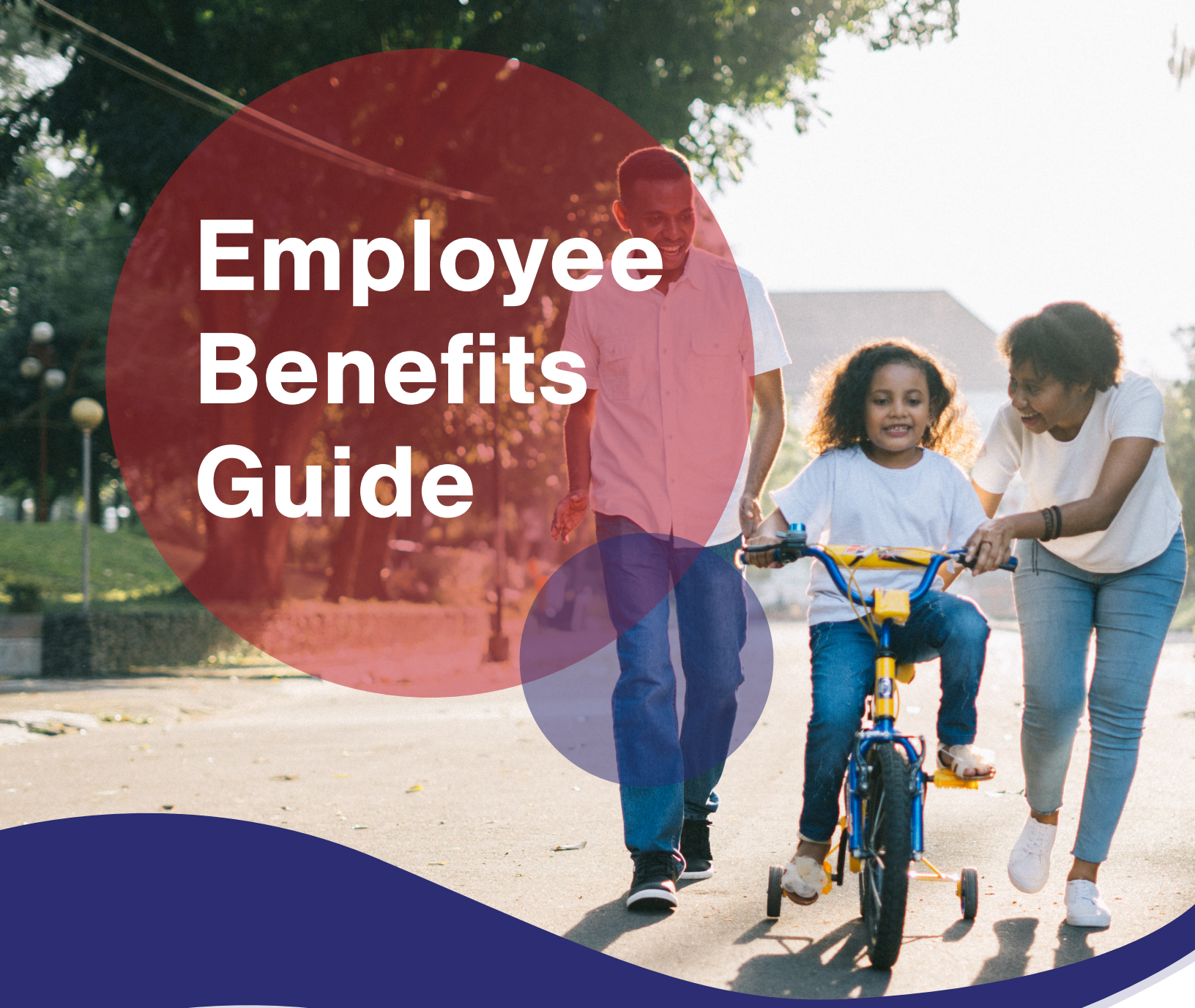

Employee Benefits Guide

Visit
https://kvgo.com/psa/Alko2020
or scan the QR code with your smartphone to view a short presentation about your benefits.

ALKO

2020

April 1, 2020–March 31, 2020

Eligibility

Employees

Full-time employees working at least 30 hours per week are eligible for medical and dental benefits. If you are a new hire, you will be eligible for medical and dental benefits on the first of the month following 60 days of employment.

Eligible Dependents

In addition to yourself, you may also enroll any eligible dependents. Eligible dependents are defined below:

- **Spouse:** a person to whom you are legally married by ceremony.
- **Dependent Children:** your biological, adopted, or legal dependents up to age 26 regardless of student, financial, and marital status. Dependent coverage terminates at the end of the month in which the dependent ceases to meet the definition of an eligible dependent.

Resources

Plan	Phone Number	Website/Email
Medical Cigna	1 -800-244-6224	**www.cigna.com**
Dental CareFirst	1-866-891-2802	**www.carefirst.com**
Health Reimbursement Arrangement Innovative Health Services	1-888-769-8787	**www.innovativehealthservices.com**
Benefit Questions PSA Insurance & Financial Services	1-877-716-6618 Monday–Friday, 8:30 a.m.–5 p.m. ET.	**benefitshotline@psafinancial.com**

2020–2021 Payroll Deductions

Based on 26 Pays

	OAP 5000	OAP HSA	Dental
Employee	$132.78	$57.00	$6.58
Employee + Child(ren)	$358.50	$268.28	$17.76
Employee + Spouse	$478.01	$358.07	$23.67
Family	$674.52	$505.73	$33.41

Making Changes

The benefits plan year runs April 1 through March 31. The elections you make will remain in effect through March 31, 2021 unless you, your spouse, or your dependent child(ren) experience a qualified change-in-status event. Some examples of qualified change-in-status events are listed below:

- Legal marital status, including marriage and divorce
- Number of covered dependents due to birth, death, adoption, granting of legal custodianship, or reaching maximum age for coverage
- Involuntary loss of other health coverage
- Gain/loss of health coverage for spouse or dependent

You must notify the Human Resources Department within 30 days of the qualified change-in-status event in order to make a change to your benefit elections. A benefit change must be consistent with the qualified change-in-status event. Documentation supporting the change will be required.

Important Notice about Your Prescription Drug Coverage and Medicare—see page 8

Please read it and share it with any of your Medicare-eligible dependents.

This communication highlights some of the benefit plans available at Alko Distributors. 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 official plan documents will always govern. Alko Distributors reserves the right to change any benefit plan without notice. Benefits are not a guarantee of employment.

Cigna Member Resources

Get the most out of your medical plan with value-added resources from Cigna.

myCigna.com

When you're better informed, you can make better choices. Cigna's personalized website, **www.mycigna.com**, provides access to your plan information, as well as many online tools with information to help you make more informed health decisions. Want to find out how to improve your fitness or eat better? Cigna's online tools can help you stay active and take care of your health.

Cigna Mobile app

The myCigna mobile app gives you an easy way to organize and access your important health information—anytime, anywhere. Download the free app and gain instant access to multiple services.

24/7 Medical Advice

Cigna Virtual Care

Good news! Your Cigna medical plans provide you with access to two virtual care services: **American Well** (**AmWell**) and **MDLIVE**. This service is virtual care services designed to offer you greater control when you need to see a doctor.

With Cigna Virtual Care, you can get the care you need—including most prescriptions—for a wide range of minor conditions. You can connect with a board-certified doctor when, where, and how it works best for you—via video or phone—without having to leave home or work.

AmWell and MDLIVE televisits can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. Costs are the same or less than a visit with a primary care provider.

- **Choose when:** Day or night, weekdays, weekends, and holidays
- **Choose where:** Home, work, or on the go
- **Choose how:** Phone or video chat
- **Choose who:** AmWell or MDLIVE doctors

You are encouraged to register for one or both services, so you're ready when and if you need care. Signing up is easy. Set up and create an account with one or both AmWell (**AmWellforCigna.com**) and MDLIVE (**MDLIVEforCigna.com**) complete a medical history using their "virtual clipboard," and download AmWell for Cigna App and MDLIVE for Cigna App to your smartphone/mobile device.

24-Hour Health Information Line

The 24-Hour Health Information Line (HIL) assists individuals in understanding the right level of treatment at the right time. Trained nurses are available 24 hours a day, seven days a week, 365 days a year to provide health and medical information and direction to the most appropriate resource.

To speak with a nurse, call **1-866-494-2111**.

Know before you go—when you need care

Your Doctor Knows Best

- Your personal physician best understands your health.
- Having a personal physician can result in overall better care.

But what if you get sick or injured when your doctor's office is closed?

Cigna Members—24/7 Medical Advice

- The Health Information Line provides advice on a diagnosis or where to receive care.
- Cigna Virtual Care gives you access to virtual doctor visits for common, uncomplicated, non-emergency health issues.

Urgent Care Centers

- Urgent care centers are usually open after normal business hours, including evenings and weekends.
- Many urgent care centers offer on-site diagnostic tests.
- In most situations, you'll find that you save time and money by going to urgent care instead of the ER.

Emergency Room (ER)

- This is the best place for treating severe and life-threatening conditions.
- Emergency rooms provide the most expensive type of care.

Medical and Prescription Plan Highlights

No PCP or referrals required!

Medical and prescription drug coverage is offered through **Cigna**. Your costs and copays for certain services are shown below. For full plan details, please refer to your Cigna plan summary.

To locate a participating provider visit **www.cigna.com**. Click "Find a Doctor, Dentist, or Facility" and then "Employer or School." Enter your location and search criteria—be sure to select the appropriate plan.

Plan Features	OAP 5000		OAP HSA	
	In-Network; You Pay	**Out-of-Network; You Pay**	**In-Network; You Pay**	**Out-of-Network; You Pay**
Plan Year Deductible Amount you pay per plan year before the plan begins to pay for services subject to the deductible	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family	$5,500 Individual $11,000 Family	$10,000 Individual $15,000 Family
Plan Year Out-of-Pocket Maximum Maximum amount you pay toward covered medical & prescription expenses per plan year	$6,350 Individual $12,700 Family	$15,000 Individual $20,000 Family	$6,550 Individual $13,100 Family	$13,100 Individual $25,000 Family
Preventive Care Services	No charge	Deductible, then 20%; Well-child: 20%	No charge	Deductible, then 20%; Well-child: 20%
Office Visits, Labs, and Testing				
PCP Office Visit	$20 copay	Deductible, then 20%	Deductible, then $25 copay	Deductible, then 50%
Specialist Office Visit	$20 copay	Deductible, then 20%	Deductible, then $50 copay	Deductible, then 50%
Outpatient Diagnostic Lab Test/X-Ray	Deductible, then no charge	Deductible, then 20%	Deductible, then 30%	Deductible, then 50%
Complex Imaging (MRI, CT scans)	Deductible, then no charge	Deductible, then 20%	Deductible, then $100 copay	Deductible, then 50%
Mental Health/Substance Abuse Office Visit	$20 copay	Deductible, then 20%	Deductible, then $50 copay	Deductible, then 50%
Emergency Care and Hospitalization				
Urgent Care	$20 copay	$20 copay	Deductible, then $75 copay	Deductible, then $75 copay
Emergency Room (Copay waived if admitted)	Deductible, then no charge		Deductible, then $300 copay	
Inpatient Facility	Deductible, then no charge	Deductible, then 20%	Deductible, then 30%	Deductible, then 50%
Outpatient Surgery	Deductible, then no charge	Deductible, then 20%	Deductible, then 30%	Deductible, then 50%
Prescription Drug Coverage				
Prescription Plan Year Deductible	$200 Individual /$400 Family		Combined with medical deductible	
Retail 30-Day Supply				
Tier 1	Deductible, then $15 copay		Deductible, then $15 copay	
Tier 2	Deductible, then $35 copay		Deductible, then $50 copay	
Tier 3	Deductible, then $60 copay		Deductible, then $100 copay	
Tier 4	Deductible, then $80 copay		Deductible, then $100 copay	
90-Day Supply (Mail Order/Retail)				
Tier 1	Deductible, then $30 copay		Deductible, then $30 copay	
Tier 2	Deductible, then $70 copay		Deductible, then $100 copay	
Tier 3	Deductible, then $120 copay		Deductible, then $200 copay	
Tier 4	Deductible, then $160 copay		Deductible, then $200 copay	

This chart is intended for comparison purposes only. For a comprehensive listing of what is covered and not covered under the plan, please refer to the plan document. If there are any discrepancies, the plan document will govern.

Dental Plan Highlights

The dental plan is offered through **CareFirst**. You have the freedom to select the dentist of your choice; however, when you visit a participating dentist, you will have lower out-of-pocket costs, no balance billing, and claims will be submitted by your dentist on your behalf. The chart below shows your costs as a member for certain services under the plan. Please refer to your CareFirst plan description for full details.

To locate a participating provider visit **www.carefirst.com/doctor**. Either log in or continue as a guest. Under "Browse by Category," select Dental and enter your location and search criteria.

BlueDental Plus Plan Features	In-Network; You Pay	Out-of-Network; You Pay
Plan Year Deductible Amount you must pay before the plan begins to pay benefits	$25 Individual $75 Family	$50 Individual $150 Family
Plan Year Benefit Maximum Maximum amount the plan will pay per plan year	Plan pays up to $1,500 per member per plan year	
Preventive Services	No charge, no deductible	No charge*, no deductible
Basic Services	Deductible, then 20%	Deductible, then 20%*
Major Services	Deductible, then 50%	Deductible, then 50%*
Orthodontia Adults and children	50%, no deductible Plan pays up to $1,500 lifetime maximum per member	

This chart is intended for comparison purposes only. For a comprehensive listing of what is covered and not covered under the plan, please refer to the plan document. If there are any discrepancies, the plan document will govern.

*Out-of-network providers may balance bill you for the difference between what the plan pays and their usual fees.

Health Reimbursement Arrangement (HRA)

A Health Reimbursement Arrangement (HRA) is an account that is used for eligible medical expenses—funded by Alko Distributors. You do not contribute to this account.

If you are enrolled in the OAP 5000 plan, Alko Distributors funds the entire prescription drug deductible ($200/individual or $400/family) and the entire in-network deductible ($5,000/individual or $10,000/family).

The HRA is administered through **Innovative Health Services** and you will receive a debit card to access the HRA funds.

Your deductible/HRA

Your HRA pays first when you have an eligible medical or pharmacy expense that is subject to the deductible.

If you spend all of your HRA money, any additional out-of-pocket expenses are your responsibility.

Your insurance coverage

Once you meet the deductible, the insurance plan pays a majority of expenses—you pay the rest, either a small percentage or a fixed copay.

Your out-of-pocket maximum

After the plan maximum has been reached, the plan will pay 100% of remaining covered expenses. The deductible, medical coinsurance, and prescription copays apply toward the out-of-pocket maximum.

Health Savings Account (HSA)

Available to employees who enroll in the OAP HSA medical plan

When you enroll in the OAP HSA high deductible health plan, you are eligible to set up a Health Savings Account (HSA). An HSA can help you save money by allowing you to pay for health care expenses with tax-free dollars. You can use the funds to pay for qualified health care expenses, such as medical and prescription drug expenses until you meet your deductible, coinsurance, copays, and other out-of-pocket expenses including dental and vision expenses, for you and your tax dependents—even if they are not enrolled in your medical plan!

To open an HSA, you must meet the below eligibility criteria:

- You must be covered by an HSA-compatible health plan, and you cannot be covered by any other medical plan or coverage that is not an HSA-compatible health plan. This would include being enrolled in your spouse's non-HDHP plan as secondary coverage, Medicare coverage, an executive medical plan, or your or your spouse's Health Care FSA offered through another employer.
- You must not be eligible to be claimed as a dependent on another individual's tax return.
- You must be enrolled in the plan on the first day of the month (otherwise, your eligibility to make contributions to your HSA begins the first day of the following month). If you are eligible as of December 1, under the last month rule you may make the maximum annual HSA contribution for the year regardless of the month you became eligible. Any contributions made under the last month rule will be subject to a testing period during which you must maintain HSA eligibility in the following year in order for the contribution to remain tax favored.

Funding your HSA

To fund your HSA, you can make deposits using one of the methods below:

- Tax deductible contributions
- Rollover funds from another HSA
- One-time trustee-to-trustee transfer from your IRA

The IRS establishes a limit that you can contribute per year. The limits are based on whether you have the individual or family coverage under the qualifying medical plan.

Coverage Tier	2020 Limits
Individual	$3,550
Family	$7,100

Individuals over age 55 may make an additional "catch-up" contribution of $1,000 per year.

Please note the limits are based on a calendar year and subject to change each year based on IRS regulations.

Reasons to love an HSA

- Triple tax savings
  - You can contribute to your HSA using tax-free dollars.
  - You can use the money in your HSA to pay for health care expenses with tax-free money.
  - Whatever you don't use in a year rolls over to the next year, and earns tax-free interest!
- You decide how and when to use the funds in your account. You can use the funds to pay for your health care expenses or save them for future health care costs.
- The account may be used to build funds for retirement. Once you reach age 65, you can withdraw the money for non-medical reasons without a penalty.

Want to learn more about HSAs?

Scan the QR code with your smartphone or tablet, or visit **https://kvgo.com/psa/HSA101** to view a short presentation.

How the Medical Plan and HSA work together

Preventive care covered 100% by the Health Plan

In-network preventive care is covered at 100% with no deductible. You pay $0 out-of-pocket for your annual physical, well-woman visit, mammogram, colonoscopy, routine immunizations, preferred preventive drugs, and other eligible services.

Pay for other medical expenses

You pay for additional medical and prescription drug expenses as you incur them until your annual deductible is met.

Use your HSA

You can use the funds in your HSA to pay for qualified health care expenses, such as medical and prescription drug expenses, until you meet your deductible, coinsurance, copays, and other out-of-pocket expenses, including dental and vision expenses.

Important Reminders

- To pay for qualified expenses, your HSA must be opened prior to incurring those expenses.
- You may not have any other health insurance coverage (including through your spouse, a Health Care FSA, or Medicare).
- You are responsible for reporting your HSA contributions and/or distributions on your annual tax filing.
- Keep your receipts in case they are needed by the IRS to verify eligible expenses.

Eligible HSA Expenses

The below is a partial list of allowable expenses for an HSA, according to IRS guidelines.

- Prescription drugs or insulin
- Prescribed birth control
- Medical equipment, such as a wheelchair, crutches, artificial limbs, and wigs (where prescribed by a physician for mental health or due to hair loss because of disease)
- Treatments and therapies, such as treatment for alcoholism or drug addiction, acupuncture to treat a medical condition, physical therapy, and smoking cessation programs
- Dental and orthodontic care, such as x-rays, braces, and dentures
- Vision care expenses, including eye exams, eyeglasses, and contacts
- Hearing aids
- Assistance for the handicapped, such as a guide dog, braille book, and home or car equipment
- Mental health institute treatment
- Other fees and services such as hospital services, home care services, laboratory fees, surgical fees, x-rays, and chiropractic fees

Please consult your tax advisor should you require specific tax advice.

This list is subject to change. A complete list of eligible expenses is available on the IRS website at **www.irs.gov**.

Important Notice About Your Prescription Drug Coverage and Medicare

If you and your covered dependents are not currently covered by Medicare and will not become covered by Medicare within the next 12 months, this Notice is for informational purposes only.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Alko Distributors 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.
2. Alko Distributors has determined that the prescription drug coverage offered by Alko Distributors through UnitedHealthcare 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 through 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 coverage with Alko Distributors will not be affected. You can keep this coverage if you join a Medicare drug plan and this plan will coordinate with your Medicare drug coverage. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your Medical and prescription drug coverage through Alko Distributors, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period.

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 Alko Distributors 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.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed on this notice for further information. 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 Alko Distributors 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).

Date:	April 1, 2020
Sender:	Alko Distributors
Contact - Position:	Joanne Almsteadt
Address:	8801 Kelso Drive, Baltimore, MD 21221
Phone:	410-391-4270 ext. 39

Remember: Keep this 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 January 31, 2020. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: 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: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-800-541-5555

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHIP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-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: http://www.indianamedicaid.com
Phone: 1-800-403-0864

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

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 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"]
Phone: 1-800-657-3739

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

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

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

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

NEW JERSEY – Medicaid and CHIP
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

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

NORTH CAROLINA – Medicaid
Website: https://medicaid.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 and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

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

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, 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://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/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, 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

Required Notice

Women's Health and Cancer Rights Act of 1998

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). WHCRA requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. 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.

Breast reconstruction benefits are subject to deductibles and coinsurance limitations that are consistent with those established for medical and surgical benefits under the plan.

Health Insurance Portability and Accountability Act (HIPAA)

This group health plan complies with the privacy requirement for Protected Health Information (PHI) under HIPAA. A copy of the Notice of Privacy Practices is available from the insurance carriers for medical and dental insurance.

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Special Enrollment Rights

If you are declining enrollment for yourself, or your dependents (including your spouse) because of other health insurance or other group health plan coverage, you may be able to enroll yourself and/or 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' coverage). However, you must request enrollment within 30 days after your previous coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.

If you or your dependent lose eligibility for coverage under Medicaid or a State child health plan or if you or your dependent become eligible for State-sponsored premium assistance for the medical plan, you may be able to enroll yourself and/or your dependents in this plan if you request enrollment within 60 days of the date of termination of Medicaid or State child health plan coverage or your eligibility for premium assistance.