

2027 | All Employees

Benefits Guide



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Disclaimer: The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Human Resources Department.

Resources:

Self-Guided Tour of all Benefits:



ezICHRA Benefit Instructions:



Paycom Benefits Instructions:

Log into Paycom Employee Self-Service >Go to Learnings >Open Assigned Learning or History Tab

Welcome

We understand that your life extends beyond the workplace. That's why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

When to Enroll

- **Current Employees:** Open enrollment is your once-a-year opportunity to adjust benefit coverages and update any dependents. It's also a good time to review and update your beneficiaries on applicable policies.
- **New Hires:** Complete your enrollment with 30 days of hire. Some benefits have "guarantee issue" at your first opportunity only, so please carefully consider this before you decline any coverage.

Two Step Enrollment

1. Enroll in medical in the ezICHRA portal
2. Enroll in Guardian plans & FSA in Paycom

***Selecting the "Medical Plan Placeholder" in Paycom does NOT enroll the employee in medical coverage.**

When to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 30 days of the qualifying event. Examples include:

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

Benefit Highlights

Benefit changes take effect on **01/01/2027**.



Protect Your
Health

- If you are currently enrolled and miss the deadline, ezICHRA will automatically renew your current plan or assign a comparable option at the new 2027 rates. *Only if it is available
- If you are not currently enrolled and do not complete the enrollment, you will be waiving medical coverage for 2027.
- If you do not wish to enroll, please log into the portal and waive coverage.



Employer
Provided
Benefits

- **Employer Provided Benefits at No Cost to You**
- **Basic Life/AD&D:** Choices in Community Living Inc provides \$15,000 of coverage! Employees working 17 hours or more per week are eligible for this benefit. *Subject to age reduction
- **Short-Term Disability:** Choice in Community Living Inc provides Short-Term Disability coverage at no cost to you! 60% of your salary up to \$1,000/week. Employees working 17 hours or more per week are eligible for this benefit.
- **Teladoc Virtual Care:** For all employees and their dependents.



Plan for the
Unexpected

- **Voluntary Life/AD&D:** Provide financial security for your loved ones if you pass away. **THIS YEAR ONLY**, elect up to \$200,000 of coverage for yourself with no health questions. Guaranteed issue coverage is also available for spouses (\$50,000) and dependents (\$10,000). Limits may apply.
- **Voluntary Long-Term Disability:** This coverage provides income replacement in the event you are unable to work due to injury or illness. Pre-existing condition limitations may apply.



Protect Your
Wallet

- **Voluntary Accident, Critical Illness, and Hospital Indemnity:** Get cash benefits for non-work-related accidents, diagnoses such as cancer, stroke, or heart attack, or hospital stays including routine pregnancy. **NEW this year- Each plan now includes a \$100 wellness benefit that pays you for completing annual health screenings. That is up to \$300 annually for each enrolled member!**

How to Enroll

Two-Step Enrollment

1. Enroll in Medical in ezICHRA Portal



Scan QR code or visit ezICHRA portal

2. Enroll in Guardian + FSA in Paycom



Scan QR code or visit Paycom

Don't Miss Out!

To ensure you are covered appropriately, everyone is encouraged to complete open enrollment between

Nov 6st - Nov 15th 2026



Contacts

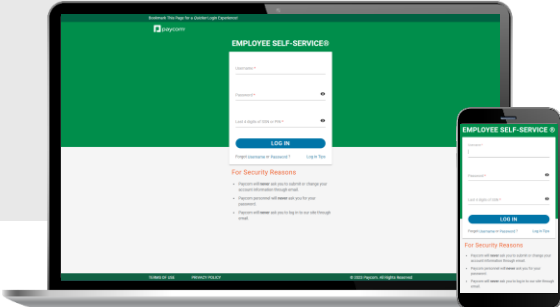
Choices in Community Living Inc Benefits Contact	
<p>Payroll and Benefits Department 937-898-2220</p>	<p>For enrollment assistance schedule an appointment via the QR Code, Select a Date & Time - Calendly, or contact the office.</p> <p>For existing medical insurance renewal, bring the renewal letter from your carrier to the appointment.</p> 

Coverage	Carrier	Phone Number	Website/Email
Dental Insurance	Guardian	888-600-1600	www.guardianlife.com
Vision Insurance			
FMLA, STD, LTD Leave Request	Guardian	888-889-2953	guardiananytime.com
Flexible Spending Account	Chard Snyder	800-982-7715	www.chard-snyder.com
Teladoc	Teladoc Health	800-835-2362	Teladochealth.com



Enroll through Paycom

Scan QR code or visit Paycom



Eligibility

Employee Eligibility

All employees working 17+ hours per week will be eligible for Guardian and FSA benefits.

All employees working 30+ hours per week will be eligible for Guardian, FSA, and Medical Insurance.

As a new employee, you must enroll within 30 days from the date of hire.

All benefits will take effect on the first of the month following 60 days of employment.

*** IMPORTANT:** These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

Dependent Eligibility

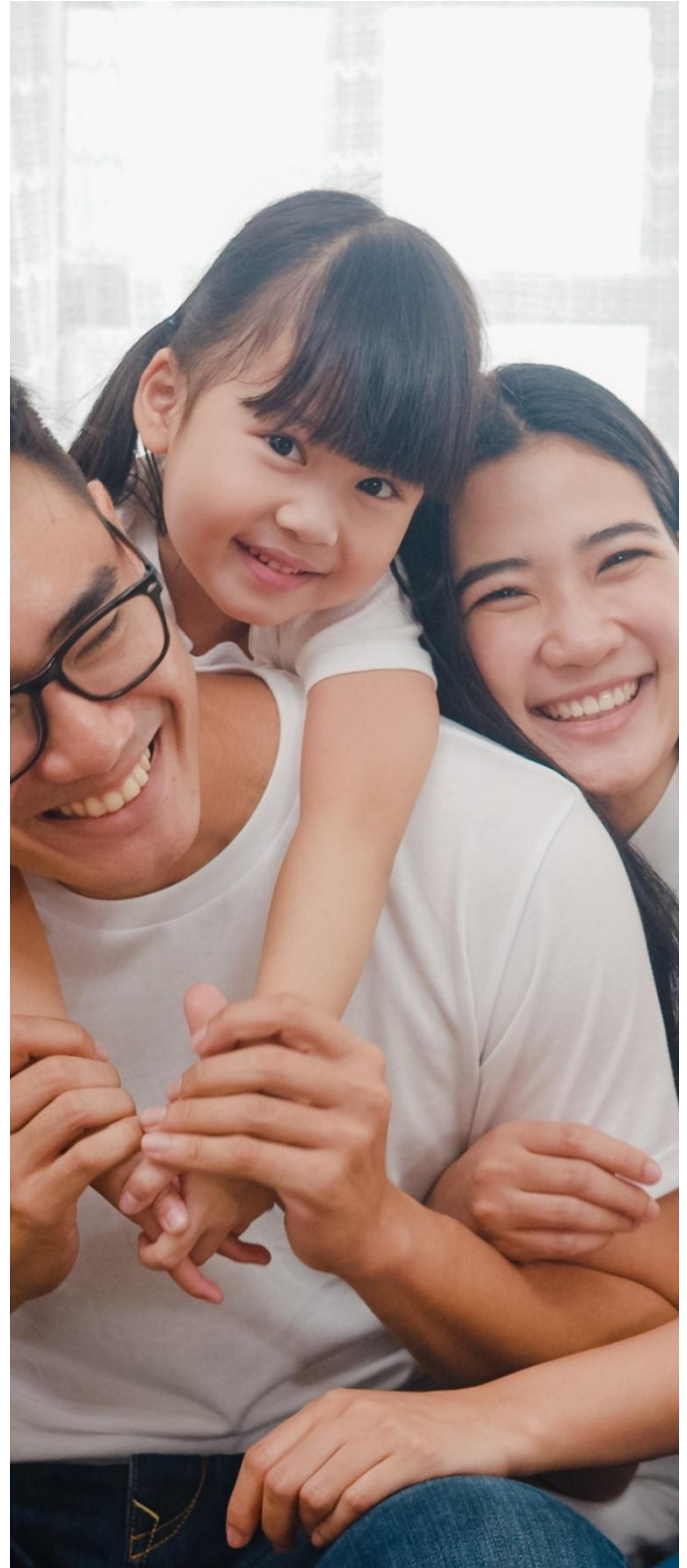
If you are enrolled in coverage, you may also have the option to enroll your dependents in coverage.

Definition of “Eligible Dependents”

Dental, and Vision Coverage dependents include:

- **Your legally married spouse.** Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, “spouse” shall not mean a common law spouse or domestic partner.
- **Your dependent children under age 26.** This includes natural, step, foster, adopted, or other children under your legal guardianship.
- For additional eligibility details, please refer to the policy contract or summary plan documents.

Other Coverages: See page 10 for definitions of an “eligible dependent” under the Voluntary Life/AD&D Policy. Please note that benefit-eligible employees cannot be enrolled as a “spouse”, and dependent children cannot be covered more than once. Please refer to the policy certificate or HR for more information.





Employee Contributions

If you elect coverage, your premiums will be conveniently deducted from your paycheck **each pay period**. Please contact the Benefits Department regarding any questions or concerns.

Dental	
Employee Only	\$13.25
Employee + 1	\$25.64
Family	\$45.25
Vision	
Employee Only	\$3.10
Employee + Spouse	\$6.20
Employee + Child(ren)	\$6.35
Family	\$9.46

Basic Life/AD&D	Employer-provided
Short-Term Disability	Employer-provided
Voluntary Life/AD&D	To view your personalized rates, log in to Paycom
Vol Long-Term Disability	
Accident	
Critical Illness	
Hospital Indemnity	



Employee Assistance Program

Guardian

*Available to all employees enrolled in
Guardian products.*

Life. Just when you think you've got it figured out, along comes a challenge. This safe and confidential program is here for you and can help you and your family find solutions and peace of mind.

Confidential Support

- Alcohol or substance abuse
- Childcare
- Eldercare
- Financial problems
- Gambling addiction
- Grief and loss
- Job pressures
- Mental health
- Legal concerns
- Relationships

Connect with a counselor

1-855-239-0743

[Guidanceresources.com](https://www.guidanceresources.com)



Dental

Guardian

Dental	In-Network
Annual Deductible	\$0 per individual \$0 per family
Annual Benefit Maximum	\$1,000
Lifetime Orthodontia Maximum	\$1,000
Plan Pays	In-Network
Preventive Care (Deductible waived)	100% Covered
Basic	100% Covered in Value Network 80% Covered in NAP Network
Major	60% Covered in Value Network 50% Covered in NAP Network
Orthodontia	50%

Dental BiWeekly Cost	
Employee Only	\$13.25
Employee + 1	\$25.64
Family	\$45.25

Locate an in-network provider near you at www.guardianlife.com
or call 888-600-1600

Please review the full plan documents for details **including out-of-network coverage**. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Vision

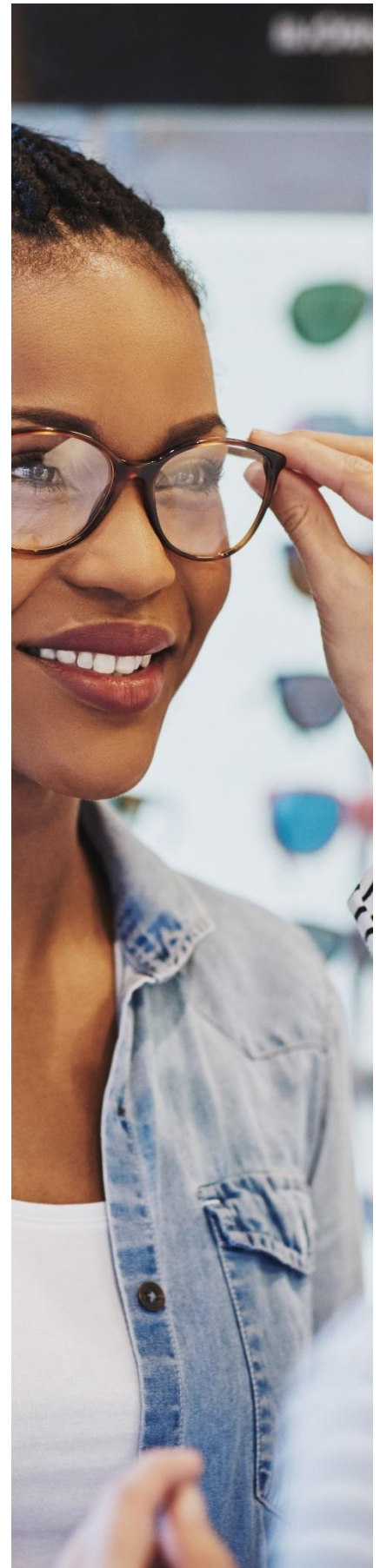
Guardian

Vision	In-Network
Exam	\$10 copay in-network
Lenses	\$25 copay in-network
Frames	\$130 allowance in-network
Contact Lenses	\$130 copay for Elective in-network 100% covered if medically necessary in-network
Frequencies	
Exams	1 per 12 months
Lenses or Contacts	1 per 12 months
Frames	1 per 24 months

Vision Cost	BiWeekly
Employee Only	\$3.10
Employee + Spouse	\$6.20
Employee + Child(ren)	\$6.35
Family	\$9.46

Locate an in-network provider near you at www.guardianlife.com
or call 888-600-1600

Please review the full plan documents for details **including out-of-network coverage**. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.



Life/AD&D

Guardian

Life insurance protects your loved ones financially in the event of your death. Accidental death and dismemberment (AD&D) provides an additional benefit if you die or experience other covered catastrophic loss due to a covered accident.

Basic Life/AD&D

Benefit Amount	Employee: \$15,000*
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Benefit Cost	Employer-provided
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Voluntary Term Life/AD&D

Benefit Amount	Employee: 5x salary up to \$500,000
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	Spouse: Up to \$50,000^
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	Child(ren): Up to \$10,000^
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Guaranteed Issue Amount^A	
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	Employee: \$200,000
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Benefit Cost	
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	To view your personalized rates, log in to Paycom .
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Benefits may be reduced for employees over age 65 per ADEA.

Actively-At-Work Requirement:

New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Dependent Delayed Effective Date:

Dependents may have a delayed effective date based on his/her health status at time of the effective date. Please refer to the policy certificate or HR for more details.

Definition of "Eligible Dependents"

It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies.

- **Spouse:** Eligibility may terminate at Spouse age 70.
- **Child:** Eligibility terminates earliest of age 26, married, or employed full time, or no longer a Full Time Student. Terms may vary for children with special needs. Benefits may be limited for children under age 6 months.

*Subject to age reduction

Please refer to the policy certificate or HR for more information.



Remember to update your beneficiaries.

It is important to update your beneficiaries and make sure they are accurate periodically. Having out of date beneficiaries listed will make it difficult to pay the benefit to the correct person in case it is ever needed.

^A Dependent elections require employee enrollment and may be limited by employee volume.

^A If you enroll when first eligible, you may receive up to the listed amount without having to answer medical questions.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Disability

Guardian

If you become disabled due to a covered injury or illness, disability income benefits may provide a partial replacement of lost income.

Company-Provided Short-Term Disability

Benefit Amount	Replaces 60% of earnings, up to a \$1,000 benefit per week
Benefit Begins	Injury: after 7 days Illness: after 7 days
Benefit Duration	Up to 12 weeks

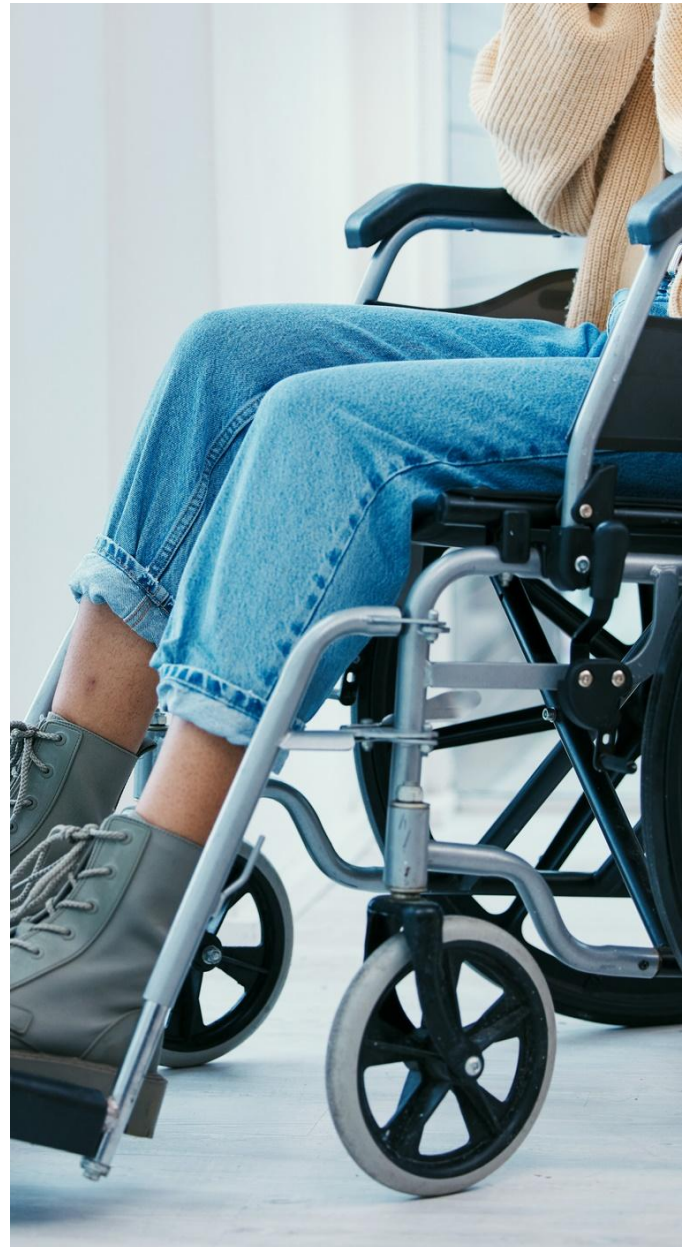
Short-term disability excludes work-related injury or illness.

Voluntary Long-Term Disability

Benefit Amount	Replaces 60% of earnings, up to a \$5,000 benefit per month
Benefit Begins	After a period of 90 days
Benefit Duration	Up to 5 Years
Pre-Existing Condition Limitations	3-month look back period 12-month exclusion period

*Executive benefits may differ

Disability Cost	To view your personalized rates, log in to Paycom .
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Pre-Existing Condition Limitations:

If you file a claim within the exclusion period following your plan effective date, the carrier will review to determine if the condition existed during the look back period. If so, benefits may be denied.

Actively-At-Work Requirement:

New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Statutory Benefits Offset:

Your short-term disability benefit will be reduced by benefits from State Disability/Paid Family & Medical Leave for which you may be eligible.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Supplemental Health

Guardian

The following benefits may protect your financial security in the event of an unexpected medical expense.

Accident		
Helps cover the cost of expenses if you are injured in a non-work-related, covered accident.		
Benefit Amount	Benefit amounts vary by severity. See schedule of benefits for details.	
Wellness Benefit	\$100	
Common Covered Injuries	Dislocations Fractures	Concussions Lacerations
Common Medical Services	Ambulance Emergency room visits Hospital admission	Surgical benefits Follow-up treatments
Other Benefits	Travel Lodging Child organized sports-rider	Accidental death and dismemberment

Critical Illness		
Helps cover the cost of expenses if you are diagnosed with a covered condition.		
Benefit Amount	Employee: Up to \$50,000 Spouse: Up to \$50,000 Child: Up to \$25,000	
Wellness Benefit	\$100	
Pre-Existing Condition Limitations	None	
Common Covered Conditions	Cancer Heart attack Stroke	Major organ failure Degenerative neurological disorders



Get paid for taking care of your health!

New this year, a \$100 wellness benefit payment per covered person, per policy.

Hospital Indemnity	
Helps cover the cost of hospital stays—including pregnancy and childbirth.	
Benefit Amount	\$1,000 hospital admission benefit \$200 daily confinement
Wellness Benefit	\$100
Pre-Existing Condition Limitations	None
Supplemental Health Cost	To view your personalized rates, log in to Paycom .

Actively-at-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-at-Work/eligible status.

Dependent Delayed Effective Date:
Dependents may have a delayed effective date based on his/her health status at the time of the effective date. Please refer to the policy certificate or HR for more details.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Discount Program

PerkSpot is offered through our partnership with Cottingham & Butler

This program provides you access to an online marketplace that delivers thousands of discounts for everyday business and personal purchases, leveraging the purchasing power of some of the largest employers in the United States.

Discount Program

Shop for a Variety of Coupons & Deals from these Categories:

Apparel	Home & Garden
Auto Buying	Home Services
Automotive	Insurance & Protection Services
Beauty & Fragrance	Jewelry & Watches
Books, Movies, & Music	Movie Tickets
Business Perks	Office & Business
Cell Phones	Pets
Education	Real Estate & Moving Services
Electronics	Sports & Outdoors
Financial Wellness	Tickets & Entertainment
Flowers & Gifts	Toys, Kids & Babies
Food	Travel
Health & Wellness	
Hobbies & Creative Arts	

Popular Discounted Brands*

Avis	Dell	Home Chef
Canon	Enterprise	HP
Casper	Holiday Inn	Ray-Ban
Columbia		

Benefit Cost

Included in our partnership with Cottingham & Butler

* All brands and discounts available are subject to change. For a current listing of discounts and brands offered visit the website at <https://cottinghambutler.perkspot.com>.



Unlock discounts for you and your family!

Visit: <https://cottinghambutler.perkspot.com>

If prompted to find your community, select our PerkSpot partner: Cottingham and Butler.

Who is PerkSpot?

- Online savings resource for employees
- Headquartered in Chicago, IL – Founded in 2006
- 750+ clients nationwide, 15 million members
- 30,000+ discount offers

Website Features

- Recommended for You: chosen based on your top interests
- Featured Offers: hand-selected to help you stretch your dollars
- Today's Perk Alerts: today's best limited-time sales
- Popular Savings: trending offers
- Categories: shop by category

Benefit Terms

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a \$1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is \$800. Because John hasn't paid anything toward his deductible yet this year, and because the \$800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.
- **HDHP**—High deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

Choices in Community Living, Inc. Health Plan: Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage. ❖

Benefits during a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the State

Medicaid or CHIP office to find out if premium assistance is available.

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

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

Employees living in one of the following States may be eligible for assistance paying employer health plan premiums. The following list of States is current as of July 31, 2026. V8. The most recent CHIP notice can be found at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra>. Contact the respective State for more information on eligibility –

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA – Medicaid

AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
<https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
Website: <https://www.dhcs.ca.gov/services/health-insurance-premiumpayment-program-cost-avoidance/>
Phone: 916-445-8322

Fax: 916-440-5676

Email: hipp@dhcs.ca.gov

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+ Website: <https://hcpf.colorado.gov/child-health-plan-plus>
CHP+ Customer Service:
1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI) Website:
<https://www.mycohibi.com/>
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
Phone: 678-564-1162, Press 1
GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
Phone: 678-564-1162, Press 2

ILLINOIS – Medicaid

Illinois Medicaid Premium Assistance Information
Medicaid Application Website:
<https://abe.illinois.gov>
HIPP Hotline Number: 217-524-8268
HIPP Email: mhfs.boc.hipp@illinois.gov

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: <https://www.in.gov/medicaid/http://www.in.gov/fssa/dfr/>
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment

(HIPP) | Health & Human Services (iowa.gov)

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

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://kynect.ky.gov>

Phone: 1-877-524-4718

Kentucky Medicaid Website:

<https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

Website: <https://www.ldh.la.gov/healthy-louisiana>

Medicaid Customer Service Line: 1-888-342-6207

Louisiana Medicaid email: healthy@la.gov

Louisiana Health Insurance Premium Program

(LaHIPP) Website: <https://www.ldh.la.gov/la hipp>

LaHIPP phone: 1-877-697-6703

LaHIPP email: La.HIPP@la.gov

LaHIPP fax: 1-888-716-9787

LaHIPP mailing address: 100 Crescent Centre

Parkway, Suite 1000 Tucker, GA 30084

MAINE – Medicaid

Enrollment Website:

https://www.mymaineconnection.gov/benefits/s/?language=en_US

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

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>

Phone: 1-800-862-4840

TTY: 711

Email: masspreassistance@accenture.com

MINNESOTA – Medicaid

Website:

<https://mn.gov/dhs/health-care-coverage/>

Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 573-751-2005

MONTANA – Medicaid

Website:

<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084

Email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://accessnebraska.ne.gov>

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcfp.nv.gov>

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website:

<https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>

Phone: 603-271-5218

Toll free number for the HIPP program:

1-800-852-3345, ext. 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website:

<https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/>

Phone: 1-800-356-1561

CHIP Premium Assistance Phone: 609-631-2392

CHIP Website:

<http://www.nifamilycare.org/index.html>

CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <https://www.hhs.nd.gov/healthcare>

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>

Phone: 1-888-365-3742

OREGON – Medicaid

Website:

<http://healthcare.oregon.gov/Pages/index.aspx>

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>

Phone: 1-800-692-7462

CHIP Website: [Children's Health Insurance Program \(CHIP\) \(pa.gov\)](http://childrens.healthinsurancesystem.org/CHIP)

CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>

Phone: 1-855-697-4347 or

401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>

Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>

Phone: 1-888-828-0059

TEXAS – Medicaid

Website: <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance

(UPP) Website: <https://medicaid.utah.gov/upp/>

Email: upp@utah.gov

Phone: 1-888-222-2542

Adult Expansion Website:

<https://medicaid.utah.gov/expansion/>

Utah Medicaid Buyout Program Website:

<https://medicaid.utah.gov/buyout-program/>

CHIP Website: <https://chip.utah.gov/>

VERMONT – Medicaid

Website: <https://dvha.vermont.gov/members/medicaid/hipp-program>

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>

<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>

Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: <https://bms.wv.gov/>

<http://mywvhipp.com/>

Medicaid Phone: 304-558-1700

CHIP Toll-free phone:

1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:

<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/>

healthcarefin/medicaid/programs-and-eligibility/

Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since July 31, 2026, 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 ❖

Patient Protection Notice

If the Choices in Community Living, Inc. Health Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, you will be able to designate a new provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources. ❖

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). 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.
- 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. ❖

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers offering group health insurance coverage 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 normal 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 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). ❖

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge. ❖

Special Enrollment Rights

If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.