



Your Employee Benefits 2026



Welcome to your 2026 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 Advisory Health Administrators		www.advisoryha.com	1.833.200.3095
Pharmacy TrueRx		www.truerx.com	1.866.921.4047
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 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 Advisory Health Administrators please visit www.advisoryha.com or call 1.833.200.3095.

Deductible	PPO Plan		HSA 5000 Plan	
	In Network	Out-of-Network	In Network	Out-of-Network
Single	\$1,500	\$1,500	\$5,000	\$5,000
Family*	\$3,000	\$3,000	\$15,000	\$15,000
Out-of-Pocket				
Single	\$6,000	\$12,000	\$5,000	\$10,000
Family	\$12,000	\$24,000	\$10,000	\$20,000
PCP	\$25 copay	\$25 copay + amounts that exceed reasonable allowable charge	0% after deductible	0% after deductible + amounts that exceed reasonable allowable charge
Specialist	\$45 copay	\$45 copay + amounts that exceed reasonable allowable charge	0% after deductible	0% after deductible + amounts that exceed reasonable allowable charge
Emergency Room	30% after deductible	30% after deductible	0% after deductible	0% after deductible
Urgent Care	\$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	30% after deductible	50% after deductible	0% after deductible	50% after deductible
Outpatient Services	30% after deductible	50% after deductible	0% after deductible	50% after deductible

Prescription Drugs	PPO Plan		HSA 5000 Plan	
	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
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

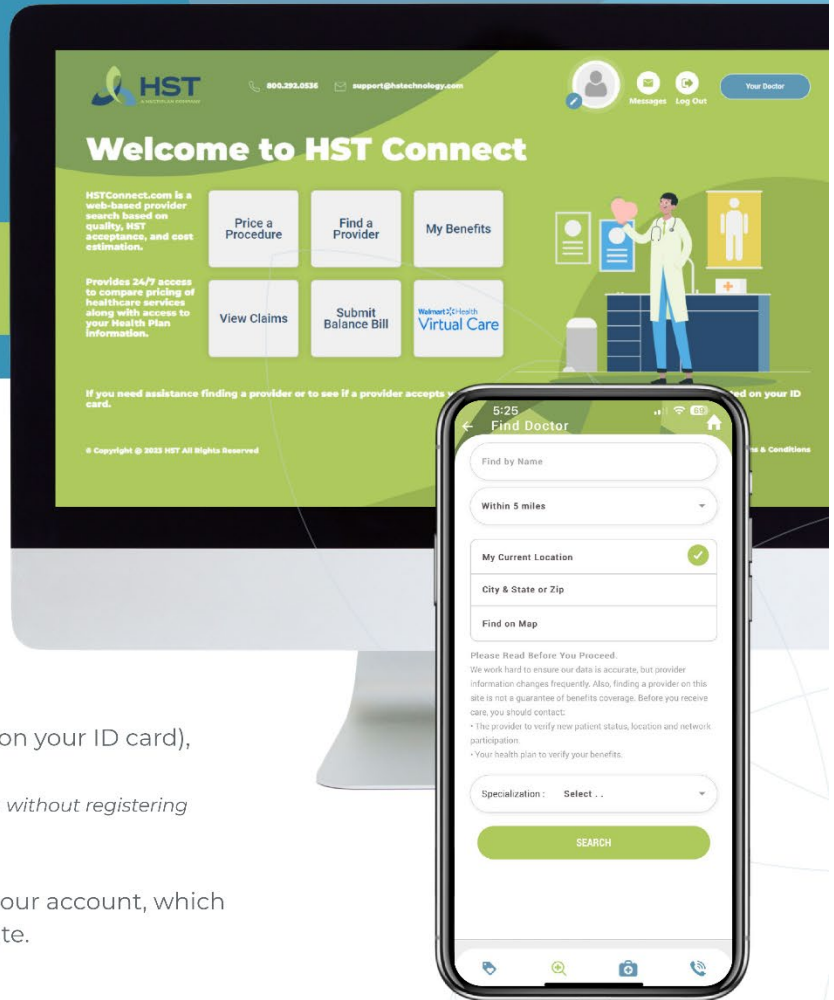
Plan Cost Per Pay	PPO Plan		HSA 5000
	3-year employee		
Employee	\$200.00	\$100.00	\$80.00
Employee + Child(ren)	\$550.00	\$225.00	\$155.00



How to Access HST Connect®

Healthcare pricing and more!

★★★★★ - Rated by Clients



Download the mobile app:

- 1 Go to the App Store for iOS or Android or scan the QR Code below.
- 2 Search for “HST Connect” and click Download.
- 3 Open the app and click “Register.”
- 4 Enter Member ID and Group ID (found on your ID card), your name and date of birth.
- Alternatively, you can proceed with your search without registering or by calling (800) 440- 7427.
- 5 Follow the registration steps to set up your account, which you can use both on the app and website.

Use the website version:

- 1 Go to hstconnect.com.
- 2 Enter Member ID and Group ID (from your ID card), your name and date of birth.
- Alternatively, you can proceed with your search without registering or by calling (800) 440- 7427.
- 3 Complete all the registration steps to set up your account.



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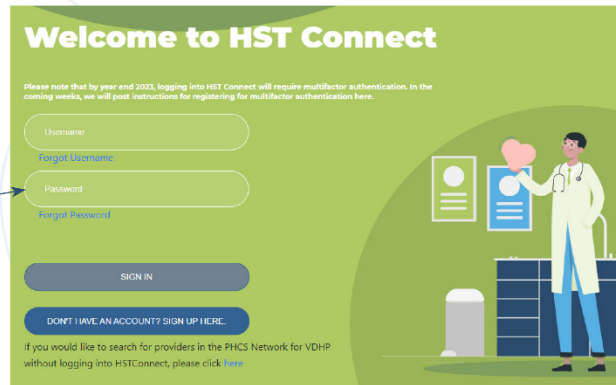


How to Find a Network Provider on HST Connect®

To find a provider in your network, it is recommended that you log in or set up an account to view your plan's provider network offering.

- 1 Go to hstconnect.com.
- 2 Once on the home screen you will either:
 - Enter your username/ password to sign in.
 - Sign up for an account.
- 3 To find a provider, click [here](#).
- 4 Enter the provider's name.
 - Adjust the radius as needed.
Example: select a different distance if the provider is more than 5 miles away.
 - Select the "My Current Location" bubble.
 - Click "Search".
- 5 In the search results, look for the "VDHP Acceptance" to determine if the provider shows a purple "In Network" rating.

VDHP Acceptance
In Network ●
- 6 If you have any questions or do not see your provider when searching, call us at 800-440-7427 and we will assist you.

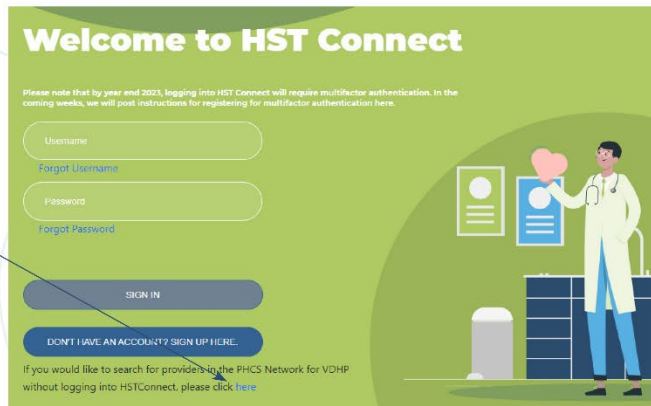


If your provider does not participate in one of our networks, you can nominate them in HST Connect.



How to Find a Network Provider on HST Connect without logging in

- 1 Go to hstconnect.com.
- 2 On the home screen, proceed without logging in.



- 3 On this search screen, enter the provider's name and city/state or zip code.

- Click "Search".

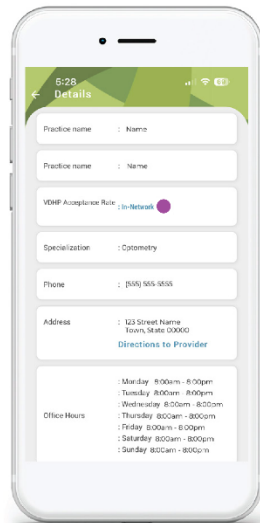
- 4 All the search results that populate are in-network providers.

- 5 If you have any questions or do not see your provider when searching, call us at 800-440-7427 and we will assist you.



HST Connect Features

Shop for quality, cost-effective healthcare on HST Connect®



HST Connect Features:

- ▶ Find a provider, facility or other healthcare service, either in-network or with high Value-Driven Health Plan™ acceptance rates.
- ▶ Compare facility quality ratings, reported by the Centers for Medicare and Medicaid (CMS).
- ▶ Use HealthCorum's physician quality scores for Cost, Appropriateness and Effectiveness of Care when selecting a provider.
- ▶ View deductible, copays and other plan information.
- ▶ Direct-dial healthcare providers and get driving directions.
- ▶ Communicate with and receive notifications from the Patient Advocacy Center and directly submit balance bills.
- ▶ Access HST's Provider Acceptance Rates to help minimize the risk of balance billing.
- ▶ Use the Price a Procedure tool to get out-of-pocket cost estimates for all providers and services (compliant with No Surprises Act guidelines and Transparency in Coverage regulations).
- ▶ See our Cost Estimation video at hstechnology.com/members.
- ▶ Nominate a Provider to join one of our networks if they do not already participate.



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hstechnology.com

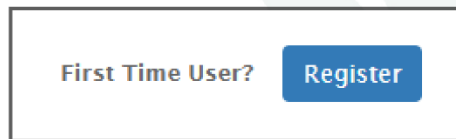
Accessing the Web Portal

Visiting the Site

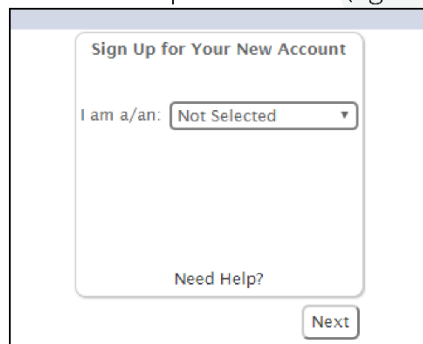
1. Open up the internet browser of your choice (eg. Google Chrome, Mozilla Firefox, Internet Explorer) and go to www.advisoryha.com
2. Click on “Member Resources”
3. Select Member: “My Benefits Portal”

Registering as a User

1. Click on “Register.”



2. Select your relation from the dropdown menu (eg. “Employee/Insured”).



3. Then select “I Accept” from the Statement of Understanding when it pops up. Click “Next.”
4. Fill out the requested information: your first name, last name, date of birth and Member ID number (the one matching your insurance ID card). Click “Next.”
5. Then fill out your profile information, such as a username, password, and email address. Click “Create User.”

Sign Up

User Name:

Password:

Password minimum length 8, maximum 16, with at least 1 letter, 1 number and 1 of the following: !@#%&(*)

Confirm Password:

E-mail:

Confirm E-mail:

Security Question:

Will be displayed as a reminder when using "Forgot Password"

Security Answer:

When using "Forgot Password" you must enter the answer as defined here

Medical
 Dental
 Vision
 Drug
 M&N
 LTD
 STD
 Flex
 Other

Logging In

1. On the portal home page, enter your User Name and Password, then click on "Log In."

FYI: Multiple failed attempts at logging in will lock you out of your account, so please contact Advisory Health Administrators' customer service team to unlock your access.

Employee & Dependent Users

The Home Page

Menu Bar

The Menu Bar will show members three primary menus, each with dropdown options:

1. **Members**, which gives you the chance to return to the home page and any documents available to you.
2. **Messages**, which lets you view and create new messages.
3. **My Account**, which lets you change your password and your email address for your profile.

Tab Options

From the Member's home page, there are up to seven tabs with various account and plan information. Each tab will be explained further below.

Quick Links

On the righthand side of the Member's home page, there are buttons to print or request ID cards.

Member Info

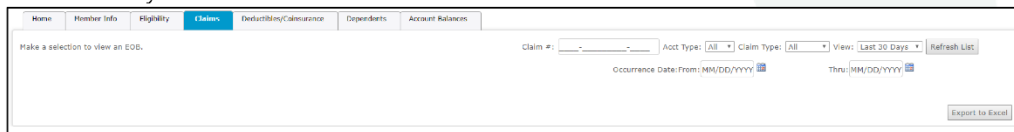
The Member Info tab shows the member's general information such as name, address, date of birth, and contact information.

Eligibility

The Eligibility tab shows the date ranges for coverage while on the plan. Please note: we currently do not administer plans for life insurance, long term disability, or short-term disability, so please reach out to your Human Resources department to verify any eligibility for those products.

Claims

The Claims tab will list all received claims and their processing stage. Make sure to browse the "View" options on the righthand side (and click "Refresh List" whenever you make a change) to view any claims that might not show immediately.



The screenshot shows the Claims tab interface. At the top, there are navigation tabs: Home, Member Info, Eligibility, Claims (selected), Deductibles/Coinsurance, Dependents, and Account Balances. Below the tabs, there is a search area with the text "Make a selection to view an EOB." and a "Claim #" input field. To the right of the search area, there are dropdown menus for "Acct Type: [All]", "Claim Type: [All]", and "View: [Last 30 Days]". There is also a "Refresh List" button. Below these filters, there are date range selectors for "Occurrence Date: From: MM/DD/YYYY" and "Thru: MM/DD/YYYY". At the bottom right of the interface, there is an "Export to Excel" button.

Deductibles/Coinsurance

The Deductibles/Coinsurance tab will list the current applied accumulation toward your deductible or out-of-pocket maximum, as well as any annual limits.

Dependents

If you have any dependents, they will be listed on the Dependents tab and their account can be selected here to view.

Account Balances

The Account Balances tab will only populate information if you elect an FSA that Advisory Health Administrators manages. If so, you can view your current balance here.



Experience the
HEALTH STRATEGISTS
Difference

You're More Than a Member Number. You Are *Our Patient*.

Your well-being is our priority, and we are here to support you every step of the way.

Live representatives answer your call

Our Patient Experience representatives are specially trained to address your pharmacy benefit questions.

Support for specialty medications

Dedicated care managers and clinical pharmacists are highly experienced in addressing the complexities and costs of specialty medications providing you with personalized care.

Manage your benefits anywhere with the True Rx+ mobile app

Access your insurance card and plan details, compare medication prices at local pharmacies, chat with a live True Rx Health Strategist, and more.

Next Steps

01 | Watch for your new insurance card and bring it with you to the pharmacy.

02 | Download True Rx+ in your app store or use the member portal at "member.myplantruerox.com" .





Frequently Asked Questions

How much will my medication cost?

To view the closest estimate of the amount you would pay for a medication, use the price check tool in the “Savings Center” in the True Rx+ app or member portal.

What should I do if my medication is delayed or denied?

The primary reason a prescription is delayed or denied is that the pharmacy lacks necessary insurance information from your new ID card. Be sure to give the pharmacy your updated information. If you have questions, give us a call or chat with us through the True Rx+ app. Our Patient Care team would be happy to help.

What should I do if I need a Prior Authorization?

Some medications require a prior authorization (PA). This means your provider must submit documentation showing the medication is safe, effective, and meets certain criteria set by your plan and FDA regulations. Your medication will only be covered once True Rx approves the PA.

You can check the status of your PA in the True Rx+ app and member portal.

I take a specialty medication. What should I do?

You have access to a dedicated specialty care manager to help address any questions you may have. Please give us a call and we would be happy to assist you.

Call Our Patient Care Team

Live representatives answer your call
Monday – Friday 8am to 8pm ET.

 **866-921-4047**



Kyra, Patient Care Manager



Manage Your Pharmacy Benefits *Anytime, Anywhere*



Say *hello* to True Rx+, an Enhanced App and Portal

True Rx+ is more than just a pharmacy app. It's your personalized digital pharmacy experience designed to help you stay informed, save money, and get support when you need it the most.

What You Can Do With True Rx+



View your insurance card and plan details



See your active prescriptions, deductible, and out-of-pocket status



Compare medication prices at local pharmacies



Track prior authorizations in real time



Set refill reminders



Chat with a live True Rx Health Strategist

Download True Rx+ *today!*





Medication Delivered to Your Door

Skip the pharmacy line and receive personalized care.

True Rx Health Strategists partners with WB Rx Express to deliver your prescriptions right to your door. With WB Rx Express, you can manage, refill, and get information about your medications with ease, while receiving exceptional service.

Like True Rx, WB Rx Express is a family-run pharmacy serving communities for decades. It's the place to go if you want personalized and friendly service that is convenient and accessible.

Zero hassles—WB Rx Express makes medication easy

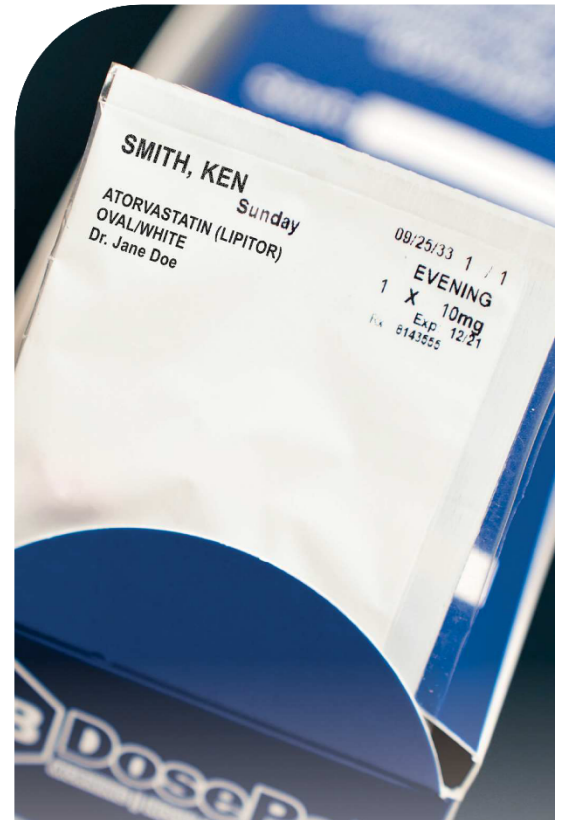
WB Rx Express offers options to simplify your medication management:

- ✓ ***Never miss a dose with WB DosePak!***
Pharmacists sort your medications by day and time, making it easier for you take them exactly as prescribed.
- ✓ ***Synchronized refills***
Sync your medication fills to get them all at once.
- ✓ ***Prescription autofill***
Refills are automatically shipped before you run out.

Did You Know?

By ordering a mail order 90-day supply, stock up and enjoy savings for months to come.

- **98% PATIENT SATISFACTION**
- **99.8% QUESTIONS RESOLVED IN ONE CALL**
- **5 SECOND AVERAGE TIME TO ANSWER**
- **PRESCRIPTIONS SHIPPED IN 24 HOURS***
*Average turnaround time



Get Started in Three Easy Steps

step
01

Go to wbrxexpress.com and click "Become a New Patient".

step
02

Complete the online form and click the red "Submit" button.

You can also set up your account by calling the pharmacy at 833-391-0126.

step
03

WB Rx Express will contact you within two business days to verify your account and medication information.

Kindly inform us at least 14 days in advance if you need a refill or wish to cancel your automatic refill.

Mail Order Medication Prices in the Member Portal

Mail order pricing is integrated with the True Rx+ app and member portal, member.myplantruex.com. Compare mail order pricing with retail pharmacies in your area.

Payment Options

WB Rx Express accepts MasterCard, Visa, Discover, and American Express.

Limitations of Mail Order

- Please use your local pharmacy for a 30-day or less supply of medication.
- Refill orders submitted prematurely may be delayed until the earliest allowable date for processing.
- For your safety, WB Rx Express does not dispense Schedule II controlled substances.

PHONE: 833-391-0126 | FAX: 855-899-3925 | Monday-Friday, 8am-8pm ET | wbrxexpress.com



Low-Cost Medication with Personalized Care

Mark Cuban Cost Plus Drugs is an in-network mail order pharmacy for patients

True Rx Health Strategists has teamed with Mark Cuban Cost Plus Drug Company to provide you with another easy option to get low-cost medications. You can choose to purchase your medications directly through the Cost Plus Drugs website, costplusdrugs.com. You may also access the Cost Plus Drugs website through the True Rx+ app or member portal, member.myplantruerx.com.

Medications ordered through Cost Plus Drugs will be considered in-network for your insurance plan.

- ✓ The cost of your medication will apply toward your insurance deductibles and out-of-pocket maximums.
- ✓ Your co-pay will be applied following your pharmacy benefit plan guidelines.
- ✓ You can rely on the True Rx Patient Care team for help with your pharmacy benefit questions.

It's Easy to Get Started with Cost Plus Drugs

step
01

Check to see if your medication is available

- Visit [CostPlusDrugs.com](https://www.CostPlusDrugs.com) and click see all medications.
- If you see your medication, follow the steps to create an account.

step
02

Create your account

- Enter your basic health information, your True Rx pharmacy insurance card information, and your health care provider information.

step
03

Ask your doctor to send prescriptions to Cost Plus Drugs

- Click how to contact your doctor for information to help when asking your doctor to send in your prescription.

step
04

Look for your confirmation email and complete your medication order

- You will receive an email from Cost Plus Drugs when they receive your prescription.
- Be sure to check request insurance price to have your prescription process with your True Rx insurance.
- Enter your shipping address and payment information.
- Your medication will be shipped to your doorstep.

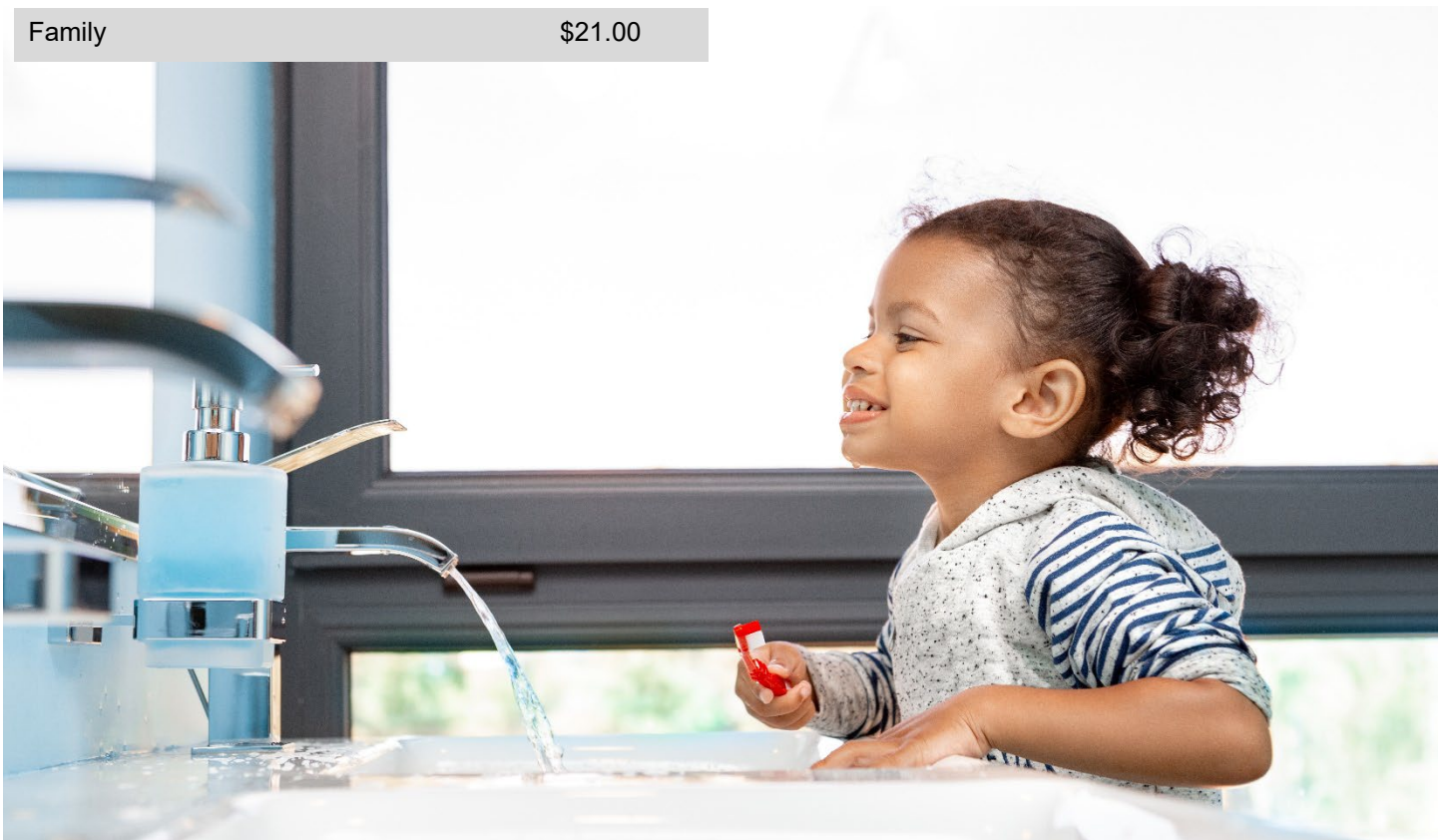
Dental Insurance



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	100%
Oral Examination, Cleanings, X-Rays, Sealants, Fluoride	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



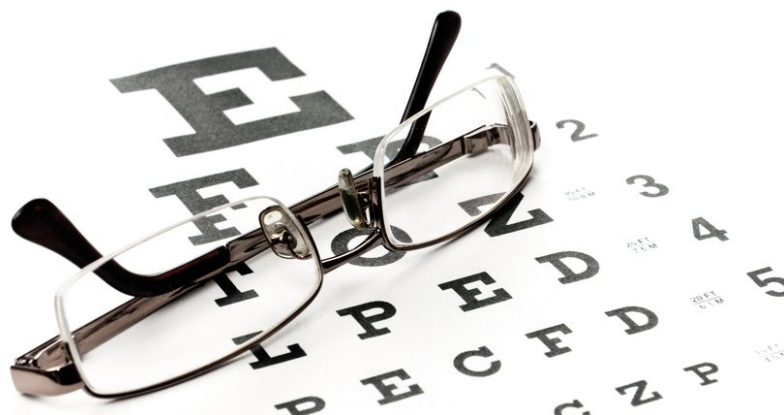
Vision Insurance



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)



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 \$25 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. CARS will reimburse an employee (1) one \$49 heart scan every 3 years.**

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



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.

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



**CONFIDENTIAL AND CONVENIENT
CALL: 800-456-6327**

Visit www.perspectiveld.com/login

Access Code: CH1506

Password: Perspectives

Compliance Notices



AssuredPartners



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, 2025. 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/hcpt/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.flmedicaidprecovery.com/flmedicaidprecovery.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-party/ability/childrens-health-insurance-program-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](http://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 \(iowa.gov\)](http://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: KIHIPPPROGRAM@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: masspremiassistance@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://dhcnp.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@dhs.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.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 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 \(CHIP\) \(pa.gov\)](http://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 Rlte 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](http://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](http://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/>
<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: <http://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, 2025 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 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](https://www.healthcare.gov) to find more information.

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