Your Employee Benefits 2025

Welcome to your 2025 Employee Benefits!

Child Adult Resource Services, Inc. recognizes the important role employee benefits play as a critical component of your overall compensation. We strive to maintain a benefits program that is competitive within our industry and designed to protect your health, your family and your way of life.

This guide was created to answer some of the questions you may have and provide the tools and resources you will need to take full advantage of the programs and plans being offered. Please read it carefully along with any supplemental materials you receive.

For any questions about the benefits outlined in the guide, please contact your Human Resources Department.

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PLEASE NOTE: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). Your company reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

Carrier Contacts

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. Follow these steps if you require assistance:

- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.
- For claims assistance, please contact the insurance carrier. You will need your ID number or Social Security number along with date of service and provider name.

Carrier Contacts	Group #	Website	Phone
Medical & Prescription			
Clearwater		www.clearwaterhealth.com	1.855.759.0684
EHIM		https://www.ehimrx.com	1.800.311.3446
Dental			
Anthem	W11697	www.anthem.com	1.877.604.2142
Vision			
Anthem	W11697	www.anthem.com	1.866.723.0515
Basic Life and AD&D			
Anthem	00250296	www.anthem.com	1.800.801.6142
Employee Assistance Program			
Perspectives		https://perspectives.mylifeexpert.com	1.800.456.6327
401(k)			
Mutual of America		www.mutualofamerica.com	1.800.468.3785
CARS Human Resources			
Teri King		tking@cars-services.org	1.765.569.2076
AssuredPartners Broker Advisor			
Jonathan Bozarth		jonathan.bozarth@assuredpartners.com	1.270.663.7225
Joe Eames		joe.eames@assuredpartners.com	1.270.663.7226
AssuredPartners Account Manager			
Laurie Payne		laurie.payne@assuredpartners.com	1.270.663.7231

Eligibility

Child Adult Resource Services, Inc. shares in the cost by paying for a portion of the employee and dependent health insurance costs. Dependents are eligible to participate in the health & welfare plan. Your completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

Any elections made will remain in effect and cannot be changed or revoked until the next annual Open Enrollment period, unless the change is due to and consistent with a family/life status change.

Who is eligible for Benefits?

Employees working 30+ hours per week, benefits begin on the first of the month following 60 days.

Eligible Dependents

- A spouse whom you are legally married. (dental & vision coverage only)
- A dependent child under age 26.

Coverage for eligible dependents generally begins on the same day your coverage is effective.

**Additional carrier conditions may apply.*

Benefit Change in Status

Child Adult Resource Services sponsors a cafeteria plan which allows eligible employees to choose from a menu of different benefits to suit their needs and to pay for some or all of those benefits with pre-tax dollars.

Participant elections made under a cafeteria plan are generally irrevocable and run from the beginning of the Plan Year (or date of initial eligibility) through the end of the Plan Year. With the exception of HSA contribution elections, you will not be able to change or revoke your elections during the Plan Year unless you experience an IRS permitted qualifying event. Any change you make must be consistent with the qualifying event. Examples of qualifying events that may entitle you to make a mid-year change in your election during a Plan Year, include:

- Birth / Adoption
- Divorce
- Death
- FMLA Related Leave
- Dependent Child Age Limit
- Marriage
- Loss of Coverage
- Eligible for Medicare

Employers do not have to permit any exceptions to the election irrevocability rule for cafeteria plans. Please consult your Plan Administrator for the specific qualifying events permitted by your plan.

You must notify your Human Resources Department within 31 days from the Status Change in order to make a change in your benefit selections.

Medical Insurance

CARS is proud to offer you a choice between two different medical plans. Coverage under both plans includes comprehensive medical care and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle. Below is a brief description of these plans. To locate a participating provider with Clearwater please visit www.clearwaterhealth.com or call 1.855.759.0684.

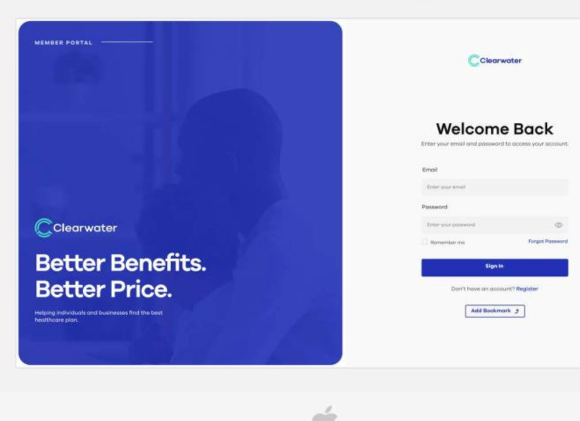
	Clearwater PPO Plan			Clearwater HSA 5000 Plan	
Deductible	Tier 1	Tier 2	Tier 3	In Network	Out-of-Network
Single	$0	$1,500	$1,500	$5,000	$5,000
Family*	$0	$3,000	$3,000	$15,000	$15,000
Out-of-Pocket					
Single	$6,000	$6,000	$12,000	$5,000	$10,000
Family	$12,000	$12,000	$24,000	$10,000	$20,000
PCP	N/A	$25 copay	$25 copay + amounts that exceed reasonable allowable charge	0% after deductible	0% after deductible + amounts that exceed reasonable allowable charge
Specialist	No Charge	$45 copay	$45 copay + amounts that exceed reasonable allowable charge	0% after deductible	0% after deductible + amounts that exceed reasonable allowable charge
Emergency Room	N/A	30% after deductible	30% after deductible	0% after deductible	0% after deductible
Urgent Care	No Charge	$65 copay	50% after deductible + amounts that exceed reasonable allowable charge	0% after deductible	50% after deductible + amounts that exceed reasonable allowable charge
Inpatient Services	No Charge	30% after deductible	50% after deductible	0% after deductible	50% after deductible
Outpatient Services	No Charge	30% after deductible	50% after deductible	0% after deductible	50% after deductible

Prescription Drugs	In-Network	Out-of-Network	In-Network	Out-of-Network
Retail (30-day)				
Generic	$0 copay	Not Covered	0% after deductible	50% after deductible
Preferred Brand	$35 copay	Not Covered	0% after deductible	50% after deductible
Non-Preferred Brand	$75 copay	Not Covered	0% after deductible	50% after deductible
Specialty	Contact Care Coordination	Not Covered	Contact Care Coordination	Not Covered
Mail Order (90-day)				
Generic	$0 copay	Not Covered	0% after deductible	50% after deductible
Preferred Brand	$70 copay	Not Covered	0% after deductible	50% after deductible
Non-Preferred Brand	$150 copay	Not Covered	0% after deductible	50% after deductible
Specialty	Contact Care Coordination	Not Covered	Contact Care Coordination	Not Covered

Plan Cost Per Pay	PPO Plan		HSA 5000
		3-year employee	
Employee	$200.00	$100.00	$80.00
Employee + Child(ren)	$550.00	$225.00	$155.00

Logging into your Member Portal

Your member portal is your all-in-one tool for managing your healthcare benefits. Follow these simple steps to log in and get started:



Access the Portal

1. Visit members.clearwaterhealth.com in your web browser.
2. Enter your email and password.
3. Click on the **"Login"** button.

Logging in For the First Time

You should have received a Welcome Email in the inbox of the email address you used to enroll. Click the link in that email to set your portal password and activate your account.

If you didn't receive the email, visit members.clearwaterhealth.com and click **"Register**" at the bottom of the screen. Be sure to use the email address associated with your enrollment!

Invite Adult Dependents

Want to give your dependents access? Head to Settings > Profile, select their name, enter their email, and save. Your dependent can then visit the Register page to sign up, receive their Welcome email, and set their password.

Bookmark the portal page for quick and easy access to your healthcare benefits anytime, anywhere.

Troubleshooting Tips

- If you experience issues logging in, double-check that you're using the correct email address. You should be using the same one you used to enroll with.
- Ensure your password meets the security requirements (e.g., minimum characters, includes numbers, or special characters).

Still having trouble? Contact Member Services for assistance.

members@clearwaterhealth.com (877) 405-2926

Accessing Care For Employer Group Plans

Major Medical

Clearwater makes it easy for you to get the care you want when you need it. With our convenient 24/7 concierge telemedicine provider and our tiered provider network structure there are numerous options to get timely, affordable, quality care.

Access Your Plan Online

Did you know that you can access your cards and more online?
Visit clearwaterhealth.com/members to learn how.

Experience the comfort of 24/7 Concierge Medical Support with Amaze Health.

Get quality medical care for $0 anytime via phone, text, or the Amaze app. Your concierge medical team may assess, diagnose, prescribe a treatment plan, and send prescriptions to your local pharmacy. If in-person care is required, they'll suggest nearby providers.

- Urgent care
- Chronic disease management
- Mental healthcare
- Prescription refills
- Weight management
- Ortho support
- And more!

Care Coordination

When you need lab work, imaging, or a major procedure, contact Care Coordination. The team makes it easy to get great care while saving money.

On plans with Tier 1 preferred providers, if you use the provider that the Care Coordination team suggests, we will waive some of your out-of-pocket costs. In many cases, you may pay NOTHING for your care.

Contact Care Coordination

855-759-0684

members@clearwatersavings.com

3500, 4500, 8000 Copay Plans

Access $0 out-of-pocket services through our Tier 1 Preferred Provider Network. Contact our Care Coordination team before scheduling appointments to access this benefit. They'll guide you to top providers and facilities for eligible services.

Follow our recommendations to book appointments with no cost, even for surgeries. While our team will work diligently to find you a Tier 1 provider, these benefits are not guaranteed as there may be instances where no provider is available.

Nationwide Network

Expand Your Options with Participating Providers

We utilize Multiplan's PHCS Network for Value-Driven Health Plans (VDHPs) for access to nearly a million providers nationwide. We recommend you always check to see if your current provider is in-network before your appointment. To find a participating provider visit: https://portal.hstechnology.com/PHCS

Hospital Services

Your plan pays hospitals and facilities based on a reference-based price, which is fair and objective. For Non-Participating Providers, you pay your copay or coinsurance plus any difference between the reimbursement level and the billed amount. Any excess charges aren't counted towards your deductible or out-of-pocket maximum. If you get a bill for these charges, call us for help.

Prior Authorization Requirements

Certain services require prior authorization. To avoid penalty, you MUST contact Care Coordination BEFORE obtaining services. See your plan documents for a complete list of services that require prior authorization. You can find them in your member portal: www.clearwaterhealth.com/members.

www.ClearwaterHealth.com

Making *extraordinary* care ordinary

Set-up your Amaze account now, so you'll have us when you need us.

Amaze Offers:

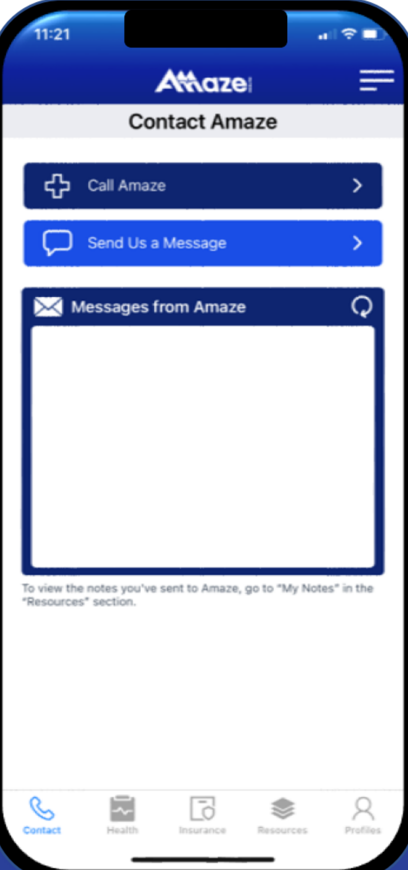
- Urgent Care
- Chronic Medical Condition Management
- Mental Health Support
- Health Education Center
- Prescriptions
- Imaging, Testing & Specialist Referrals
- Billing Support
- Care for the Whole Family

The Amaze Difference

- ✓ We don't bill you or your insurance
- ✓ We stay with you until your problem is resolved
- ✓ We follow-up
- ✓ We are always here when you need us

Access your Amaze Health account in two easy steps:

Step 1: Download the Amaze app. Search for "Amaze Health" in your app store or scan this QR code from your mobile device to go directly to the Amaze app in your app store.

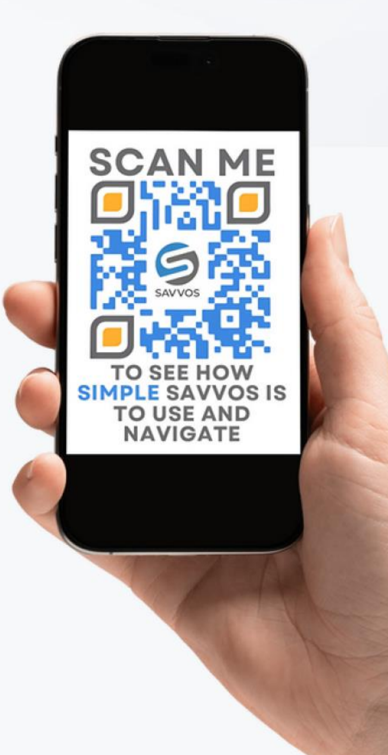


Step 2: Log in to the Amaze app. Your username is your email address (either your company email or personal email). Once you enter your username, follow the steps to set a password for the first time.

If you don't know your username, please search your email inbox for login credentials from Amaze Member Services or call 720-577-5251 and we'll help you retrieve your username.

Free Surgeries, Imaging, and more through Savvos!

No more high-deductibles. No more delays.



Tired of healthcare feeling like trying to solve a Rubik's Cube blindfolded? Savvos connects you with quality providers that offer incredible prices because they get paid immediately.

Unlock the benefits of our exclusive Immediate Cash Payment relationship, offered at no cost to Clearwater members! This remarkable service enhances your customer experience and dramatically slashes the costs of your medical procedures, making quality healthcare easier than ever!

www.ClearwaterHealth.com

Prescriptions that deliver in every way.

Alliance Rx Walgreens Prime

As a member of EHIM, you are eligible to enroll in Alliance Rx Walgreens Prime, offering you convenient delivery of your ongoing maintenance medications from Walgreens to the location of your choice.

It's easy to register and order prescriptions, just have the following ready:

- **Member ID Number** (Located on ID Card)
- **Group Number**
- **Payment Information**

Select the option that works for you and follow the steps to get started.

	Online	Fax	Mail	Phone
1 REGISTER	Register or Sign In at Walgreens.com/ MailService. Follow the prompts to complete enrollment.	Not available	Send completed *Registration and Prescription Order Form* to: Alliance Rx Walgreens Prime P.O. Box 29061 Phoenix, AZ 85038	Call 800-345-1985 and ask to be registered for Walgreens mail service. Please have your insurance information handy.
2 ORDER your first prescription.	Ask your doctor if he or she can prescribe your medications electronically. If he or she is unable, select an alternative option.	Have your doctor complete and fax the Prescriber Fax Form to: 800-332-9581*	Send completed *Registration and Prescription Order Form along with your original prescription* to: Alliance Rx Walgreens Prime P.O. Box 29061 Phoenix, AZ 85038	Call 800-345-1985 and request that Walgreens reach out to your doctor for a new prescription.[†]
3 REFILL[‡]	Prescriptions eligible for refills are listed in your member profile at Walgreens.com/ MailService.	Not available	Send completed *Preprinted Refill Order Form* enclosed with your last order to: Alliance Rx Walgreens Prime P.O. Box 29061 Phoenix, AZ 85038	Call 800-345-1985 and select "refill a prescription" or ask to speak with a customer service representative.

*By law, prescriber fax forms and e-prescriptions are valid only if sent from a prescriber's office.
[†]You will need to provide your doctor's contact information as well as the name and dosage of your medication. Walgreens will notify you if your doctor doesn't respond.
[‡]To automatically receive refills of your medications, select the "Auto Refill" option in your online profile or on the Registration and Prescription Order Form.
[§]Scripts that cannot be transferred and require a new written prescription include: expired prescriptions, no refills remaining, controlled substances & compound medications.

Dental Insurance

Dental insurance is provided by Anthem. The dental plan offers flexibility to see the provider of your choice each time you seek dental care. You can find a network dentist online at www.anthem.com or call 1.877.604.2142

Anthem Dental	
	PPO Network
Deductible	$50 / person
Maximum Benefit	$1,000 / person
Diagnostic & Preventive Services Oral Examination, Cleanings, X-Rays, Sealants, Fluoride	100% Deductible waived
Basic Restorative Services Routine Fillings, Simple Extractions, Periodontal Services, Endodontics / Root Canals	80% after Deductible
Major Services Periodontal Services, Endodontic Services, Bridges, Resin, Metal, Porcelain Crowns, Inlays, Onlays, Posts, and Dentures	50% after Deductible

Plan Cost Per Pay	
Employee	$0.00
Employee + Spouse	$12.24
Employee + Child(ren)	$8.38
Family	$21.00

Vision Insurance

CARS provides employees with vision coverage through Anthem. The Blue Vision provider network is comprised of over 30,000 doctors at more than 25,000 locations nationwide. They offer a generous mix of independent practitioners and retail locations including 1.800.CONTACT, LensCrafters, Pearle Vision, Sears Optical, Target Optical, and JC Penney Optical. While benefits and savings are typically greater from in-network providers, members are free to visit a non-network provider. Below is a brief summary of the vision plan. Call 1.866.723.0515 for assistance.

Anthem Vision	In-Network
Routine Exam (once a year)	$10 copayment
Frames (every 24 months)	Included with $25 lens copay; maximum benefit of $130
Spectacle Lenses (once a year)	
Single Vision	$25 copayment
Bifocal	$25 copayment
Trifocal	$25 copayment
Contact Lenses	
Medically Necessary	Plan pays 100%
Elective	Plan pays max $130 benefit

Plan Cost Per Pay	
Employee	$3.62
Employee + Spouse	$6.90
Employee + Child(ren)	$7.23
Family	$11.12

Basic Life and AD&D Insurance

CARS provides Basic Life and Accidental Death and Dismemberment (AD&D) insurance in the amount of $50,000 at no cost to its employees. This benefit will terminate when your employment terminates or upon retirement, and benefits will reduce by 35% at age 65, and then to 50% at age 70.

401(k)

MUTUAL OF AMERICA
Your Retirement Company

Employees who are at least 18 years of age and who have six months of employment are eligible to contribute into the CARS 401k. Both full-time and part-time employees are eligible.

Open enrollment for the 401k is held monthly, beginning with January. CARS will review and determine annually as to whether an employer contribution or form of matched funds will be implemented. Currently CARS matches up to 5%.

Corporate Wellness

Full-time and part-time employees who have completed 90 days of employment are eligible. If you wish to participate in the wellness plan, **you will receive a $10 stipend each month if you provide documentation that you are a member of, and have participated in, a fitness membership at a facility of your choice, the previous month.**

To receive the stipend, you must submit to the accounting department the necessary supporting documentation, along with a check request showing you participated in a fitness membership the previous month.

Employee Assistance Program

FINANCIAL SERVICES

CHILDCARE AND ELDER SERVICES

LEGAL SERVICES

COUNSELING

HELPFUL WEB TOOLS

The EAP:

- Confidential
- Easily accessible
- Counseling service
- All employees and their immediate family members
- Free - CARS pays the cost for the Employee Assistance Program.

CONFIDENTIAL AND CONVENIENT
CALL: 800-456-6327

You may contact the EAP for:

- Legal
- Family matters and relationships
- Financial issues
- Child care
- Elder care
- Substance abuse or addiction
- Questions and concerns
- Work-related issues
- Mental health

Visit www.perspectiveltd.com/login
Access Code: CH1506
Password: Perspectives

PLAN ADMINISTRATOR / HR CONTACT INFORMATION

Plan Administrator/HR Contact: Teri King
Plan Administrator/HR Contact Phone Number: 1.765.569.2076
Plan Administrator/HR Contact Email: tking@cars-services.org

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
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 http://dhcs.ca.gov/hipp
Phone: 1-916-445-8322 Fax:1-916-440-5676
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 Ctr:
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.mycohibi.com/ HIBI Customer Service: 1-855-692-6422

FLORIDA – Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
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-partyliability/childrens-health-insuranceprogram-reauthorizationact-2009-chipra Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Phone: 1-877-438-4479
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: www.Medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
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: masspremassistance@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:HHSHIPPProgram@mt.gov

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

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/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:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.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 and CHIP
Website:
http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
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)
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: Health Insurance Premium Payment (HIPP)Program | Texas Health and Human Services
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: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427

VIRGINIA– Medicaid and CHIP
Website:
https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select
https://coverva.dmas.virginia.gov/learn/premiumassistance/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://dhhr.wv.gov/bms/
https://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, 2024 or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agengies/ebsa
1.866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid
www.cms.hhs.gov
1.877.267.2323, Menu Option 4, Ext.61565

Notice of HIPAA Special Enrollment Rights

You have the right to request special enrollment (outside of the plan's annual enrollment period) for yourself and your eligible dependents (including your spouse) under certain circumstances, as described below.

If you decline enrollment for yourself or for an eligible dependent while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment **within 30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment **within 30 days** after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or coverage under a state children's health insurance program, or when you and/or your dependents become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan. However, you must request enrollment **within 60 days** after your or your dependents' coverage ends under Medicaid or a state children's health insurance program or **within 60 days** after the determination of eligibility for assistance.

If you would like more information on your special enrollment rights or need to request enrollment, contact Human Resources and/or the Plan Administrator, see the Notices Title page for contact information.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to health care 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.

Any benefits payable will be subject to the same deductibles, coinsurance and other provisions applicable to other surgical and medical benefits provided under the plan. Please see your Summary of Benefits and Coverage (SBC) or other plan materials for your medical and surgical deductible and coinsurance information.

If you would like more information on WHCRA benefits, contact Human Resources and/or the Plan Administrator, see the Notices Title page for contact information.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Note, more generous lengths of stay may apply under certain state laws, when applicable. In such cases, please refer to plan documents for a description of these richer guidelines.

If you would like more information on the NMHPA, contact Human Resources and/or the Plan Administrator, see the Notices Title page for contact information.

Notice of Patient Protections and Selection of Providers

Designation of a Primary Care Provider (PCP) - If the health plan in which you are enrolled (or enrolling) requires the designation of a primary care provider (or "PCP"), you have the right to designate any PCP who participates in the plan's provider network and who is available to accept you or your family members. For children, you may designate a participating pediatrician as the PCP. For information on how to select a PCP, and for a list of the participating primary care providers, contact Human Resources and/or the Plan Administrator, see the Notices Title page for contact information.

Direct Access to Obstetrics and/or Gynecological Specialists - If the health plan in which you are enrolled (or enrolling) requires referrals to see specialists, you do not need prior authorization to obtain access to obstetrical and/or gynecological care from a health care professional in the plan's network who specializes in obstetrics or gynecology. Please note, however, the health care professional, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Human Resources and/or the Plan Administrator, see the Notices Title page for contact information.

Notice of Availability of Plan's Notice of Privacy Practices (NPP)

Certain employer-sponsored health plans are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of your health information that the plan creates, requests, or is created on the plan's behalf, called Protected Health Information ("PHI") and to provide you, as a participant, covered dependent, or qualified beneficiary, with notice of the plan's legal duties and privacy practices concerning Protected Health Information. The privacy policies are described in more detail in the plan's Notice of Privacy Practices (NPP). The NPP describes how medical information about you may be used and/or disclosed and how you can get access to this information. If you would like a copy of the Notice of Privacy Practices, please contact Human Resources and/or the Plan Administrator, see page see the Notices Title page for contact information. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Continuation of Coverage under COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Employers who employ 20 or more employees are subject to the continuation provisions of COBRA.

COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end because of certain "qualifying events", such as termination of employment (for reasons other than gross misconduct), reduction in hours, divorce, legal separation, death, or a child ceasing to meet the definition of dependent under the group health plan coverage. 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 group health plan coverage is lost because of a COBRA qualifying event. Upon termination, or other COBRA qualifying event, all qualified beneficiaries will receive COBRA election information.

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

After your initial enrollment in our group health plan(s), you, and any other members of your family who you also enroll in coverage, will receive a COBRA Initial (or General) Notice that will explain your COBRA rights and responsibilities. Please read it carefully.

For more information about your rights and obligations, you should review the plan's Summary Plan Description or contact Human Resources and/or the Plan Administrator, see the Notices Title page for contact information.

Coverage While on FMLA Leave

The FMLA entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

If you take Family and Medical Leave Act (FMLA) leave, we will continue to maintain your coverage to the extent required by the FMLA (that is, we will continue to pay our share of the premiums to the extent that you opt to continue coverage). If your coverage ceases during the FMLA leave (for example, because you opted not to continue coverage or due to nonpayment of your share of the health insurance premiums), you may resume your coverage upon return from FMLA leave on the same terms as before the leave was taken, or as otherwise required by the FMLA. Under special rules that apply if an employee does not return to work at the end of an FMLA leave, you may be entitled to elect COBRA even if you were not covered under the plan during the leave. Contact Human Resources and/or the Plan Administrator for more information about your rights and responsibilities under the FMLA, see the Notices Title page for contact information.

Continuation of Coverage under USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including your spouse) for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

For more information about your rights under USERRA, contact Human Resources and/or the Plan Administrator, see the Notices Title page for contact information.

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we ask employees NOT to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. We may use aggregate information to design a program based on identified health risks in the workplace. Your physician and the vendors who administer and provide screenings will not disclose any of your personal information either publicly or to the employer, except as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment. In addition, all health information obtained through the wellness program will be maintained separately from your personnel records, stored electronically and encrypted, and not be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. You will not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor will you be subjected to retaliation if you choose not to participate.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving a reward. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. We may be provided with an aggregate report (summary of results with no identifying information) or a list of names of participants for programs where participation is tracked for the purposes of distributing rewards.

If you have questions or concerns regarding this program, or about protections against discrimination and retaliation contact Human Resources and/or the Plan Administrator, see the Notices Title page for contact information.

Marketplace (Exchange) Notice PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace (the "Exchange") and health coverage offered through your employment.

What is the Health Insurance Marketplace (Exchange)?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does My Employer's Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium and a reduction in plan cost-sharing if your employer a) does not offer coverage to you at all or b) does not offer coverage that meets certain standards. Specifically, if your cost for SELF-ONLY coverage on a plan offered to you by your employer is more than 9.5%[1] of your annual household income for the year, OR if the coverage your employer provides does not meet the "Minimum Value (MV) Standard" set by the Affordable Care Act, you may be eligible for a tax credit.[2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When can I enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts each Nov. 1 and continues through at least Dec. 15. Certain events may also trigger a midyear Special Enrollment Period, such as when getting married, having a baby, or adopting a child, or losing eligibility for other health coverage, including Medicaid and CHIP. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

How can I get more information?

For more information about your coverage offered by your employer, please check your coverage materials or contact Human Resources and/or the Plan Administrator, see Notices Title page for contact information. The Marketplace or a licensed insurance broker can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov to find more information.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop

[2] An employer-sponsored health plan meets the "Minimum Value (MV) Standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs and meets other requirements.

PART B: General Information

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name			4. Employer Identification Number
Child-Adult Resource Services, Inc.			35-1183291
5. Employer address			**6. Employer phone number**
201 North Dormeyer Avenue, PO Box 170			765-569-2076
7. City	**8. State**		**9. Zip code**
Rockville	IN		47872
10. Who can we contact about employee health coverage at this job?			
Teri King			
11. Phone number (if different from above)	**12. Email address**		
765-569-2076, Ext 1001	tking@cars-services.org		

Here is some basic information about health coverage we offer:

As your employer, we offer a health plan to:

Full-time employees working 30 hours or more per week.

With respect to dependents:

Dependent children to age 26

X If checked, this coverage meets the minimum value standard and the cost of this coverage is intended to be affordable for most or all full-time employees under one of the §4980H Affordability Safe Harbors.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. You may need to get information from your employer, about their coverage, in order to find out if you qualify for a tax credit to lower your monthly premiums.