BENEFITS ENROLLMENT GUIDE 2021

Amerit FLEET SOLUTIONS

BE READY FOR ENROLLMENT

Amerit Fleet Solutions (AFS) is committed to providing our employees with a benefits program that is both comprehensive and competitive. Our benefits program offers health care, dental and vision coverage, as well as financial security to our employees and their families. This guide provides a general overview of your benefit choices and enrollment information to help you select the coverage that is right for you.

Eligibility

If you are a full-time and temp employee working 30 or more hours per week, the chart below lists the benefits you may be eligible for after meeting each plan's eligibility requirements. Temp employees are not eligible for Life and disability, Short and Long-Term Disability and EAP.

BENEFIT
Medical & Prescription Drug
Dental
Vision
Basic Life, Accidental Death & Dismemberment
Supplemental Life, Accidental Death & Dismemberment
Supplemental Short-Term Disability
Supplemental Long-Term Disability
Flexible Spending Accounts (FSAs)
Voluntary Accident, Criticall Illness & Hospital Indemnity
Voluntary Legal and ID Theft
Retirement 401(k) Savings Plan

Dependent Eligibility

You can enroll your dependents in plans that offer dependent coverage. Eligible dependents are defined as your legal spouse or domestic partner and eligible children who reside in your household and depend primarily on you for support. This includes your own children, legally adopted children, stepchildren, a child for whom you have been appointed legal guardian, and/or a child for whom the court has issued a Qualified Medical Child Support Order (QMCSO) requiring you or your spouse or domestic partner to provide coverage.

Spousal Surcharge

A 25% surcharge will apply on medical plans if your spouse is eligible for benefits with their own employer.

Medical, Dental, and Vision Plan Dependent Coverage

You may cover your eligible dependent children up to age 26, regardless of marital or student status (this does not include spouses or domestic partners of adult children).

Dependent coverage will cease for your covered dependent children at the end of the month in which an eligible dependent reaches age 26.

You will be required to provide proof of eligibility for any new dependent you want to add to your coverage. You'll receive information about eligibility and documentation requirements after you enroll. AFS may conduct a dependent eligibility audit at any time.

Domestic Partner Coverage

Domestic partners are eligible to enroll as dependents in the benefit plans. You and your partner must meet specific criteria to qualify for domestic partner coverage. A domestic partnership is different than a marriage with an individual of the same-sex. A same-sex spouse is a federal tax dependent for group health plan purposes; whereas, a domestic partner often is not. If you cover a domestic partner, a domestic partner's child or another person who is not considered an IRS tax dependent for group health plan purposes, AFS is required to report income for you that reflects the value of coverage for tax-reporting purposes. This is known as imputed income. You will receive a W-2 annually for the value of coverage for any dependent who is not an IRS tax dependent.

Enrollment Periods

New Employees

If you're enrolling as a new employee, you become eligible for benefits within 31 days of your date of hire to have coverage for the rest of the plan year. You will also need to enroll for the next plan year's benefits during the annual enrollment period.

Open Enrollment

As a benefits-eligible employee, you have the opportunity to enroll in or make changes to your benefit plans during our annual open enrollment period. Annual Open Enrollment is October 26th-November 6th with benefit choices being effective January 1, 2021. Our benefits plan year is January 1, 2021 through December 31, 2021.

Making Changes During the Year

Choose your benefits carefully. Medical, dental, vision, and flexible spending account contributions are made on a pre-tax basis and IRS regulations state that you cannot change your pre-tax benefit options during the year unless you have a qualified life event. Qualified life events include:

- Marriage or divorce;
- Death of your spouse, domestic partner, or dependent;
- Birth or adoption of a child;
- Your spouse or domestic partner terminating or obtaining new employment (that affects eligibility for coverage);
- You or your spouse or domestic partner switching employment status from full-time to part-time or vice versa (that affects eligibility for coverage);
- Significant cost or coverage changes; or
- Your dependent no longer qualifies as an eligible dependent.

You must notify and submit any applicable forms and/or documentation to the Benefits Administrator within 30 days of the event. The Benefits Administrator will review your request and determine whether the change you are requesting is allowed. Only benefit changes which are consistent with the qualified life event are permitted.

Consider Your Costs

When you think about your health care costs, the first thing that comes to mind is probably your premium - the amount that comes out of every paycheck for coverage. But to see the total picture, you also have to consider what you're likely to pay out-of-pocket, such as when you go to the doctor or get a prescription filled. Keep this in mind as you review the health care plan sections.

Remember, take what you'll pay for the different coverage options and then add what you think you'll pay for health care services during the year. Estimating your health care costs this way could give you an idea which option will be the best total value for your family.

Medical Benefits

AFS seeks to provide the best possible medical benefits at a reasonable cost. Employees are provided with five medical plan options that include prescription drug coverage.

Please refer to the chart on the next page for a comparison of medical plan benefits.

In-Network Advantage

Within some of the medical, dental and vision plans, you have the freedom to use any provider. However, when you use an in-network provider, the percentage you pay out-of-pocket will be based on a negotiated fee, which is usually lower than the actual charges. If you use a provider who is outside of the network, you may be responsible for paying for the difference between the Usual, Customary and Reasonable (UCR) charges and what the provider charges. You also may need to submit claim forms.

Medical and Prescription Drug Benefits

The information below is a summary of medical coverage only. Visit **https://app.league.com/sign-in** or contact the HR Department at **HRSUPPORT@ameritfleet.com** for detailed plan summaries.

Any deductibles and copays shown in the chart below are amounts for which **you** are responsible.

Cost of Coverage

BENEFIT	BLUE SHIELD GOLD PPO		BLUE SHIELD GOLD HSA		BLUE SHIELD SILVER PPO*		BLUE SHIELD BRONZE PPO	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual/Calendar Year Deductible (Individual/Family)	$850/$1,700	$850/$1,700	$1,500/$3,000	$3,000/$6,000	$2,000/$4,000	$4,000/$8,000	$3,000/$6,000	$6,000/$12,000
Out-of-Pocket Maximum (Individual/Family)	$4,500/$9,000	$9,000/$18,000	$4,500/$9,000	$9,000/$18,000	$6,000/$12,000	$12,000/$24,000	$6,000/$12,000	$12,000/$24,000
Coinsurance	20%	50%	20%	50%	20%	50%	25%	50%
Physician Services								
Doctor's Office Visit	$25 (not subject to deductible)	50%	$25 after deductible	50%	$25 (not subject to deductible)	50%	$25 (not subject to deductible)	50%
Specialist Office Visit	$30 (not subject to deductible)	50%	$30 after deductible	50%	$30 (not subject to deductible)	50%	$30 (not subject to deductible)	50%
Preventive Care	No charge	50%	No charge	50%	No charge	50%	No Charge	50%
Lab & X-ray Services	20%	50%	20%	50%	20%	50%	25%	50%
Hospital Services								
Inpatient	20%	50%	20%	50%	20%	50%	25%	50%
Outpatient	20%	50%	20%	50%	20%	50%	25%	50%
Emergency Care	$200 copay (subject to deductible, copay waived if admitted) + 20%		$200 copay (subject to deductible, copay waived if admitted) + 20%		$200 copay (subject to deductible, copay waived if admitted) + 20%		$200 copay (subject to deductible, copay waived if admitted) + 25%	
Pregnancy & Maternity Care (Prenatal)	20%	50%	20%	50%	20%	50%	25%	50%
PRESCRIPTION DRUGS								
Retail (30-day Supply)								
Generic	20%	Not covered	20%	Not covered	$15 copay	Not covered	$15 copay	Not Covered
Preferred Brand	20%	Not covered	20%	Not covered	$50 copay	Not covered	$50 copay	Not Covered
Non-preferred Brand	20%	Not covered	20%	Not covered	$75 copay	Not covered	$75 copay	Not Covered
Mail Order (90-day Supply)								
Generic	20%	Not covered	20%	Not covered	$30 copay	Not covered	$30 copay	Not Covered
Preferred Brand	20%	Not covered	20%	Not covered	$100 copay	Not covered	$100 copay	Not Covered
Non-preferred Brand	20%	Not covered	20%	Not covered	$150 copay	Not covered	$150 copay	Not Covered
EMPLOYEE CONTRIBUTIONS (PER WEEK)**								
Employee Only	$57.60		$38.40		$25.66		$22.62	
Employee + Spouse/ Domestic Partner	$176.84		$146.66		$121.49		$90.06	
Employee + Child(ren)	$136.16		$95.21		$81.09		$67.28	
Family	$225.87		$174.47		$145.56		$112.51	

NOTE: *Deductibles, copays and coinsurance accumulate toward the out-of-pocket maximums. Usual, Customary and Reasonable charges apply for all out-of-network benefits.*

**Formerly Blue Shield Silver HRA plan. All HRA funds must be used during the year or you will lose them. The run out period allows employees to submit eligible claims incurred during 2020 up until 3/31/2021.*

***Contributions do not include spousal surcharge.*

Medical and Prescription Drug Benefits

BENEFIT	KAISER CA	KAISER GA
	IN-NETWORK	IN-NETWORK
Annual/Calendar Year Deductible (Individual/Family)	$1,500/$3,000	$1,500/$3,000
Out-of-Pocket Maximum (Individual/Family)	$4,000/$8,000	$5,500/$11,000
Coinsurance	20%	20%
Physician Services		
Doctor's Office Visit	$20	$20
Specialist Office Visit	$20	$20
Preventive Care	No Charge	No Charge
Lab & X-ray Services	$10	20%
Hospital Services		
Inpatient	20%	20%
Outpatient	$20	$20
Emergency Care	20%	20%
Pregnancy & Maternity Care (Prenatal)	20%	20%
PRESCRIPTION DRUGS		
Retail (30-day Supply)		
Generic	$10 copay	$15 copay
Preferred Brand	$30 copay	$30 copay
Non-preferred Brand	$30 copay	Not Covered
Mail Order (90-day Supply)		
Generic	$20 copay	$30 copay
Preferred Brand	$60 copay	$60 copay
Non-preferred Brand	$60 copay	Not Covered
EMPLOYEE CONTRIBUTIONS (PER WEEK)**		
Employee Only	$19.30	$20.47
Employee + Spouse/ Domestic Partner	$79.68	$86.41
Employee + Child(ren)	$56.26	$60.22
Family	$95.31	$103.34

NOTE: *Deductibles, copays and coinsurance accumulate toward the out-of-pocket maximums. Usual, Customary and Reasonable charges apply for all out-of-network benefits.*

***Contributions do not include spousal surcharge.*

Dental Benefits

Dental coverage is key to your overall health. AFS offers employees two dental plan options through MetLife. You may go online at **https://app.league.com/sign-in** or contact the HR Department at **HRSupport@ameritfleet.com** for plan summaries that offer detailed information about your coverage, limitations and exclusions. Review the details about each plan carefully so you can determine which plan meets your needs. Your dental plans offer choices that cover four main types of expenses:

- Preventive and diagnostic services like routine exams and cleanings, fluoride treatments, sealants, and x-rays
- Basic services such as simple fillings and extractions, root canals, oral surgery, and gum disease treatment
- Major services such as crowns and dentures
- Orthodontia

Dental Benefits At-a-Glance and Cost of Coverage

BENEFIT	METLIFE PPO HIGH		METLIFE PPO LOW	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual/Calendar Year Maximum	$2,000	$1,500	$1,000	
Annual/Calendar Year Deductible (Individual/Family)	$50/$150	$50/$150	$50/$150	$75/$225
Preventive Services	100%		100%	80%
Basic Services	90%	80%	50%	40%
Major Services	60%	50%	80%	70%
Orthodontia Lifetime Maximum (Children up to Age 19)	$2,000	$1,500	$1,000	
EMPLOYEE CONTRIBUTIONS (PER WEEK)				
Employee Only	$6.42		$2.11	
Employee + Spouse/Domestic Partner	$14.79		$5.56	
Employee + Child(ren)	$16.51		$6.60	
Family	$25.89		$10.50	

Vision Benefits

AFS offers employees one vision plan through Davis Vision that include coverage for eye exams and eyeglasses or contact lenses. You may go online at **https://app.league.com/sign-in** or contact the HR Department at **HRSupport@ameritfleeet.com** for plan summaries that offer detailed information about your coverage, limitations and exclusions.

Vision Benefits At-a-Glance and Cost of Coverage

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Exam	$10 copay	$40 allowance
Lenses	$25 copay	$40 allowance (single vision) $50 allowance (bifocal) $60 allowance (trifocal)
Frames	Collection: Fashion/Designer Covered in Full up to $160	$63 allowance
Contact Lenses Instead of Glasses		
Conventional/Disposable	$120 allowance + 15% off balance over $120	$100 allowance
Medically Necessary	$0 copay	$225 allowance
BI-WEEKLY PAYCHECK DEDUCTIONS		
Employee Only	$1.18	
Employee + Spouse/Domestic Partner	$2.33	
Employee + Child(ren)	$2.28	
Family	$3.47	

NOTE: *ID Card not required for vision services.*

Income Protection Benefits

Basic Life & Accidental Death & Dismemberment (AD&D)

AFS provides you with Basic Life Insurance and AD&D coverage in the amount of $25,000 at no cost if enrolled in a AFS medical plan.

Supplemental Life & AD&D

You can purchase supplemental life coverage for you and your family. You can elect additional life insurance for:

Yourself:	$10,000 increments up to 5x salary or $500,000
Your Spouse/ Domestic Partner:	$5,000 increments up to the lesser of 100% of the employee life amount or $100,000
Your Child(ren):	Less than 14 days: $1,000 14 days - 6 months: $1,000 6 months +: $5,000 increments up to lesser of 100% of the employee life amount of $10,000

To purchase coverage for your spouse, domestic partner, or child(ren), you must enroll yourself for coverage. You pay 100% of the cost for this coverage. Please refer to the plan summaries for the low-cost, age-related rates. Statement of Health application may be required if you elect coverage over the guaranteed issue amount or if you enroll after your initial eligibility period. Age reductions may apply to life insurance amounts.

WHAT DOES GUARANTEED ISSUE MEAN?

Guaranteed issue refers to the amount of insurance you may buy without the insurance company requiring you to provide evidence of insurability (EOI), or Statement of Health.

Voluntary Short-Term Disability (STD)

If you aren't able to work after 7 consecutive days of disability due to an eligible injury or illness, this benefit pays 20% of your weekly pay up to a maximum benefit of $1,216 per week, for a maximum of 12 weeks. You pay the full cost of this coverage.

Voluntary Long-Term Disability (LTD)

This benefit pays a portion of your income if you continue to be disabled and your short-term disability benefits end. To qualify, you must be disabled for 90 days. LTD benefits provide you with 60% of your annual base pay up to a $10,000 monthly maximum. You pay the full cost of coverage.

Flexible Spending Accounts

FSAs help you save money by allowing you to pay for certain types of health care and dependent care expenses on a pre-tax basis. You decide how much money to put aside each payday to cover these expenses up to the maximum.

This amount is then deducted from your pay before taxes and deposited into your FSA. When you need money to cover an eligible expense, you can get reimbursed using a variety of reimbursement methods. Remember to always keep your receipts.

HEALTH CARE SPENDING ACCOUNT	
Use for:	Eligible health care expenses
Annual contribution:	$2,750
DEPENDENT CARE SPENDING ACCOUNT	
Use for:	Eligible child and/or elder care expenses
Annual contribution:	$5,000

NOTE: *Your maximum contribution to the Health Care Spending Account will be limited to $2,750. The maximum for the Dependent Care Spending Account is $5,000 ($2,500 maximum if you are married and file separate tax returns).*

IMPORTANT: USE IT OR LOSE IT!

According to IRS rules, any money remaining in a Health Care or Dependent Care Spending Account after the deadline for filing claims will be forfeited. If you have money left in your Health Care FSA at the end of 2021, you may carry over up to $500 for use in 2022. The money you carry over doesn't count against the IRS annual contribution maximum, which means you can start the year with an amount $500 greater than the IRS limit in your Health Care FSA. You can use the amount throughout the 2021 plan year. This rule applies each subsequent calendar year. This does not apply to the Dependent Care FSA.

Voluntary Benefits

Critical Illness Insurance

Critical Illness Insurance is designed to protect your income and personal assets when your out-of-pocket expenses increase as a result of an illness. Health insurance is not always enough to cover all of the unforeseen expenses associated with a serious medical condition like a heart attack or cancer. Critical Illness Insurance pays a lump sum benefit that can be used any way you choose, and benefits are paid in addition to any other insurance coverage you may have.

COVERED ILLNESSES	PAYMENT PERCENTAGES
Heart Attack	100%
Stroke	100%
Major Organ Transplant	100%
End Stage Renal (Kidney) Failure	100%
Coronary Artery Bypass Surgery*	50%
Invasive Cancer	100%
Non-Invasive Cancer	25%

Plan Features

- You do not have to be terminally ill to receive benefits.
- Coverage options are available for your spouse/domestic partner and children as riders to your coverage.
- Coverage is portable — you can take your policy with you if you change jobs or retire.

NOTE: *The policy/certificate of coverage has exclusions and limitations which may affect any benefits payable.*

Accident Insurance

You don't have to be especially clumsy to experience accidents. These events are all too common, and so are the high medical expenses that come with them.

Accidents are unplanned and unpredictable, but the financial impact that they have on you doesn't have to be either of those things. Voluntary Accident Insurance pays direct benefits for a range of injuries and accident-related expenses such as:

- Fractures
- Dislocations
- Concussion
- Emergency Room Treatment
- Hospitalization
- Accidental Death

Benefit amounts are based on the type of injury and treatment needed. No matter how great your medical plan is, you will have to share the costs of medical care and rehabilitation that follow an accident. Accident Insurance is designed to help you pay for out-of-pocket expenses that insurance doesn't cover, like copays and deductibles, but the benefit payout can be used however you'd like.

Plan Features

No health questions or physical exams are required for enrolling yourself, your spouse or your children in the plan. If you retire or leave AFS, the plan also offers the option for portability.

NOTE: *The policy/certificate of coverage or its provisions may vary or be unavailable in some states. The policy/certificate of coverage has exclusions and limitations which may affect any benefits payable.*

Hospital Indemnity Insurance

If you've ever been in the hospital, you know that it may be difficult to focus on your recovery. You'd rather be in your own bed, eating your own food, and your family might be spending a ton of money to stay at a hotel near you.

The last thing you want to think about is the bill you will receive after your insurance company covers its portion of your hospital stay. Since out-of-pocket costs including deductibles and coinsurance can build quickly, the bills that result from a hospital stay can be overwhelming for anyone – with or without Medical Insurance.

Hospital Indemnity Insurance can help to ease the sticker-shock by paying a benefit directly to you (not to the hospital, or to an insurance company) if you or a covered family member has to stay in the hospital.

Plan Features

Employees who are newly eligible are able to enroll without answering medical questions, meaning acceptance is guaranteed. The plan includes coverage options for spouses and children, and can be taken with you if you leave AFS or retire.

NOTE: *The policy/certificate of coverage or its provisions may vary or be unavailable in some states. The policy/ certificate of coverage has exclusions and limitations, which may affect any benefits payable. The benefits explained in the example above are for illustrative purposes only. Please see your Summary Plan Description (SPD) for complete details.*

Purchasing Power

From computer crashes to appliance breakdowns, the need to make a major purchase can happen when you least expect it. Not to worry–Purchasing Power offers you a better way to buy(TM). The program makes it easy to shop for thousands of brand-name products and pay for them over time through the convenience of automated payroll deduction. And unlike with layaway programs, Purchasing Power allows you to receive your order up front. All with zero interest, no credit check and no hidden fees.

Identity Theft Insurance

Allstate Identity Theft

Allstate Identity Theft plan offers an affordable, comprehensive defense to limit your chances of experiencing fraud and to restore your identity if it does become compromised. Your identity is made up of more than your Social Security number and credit score. That's why Allstate does more than monitor your credit reports. They help you look after your online activity, from financial transactions to what you share on social media — so you can protect the trail of data you leave behind. The plan isn't only for adults, kids' online identities can grow up faster than they do. The Family Plan provides coverage for kids and teens of all ages, so you can help protect their personal data and give them a safe head start. If they are dependent on you financially or live under your roof, they're covered. It includes credit monitoring, an expert to help restore your identity, an identity theft insurance policy and more.

MetLife Legal Plan

Affordable legal assistance can sometimes be difficult to find. If you enroll in the MetLife Legal Plan, you will have access to a network of attorneys. This network can provide comprehensive legal assistance, telephone advice, and office consultations on many different legal services, including:

- Wills & Estate Planning
- Real Estate Matters
- Debt Collection
- Consumer Protection
- Document Review
- Elder Care Issues
- Identity Theft Defense
- Traffic Tickets
- Family Law
- Immigration Assistance
- Advice & Consultation

Premiums for the plan are deducted from your paycheck.

Retirement 401(k) Savings Plan

AFS provides the Amerit Fleet Solutions 401(k) Plan to help secure your financial future and makes it convenient to save through payroll deductions. Your contributions are made on a before-tax basis, so you get an immediate tax break on what you save. Also, you don't pay taxes on your savings or the earnings until funds in your account are paid to you. Contact your HR Department at **HRSupport@ameritfleet.com** for plan information.

Benefits Administrator Information

If you have any questions regarding eligibility, benefit plans or enrollment periods or would like additional information, contact Human resources at **HRSupport@ameritfleet.com**.

Get More Information

BENEFIT	WHO TO CALL	WEBSITE/EMAIL	PHONE NUMBER	PLAN/GROUP ID
Medical & Prescription Drug	Blue Shield of CA	www.blueshieldca.com	1-415-229-5000	W0065269
	Kaiser GA	www.kp.org	1-404-261-2590	231001
	Kaiser CA	www.kp.org	1-800-464-4000	603567
Dental	MetLife	www.metlife.com	1-800-METLIFE	216627
Vision	Davis Vision	www.davisvision.com	1-800-999-5431	505451
Life and AD&D	Unum	www.unum.com	1-866-679-3054	701789
Short-Term Disability Claims	Unum	www.unum.com	1-866-679-3054	701790
Long-Term Disability Claims	Unum	www.unum.com	1-866-679-3054	701790
Voluntary Benefits	Unum	www.unum.com	1-866-679-3054	N/A
Identity Theft	Allstate	www.allstateidentityprotection.com	1-800-789-2720	N/A
Legal Plan	MetLife	www.info.legalplans.com access code 9903774	1-800-821-6400	9903774
Flexible Spending Accounts	Health Equity*	www.wageworks.com	1-877-924-3967	N/A
Health Savings Account	Health Equity*	www.wageworks.com	1-877-924-3967	N/A
COBRA	Health Equity*	www.wageworks.com	1-877-924-3967	N/A
Commuter	WageWorks	www.wageworks.com	1-877-924-3967	N/A
Employee Assistance Program	Unum	www.unum.com	1-866-679-3054	N/A
Retirement 401(k) Savings Plan	Voya	www.voyaretirementplans.com	1-800-584-6001	775028
Human Resources	Amerit Human Resources	HRSupport@ameritfleet.com	1-855-843-9798	N/A
Questions?	help@league.com	https://app.league.com/sign-in		N/A

*Formerly WageWorks.

ABOUT THIS GUIDE: *This guide highlights all employee benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual Summary Plan Description (SPD), plan document or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail.*

Updated 11/2020

Important Notices

About This Guide

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan descriptions (SPDs), plan document, or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail. Amerit Fleet Solutions reserves the right to make changes at any time to the benefits, costs, and other provisions relative to benefits.

Reminder of Availability of Privacy Notice

This is to remind plan participants and beneficiaries of the Amerit Fleet Solutions Health and Welfare Plan (the "Plan") that the Plan has issued a Health Plan Privacy Notice that describes how the Plan uses and disclosed protected health information (PHI). You can obtain a copy of the Amerit Fleet Solutions Health and Welfare Plan Privacy Notice upon your written request to the Human Resources Department, at the following address:

Amerit Fleet Solutions, Human Resources
1331 N California Blvd #150
Walnut Creek, CA 94596

If you have any questions, please contact the Amerit Fleet Solutions Human Resources Office at 1-855-843-9798.

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator 1-855-843-9798.

Newborns' and Mothers' Health Protection Act Disclosure

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

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted and you will continue to pay the same amount as if you were not absent. If the absence is for more than 31 days and not more than 24 months, you may continue to maintain your coverage under the Plan by paying up to 102% of the full amount of premiums. You and your dependents may also have the opportunity to elect COBRA coverage. Contact Amerit Human Resources for more information.

Also, if you elect not to continue your health plan coverage during your military service, you have the right to be reinstated in the Plan upon your return to work, generally without any waiting periods or pre-existing condition exclusions, except for service connected illnesses or injuries, as applicable.

This guide contains important information about the Medicare Part D creditable status of your prescription drug coverage on page 11.

Medicare Part D Notice Of Creditable Coverage

Your Options

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Amerit Fleet Solutions 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. Amerit Fleet Solutions has determined that the prescription drug coverage offered by the Medical Plans through Blue Shield of California and Kaiser Permanente is, on average, for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through 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 Amerit coverage will not be affected.

Your Amerit coverage pays for other medical expenses in addition to prescription drugs. If you or your covered family member for whom Medicare pays second enrolls in a Medicare drug plan, your Amerit medical and prescription drug coverage will not be impacted. For example,

Medicare pays second for active employees who are Medicare eligible due to age and spouses of active employees who are Medicare eligible due to age. As a result, these individuals will not be disenrolled from the Amerit medical or prescription drug plans if they enroll in a Medicare drug plan. However, you should be aware that Amerit will not reimburse you for any Part D premium that may apply to your enrollment in a Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your current Amerit coveage, be aware that you and your dependents may not be able to get this coverage back except during the annual open enrollment period.

When will you pay a higher premium (penalty) to join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Amerit Fleet Solutions 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 through Amerit Fleet Solutions 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 for personalized help. See the inside back cover of your copy of the "Medicare & You" handbook for their telephone number.
- 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: **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: 10/15/2020
Name of Entity/Sender: Amerit Fleet Solutions
Contact: HR Support
Amerit Fleet Solutions
Address: 1331 N California Blvd #150
Walnut Creek, CA 94596
Phone Number: **1-855-843-9798**

Your ERISA Rights

As a participant in the Amerit Fleet Solutions benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan participants shall be entitled to receive information about their plan and benefits, continue group health plan coverage, and enforce their rights. ERISA also requires that plan fiduciaries act in a prudent manner.

Receive Information About Your Plan and Benefits

You are entitled to:

- Examine, without charge, at the plan administrator's office, all plan documents—including pertinent insurance contracts, trust agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the plan's administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary report of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continued Group Health Plan Coverage

You are entitled to:

- Continued health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have credible coverage from another plan. You should be provided a certificate of credible coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the plan;
  - You become entitled to elect COBRA continuation coverage;
  - You request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plans. The people who operate your plans are called "fiduciaries," and they have a duty to act prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to:

- Know why this was done;
- Obtain copies of documents relating to the decision without charge; and
- Appeal any denial.

All of these actions must occur within certain time schedules. Under ERISA, there are steps you can take to enforce your rights. For instance, you may file suit in a federal court if:

- You request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator;
- You have followed all the procedures for filing and appealing a claim (as outlined earlier in this summary) and your claim for benefits is denied or ignored, in whole or in part. You may also file suit in a state court.
- You disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order; or
- The plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. This should occur if the court finds your claim frivolous.

Assistance with Your Questions

If you have questions about how your plan works, contact the Human Resources Department. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office listed on EBSA's website: **https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/regional-offices**

Or you may write to the:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee and Employer Hotline of the Employee Benefits Security Administration at: **1-866-275-7922**. You may also visit the EBSA's web site on the Internet at: **http://www.dol.gov/ebsa**.

Continuation Coverage Rights Under Cobra

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage.

It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

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

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

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

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

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

- 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 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Amerit Fleet Solutions Human Resources.

How is COBRA 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. Any qualified beneficiary who does not elect COBRA within the 60-day election period specified in the election notice **will lose his or her right to elect COBRA.**

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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Continuation Coverage Rights Under Cobra

Disability extension of 18-month period of continuation coverage

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

The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of the date of the Social Security Administration's disability determination; the date of the covered employee's termination of employment or reduction in hours; and the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction in hours. You must also provide this notice within 18 months after the covered employee's termination or reduction in hours in order to be entitled to this extension. You must provide the notice by sending to the Plan Administrator or its designee in accordance with the procedures above.

Second qualifying event extension of 18-month period of continuation coverage

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

Other Coverage Options

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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

For further information regarding the plan and COBRA continuation, please contact:

Amerit Fleet Solutions Benefits Supervisor
1331 N California Blvd #150
Walnut Creek, CA 94596
1-855-843-9798

Summaries of Benefits and Coverage (SBCs)

As required by the Affordable Care Act, Summaries of Benefits and Coverage (SBCs) are available on the Amerit Fleet Solutions website at **www.ameritfleetsolutions.com/employee**. If you would like a paper copy of the SBCs (free of charge), you may also call HR Support at **1-855-843-9798**.

Amerit Fleet Solutions is required to make SBCs available that summarize important information about health benefit plan options in a standard format, to help you compare across plans and make an informed choice. The health benefits available to you provide important protection for you and your family and choosing a health benefit option is an important decision.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

1. ALABAMA – Medicaid
   Website: http://myalhipp.com/
   Phone: 1-855-692-5447
2. 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
3. ARKANSAS - Medicaid
   Website: http://myarhipp.com/
   Phone: 1-855-MyARHIPP (855-692-7447)
4. CALIFORNIA – Medicaid
   Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
   Phone: 916-440-5676
5. COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado Website: https://www.healthfirstcolorado.com/
   Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
   CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
   CHP+ Customer Service: 1-800-359-1991/ State Relay 711
   Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
6. FLORIDA – Medicaid
   Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
   Phone: 1-877-357-3268
7. GEORGIA – Medicaid
   Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
   Phone: 1-678-564-1162 ext 2131
8. INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64
   Website: http://www.in.gov/fssa/hip/
   Phone: 1-877-438-4479
   All other Medicaid
   Website: https://www.in.gov/medicaid/
   Phone 1-800-457-4584
9. IOWA – Medicaid and CHIP (Hawki)
   Medicaid Website: https://dhs.iowa.gov/ime/members
   Medicaid Phone: 1-800-338-8366
   Hawki Website: http://dhs.iowa.gov/Hawki
   Hawki Phone: 1-800-257-8563
10. KANSAS-Medicaid
    Website: http://www.kdheks.gov/hcf/default.htm
    Phone: 1-800-792-4884
11. KENTUCKY-Medicaid
    Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
    Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx - Phone: 1-855-459-6328
    Email: KIHIPP.PROGRAM@ky.gov
    KCHIP Website:https://kidshealth.ky.gov/Pages/index.aspx
    Phone: 1-877-524-4718
    Kentucky Medicaid Website: https://chfs.ky.gov
12. LOUISIANA – Medicaid
    Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
    Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
13. MAINE – Medicaid
    Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
    Phone: 1-800-442-6003 TTY: Maine relay 711
    Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
    Phone: 1-800-977-6740 TTY: Maine relay 711
14. MASSACHUSETTS – Medicaid and CHIP
    Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
    Phone: 1-800-862-4840
15. 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
16. MISSOURI – Medicaid
    Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
    Phone: 573-751-2005
17. MONTANA – Medicaid
    Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
    Phone: 1-800-694-3084
18. NEBRASKA – Medicaid
    Website: http://www.ACCESSNebraska.ne.gov
    Phone: 1-855-632-7633
    Lincoln: 402-473-7000
    Omaha: 402-595-1178
19. NEVADA – Medicaid
    Medicaid Website: http://dhcfp.nv.gov
    Medicaid Phone: 1-800-992-0900
20. NEW HAMPSHIRE – Medicaid
    Website: https://www.dhhs.nh.gov/oii/hipp.htm
    Phone: 603-271-5218
    Toll free number for the HIPP program: 1-800-852-3345, ext 5218
21. 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 index.html CHIP Phone: 1-800-701-0710
22. NEW YORK – Medicaid
    Website: https://www.health.ny.gov/health_care/medicaid/
    Phone: 1-800-541-2831
23. NORTH CAROLINA – Medicaid
    Website: https://medicaid.ncdhhs.gov/
    Phone: 919-855-4100
24. NORTH DAKOTA – Medicaid
    Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
    Phone: 1-844-854-4825
25. OKLAHOMA – Medicaid and CHIP
    Website: http://www.insureoklahoma.org
    Phone: 1-888-365-3742
26. OREGON – Medicaid
    Website: http://healthcare.oregon.gov/Pages/index.aspx
    http://www.oregonhealthcare.gov/index-es.html
    Phone: 1-800-699-9075
27. PENNSYLVANIA – Medicaid
    Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
    Phone: 1-800-692-7462
28. RHODE ISLAND – Medicaid and CHIP
    Website: http://www.eohhs.ri.gov/
    Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
29. SOUTH CAROLINA – Medicaid
    Website: https://www.scdhhs.gov
    Phone: 1-888-549-0820
30. SOUTH DAKOTA - Medicaid
    Website: http://dss.sd.gov
    Phone: 1-888-828-0059
31. TEXAS – Medicaid
    Website: http://gethipptexas.com/
    Phone: 1-800-440-0493
32. UTAH – Medicaid and CHIP
    Medicaid Website: https://medicaid.utah.gov/
    CHIP Website: http://health.utah.gov/chip
    Phone: 1-877-543-7669
33. VERMONT– Medicaid
    Website: http://www.greenmountaincare.org/
    Phone: 1-800-250-8427
34. VIRGINIA – Medicaid and CHIP
    Website: https://www.coverva.org/hipp/
    Medicaid Phone: 1-800-432-5924
    CHIP Phone: 1-855-242-8282
35. WASHINGTON – Medicaid
    Website: https://www.hca.wa.gov/
    Phone: 1-800-562-3022
36. WEST VIRGINIA – Medicaid
    Website: http://mywvhipp.com/
    Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
37. WISCONSIN – Medicaid and CHIP
    Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
    Phone: 1-800-362-3002
38. WYOMING – Medicaid
    Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
    Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

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

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

Glossary

Affordable Care Act and Patient Protection (ACA)
Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, reduced FSA contributions, covering preventive care without cost-sharing, etc, among other requirements.

Brand Name Drug
The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

Coinsurance
A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

Copayment (Copay)
A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Deductible
The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Employer Contribution
Each week, the company provides you with an amount of money that you can apply toward the cost of your health care premiums. The amount of the employer contribution depends on who you cover. You can see the amount you'll receive when you enroll. If you're enrolling as a new hire, the employer contribution amount will be prorated based on your date of hire.

Generic Drug
Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)
High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

Health Savings Account (HSA)
A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

Out-of-Pocket Maximum
The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Plan Year
The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

Preventive Care
Health care services you receive when you are not sick or injured—so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

Amerit
FLEET SOLUTIONS