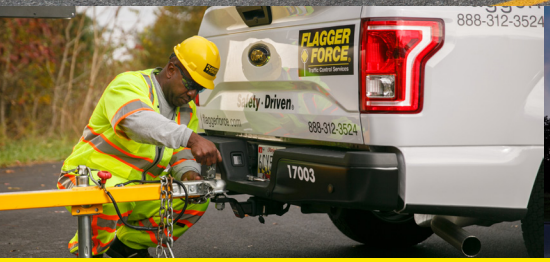
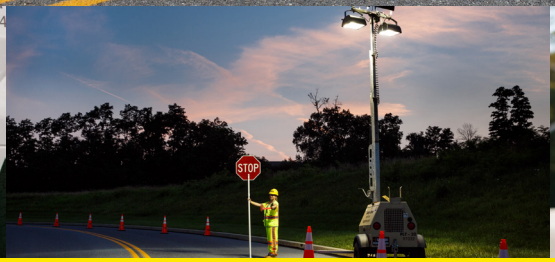
FF Benefits

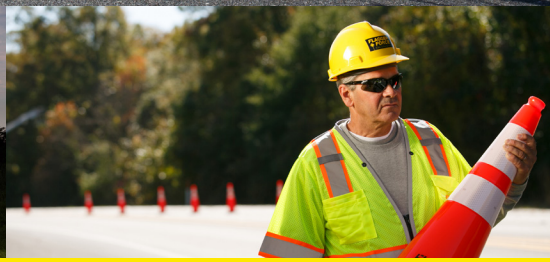
Guide to Your

2019-2020 Benefits

Field Staff







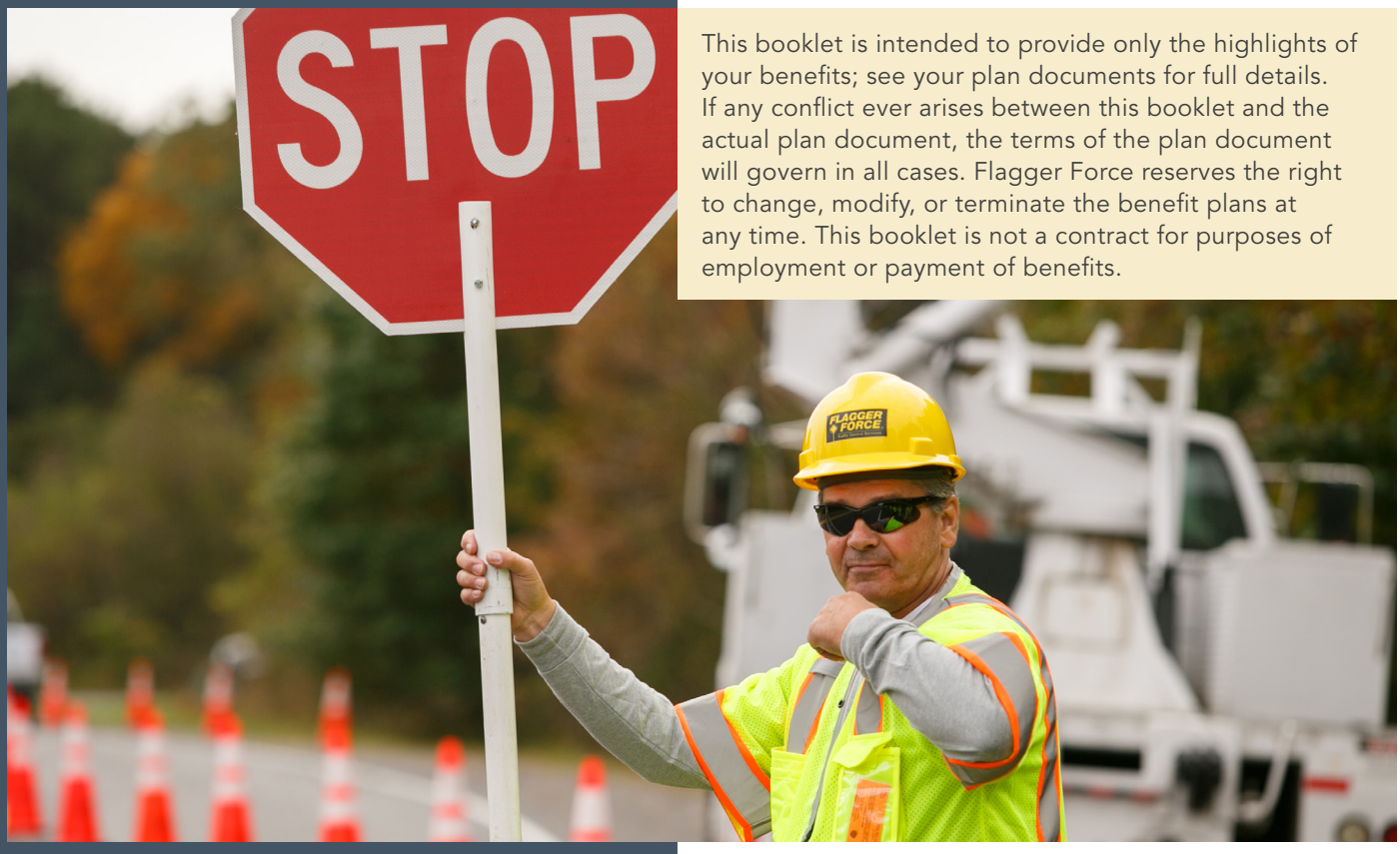
September 1, 2019 — August 31, 2020

Table of Contents

Welcome to the Flagger Force - Field Staff Benefits Program

Flagger Force is pleased to present this overview of your employee benefits. We offer a variety of benefits to help you protect your health, your family, and your way of life.

Your benefits are a valuable part of your compensation package. Please take the time to review this information carefully, along with the materials provided by the insurance carriers, and keep it handy for future reference. You may also contact the insurance carriers directly if you have any questions; their phone numbers and websites are listed under the Contact Information section.



This booklet is intended to provide only the highlights of your benefits; see your plan documents for full details. If any conflict ever arises between this booklet and the actual plan document, the terms of the plan document will govern in all cases. Flagger Force reserves the right to change, modify, or terminate the benefit plans at any time. This booklet is not a contract for purposes of employment or payment of benefits.

General Information

Who Is Eligible

To be considered full time and benefit eligible, an employee must average 30 or more hours worked per week, measured over a six (6) month period.

You may also enroll your eligible dependents for benefits. Generally, your eligible dependents are:

- Your legal spouse, as defined by federal law.
- Your children up to age 26. This includes your natural children, stepchildren, adopted children, and children for whom you are the legal guardian.
- Your mentally or physically disabled children over age 26 (if they depend on you for support). You will be required to provide appropriate documentation of their disability.

How To Enroll?

All enrollments/change requests must be submitted online using the KRONOS Employee Self Service site.

1. It is strongly recommended that you take the time to review the Enrollment Guide to make your election decisions before logging on to submit your elections.
2. Be sure you have dependent information ready, such as full names, dates of birth, and Social Security Numbers that will be required for any dependent coverage elected.
3. Once you have made your decisions and you are ready to submit elections online, go to **www.flaggerforce.com/benefits** and click "Enroll Now".

- If you cannot remember your Username, contact the Benefits Specialist for assistance at 717-256-9048.
- If you cannot remember your password, click the "Forgot your password?" link and follow the instructions. Contact the Benefits Specialist if you continue to have trouble.

NOTE: You MUST make an election for EVERY benefit type, even those you choose to waive.

4. Once you reach the "Confirm Selections" section, click "Save" then "Submit Request" to send your elections to Human Resources. If you fail to click "Submit Request", your enrollment/changes will not be received/processed by HR.

When Coverage Starts

New Employees. Flagger Force Field Staff are classified as variable-hour employees. To be considered full time and benefit eligible, an employee must average 30 or more hours worked per week, measured over a six (6) month period. If an employee qualifies, they will be offered the opportunity to join the plan following the six (6) month measurement period. Hours will be averaged each subsequent 6-month period to determine eligibility.

Open Enrollment. If you sign up for benefits during open enrollment, your coverage becomes effective September 1.

Changing Your Coverage During the Year

Once you enroll for coverage, you may not change or cancel your benefits until the next open enrollment period unless you have a "qualifying event," such as marriage, divorce, birth or adoption of a child, death of a dependent, or certain events that affect your dependent's insurance coverage (for example, your spouse losing his or her job). If you experience a qualifying event, you must contact Human Resources to change your coverage within 30 days of the event.

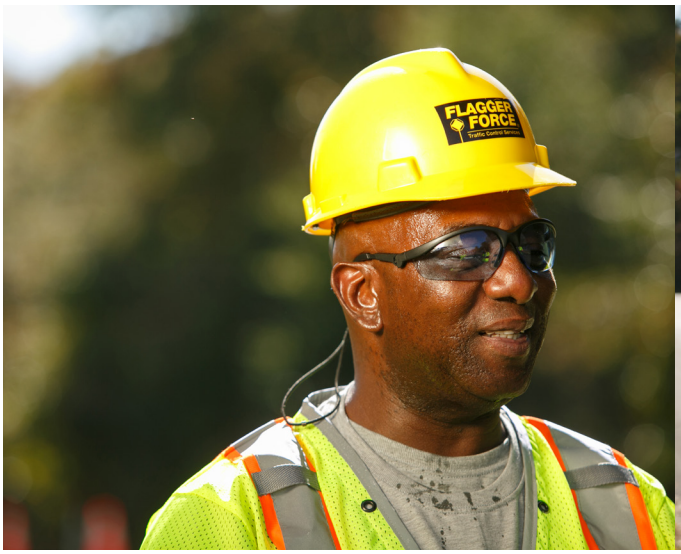
What's New in 2019

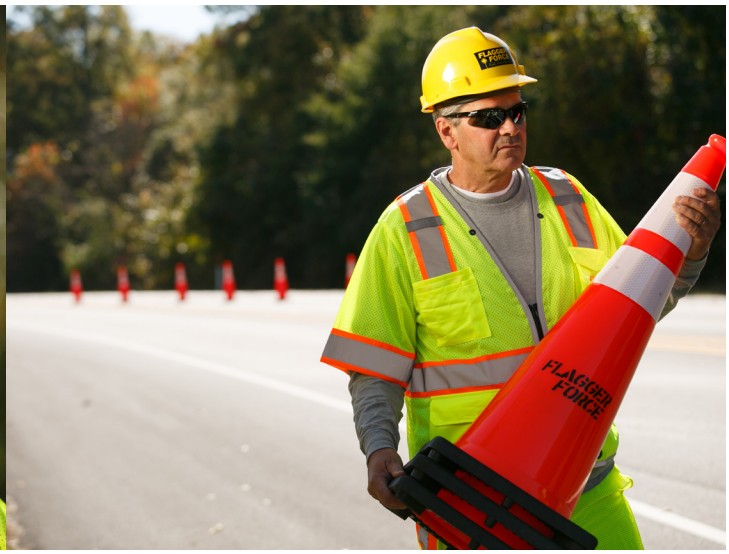
- New Consumer Value HDHP with HSA. This replaces the PPO 2700 with HSA Plan which is no longer offered.
- PPO 3000 and PPO 6000 will continue to be offered but have been renamed to Gold PPO and Silver PPO, respectively.
- Specialist Visit copay will be lowered from $40 to $30 for all three plans.
- Emergency Room copay will increase from $200 to $250 per visit for all three plans.
- If you go to an independent lab or free-standing facility (non-hospital), you will only pay a copay. Deductible is waived.
- Virtual Visits (Now with $0 copay for Gold and Silver PPO Plans): Convenient care everywhere from your phone, tablet, or computer, get treatment from a Virtual Care doctor or behavioral health specialist within minutes.

  Two ways to sign up:

  1. Download free Virtural Care app
  2. Visit **virtualcarecbc.com**

- Basic Life and AD&D will be one (1) times annual base earnings up to $100,000.
- NEW - Voluntary AD&D is a new benefit through Guardian
- Guardian will replace Mutual of Omaha and Colonial Life for Life insurance, Disability, Accident and Hospital Indemnity coverage. See Enrollment Booklet for more details.
  - **Basic Life Insurance** - 1x Annual Base Pay, up to $100,000.
  - **Voluntary Term Life Insurance** - you will have a one-time opportunity at open enrollment to elect coverage for you and your family up to a guarantee issue without evidence of insurability.
  - **Voluntary AD&D** - NEW benefit offered through Guardian.
  - **Voluntary Short Term Disability** will be offered in $100 increments up to a maximum of 60% of your weekly salary.
  - **Voluntary Long Term Disability** will be offered in $250 monthly increments up to $2,000; but it may not exceed 60% of your weekly salary.
  - **Accident Insurance** – benefits can help you with your medical deductibles, copays, and with household expenses.
  - **Hospital Indemnity** insurance helps provide financial peace of mind – if you are hospital confined due to an illness or injury this coverage will help pay for out-of-pocket healthcare costs or other household expenses which can pile up during a hospital stay.





Medical

Flagger Force offers comprehensive medical plan coverage through Capital Blue Cross. You have your choice of the following plans:

- Gold PPO - $3,000 deductible
- Silver PPO - $6,000 deductible
- Consumer Value HDHP - $3,500 individual deductible, $7,000 family deductible

How the Gold and Silver PPO Plans Work

The Gold and Silver PPO Plans are traditional PPO plans. A preferred provider organization (PPO) is a network of doctors and health care facilities that provide services to plan members at discounted rates. You can go to any doctor you like within the PPO network, including specialists, without a referral. In-network preventive care is covered in full.

If you go to an out-of-network provider, the plan will pay benefits based on Usual and Customary Rates (UCR) for a particular health care service in your geographic area. ***If your out-of-network provider charges more than the amount covered by the plan, you will have to pay all charges over that amount.***

How the Consumer Value HDHP Works

This is an HSA-compatible plan, which works very similar to the traditional PPO plans. The same network of doctors and hospitals are available and, outside of preventive care, you must satisfy the deductible before the plan pays for any medical services. ***If you enroll one or more dependents in the plan, you must pay the entire family deductible before the plan will begin paying benefits.***

Unlike the traditional PPO plans, you must pay the full discounted price for your prescriptions and medical care until you have met the deductible. After you have paid the deductible, you will pay copays for your prescription drug and certain medical expenses until you reach the out-of-pocket limit**. Please note certain preventative prescriptions are available with a copay before your meet your deductible. Please refer to the Health Savings Account Preventative Medication List for additional deta**ils.

In addition, enrolling in this plan automatically opens a Health Savings Account (HSA) to help pay for your medical expenses and prescription drugs while you are still paying your deductible. See page 6 for more information about HSAs.

If you go to an out-of-network provider, the plan will pay benefits based on Usual and Customary Rates (UCR) for a particular health care service in your geographic area. ***If your out-of-network provider charges more than the amount covered by the plan, you will have to pay all charges over that amount.***

The Medical Plan Detail charts on pages 7-9 shows the key benefits for each of the medical plans.

Availability of Summary Health Information

To help you make an informed choice, Capital Blue Cross makes available a Summary of Benefits and Coverage (SBC), for each plan option. The SBC summarizes important information about the plan's benefits, limitations and exclusions, in a standard format. It is a great resource as you compare your medical plan options, and is available **www.capbluecross.com**. You may also request a copy of the SBC and Summary Plan Description (SPD) by contacting Human Resources.

See page 10 for a glossary of medical plan terms.

Health Savings Account (HSA)

An HSA is a savings account that lets you set aside tax-favored money to pay for your qualified health care expenses, like your deductible, prescription drug costs, dental and vision expenses. You are able to fund this account through pre-tax payroll deduction or by making after- tax contributions. Elect to contribute at least $100 annually to your HSA through pretax payroll deductions to receive the Flagger Force annual HSA contribution of $250 approximately one month after enrollment

Coverage Tier	Your Maximum Annual Contribution*	2019 IRS Contribution Limits (Your Contributions + Flagger Force LLC Contribution)
Employee Only	$3,250	$3,500
Employee + Spouse	$6,750	$7,000
Employee + Child(ren)	$6,750	$7,000
Employee + Family	$6,750	$7,000

*If you will be 55 or older, you may make an additional "catch-up" contribution of up to $1,000.

It is very important that you do not exceed the maximum contribution level. Remember that the IRS contribution limit includes your personal contributions as well as Flagger Force's contribution amount. Excess contribution dollars are subject to adverse tax consequences.

Please note: If you use the money in your HSA for something other than a qualified health care expense, you will have to pay income tax on the amount you spent, as well as an additional 20% penalty if you are younger than 65 years old. Once you turn 65, the penalty will not apply.

Make sure you understand the IRS eligibility rules before you contribute to an HSA (or let your employer make contributions on your behalf), or there could be negative tax consequences. You can contribute money to an HSA if:

- You are not covered by any other medical plan, unless it is also a qualified high-deductible health plan.
- Neither you nor your spouse participates in a health care flexible spending account, unless it is a limited FSA used for dental and vision expenses only.
- You are not enrolled in Medicare (Part A or B).
- You cannot be claimed as a dependent on another person's tax return, except as a spouse.

If you have questions regarding HSA eligibility, please consult with your financial institution or your tax advisor.

HSA Advantages

- The money you contribute to your HSA is exempt from all federal taxes—and it stays this way as long as you spend it on qualified health care expenses. (State income tax may still apply.)
- The money in your HSA always belongs to you. Any money you haven't spent at the end of the plan year will stay in your account—you do not have to "use it or lose it" during the plan year, as you do with a health care FSA.
- When you retire or leave Flagger Force, you could use the money in your HSA to pay for COBRA coverage, Medicare premiums and out-of-pocket expenses, or long-term care insurance.

Log on to Health Equity's portal to learn more about an HSA. The website address is: www.healthequity.com/flaggerforce

Plan Options

Medical

Plan Name	Gold PPO Plan	Silver PPO Plan	Consumer Value HDHP
	YOU PAY	YOU PAY	YOU PAY
Preventive Care	Covered in full	Covered in full	Covered in full
Doctor's Office Visits	Copay only	Copay only	Copays begin after deductible is met
Prescription Drug Coverage – Retail	$10 / $30 / $60	$10 / $30 / $60	$10 / $30 / $60 after deductible is met
Virtual Care (online medical visits)	Covered in full	Covered in full	$49 Copay after deductible is met
Urgent Care	Copay only	Copay only	$50 Copay after deductible is met
Emergency Room Care	$250 Copay, then deductible	$250 Copay, then deductible	$250 Copay after deductible is met
Hospitalization	0% after deductible	0% after deductible	0% after deductible
Annual Deductible*	$3,000	$6,000	$3,500 single** $7,000 family**
Out-of-Pocket*	$6,850	$6,850	$4,500**
Annual Out-of-Pocket Limit	$6,850	$6,850	$9,000
Flagger Force Annual HSA Contribution	N/A	N/A	$250 [1]

**Benefits illustrated above are for in-network services using Capital Blue Cross providers. Services incurred out-of-network are covered at a lower benefit schedule and are subject to balance billing above the Cigna allowed amount.*

***Aggregate: All eligible family members contribute towards the family limit before the plan begins to pay.*

1 Employee must elect to contribute at least $100 to Health Savings Account (HSA) per year to receive Flagger Force HSA contribution.

Dental

Plan Name	Base PPO Plan	Buy-Up PPO Plan
	YOU PAY	YOU PAY
Preventive	Covered in full	Covered in full
Basic	20% after deductible	20% after deductible
Major	Not covered	30% after deductible
Orthodontia	Not covered	50%, $1,500 lifetime max per person
Deductible*	$50/person $150/family	$50/person $150/family
Annual Maximum Benefit*	$1,500/person	$1,500/person

** PPO Benefits are for in-network services using Guardian preferred providers. Services incurred out-of-network are covered at lower coinsurance levels and are subject to balance billing above the Guardian allowed amount.*

Vision

Plan Name	12/10 Plus Plan	
	FREQUENCY	YOU PAY
Eye Exam*	Every 12 months	$10 copay
Lenses*	Every 12 months	100% covered
Frames*	Every 12 months	$100 allowance
Contact Lenses*	Every 12 months	$100 allowance

**Benefits illustrated above are for in-network services using Capital Blue Cross providers. Services incurred out-of-network are reimbursed directly to the member at lower, specified limits*

Employee Contributions

Coverage Tier	MEDICAL		
	Your GOLD PPO PLAN Contribution Per Pay	Your SILVER PPO PLAN Contribution Per Pay	Your CONSUMER VALUE HDHP PLAN Contribution Per Pay
Employee Only	$36.24	$30.77	$28.19
Employee + Spouse	$157.81	$137.88	$126.35
Employee + Child	$118.58	$102.91	$94.30
Employee + Children	$158.22	$138.87	$127.26
Employee + Family	$198.35	$149.87	$137.34

Coverage Tier	DENTAL	
	Your BASE DENTAL Contribution Per Pay	Your BUY-UP DENTAL Contribution Per Pay
Employee Only	$1.23	$3.00
Employee + Spouse	$4.73	$8.26
Employee + Child	$3.61	$6.58
Employee + Children	$3.61	$6.58
Employee + Family	$7.10	$11.82

Coverage Tier	VISION
	Your VISION Contribution Per Pay
Employee Only	$0.18
Employee + Spouse	$1.86
Employee + Child	$1.86
Employee + Children	$1.86
Employee + Family	$1.86

Medical Plan Detail

Plan Name	Gold PPO	
Network	**In-Network**	**Out-of-Network**
Annual Deductible	$3,000/person $3,000/family	$10,000/person $10,000/family
Deductible Type	Embedded (see Medical Plan Terms You Should Know on page 10)	
Coinsurance (your share after deductible)	0%	50%
Annual Out-of-Pocket Limit (includes copays, deductible, and coinsurance)	$6,850/person $6,850/family	$20,000/person $20,000/family
Preventive Care (includes routine physical exams, well-child care, women's preventive health services, and routine diagnostic tests)	Covered in full	50% after deductible
Covered Services		
Physician Office Visits	$20 copay	50% after deductible
Specialist Office Visits	$30 copay	50% after deductible
Virtual Visits	$0 copay per visit/PCP $30 copay per visit/Specialist	Not covered
Inpatient Hospital Services	0% after deductible	50% after deductible
Outpatient Services	0% after deductible	50% after deductible
Urgent Care	$50 copay	50% after deductible
Emergency Room Care	$250 copay, then deductible	
Lab & Radiology Independent Radiology Independent Laboratory Hospital Owned Facilities Medical Tests	 $75 copay, waive deductible $30 copay, waive deductible 0% after deductible 0% after deductible	50% after deductible
Participating Pharmacies – Retail (up to 30-day supply) • Generic Preferred • Generic Non-Preferred • Brand Preferred • Brand Non-Preferred	 $10 copay $10 copay $30 copay $60 copay	Not covered
Participating Pharmacies - Mail Order (up to 90-day supply) • Generic Preferred • Generic Non-Preferred • Brand Preferred • Brand Non-Preferred	 $20 copay $20 copay $60 copay $120 copay	Not covered

Medical Plan Detail

Plan Name	Silver PPO	
Network	**In-Network**	**Out-of-Network**
Annual Deductible	$6,000/person $6,000/family	$10,000/person $10,000/family
Deductible Type	Embedded (see Medical Plan Terms You Should Know on page 10)	
Coinsurance (your share after deductible)	0%	50%
Annual Out-of-Pocket Limit (includes copays, deductible, and coinsurance)	$6,850/person $6,850/family	$20,000/person $20,000/family
Preventive Care (includes routine physical exams, well-child care, women's preventive health services, and routine diagnostic tests)	Covered in full	50% after deductible
Covered Services		
Physician Office Visits	$20 copay	50% after deductible
Specialist Office Visits	$30 copay	50% after deductible
Virtual Visit	$0 copay per visit/PCP $30 copay per visit/Specialist	Not covered
Inpatient Hospital Services	0% after deductible	50% after deductible
Outpatient Services	0% after deductible	50% after deductible
Urgent Care	$50 copay	50% after deductible
Emergency Room Care	$250 copay, then deductible	
Lab & Radiology Independent Radiology Independent Laboratory Hospital Owned Facilities Medical Tests	$75 copay, waive deductible $30 copay, waive deductible 0% after deductible 0% after deductible	50% after deductible
Participating Pharmacies – Retail (up to 30-day supply) • Generic Preferred • Generic Non-Preferred • Brand Preferred • Brand Non-Preferred	$10 copay $10 copay $30 copay $60 copay	Not covered
Participating Pharmacies – Mail Order (up to 90-day supply) • Generic Preferred • Generic Non-Preferred • Brand Preferred • Brand Non-Preferred	$20 copay $20 copay $60 copay $120 copay	Not covered

Medical Plan Detail

Plan Name	Consumer Value HDHP	
Network	**In-Network**	**Out-of-Network**
Annual Deductible (includes Medical & Prescription Drugs)	$3,500/person $7,000/family	$10,000/person $10,000/family
Deductible Type	Aggregate (see Medical Plan Terms You Should Know on page 10)	
Coinsurance (your share after deductible)	0%	50%
Annual Out-of-Pocket Limit (includes copays, deductible, and coinsurance)	$4,500/person $9,000/family	$20,000/person $20,000/family
Prescription Drug Out-of-Pocket Limit	Prescriptions are applied toward the medical out-of-pocket limit.	
Flagger Force Annual HSA Contribution	Employee Only: $250 Employee + Spouse: $250 Employee + Child(ren): $250 Employee + Family: $250	
Preventive Care (includes routine physical exams, well-child care, women's preventive health services, and routine diagnostic tests)	Covered in full	50% after deductible
Covered Services		
Physician Office Visits	$20 copay after deductible	50% after deductible
Specialist Office Visits	$30 copay after deductible	50% after deductible
Virtual Visits	$49 copay after deductible	Not covered
Inpatient Hospital Services	0% after deductible	50% after deductible
Outpatient Services	0% after deductible	50% after deductible
Urgent Care	$50 copay after deductible	50% after deductible
Emergency Room Care	$250 copay after deductible	50% after deductible
Lab & Radiology	0% after deductible	50% after deductible
Participating Pharmacies – Retail (up to 30-day supply) • Generic Preferred • Generic Non-Preferred • Brand Preferred • Brand Non-Preferred	 $10 copay after deductible $10 copay after deductible $30 copay after deductible $60 copay after deductible	Not covered
Participating Pharmacies – Mail Order (up to 90-day supply) • Generic Preferred • Generic Non-Preferred • Brand Preferred • Brand Non-Preferred	 $20 copay after deductible $20 copay after deductible $60 copay after deductible $120 copay after deductible	Not covered

Note: On the Consumer Value HDHP, you must pay the full discounted cost of your medical and prescription drug expenses until you satisfy the annual deductible.

Prescription Drug Benefits

To get the most out of your prescription drug benefits, please keep the following in mind.

Formulary. CVS Caremark National Network has a formulary or (preferred drug list) that is updated quarterly. We recommend that you review this list on **www.capbluecross.com** to check the cost of your prescription.

Prior Authorization. Some drugs, such as acne antibiotics, steroids, erectile dysfunction drugs, and hepatitis C medications, require prior authorization. That means you or your doctor must contact the insurance company to request approval before the drug is covered under the plan.

Step Therapy. Some medications, such as antidepressants, pain management drugs, certain cholesterol drugs, and specialty drugs for conditions like MS and rheumatoid arthritis, are subject to "step therapy." If your doctor recommends one of these drugs, you must try a "first-line" drug before the plan will cover the step therapy drug. First-line drugs are proven, cost-effective medications that are FDA-approved and treat the same condition.

Specialty Pharmacy Program. You are required to use the plan's specialty pharmacy for specialty drugs, such as injectable and infused therapies used to treat complex medical conditions such as hepatitis C, immune deficiency, hemophilia, multiple sclerosis, and rheumatoid arthritis.

HSA Plan Preventive Drugs. Certain preventive drugs are covered for only a copay–you don't have to meet the annual deductible first. See Human Resources for a list of these preventive medications.

Generic drugs will always save you money. Did you know many nationwide chains such as Walmart offer generics for just $4?

Medical Plan Terms You Should Know

Deductible	The dollar amount you pay for most services each calendar year before the plan will pay benefits. **HSA/Aggregate Deductible.** The plan will begin to pay benefits for any covered family member only after the entire family deductible has been satisfied. The deductible can be satisfied by one family member or multiple members. **PPO/Embedded Deductible.** The plan will begin to pay benefits for any covered family member who satisfies the individual deductible. Once combined individual deductible amounts reach the full family level, the plan will pay benefits to all family members, even the members who have not satisfied the individual deductible. Please refer to the Medical Plan Detail charts on pages 7-9 for your plan's family deductible type.
Coinsurance	The percentage of your medical cost you pay for most covered services. You will begin paying the coinsurance after you have met the applicable deductible.
Copay	The flat dollar amount you may pay for certain services, such as office visits and prescription drugs, when you go to a network provider.
Out-of-Pocket Limit	The maximum share of expenses you may have to pay each calendar year before the plan begins to pay at 100%. The out-of-pocket limit includes what you spend on copays, the deductible, and coinsurance.
Preferred Provider Organization (PPO)	A network of doctors and health care facilities that have agreed to provide services to plan members at discounted rates.
Medicare Reimbursement Rates	If you go to an out-of-network provider, the plan will pay benefits based on Medicare reimbursement rates for medical services in your area. Medicare's fee schedule is a national standard recognized by all providers; it is used to reimburse a significant portion of all medical claims in the United States.

AleraGroupRx

Flagger Force has made available AleraGroup Rx on a voluntary basis to eligible employees and their dependents, a cost saving mail order drug program for brand name maintenance prescriptions administered by CRX International. AleraGroupRx is a voluntary program and does not replace your current prescription benefit plan through Highmark.

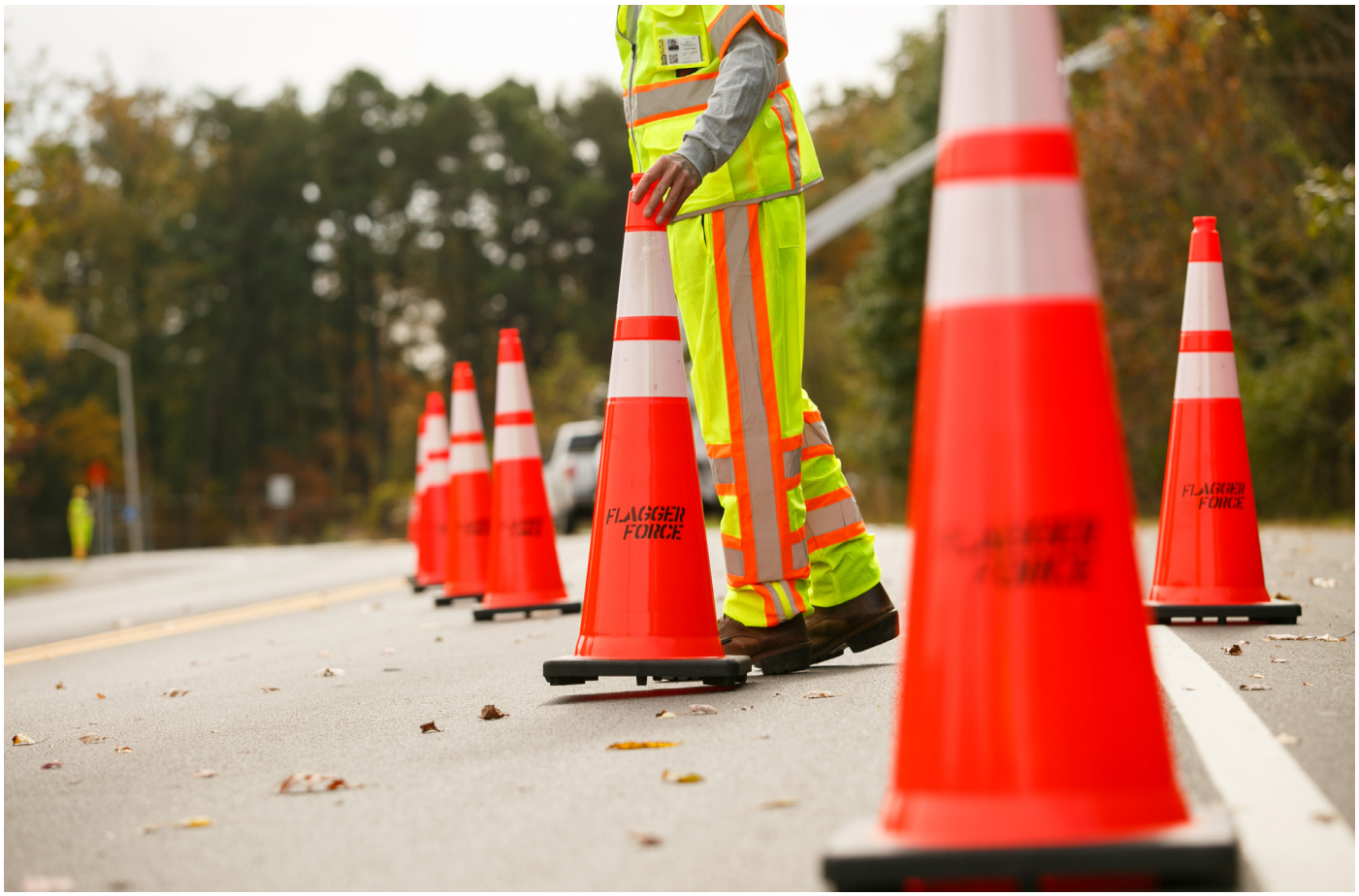
This program provides eligible members maintenance medications at no out of pocket expense. Below are some examples of maintenance medications available through this program.

- Advair Diskus
- Invokana
- Spiriva
- Januvia
- Janumet
- Crestor
- Xarelto

Please see HR for an enrollment form and Rx formulary which lists all the brand name maintenance drugs available through this voluntary program. If you have any questions regarding the AleraGroupRx program, please contact CRX toll free phone number (1-866-488-7874) with your questions.

The cost of prescription drugs go up every year. This voluntary program is made available to help you to save out of pocket expenses.

Remember.....this is a voluntary program and does not replace your current prescription benefit plan.



Vision

Flagger Force offers vision coverage through Capital Blue Cross.

Under the Capital Blue Cross vision care program, you can choose between network and out-of-network providers—but you will receive a higher level of benefits, and enjoy greater convenience, if you go to a vision care provider in the Capital Blue Cross network. If you decide to go to an out-of-network provider, you will pay the entire bill up front, then file a claim with Capital Blue Cross. The plan will reimburse you for your out-of-network services up to the allowances listed below.

12/10 Plus Plan		
Eye Exams: Once every 12 months Lenses: Once every 12 months Frames: Once every 12 months Contacts (instead of glasses): Once every 12 months		
	In-Network	**Out-of-Network**
Examination	$10 copay	Plan reimburses up to $32
Frames (standard or ANSI Certified safety glasses)	$100 allowance plus 30% off retail balance	Plan reimburses up to $30
Single Vision Lenses **Lined Standard Bifocal Lenses** **Lined Standard Trifocal Lenses** **Polycarbonate Standard Lenses (under age 19)**	100% 100% 100% 100%	Plan reimburses up to $24 Plan reimburses up to $36 Plan reimburses up to $46 Not Covered
Elective Contact Lenses **Medically Necessary Contact Lenses**	$100 allowance plus 25% off retail balance* 100%	Plan reimburses up to $50 Plan reimburses up to $200

In additional, Capital Blue Cross members can receive a number of lens options, such as progressive lenses and special coatings, at a discounted price. Capital Blue Cross - Vision 12/10 Plus also offers a discount on laser vision correction.

*Discounted amounts may vary and may not be honored at all optical retailers.

*Retail discounts do not apply to Contact Fill.

Dental

Flagger Force offers dental coverage through Guardian. You have a choice of the following plans:

- Base PPO Plan
- Buy-Up PPO Plan

How the PPO Plans Work

Under this plan, you are free to go to any licensed dentist you choose—but if you go to a dentist who is a member of **DentalGuard Preferred** network, you can take advantage of the preferred provider discounted rates and reduce your out-of-pocket costs. To find a network dentist go to **www.GuardianAnytime.com**.

If you go to a dentist outside the network, the plan's benefits will be based on the Negotiated Fee Schedule for a particular dental service in your area. If the dentist charges more than the negotiated fee, you will have to pay the difference.

Dental Plan Comparison

	Base PPO Plan		Buy-Up PPO Plan	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Plan Year Deductible	$50/person $150/family	$50/person $150/family	$50/person $150/family	$50/person $150/family
Plan Year Maximum Benefit (the most the plan will pay in benefits for each covered person per year)	$1,500/person (excludes preventive services)		$1,500/person (excludes preventive services)	
Preventive Services* (includes oral exams, cleanings, X-rays, and fluoride treatment)	Plan pays 100%; deductible waived	Plan pays 100% of Negotiated Fee Schedule; deductible waived	Plan pays 100%; deductible waived	Plan pays 100% of Negotiated Fee Schedule; deductible waived
Basic Services (includes fillings and extractions) periodontal and endodontic services, general anesthesia	Plan pays 80% after deductible	Plan pays 80% of Negotiated Fee Schedule after deductible	Plan pays 80% after deductible	Plan pays 80% of Negotiated Fee Schedule after deductible
Major Services (includes bridgework, crowns, dentures, and implants)	Not Covered	Not Covered	Plan pays 70% after deductible	Plan pays 70% of Negotiated Fee Schedule after deductible
Orthodontic Services	Not Covered	Not Covered	Plan pays 50% for Children up to age 26, up to maximum lifetime benefit of $1,500/person	

Important: If your out-of-network dentist charges more than the approved amount, you will have to pay the difference.
Preventive services do not count toward your plan year maximum benefit.

To help you make an informed choice, please refer to the plan summary for more details. The dental summary is available at www.Guardiananytime.com.

If you are enrolled in the Buy-Up PPO plan, Guardian will roll over a portion of your unused annual maximum benefit into your personal Maximum Rollover Account (MRA). If you reach your maximum benefit in future years, you can use money from your MRA to cover additional expenses. To qualify for an MRA, you must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. Your MRA balance may not exceed $1,250.

Disability Insurance

Disability insurance protects a portion of your income if you become ill or injured, to help you pay your bills until you can get back to work.

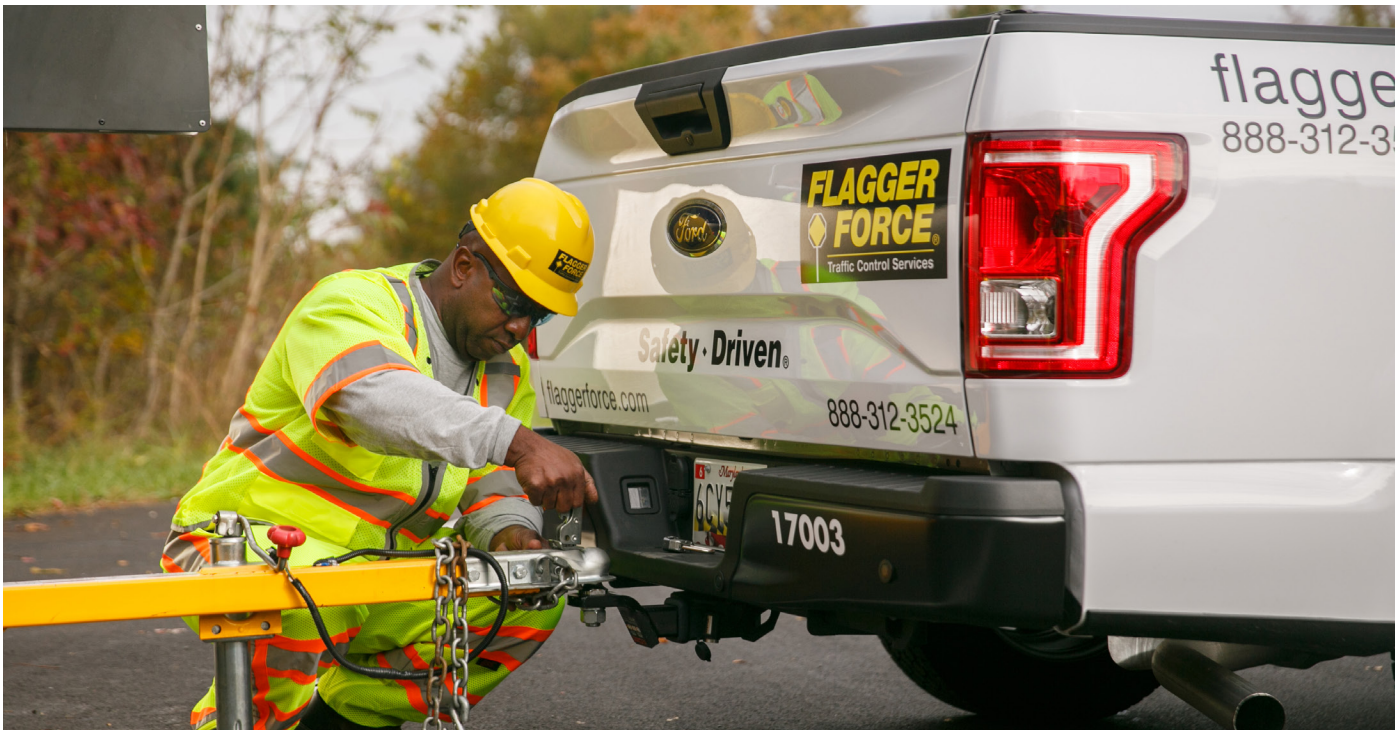
Voluntary Short-Term Disability (STD) Insurance

The STD plan provides a weekly benefit if a non-job-related disability—including pregnancy—prevents you from working.

If you enroll in the STD plan, you will pay the entire cost of your coverage through payroll deductions. STD coverage is provided through Guardian.

	STD Plan
Benefit amount:	You can choose a weekly amount in $100 increments up to $1,000. **The amount may not exceed 60% of your weekly salary.**
Maximum benefit:	$1,000 per week
Benefit reduced by:	Other disability income benefits, such as state disability insurance, sick leave, or unemployment insurance
Waiting period:	Benefits begin on your 8th day of disability
Length of payment period:	Benefits are paid as long as you remain disabled and under a physician's care, for up to 13 weeks

Pre-existing Condition Limitation. A "pre-existing condition" is any injury or sickness for which you received medical treatment or advice (including diagnostic measures), or had drugs or medicines prescribed or taken in the 3 months prior to the day your STD coverage began. Benefits will not be paid for any disability that begins in the first 12 months you are covered by the STD plan, if that disability is due to or results from a pre-existing condition. (Guardian will pay benefits with a 2-week limitation for a pre-existing condition.)



Voluntary Long-Term Disability (LTD) Insurance

The financial consequences of a lengthy disability can be very serious. The LTD plan provides monthly income protection if you become unable to work due to a disabling condition that lasts beyond 90 days. You will pay the full cost of your insurance through payroll deductions. Long-Term Disability insurance is provided through Guardian.

	LTD Plan
Benefit amount:	You can choose a monthly amount in $250 increments up to $2,000. **The amount may not exceed 60% of your weekly salary.**
Maximum benefit:	$2,000 per month
Benefit reduced by:	Other disability income benefits, such as State Disability Insurance or Social Security
Waiting period:	Benefits begin after 90 days of continuous disability
Length of payment period:	The lesser of 2 years or to age 70

Pre-existing Condition Limitation. A "pre-existing condition" is any injury or sickness for which your received medical treatment or advice (including diagnostic measures), or had drugs or medicines prescribed or taken in the 3 months prior to the day your LTD coverage began. Benefits will not be paid for any disability that begins in the first 12 months you are covered by the LTD plan, if that disability is due to or results from a pre-existing condition.

Employee Assistance Program

We all need help with life's challenges now and then. Whether it's a difficult situation affecting your home life or stress interfering with your work, the employee assistance program (EAP) is there for you and your immediate family members 24 hours a day, seven days a week.

The EAP is provided by Flagger Force at no cost to you and is administered by IBH.

The EAP provides free, strictly confidential counseling to help you resolve a wide range of personal issues, including:

- Stress and depression
- Life transitions
- Grief and loss
- Parenting and child care
- Elder care referrals
- Domestic violence
- Workplace conflict
- Work/life balance
- Addiction and recovery
- Financial issues
- Legal assistance

Call the EAP whenever you need help. Your call will be handled confidentially by a professional counselor. The EAP will also cover up to 3 free face-to-face counseling sessions per year.

401(k) Retirement Plan

Flagger Force offers a 401(K) plan administered by PenServ Plan Services. Employees are eligible for the company 401(K) plan after 90 days of consecutive service and are under full time status. You may start to contribute the 1st day of the next quarter after you are eligible. The aspects of the 401(K) plan are subject to change in the future at the Company's discretion.

Additional Voluntary Benefit Plans

Flagger Force offers valuable voluntary benefit plans through Guardian, to give you and your family members additional financial protection in the event of an accident, serious illness, or loss. If you enroll in one of these plans, you can keep your coverage if you leave Flagger Force or retire.

Voluntary Life Insurance

The Voluntary Life insurance plan lets you purchase coverage for you and your family. You will pay the full cost of your insurance through payroll deductions.

	Coverage for You	Coverage for Your Spouse	Coverage for Your Children
Coverage Options	$10,000	$5,000	$5,000
Maximum Benefit Amount	$500,000	$250,000	$10,000
Guaranteed Issue Amount*	$150,000	$25,000	$10,000

**When you first become eligible for the Flagger Force benefits program, you may purchase life insurance coverage up to the Guaranteed Issue (GI) amount without providing evidence of good health. You will have to submit evidence of good health for any coverage over the GI amount and will not be covered for the higher value until you receive approval from Guardian.*

If you enroll in the Voluntary life insurance plan when you first become eligible, you may increase your coverage by up to $50,000 each open enrollment without providing evidence of good health, until you reach the Guaranteed Issue amount. If you do not enroll when you are first eligible and later wish to purchase any amount of coverage during open enrollment, you will have to provide evidence of good health.

Voluntary Benefit

Hospital Indemnity Insurance (Guardian)

This coverage can offer you a "soft landing" if you're admitted to the hospital due to a covered accident or injury. You can use the money to help pay for out-of-pocket expenses, such as deductibles, copayments, and other expenses. It's coverage than can help protect what you've worked so hard to build.

No matter how well you plan, you can't predict when sudden medical expenses could impact your way of life. Health insurance helps, but it doesn't cover everything. For instance, the average family has more than $3,700 in out-of-pocket medical costs each year. Have you considered how you could pay for what your health insurance won't cover?

- 1 in 3 Americans have trouble paying their medical bills
- The average hospital bill is approximately $35,000 per hospital stay
- There are approximately 36 million hospital stays in the U.S. each year
- 3 in 5 bankruptcies are due to medical bills

You will pay the full cost of your insurance through payroll deductions.

Hospital Indemnity Insurance

Two plan design options are available to choose from:

Group Hospital Confinement Insurance			
		Plan 1 Medical	Plan 2 Medical
Hospital Confinement Benefit (Maximum of one day per covered person per calendar year)		$2,500	$1,500
Hospital/ICU Confinement		$100 per day to a max of 31 days per year, per insured	
Health Screenings		$50 per day of screening to a max of 1 day per year, per insured	Not Applicable
Treatment Normal Pregnancy		Hospital Admission benefits are not payable for birth within first 9 months of coverage	
Pre-Existing Condition Limitation		3 month look back period, 12 month exclusion period	
Tier of Coverage	**Age Band**	**Weekly Premium:**	
Employee	< 50	$4.70	$3.62
Employee & Spouse		$12.20	$7.51
Employee & Children		$8.62	$6.08
Family		$16.12	$9.97
Employee	50-59	$6.40	$5.11
Employee & Spouse		$12.26	$10.18
Employee & Children		$10.32	$7.57
Family		$16.58	$12.64
Employee	60-64	$9.99	$8.41
Employee & Spouse		$19.12	$16.35
Employee & Children		$13.91	$10.87
Family		$23.04	$18.81
Employee	65-69	$18.16	$11.88
Employee & Spouse		$34.96	$22.60
Employee & Children		$22.08	$14.34
Family		$38.88	$25.05

Spouse premium is based on employee's age.

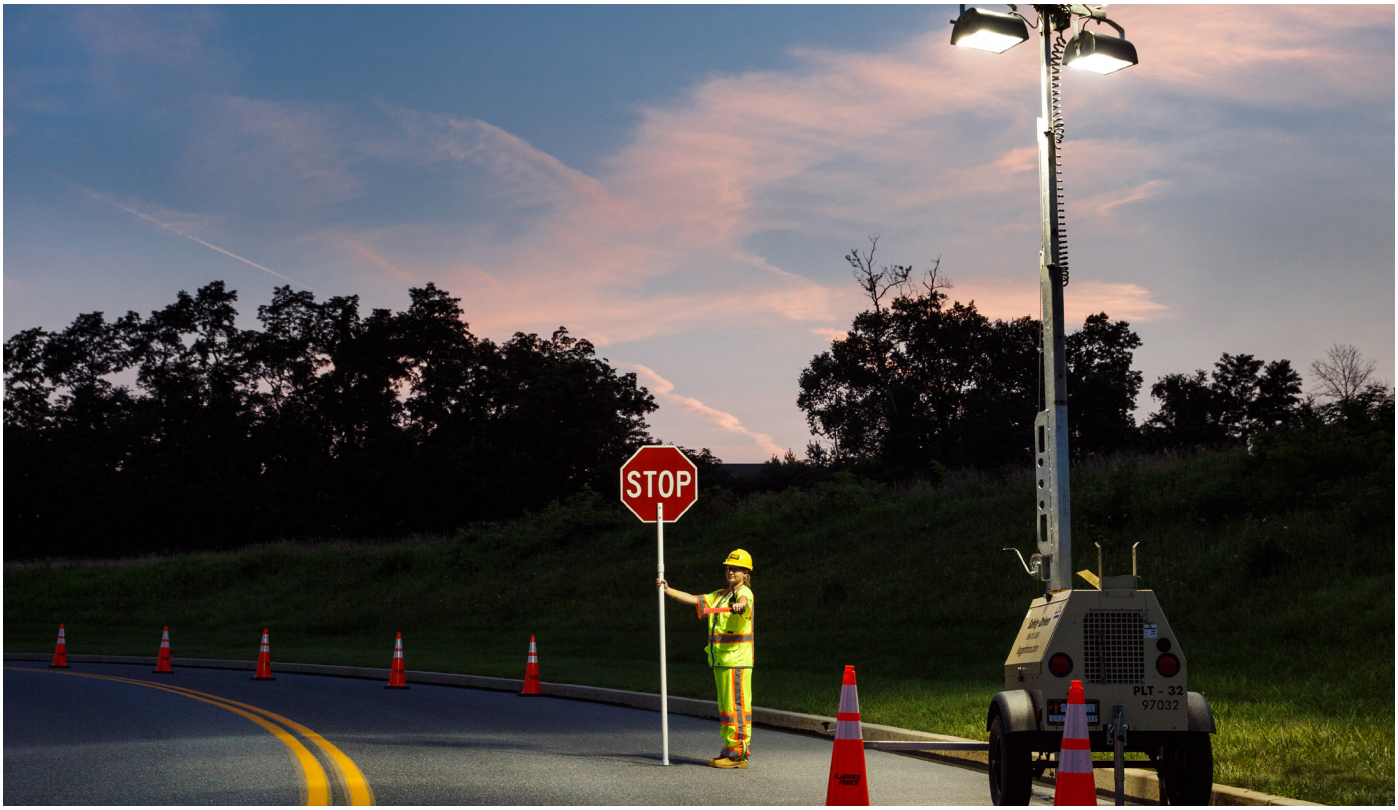
Accident Insurance

This coverage can pay a specific dollar amount for on and off the job accidents. If you suffer a covered injury, the plan pays cash benefits that you can use to help with hospital deductibles, doctor visits, emergency room care, and physical therapy.

Accident Insurance	
Accident Coverage	On and Off the Job
Accident Death & Dismemberment	Included
Wellness Benefit	$50 per year benefit for completing certain routine wellness screenings
Accident Emergency Treatment	$175
Accident Follow-up Doctor Visits	$50 up to 6 treatments
Hospital Admission	$1,000
Hospital Confinement	$225/day – up to 1 year
Hospital ICU Admission	$2,000
Hospital ICU Confinement	$450/day – up to 15 days
Fracture	Schedule up to $5,500
COST PER WEEK	
Employee	$3.98
Employee & Spouse	$6.41
Employee & Child(ren)	$6.62
Family	$9.05

Please refer to Guardian's enrollment guide and benefit schedule for additional coverage under this benefit.

You will pay the full cost of your insurance through payroll deductions.



Cost of Coverage (Weekly)

MEDICAL CONTRIBUTIONS (PER PAY) - EFFECTIVE SEPTEMBER 1, 2019 - AUGUST 31, 2020

Gold PPO	
Employee Only	$36.24
Employee + Spouse	$157.81
Employee + Child	$118.58
Employee + Children	$158.22
Employee + Family	$198.35
Silver PPO	
Employee Only	$30.77
Employee + Spouse	$137.88
Employee + Child	$102.91
Employee + Children	$138.87
Employee + Family	$149.87
Consumer Value HDHP	
Employee Only	$28.19
Employee + Spouse	$126.35
Employee + Child	$94.30
Employee + Children	$127.26
Employee + Family	$137.34

DENTAL CONTRIBUTIONS (PER PAY) - EFFECTIVE SEPTEMBER 1, 2019 - AUGUST 31, 2020

Base PPO Plan	
Employee Only	$1.23
Employee + Spouse	$4.73
Employee + Child	$3.61
Employee + Children	$3.61
Employee + Family	$7.10
Buy-Up PPO Plan	
Employee Only	$3.00
Employee + Spouse	$8.26
Employee + Child	$6.58
Employee + Children	$6.58
Employee + Family	$11.82

VISION CONTRIBUTIONS (PER PAY) - EFFECTIVE SEPTEMBER 1, 2019 - AUGUST 31, 2020

Vision 12/10 Plus Plan	
Employee Only	$0.18
Employee + Spouse	$1.86
Employee + Child	$1.86
Employee + Children	$1.86
Employee + Family	$1.86

Cost of Coverage

VOLUNTARY LIFE INSURANCE RATES (PER MONTH)

Age	Employee	Spouse
	Cost per $1,000 of Benefit	Cost per $1,000 of Benefit
<30	$0.078	$0.078
30 – 34	$0.093	$0.093
35 – 39	$0.122	$0.122
40 – 44	$0.173	$0.173
45 – 49	$0.277	$0.277
50 – 54	$0.470	$0.470
55 – 59	$0.718	$0.718
60 – 64	$1.118	$1.118
65 – 69	$2.398	$2.398
70 – 74	$4.695	$4.695
75 – 79	$4.695	$4.695
80 and above	$4.695	$4.695
Children*	$0.167 for $5,000 or $10,000 of benefit	
Voluntary AD&D	$0.042 per $1,000 of benefit	

‡*Your spouse rate is based on your age.*
** Just one premium will cover all your eligible children, no matter how many you have.*

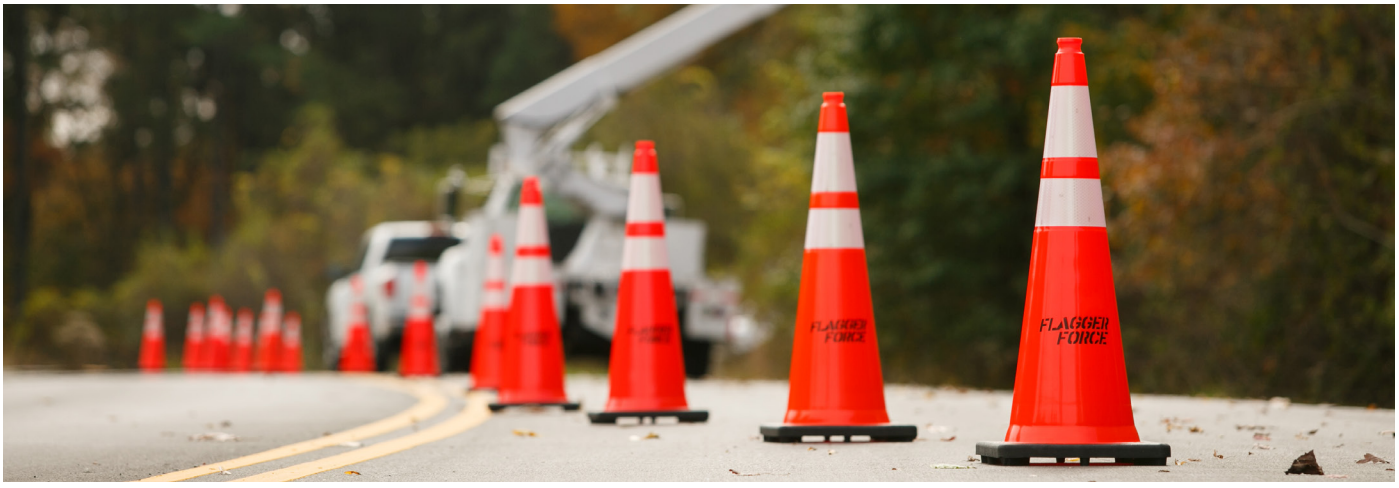
How to Calculate Your Voluntary Life Insurance Contribution

1. Divide the amount of coverage you want by $1,000.
2. Multiply this amount by the rate in the chart to get your **monthly** cost.

Example. Dan is 38 years old and would like a voluntary life insurance benefit of $100,000. The rate per $1,000 of benefit for an employee his age is $0.122. Here's how Dan would figure his monthly cost:

1. $100,000 ÷ 1,000 = 100
2. 100 x $0.122 = $12.20 per month*

**Multiply this monthly rate by 12 and divide by the number of pay periods to get your cost per pay period.*



Cost of Coverage

VOLUNTARY SHORT TERM DISABILITY RATES (PER MONTH)

Monthly Premium									
Weekly Beneft	**Minimum Annual Salary Required**	**<30**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60+**
$100	$8,667	$7.92	$10.37	$8.70	$5.56	$5.32	$6.32	$7.18	$10.47
$200	$17,333	$15.84	$20.74	$17.40	$11.12	$10.64	$12.64	$14.36	$20.94
$300	$26,000	$23.76	$31.11	$26.10	$16.68	$15.96	$18.96	$21.54	$31.41
$400	$34,667	$31.68	$41.48	$34.80	$22.24	$21.28	$25.28	$28.72	$41.88
$500	$43,333	$39.60	$51.85	$43.50	$27.80	$26.60	$31.60	$35.90	$52.35
$600	$52,000	$47.52	$62.22	$52.20	$33.36	$31.92	$37.92	$43.08	$62.82
$700	$60,667	$55.44	$72.59	$60.90	$38.93	$37.24	$44.24	$50.26	$73.29
$800	$69,333	$63.36	$82.96	$69.60	$44.48	$42.56	$50.56	$57.44	$86.76
$900	$78,000	$71.28	$93.33	$78.30	$50.04	$47.88	$56.88	$64.62	$94.23
$1,000	$89,667	$79.20	$103.70	$87.00	$55.60	$53.20	$63.20	$71.80	$104.70

Cost of Coverage

VOLUNTARY LONG TERM DISABILITY RATES (PER MONTH)

Monthly Premium									
Monthly Beneft	**Minimum Annual Salary Required**	**<30**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60+**
$250	$5,000	$0.63	$0.90	$1.27	$1.51	$2.04	$2.80	$3.76	$3.21
$500	$10,000	$1.27	$1.79	$2.53	$3.01	$4.09	$5.59	$7.52	$6.43
$750	$15,000	$1.90	$2.69	$3.80	$4.52	$6.13	$8.39	$11.27	$9.64
$1,000	$20,000	$2.53	$3.58	$5.06	$6.02	$8.17	$11.18	$15.03	$12.85
$1,250	$25,000	$3.16	$4.48	$6.33	$7.53	$10.21	$13.98	$18.79	$16.06
$1,500	$30,000	$3.80	$5.37	$7.59	$9.03	$12.26	$16.77	$22.55	$19.28
$1,750	$35,000	$4.43	$6.27	$8.86	$10.54	$14.30	$19.57	$26.30	$22.49
$2,000	$40,000	$5.06	$7.16	$10.12	$12.04	$16.34	$22.36	$30.06	$25.70

Contact Information

Benefit Plan	Carrier/ Administrator	Group Number	Phone	Website
Medical Gold PPO and Silver PPO Plans	Capital Blue Cross	00522551	1-800-962-2242	www.capbluecross.com
Consumer Value HDHP	Capital Blue Cross	00522551	1-800-962-2242	www.capbluecross.com
Virtual Visits	Capital Blue Cross/ Virtual Care	00522551	1-833-433-5914	www.virtualcarecbc.com
Pharmacy Benefit Manager	Capital Blue Cross/ CVS Caremark National Network	00522551	1-800-962-2242	www.capbluecross.com
Dental PPO Plan	Guardian Life Insurance	00551984	1-800-627-4200	www.guardiananytime.com
Vision Plan	Capital Blue Cross	00522551	1-800-962-2242	www.capbluecross.com
Health Savings Account Learning Portal	Health Equity	N/A	1-866-346-5800	www.healthequity.com www.healthequity.com/ flaggerforce
Voluntary Life Insurance	Guardian Life Insurance	00551984	1-800-627-4200	www.guardiananytime.com
Disability Insurance	Guardian Life Insurance	00551984	1-800-627-4200	www.guardiananytime.com
Employee Assistance Program	Guardian/IBH	N/A	1-800-386-7055	www.ibhworklife.com
Accident Insurance	Guardian Life Insurance	00551984	1-800-627-4000	www.guardiananytime.com
Hospital Indemnity Plan	Guardian Life Insurance	00551984	1-800-627-4200	www.guardiananytime.com
401(k) Plan	PenServ Plan Services	N/A	1-800-849-4001	www.penserv.com
Flagger Force Contact	Employee Services	N/A	717-256-9048 or 1-888-312-3524	employeeservices@flaggerforce.com

Most insurance companies now offer free mobile apps to help manage your care on the go. Visit their website for details.

FF Benefits

2019 Annual Notices For Group Health Plan Benefits

The following notices are not intended to be a description of the benefits offered under the Plan. For more information about specific benefits, refer to the Summary Plan Descriptions for the Plan, which are available by going to your insurance carrier website or calling the number on the back of the insurance ID Card. You can always contact Ashley Sellers and/or the benefits administration team.

Important Notice about the 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. 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 your group health plan coverage.

Therefore, the following deductibles and coinsurance will apply: Please refer to your Summary of Benefits and Coverage (SBC).

For more information on benefits under the Women's Health and Cancer Rights Act of 1998, contact Ashley Sellers and/or your benefits administration team.

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).

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

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) Blue Cross Blue Shield in order to provide you with incentives under the wellness program.

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

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact:

Michael Nichols
Human Resources
(717) 256-9048
michael.nichols@flaggerforce.com

Important Notice about Group Health Plan Special Enrollment Rights

This notice is being provided so that you understand your right to apply for group health plan coverage outside of the open enrollment period. You should read this notice regardless of whether you are currently covered under the Flagger Force plan.

You may have the right to enroll in the following group health plan options if certain events (listed below) occur at any time during the year:

- Health plan options where applicable and offered such as of medical, dental, and/or vision are subject to HIPAA's portability requirements. You can always contact Ashley Sellers and/or your benefits administration team for specific coverage options available to you for specific coverage options available to you.

The following are the events for which you may have a special enrollment right:

Loss of Other Group Health Plan Coverage or Health Insurance

If you decline coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in any of the group health plan options for which you are eligible if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards 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).

Marriage, Birth or Adoption

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 any of the group health plan options for which you are eligible. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Loss of Coverage under Medicaid or State Children's Health Insurance Program

If you decline coverage for yourself or your dependents while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in any of the group health plan options for which you are eligible if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage under Medicaid or state children's health insurance program ends.

Eligibility for State Premium Assistance Subsidy

If you or your dependents become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to group health plan coverage under this Plan, you may be able to enroll yourself and your dependents in any of the group health plan options for which you are eligible. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. More information about these subsidies is included in "Important Notice about Free or Low-Cost Health Coverage for Children and Families under Medicaid and the Children's Health Insurance Program" below.

Important Notice from Flagger Force 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 Flagger Force 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. Flagger Force has determined that the prescription drug coverage offered by the Flagger Force Employee Benefit Plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are 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 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 may be affected. If you do decide to join a Medicare drug plan and drop your current coverage, 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 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 below 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 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).

Date: 9/1/2019
Name of Entity/Sender: Flagger Force
Contact – Position/Office: Michael Nichols, HR Benefits Specialist
Address: 8170 Adams Drive
Hummelstown, PA 17036
Phone Number: (717) 256-9048

Continuation Coverage Rights Under COBRA

Introduction

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following
qualifying events:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and
other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
Michael Nichols
HR Benefits Specialist
Flagger Force
8170 Adams Drive
Hummelstown, PA 17036
(717) 256-9048
michael.nichols@flaggerforce.com

Effective: 9/1/2019

NOTICE OF PRIVACY PRACTICES
Flagger Force Group Health Benefits Plan

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.

This Notice of Privacy Practices (Notice) describes the privacy practices and obligations of:

- The health, mental health, dental and vision benefits available under the Flagger Force Group Health Benefits Plan.

For your convenience, this Notice uses the term "Plan" to refer to these different benefits.

Your health information is highly personal, and the Plan is committed to safeguarding your privacy. This Notice describes how your protected health information held by the Plan may be used or disclosed, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. It also describes your ability to access and control the use and disclosure of your protected health information.

This Notice does not apply to Flagger Force benefit plans or policies that are not health plans, such as disability, life insurance, accidental death and dismemberment insurance and leave of absence. In addition, some of the benefits under the Plan are provided through insurance. If you receive Plan benefits through insurance companies, you may receive separate notices from the Plan's insurers describing how they use and disclose protected health information.

The Plan reserves the right to change the terms of this Notice at any time and to implement new notice provisions effective for all PHI held by or on behalf of the Plan. In the event of a change to this Notice, an updated Notice will be mailed to your address on file.

PLAN RESPONSIBILITIES

In General

The Plan is a "covered entity" as this term is defined in the HIPAA. HIPAA requires the Plan to:

- Maintain the privacy of your protected health information (PHI);
- Provide you with certain rights with respect to your PHI;
- Give you a copy of this Notice explaining the Plan's legal duties and privacy practices regarding PHI;
- Notify an individual following a breach of unsecured PHI; and
- Follow the terms of the Notice that is currently in effect.

Generally, PHI is individually identifiable information created or received by, or on behalf of, the Plan 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.

How the Plan May Use or Disclose Your PHI

The following categories describe the different ways that the Plan may use or disclose your PHI without first obtaining your authorization. For each category of uses and disclosures, the Notice explains what the category means generally and presents examples. Not every possible use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose PHI without first obtaining your authorization will fall within one of these categories.

Treatment: The Plan may use or disclose your PHI to facilitate medical treatment or services by providers (e.g., doctors and hospitals). For example, the Plan may share your PHI with your doctor or other health care provider who needs such information to treat you properly.

Payment: The Plan may use or disclose your PHI for payment-related purposes, such as determining your eligibility for Plan benefits, coordinating coverage between the Plan and another plan, and facilitating payment for services you receive. For example, the Plan may share your PHI with another health plan to coordinate payment of benefits.

Health Care Operations: The Plan may use or disclose your PHI for various administrative purposes that are called "health care operations" of the Plan. For example, your PHI might be included as part of any audit designed to ensure that the Plan's outside claims administrator is properly performing its job, or your PHI might be included each year to set appropriate premiums for the Plan or to help secure insurance. In no event, however, will the Plan use or disclose your PHI that is genetic information for underwriting purposes.

Business Associates: The Plan may contract with service providers, called business associates, to perform various administrative functions on its behalf. For example, the Plan's claims administrators and pharmacy benefits manager are business associates of the Plan. The Plan is permitted to use or disclose your PHI to a business associate when the business associate needs the information to perform administrative tasks for the Plan, but only after the Plan and the business associate agree in writing to require the business associate to keep your PHI confidential.

Disclosures to the Plan Sponsor: Generally, Flagger Force (the Plan sponsor) does not maintain any PHI. However, the Plan may disclose certain PHI to designated Flagger Force employees when such disclosure is necessary to enable Flagger Force to fulfill its administrative duties as Plan sponsor. For example, the Plan may disclose enrollment information to Flagger Force to facilitate payroll deductions for your required premium contributions. Flagger Force has agreed to prevent unauthorized uses or a disclosure of any PHI disclosed by the Plan and has agreed to limit access to such information. In no event may Flagger Force use PHI it receives from the Plan for benefit programs that do not provide health benefits, to make any employment-related decisions, or for any other purpose other than as required by law or permitted by the Plan.

Disclosures Permitted or Required by Law: The Plan may disclose your PHI to you or to your legal representative. HIPAA also allows the Plan to use or disclose PHI without obtaining your written authorization in the following situations:

- **Workers' Compensation:** To comply with workers' compensation or similar laws providing benefits for work-related injuries or illnesses.
- **Organ Donation:** To an organ procurement organization to facilitate organ or tissue donation and transplantation.
- **Death:** To coroners, medical examiners and funeral directors to help identify decedents or determine cause of death.
- **Law Enforcement:** For law enforcement purposes, including to report wounds/injuries and crimes or for the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- **Domestic Violence:** To government agencies for victims of abuse, neglect or domestic violence.
- **Public Health:** For public health activities, such as preventing or controlling disease and reporting reactions to medications.
- **Legal Proceedings:** For judicial and administrative proceedings, such as lawsuits or other disputes in response to a court order or subpoena.
- **HHS/Government Health Oversight:** To health oversight agencies for oversight activities authorized by law (audits, investigations, inspections, licensure, etc.).
- **Research:** For research purposes in certain, limited circumstances.
- **National Security/Intelligence:** To authorized Federal officials for the purpose of conducting intelligence, counter-intelligence and other national security activities.
- **Military/Veterans Activities:** To military authorities if you are a member of the armed services, and the appropriate military command authorities follow specific procedures related to the disclosure.
- **Correctional Institutions:** To correctional institutions or law enforcement officials, regarding individuals in custody.
- **Limited Data Set:** As part of a "limited data set" for research, public health and health care operations, to certain third parties who have agreed in writing to limit their use and disclosure of the information contained in the limited data set. A "limited data set" generally is information that summarizes claims history, expenses or types of claims, but which excludes certain direct identifiers as required by HIPAA.

Disclosures to Family Members/Individuals Involved in Your Care: The Plan may disclose your PHI to your family members or close personal friends if (1) the information is relevant to the individual's involvement in your health care or payment for that care; and (2) you have either agreed to the disclosure or the Plan gave you an opportunity to object and you have not objected. If you are unavailable, incapacitated, or facing a medical emergency and the Plan determines that a limited disclosure may be in your best interest, the Plan may share limited PHI with such individuals without your approval. The Plan also may disclose PHI to a parent or legal guardian in the case of services provided to a minor child or an incapacitated adult.

Uses and Disclosures Authorized by You: PHI will not be used for marketing purposes and PHI will not be sold unless the individual authorizes the use of PHI in that way. There will be no disclosure of psychotherapy notes without the individuals' authorization. Uses and disclosures that are not described above will be made only with your written authorization. You may revoke your authorization at any time in writing, but the revocation will apply only to the extent that the Plan has not already acted in reliance on your authorization.

YOUR RIGHTS

Right to Receive Privacy Notice

You have the right to receive a paper copy of this Notice at any time, even if you have previously agreed to receive this Notice electronically. You should submit your request for a paper copy of this Notice to the Contact Person listed below.

Right to Request Restrictions

You may request restrictions on certain uses and disclosures of your PHI that would otherwise be used to carry out treatment, payment or health care operations purposes. You also have the right to request limits on information the Plan may disclose to someone involved in your care or the payment for your care, like a family member.

To request a restriction, you must submit your request in writing to the Contact Person listed below. Your request must describe the PHI that you wish to limit and to whom you want the limitations to apply.

Except in limited circumstances, the Plan is not required to agree to your restriction request. If the Plan does agree to honor your request, it will follow the restriction until you revoke the restriction, or until the Plan notifies you that it is removing the restriction prospectively.

If you pay out-of-pocket in full for any health care item or service, you may ask your health care provider not to disclose to the Plan any protected health information regarding that item or service.

Right to Request Confidential Communications

You may ask to receive communications about PHI in a certain way or at a certain location (e.g., you may ask that the Plan contact you only at your work telephone number or address). To request confidential communications, you must submit a written request to the Contact Person listed below. The Plan will not ask you the specific reason for your request, and the Plan will accommodate reasonable requests. If your request clearly states that the disclosure of all or part of your PHI by the usual means could endanger you, your request will be accommodated.

Right to Access Your PHI

You may request access to inspect and copy your PHI that is maintained by the Plan. To the extent the Plan maintains your PHI in an electronic health record, you may request access to the electronic health record, and you may direct the Plan to transmit the electronic health record (in electronic form) to an individual or entity you designate.

You must submit your request in writing to the Contact Person listed below, or you may make a request directly to the relevant HMO, insurer or claims administrator. The Plan may charge you a fee for the costs of copying, mailing or other supplies associated with a request to access and copy PHI, or for the labor costs associated with processing a request to access PHI maintained in an electronic health record.

The Plan will provide the requested information within 30 days if the Plan maintains the information on site or within 60 days if the Plan maintains the information offsite. The Plan may extend the deadline with a single 30-day extension if the Plan is unable to comply with the deadline. If an extension is required, the Plan will send you a written statement of the reasons for the delay and the date by which the Plan will respond.

The Plan may deny your request to access PHI in certain very limited circumstances. If your request to access PHI is denied, the Plan will send you a written notification explaining the reason for the denial and, if applicable, any right you may have to request review of the denial.

Right to Amend Your PHI

If you believe your PHI maintained by the Plan is incorrect or incomplete, you may request that the Plan amend your PHI. You must submit your request in writing to the Contact Person listed below, or you may make a request directly to the relevant HMO, insurer or claims administrator.

The Plan has 60 days after the Contact Person receives the request to amend to act on the request. The Plan may extend this deadline with a single 30-day extension if the Plan is unable to comply with the deadline. If an extension is required, the Plan will send you a written statement of the reasons for the delay and the date by which the Plan will respond.

In certain cases, the Plan may deny your request – for example, if the Plan does not maintain the PHI or did not create the PHI, or if the Plan determines that the PHI is accurate and complete without the amendment. If the Plan denies your request for amendment, the Plan will send you a written notification explaining the reason for the denial and your right to file a statement of disagreement to be included with any subsequent disclosures of the relevant PHI.

If the Plan agrees to amend your PHI, it may notify business associates or others (such as your provider) that have copies of the uncorrected PHI if the Plan believes that such notification is necessary.

Right to Receive an Accounting of Disclosures of Your PHI

You have the right to receive an accounting of disclosures of your PHI that the Plan has made without your authorization. You must submit your request in writing to the Contact Person listed below, or you may make a request directly to the relevant HMO, insurer or claims administrator. If you request more than one accounting in a 12-month period, you may be charged a reasonable, cost-based fee.

Generally, an accounting will cover disclosures made during the six-year period prior to your request and will not include disclosures made for treatment, payment or health care operations purposes. However, to the extent required by HIPAA, if your PHI is maintained in an electronic health record, the accounting will also include information about disclosures made for treatment, payment and health care operations purposes during the three-year period prior to your request.

If the Plan cannot provide the accounting within 60 days after it receives your request, the Plan may extend the response deadline once for an additional 30 days. If an extension is required, the Plan will send you a written statement of the reasons for the delay and the date by which the Plan will provide the accounting.

Right to be Notified of a Breach

You have the right to be notified in the event that the Plan (or one of its business associates) discovers a breach of your unsecured PHI. Notice of any such breach will be made in accordance with federal requirements.

ADDITIONAL INFORMATION

Complaints

If you believe your privacy rights with respect to your PHI under the Plan have been violated, you may file a complaint with the Plan or with the Secretary of Health and Human Services, Office for Civil Rights (OCR). Complaints to the Plan should be filed in writing with the Contact Person listed below. You will not be penalized in any way for filing such a complaint.

More detailed information about how to file a complaint with the OCR regional office is located on the OCR website at: **http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html**.

Contact Person

For questions about this Notice, the Plan's privacy practices, or to exercise any of your rights described above, please contact:

Michael Nichols
HR Benefits Specialist
Flagger Force
8170 Adams Drive
Hummelstown, PA 17036
(717) 256-9048
michael.nichols@flaggerforce.com

Claims Administrators

Contact information for HMOs, insurers, and claims administrators is listed in the summary plan description for each Plan.

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, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 1-855-692-5447	**FLORIDA – Medicaid** Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
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	**GEORGIA – Medicaid** Website: www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	**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 http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	**KANSAS – Medicaid** Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY – Medicaid Website: https://chfs.ky.gov Phone: 1-800-635-2570	**NEW HAMPSHIRE – Medicaid** Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345 ext 5218
LOUISIANA – Medicaid Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	**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
MAINE – Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	**NEW YORK – Medicaid** Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	**NORTH CAROLINA – Medicaid** Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid 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 or 651-431-2760	**NORTH DAKOTA – Medicaid** Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

MISSOURI – Medicaid Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	**OKLAHOMA – Medicaid and CHIP** Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	**OREGON – Medicaid** Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	**PENNSYLVANIA – Medicaid** Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA – Medicaid Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	**RHODE ISLAND – Medicaid** Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
SOUTH CAROLINA – Medicaid Website: https://www.scdhhs.gov Phone: 1-888-549-0820	**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
SOUTH DAKOTA - Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059	**WASHINGTON – Medicaid** 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 Website: http://gethipptexas.com/ Phone: 1-800-440-0493	**WEST VIRGINIA – Medicaid** Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	**WISCONSIN – Medicaid and CHIP** Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	**WYOMING – Medicaid** Website: https://health.wyo.gov/healthcarefin/medicaid Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights,
contact either:

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

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

Paperwork Reduction Act Statement

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

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

Notes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Benefits