurance through Companion Life at group rates. Consider funeral expenses, legal expenses, and general living expenses for surviving family members when choosing additional coverage amounts.

Plan details:

- Voluntary Group Term Life insurance is equal to $20,000 for employees and $5,000 for spouse. You can elect coverage for dependent children in the following amounts:
  - Dependent children 6 months to 26 years: $2,500
  - Dependent children 10 days to 6 months: $100
- AD&D insurance is equal to the Life insurance amount
- Employees pay 100% of the insurance premium in the following amounts:

Important!

Review and update your beneficiary information as situations may change.

Voluntary Life Insurance Monthly Rates per $1,000	
Employee Only	$4.60
Employee + Spouse	$5.51
Employee + Child(ren)	$5.51
Family	$5.51

VOLUNTARY SHORT-TERM DISABILITY (STD)

An injury or illness could strike at any time and leave you unable to work. Protect you and your family financially in the event of a short-term injury or illness with Companion Life Benefits Voluntary Short-Term Disability (STD) coverage.

Plan details:

- The STD benefit begins after 7 days of an illness or injury
- STD pays up to 60% of pre-disability earnings to a maximum of $650 per month
- Benefit duration is 26 weeks
- Employee pays 100% of the insurance premium at $3.92 per week

IMPORTANT NOTICES

COBRA CONTINUATION OF COVERAGE NOTICE

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator. For additional information regarding COBRA qualifying events, how coverage is provided, and actions required to participate in COBRA coverage, please see your Human Resources department.

NEWBORNS' AND MOTHERS' 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 (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

SPECIAL ENROLLMENT EVENTS

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is elected. Please be aware that most special enrollment events require action within 30 days of the event.

Please see Human Resources for a list of special enrollment opportunities and procedures.

GINA

The Genetic Information Nondiscrimination Act (GINA) prohibits health benefit plans from discriminating on the basis of genetic information in regard to eligibility, premiums, and contributions. This generally also means that private employers with more than 15 employees, its health plan, or "business associate" of the employer, cannot collect or use genetic information (including family medical history information). The one exemption would be that a minimum about of genetic testing results may be used to make a determination regarding a claim.

You should know that GINA is treated as protected health information (PHI) under HIPAA. The plan must provide that an employer cannot request or require that you reveal whether or not you have had genetic testing; nor can you employer require you do participate in a genetic test. An employer cannot use any genetic information to set contribution rates or premiums.

PRESCRIPTION COVERAGE AND MEDICARE

This notice has information about your current prescription drug coverage with your company 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. 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.
2. Your company has determined that the prescription drug coverage offered by the Staffing Exchange is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current non-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.

For More Information About 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).

NOTICE OF PRIVACY PROVISION

This Notice of Privacy Practices (the "Notice") describes the legal obligations of The Sedona Group (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:
(1) your past, present, or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact your Human Resources department. The full privacy notice is available with your Human Resources Department.

AFFORDABLE CARE ACT (ACA)

Did you know that every American is required to have health insurance coverage as of 1/1/2014? Should you choose not to insure yourself, you could be looking at an annual penalty.

If you choose to go without health insurance coverage:
The 2019 penalty will 0% of your family income.

Open enrollment is now for your company sponsored health plan. Being open enrollment time, it is your one time of year, without a qualified life event, to enroll in the health coverage and avoid paying this penalty. The coverage that is offered through the company is fully compliant per the ACA regulations.

Should you want to explore individual health insurance options outside of your employer group plan(s), the federal exchange has an open enrollment period from 11/01/18 - 12/15/18. You can access the exchange by logging on to www.healthcare.gov if you're interested in researching individual policies today.

Should you waive health coverage during the company's open enrollment period, you will not be eligible to enroll until next year's annual open enrollment period.

USERRA NOTICE

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) established requirements that employers must meet for certain employees who are involved in the uniformed services. In addition to the rights that you have under COBRA, you (the employee) are entitled under USERRA to continue the coverage that you (and your covered dependents, if any) had under The Sedona Group Plan.

You Have Rights Under Both COBRA and USERRA. Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give you different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures described in the attached COBRA Election Notice also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

Definitions

"Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency. "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System.

Duration of USERRA Coverage

General Rule: 24-Month Maximum. When a covered employee takes a leave for service in the uniformed services, USERRA coverage for the employee (and covered dependents for whom coverage is elected) can continue until up to 24 months from the date on which the employee's leave for uniformed service began. However, USERRA coverage will end earlier if one of the following events takes place: A premium payment is not made within the required time; You fail to return to work or to apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

USERRA and Health FSAs

USERRA's continuation coverage requirements for health plans apply to health FSAs. USERRA has no special rules for health FSAs. For example, the limited COBRA obligation for certain health FSAs (as described in the attached COBRA Election Notice) does not apply under USERRA— under USERRA, the right to continuation coverage generally lasts for up to 24 months (unless one of the events described above takes place).

COBRA and USERRA Coverage Are Concurrent

This means that COBRA coverage and USERRA coverage begin at the same time. However, COBRA coverage can continue for up to 18 months (it may continue for a longer period and is subject to early termination, as described in the attached COBRA Election Notice). In contrast, USERRA coverage can continue for up to 24 months.

Premium Payments for USERRA Continuation Coverage

If you elect to continue your health coverage pursuant to USERRA, you will be required to pay 102% of the full premium for the coverage elected (the same rate as COBRA), at the times and using the procedures specified in the attached COBRA Election Notice. However, if your uniformed service period is less than 31 days, you are not required to pay more than the amount that you pay as an active employee for that coverage.

For the full USERRA notice of rights, which includes details regarding periods of uniformed service as it relates to report-to-work requirements, please see Human Resources.

PREMIUM ASSISTANCE UNDER MEDICAID AND 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, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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

OMB Control Number 1210-0137 (expires 12/31/2019)

QUESTIONS? YOUR BENEFIT CONTACTS

Benefit	Contact	Phone	Website
General Benefits Information	SISCO Call Center	(844) 631-6104	N/A
Online Enrollment	BenefitElect	(844) 631-6104	N/A
Medical	SISCO Call Center	(844) 631-6104	N/A
Medical Indemnity	SISCO Call Center	(844) 631-6104	N/A
Telemedicine	Teledoc	(844) 631-6104	N/A
Prescription Drug	CastiaRx Pharmacy Solutions	(866) 516-2121	www.CastriaRx.com
Voluntary Dental	SISCO Call Center	(844) 631-6104	www.companionlife.com
Voluntary Vision	SISCO Call Center	(844) 631-6104	www.companionlife.com
Basic Life and AD&D	SISCO Call Center	(844) 631-6104	www.companionlife.com
Voluntary Life and AD&D, Short-Term Disability, and Critical Illness	SISCO Call Center	(844) 631-6104	www.companionlife.com
Accident	IHC	(844) 631-6104	www.ihcgroup.com
COBRA	SISCO Call Center	(844) 631-6104	N/A

This communication highlights your benefit plans. Your actual rights and benefits are governed by the official plan documents. If any discrepancy exists between this communication and the official plan documents, the plan documents will prevail. Your employer reserves the right to change any benefit plan without notice. Benefits are not a guarantee of employment.