2019-2020 BENEFITS INFORMATION GUIDE

Understanding your Options

HELLO!

To Our Valued Employees,

We recognize how important your peace of mind is. That's why, at Playworks, we're providing you and your dependents with access to a quality employee benefits program to support your long-term health and wellness. Each year when we reevaluate our benefits offering, we keep in mind what's most important to you and hope you find a plan option that will meet your needs.

This Benefits Information Guide is a great tool to help you understand the plans and programs that you and your family can enroll in for the plan year. Enclosed you will find details about:

- Your medical, dental and vision benefit options, as well as additional benefits such as life and disability insurance, employee assistance program and more
- The cost of each plan
- Additional voluntary plans available to you
- Directory and contact information, in case you have questions
- Tips and tricks on how to spend your health care dollars wisely
- And much more!

Here at Playworks we value the health and well-being of our employees and their families. For this reason, we're doing our part to care for you and develop an environment in which we can all flourish together.

To your health in 2019 and beyond!

Playworks

ENROLLMENT

Who can Enroll?

If you are a full time employee regularly working a minimum of 30 hours per week, you are eligible to participate in the benefits program. Eligible employees may also choose to enroll family members, including a legal spouse/registered domestic partner (as legally defined under state and local law) **(hereinafter referred to as "registered domestic partner")**/ and/or eligible children.

Premiums for state registered domestic partners who do not meet the tax dependent definition of IRC section 152 for the employee, may be considered taxable income (unregistered domestic partners will not meet the relationship test under IRC section 152). Premiums for children / an employee's domestic partner's children under age 26 are not taxable.

Children are considered eligible if they are:

- You or your spouse's / state-registered domestic partner's biological children, stepchildren, adopted children or foster children up to age 26
- You or your spouse's / state-registered domestic partner's children of any age if they are incapable of self-support due to a physical or mental disability

When Does Coverage Begin?

Your enrollment choices remain in effect through the end of the benefits plan year, (August 1, 2019 – July 31, 2020) unless you experience a qualifying life event (QLE) during the plan year. Benefits for eligible new hires will commence as outlined below:

ELIGIBILITY DATE	BENEFIT PLAN
The first of the month following 30 days of employment	• All new employees
The first of the month following your date of hire (you must enroll within 30 days of becoming eligible)	• Rehires

TIP

If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status during the plan year. Please contact your HR Partner to discuss and review details on qualified change in status events for more information.

HOW DO I ENROLL? – ULTIPRO:

Access UltiPro by logging into Salesforce and clicking the UltiPro tile from the App Launcher tab.
New hires and rehires must go to UltiPro **Menu: Myself: Life Events** and select the Life Event titled **"I am a new employee."**
For current employees during the Open Enrollment period each year (June 27, 2019 – July 15, 2019) go to UltiPro **Menu: Myself: Open Enrollment.** These online enrollment sessions will walk you through all your benefit options and enrollment choices.

WANT RECOMMENDATIONS? JUST ASK ALEX!

ALEX is a dynamic online personal benefits counseling tool customized to our Playworks plans and benefits offerings. ALEX explains your options in plain English, asks you a series of questions and makes recommendations customized to you that might help you choose the plans that make the most sense for you and your family. ALEX only makes recommendations. **You must always complete and submit the open enrollment session in UltiPro to enroll in or waive benefits.**

Meet ALEX at: https://www.myalex.com/playworks/2019

WHAT IF MY NEEDS CHANGE DURING THE YEAR?

You are permitted to make changes to your benefits outside of the open enrollment period if you have a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change **within 30 days** of the qualified event. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse's/registered domestic partner's loss or gain of coverage through our organization or another employer.
- Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan. The plan must provide Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage.
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace or Federal Exchange and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of qualified status changes, please refer to the "Legal Information Regarding Your Plans" contents.

Please contact your HR Partner or submit a help desk ticket to the People Team if you have a qualifying life event (QLE) or status change.

DO I HAVE TO ENROLL?

Please Note: This notice is effective from August 1, 2019 – December 31, 2019.

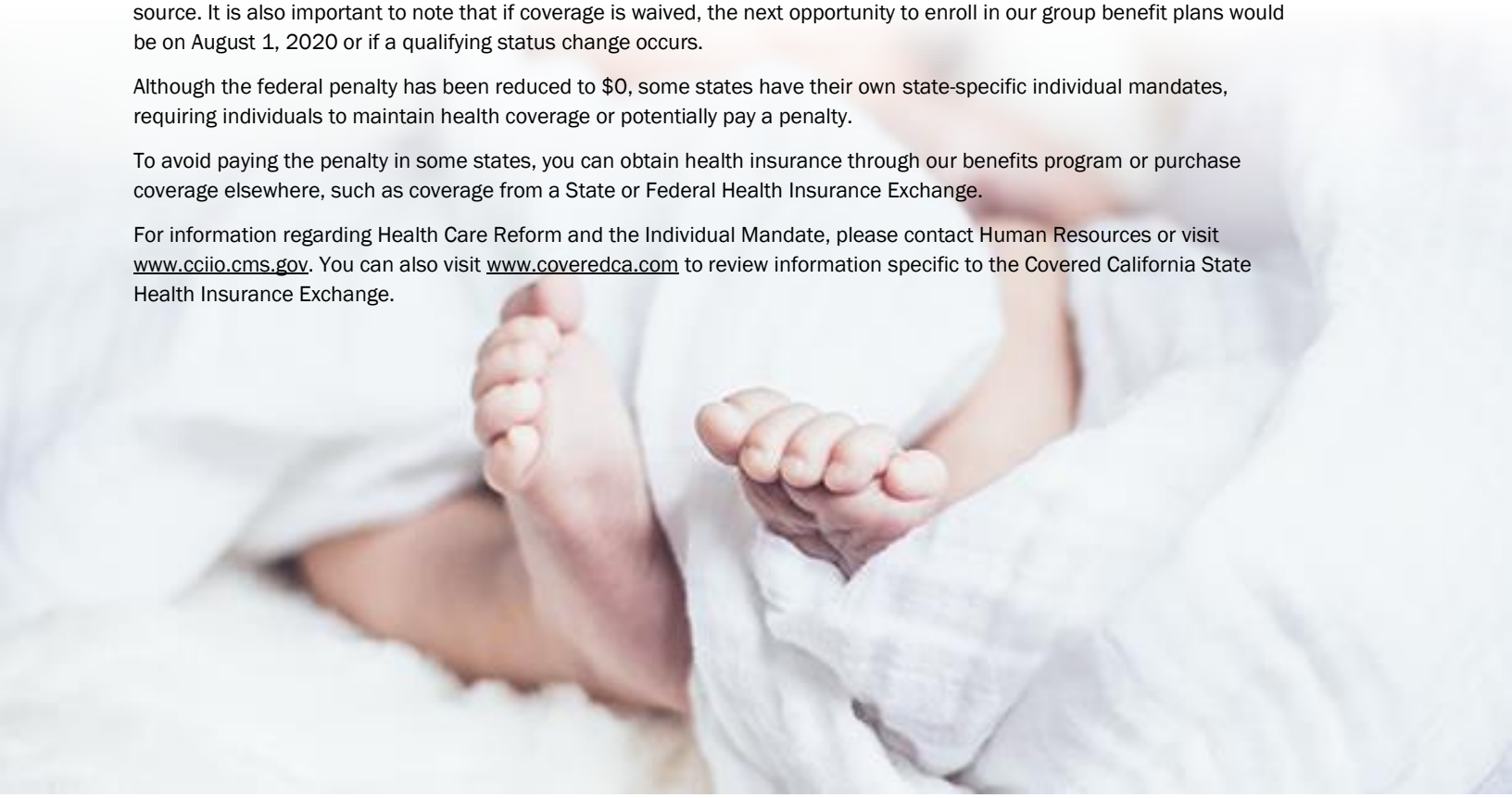
Everyone must complete a benefits enrollment event in order to enroll, waive or decline the benefits offered to you.

You may elect to "waive" coverage if you have access to coverage through another plan. If you choose not to enroll, we ask that you indicate that choice through the "waive" option. You must also provide HR with evidence of other coverage. It is important to note that if you waive our medical coverage, you must maintain medical/health coverage through another source. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be on August 1, 2020 or if a qualifying status change occurs.

Although the federal penalty has been reduced to $0, some states have their own state-specific individual mandates, requiring individuals to maintain health coverage or potentially pay a penalty.

To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as coverage from a State or Federal Health Insurance Exchange.

For information regarding Health Care Reform and the Individual Mandate, please contact Human Resources or visit www.cciio.cms.gov. You can also visit www.coveredca.com to review information specific to the Covered California State Health Insurance Exchange.



BENEFITS INFORMATION ON THE GO

iBenefits

Available for iOS and Android mobile devices, the iBenefits app makes checking your benefits information easier than ever!

With iBenefits, you can:

- View our benefit plans, 24/7.
- Access group numbers and review detailed plan information.
- Quickly contact an insurance company.
- Keep up with important benefit plan announcements such as open enrollment dates, deadlines, and more.
- Store images of your ID cards directly in the app.

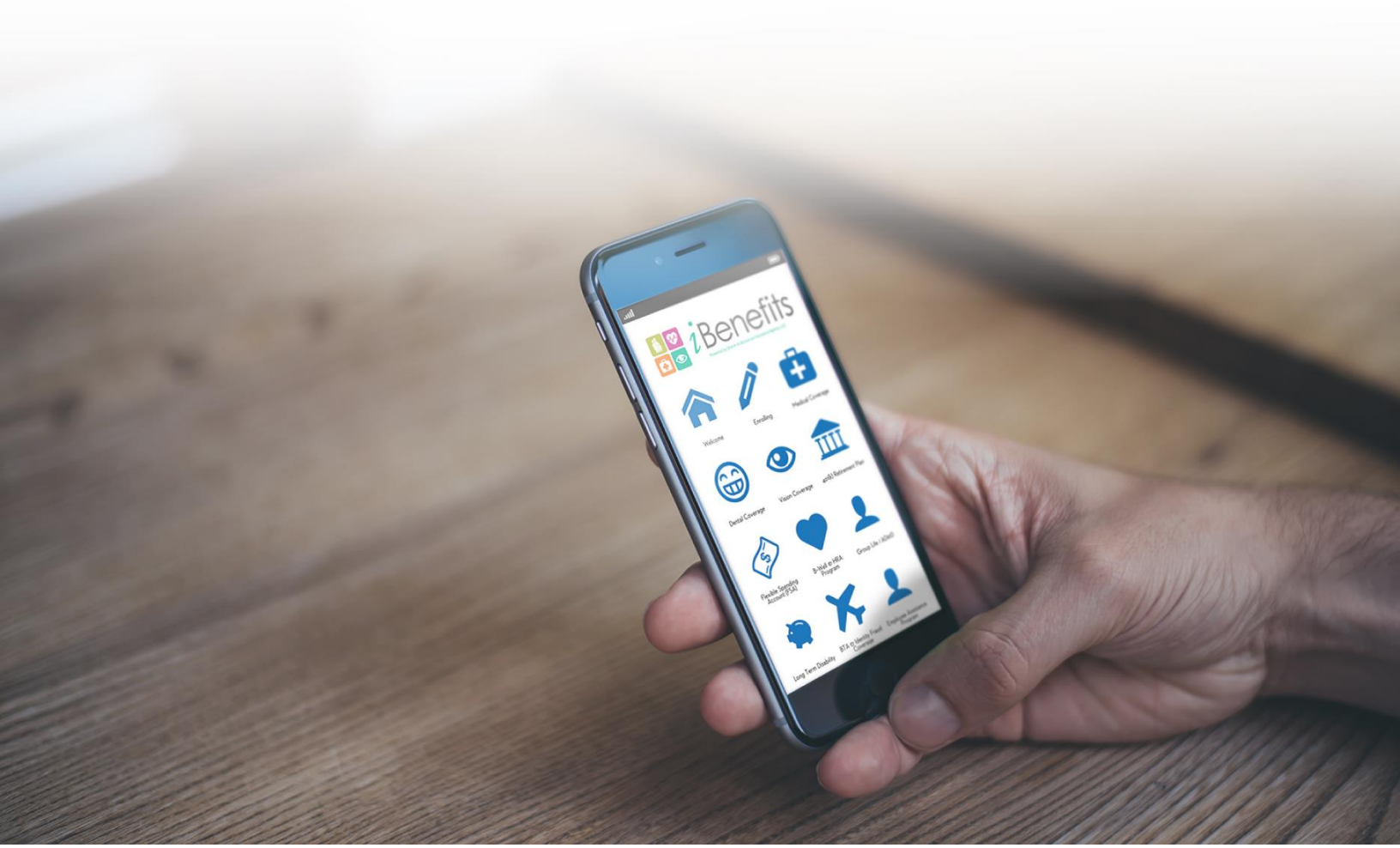
Download it now from the App Store or Google Play and use our Company Code **Playworks19** to login to the app.

Aetna Plan

With Aetna's mobile app, you can:

- Search for a doctor, dentist, hospital, or pharmacy.
- Use the "Urgent Care Finder" tool to quickly find urgent care centers and walk-in clinics.
- Register for your secure member site to view claims, coverage details, your ID card and your personal Health record.
- Contact Aetna by phone or email.

Search for Aetna's mobile app in the App Store or Google Play to get started!



MEDICAL INSURANCE (AETNA)

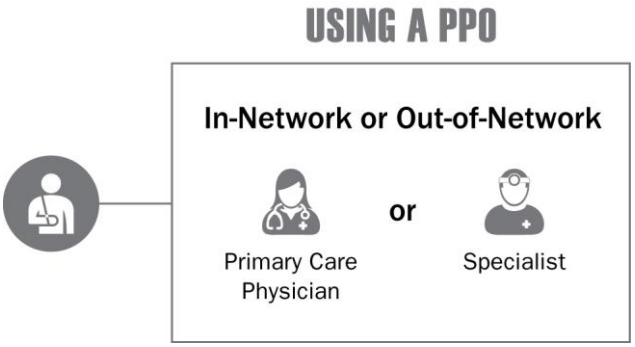
We offer three health insurance plans through Aetna Health Insurance: Platinum, Gold and Silver. Review the plan information and enroll in the plan that best meets your health care needs. For support or questions reach out to your HR Partner.

How to Find a Provider

Before you go to the doctor or receive health care services, make sure your doctor, facility or specialist is participating in your plan's network. This may ensure you receive the highest level of benefit and could reduce your health care costs.

To find an in-network Aetna doctor:

1. Log into www.aetna.com/docfind
2. Fill in the fields as indicated online. Fields marked with an "*" are required. You can search the entire directory or search for a specific provider. Login or Continue as Guest.
3. Scroll down to the section "**Aetna Open Access Plan**" then select: **Aetna Choice POS II (Open Access)**
4. Choose provider type
5. Click "**Continue**" to select specific provider types
6. Click "**Continue**" and your list will appear
7. To print your provider directory, click "**Print**"



AETNA TELADOC

Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits. Talk to a doctor anytime using the following contact information.

Teladoc.com/Aetna

1-855-TELADOC (835-2362)

PRESCRIPTION DRUG COVERAGE

Many FDA-approved prescription medications are covered through the benefits program. Important information regarding your prescription drug coverage is outlined below:

- Tiered prescription drug plans require varying levels of payment depending on the drug's tier and your copayment or coinsurance will be higher with a higher tier number.
- The Aetna plans include a four-tier prescription benefit.
- Tier 1 prescriptions offer the greatest value compared to other drugs that treat the same conditions and are often the lowest cost.
- Tier 2 drugs are generally brand name with a moderate copayment. Some drugs may also be Tier 2 because they are "preferred" among other drugs that treat the same conditions.
- Tier 3 drugs are a higher copayment compared to the lower tiers, as they are higher cost drugs. Some drugs on this list may have a generic counterpart in Tier 1 or Tier 2.
- Many drugs on Tier 4 are "specialty" drugs used to treat complex, chronic conditions, and may require special storage or close monitoring.

For a current version of the prescription drug list, go to www.aetna.com.

WHY PAY MORE?

There are a few ways you can save money when using the Prescription Drug Plan:

Mail Order

Save time and money by utilizing a mail order service for maintenance medications. A 90-day supply of your medication will be shipped to you, instead of purchasing a typical 30-day supply at a walk-in pharmacy.

Shop Around

Some pharmacies, such as those at warehouse clubs or discount stores may offer less expensive prescriptions than others. By calling ahead, you may determine which pharmacy provides the most competitive price.

Explore Over-the-Counter Options

For common ailments, over-the-counter drugs may provide a less expensive option that serve the same purpose as prescription medications.

PLAN HIGHLIGHTS

AETNA PLATINUM PPO

	In-network	Out-of-network
Annual Calendar Year Deductible		
Individual	$150	$250
Family	$300	$500
Maximum Calendar Year Out-of-pocket (1)		
Individual	$4,000	$8,000
Family	$8,000	$16,000
Professional Services		
Primary Care Physician (PCP)	$20 Copay	30% After Deductible
Specialist	$30 Copay	30% After Deductible
Preventive Care Exam	No Charge	30% After Deductible
Diagnostic X-ray and Lab	10% Coinsurance	30% After Deductible
Complex Diagnostics (MRI/CT Scan)	10% Coinsurance	30% After Deductible
Therapy, including Physical, Occupational and Speech	$20 Copay	30% After Deductible
Hospital Services		
Inpatient	$250 per day up to 5 days	30% Coinsurance after $600 Copay
Outpatient Surgery	10% Coinsurance	30% After Deductible
Emergency Room	$150 Copay (Waived if Admitted)	$150 Copay (Waived if Admitted)
Urgent Care	$20 Copay	30% After Deductible
Maternity Care		
Physician Services (prenatal or postnatal)	No Charge	Covered as any other claim
Hospital Services	$250 per day up to 5 days	30% Coinsurance after $600 Copay
Mental Health & Substance Abuse		
Inpatient	$250 per day up to 5 days	30% Coinsurance after $600 Copay
Outpatient	$20 Copay	30% After Deductible
Retail Prescription Drugs (30-day supply)		
Contraceptive Drugs & Devices	No Charge	30% After Deductible
Tier 1	$15 Copay	Member pays In-Network Copay, plus 30% of the Allowable Amount
Tier 2	$30 Copay	
Tier 3	$50 Copay	
Specialty Drugs	30% up to $200 Maximum	Not Covered
Mail Order Prescription Drugs (90-day supply)		
Tier 1	$30 Copay	Not Covered
Tier 2	$60 Copay	
Tier 3	$100 Copay	
Specialty Drugs	Not Covered	

(1) Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

PLAN HIGHLIGHTS

AETNA GOLD PPO

	In-network	Out-of-network
Annual Calendar Year Deductible		
Individual	$400	$500
Family	$800	$1,000
Maximum Calendar Year Out-of-pocket [1]		
Individual	$6,350	$10,000
Family	$12,700	$20,000
Professional Services		
Primary Care Physician (PCP)	$30 Copay	40% Coinsurance
Specialist	$40 Copay	40% Coinsurance
Preventive Care Exam	Covered in Full	40% Coinsurance
Diagnostic X-ray and Lab	20% Coinsurance	40% Coinsurance
Complex Diagnostics (MRI/CT Scan)	20% Coinsurance	40% Coinsurance
Chiropractic	$30 Copay	40% Coinsurance
Hospital Services		
Inpatient	$600 per day up to 5 days	40% Coinsurance after $600 Copay
Outpatient Surgery	20% Coinsurance	40% Coinsurance
Emergency Room	20% Coinsurance after $250 Copay	20% Coinsurance after $250 Copay
Urgent Care	$30 Copay	40% Coinsurance
Maternity Care		
Physician Services (prenatal)	No Charge	Covered as any other claim
Inpatient Hospital Services	$600 per day up to 5 days	40% Coinsurance after $600 Copay
Mental Health & Substance Abuse		
Inpatient	$600 per day up to 5 days	40% Coinsurance after $600 Copay
Outpatient	20% Coinsurance	40% Coinsurance
Retail Prescription Drugs (30-day supply)		
Contraceptive Drugs & Devices	No Charge	30% After Deductible
Tier 1	$15 Copay	Member pay In-network Copay, plus 30% of the Allowable Amount
Tier 2	$30 Copay	
Tier 3	$50 Copay	
Specialty Drugs	30% up to $200 Maximum	Not Covered
Mail Order Prescription Drugs (90-day supply)		
Tier 1	$30 Copay	Not Covered
Tier 2	$60 Copay	
Tier 3	$100 Copay	
Specialty Drugs	Not Covered	

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

PLAN HIGHLIGHTS

AETNA SILVER PPO

	In-network	Out-of-network
Annual Calendar Year Deductible		
Individual	$2,500	$2,500
Family	$5,000	$5,000
Maximum Calendar Year Out-of-pocket [1]		
Individual	$6,350	$10,000
Family	$12,700	$20,000
Professional Services		
Primary Care Physician (PCP)	$45 Copay	40% Coinsurance
Specialist	$50 Copay	40% Coinsurance
Preventive Care Exam	No Charge	40% Coinsurance
Diagnostic X-ray and Lab	$45 Copay	40% Coinsurance
Complex Diagnostics (MRI/CT Scan)	20% Coinsurance	40% Coinsurance
Therapy, including Physical, Occupational and Speech	$45 Copay	40% Coinsurance
Hospital Services		
Inpatient	20% Coinsurance	40% Coinsurance
Outpatient Surgery	20% Coinsurance	40% Coinsurance
Emergency Room	20% Coinsurance after $250 Copay	20% Coinsurance after $250 Copay
Urgent Care	$45 Copay	40% Coinsurance
Maternity Care		
Physician Services (prenatal or postnatal)	No Charge	Covered as any other claim
Hospital Services	20% Coinsurance	40% Coinsurance after $600 Copay
Mental Health & Substance Abuse		
Inpatient	20% Coinsurance	$600 Copay + 40% Coinsurance
Outpatient	$45 Copay	40% Coinsurance
Retail Prescription Drugs (30-day supply)		
Contraceptive Drugs & Devices	No Charge	30% Coinsurance
Tier 1	$15 Copay	Member pay In-network Copay, plus 30% of the Allowable Amount
Tier 2	$30 Copay	
Tier 3	$50 Copay	
Tier 4	30% up to $200 Maximum	Not Covered
Mail Order Prescription Drugs (90-day supply)		
Tier 1	$30 Copay	Not Covered
Tier 2	$60 Copay	
Tier 3	$100 Copay	
Tier 4	Not Covered	

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

DENTAL PLAN

Your Dental PPO Plan

You and your eligible dependents have the opportunity to enroll in a Dental Preferred Provider Organization (PPO) plan offered by Aetna. The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice.

Using the Plan

Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists. As a best practice, be sure to request a quote from your dental provider for any high cost dental procedure such as crowns, etc. before proceeding with a treatment plan or procedure.

PLAN HIGHLIGHTS

	AETNA DENTAL PPO NETWORK: CHOICE POS II	
	In-Network	**Out-of-Network(1)**
Annual Deductible		
Individual	$50	
Family	$150	
Annual Maximum	$1,500	
Preventive	0% Coinsurance; Deductible Waived	
Basic Services	20% Coinsurance	40% Coinsurance
Major Services	50% Coinsurance	60% Coinsurance
Orthodontia Services		
Adult & Child	50% Coinsurance	
Lifetime Maximum	$1,500	

(1) Out-of-network coinsurance is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

TIP

Choose your Primary Care Dentist

When using a Dental PPO plan, you can receive services from dental providers both in and out of your insurance network. However, you'll receive better coverage when you use an in-network dentist. To determine whether your dentist is in or out of your insurance network, go to www.aetna.com and search the Choice POS II network, or call Aetna.

VISION PLAN

Your Vision Plan

Vision coverage is offered by VSP as a Preferred Provider Organization (PPO) plan.

Using the Plan

As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount.

To locate an in-network vision provider, visit www.vsp.com.

PLAN HIGHLIGHTS	VSP VISION PPO	
	In-Network	**Out-of-Network**
Exam – Every 12 months	$20 Exam Copay	Covered to Maximum of $45
Lenses – Every 24 months	$20 Materials Copay	
Single	Covered at 100% after Copay	Covered to a Maximum of $30
Bifocal	Covered at 100% after Copay	Covered to a Maximum of $50
Trifocal	Covered at 100% after Copay	Covered to a Maximum of $65
Frames – Every 24 months	Covered to a Maximum of $130	Covered to a Maximum of $70
Contacts – Every 24 months		
In lieu of lenses & frames	Contact Lens Exam Covered to a Maximum of $60; Materials Covered to a Maximum of $130	Covered to a Maximum of $105

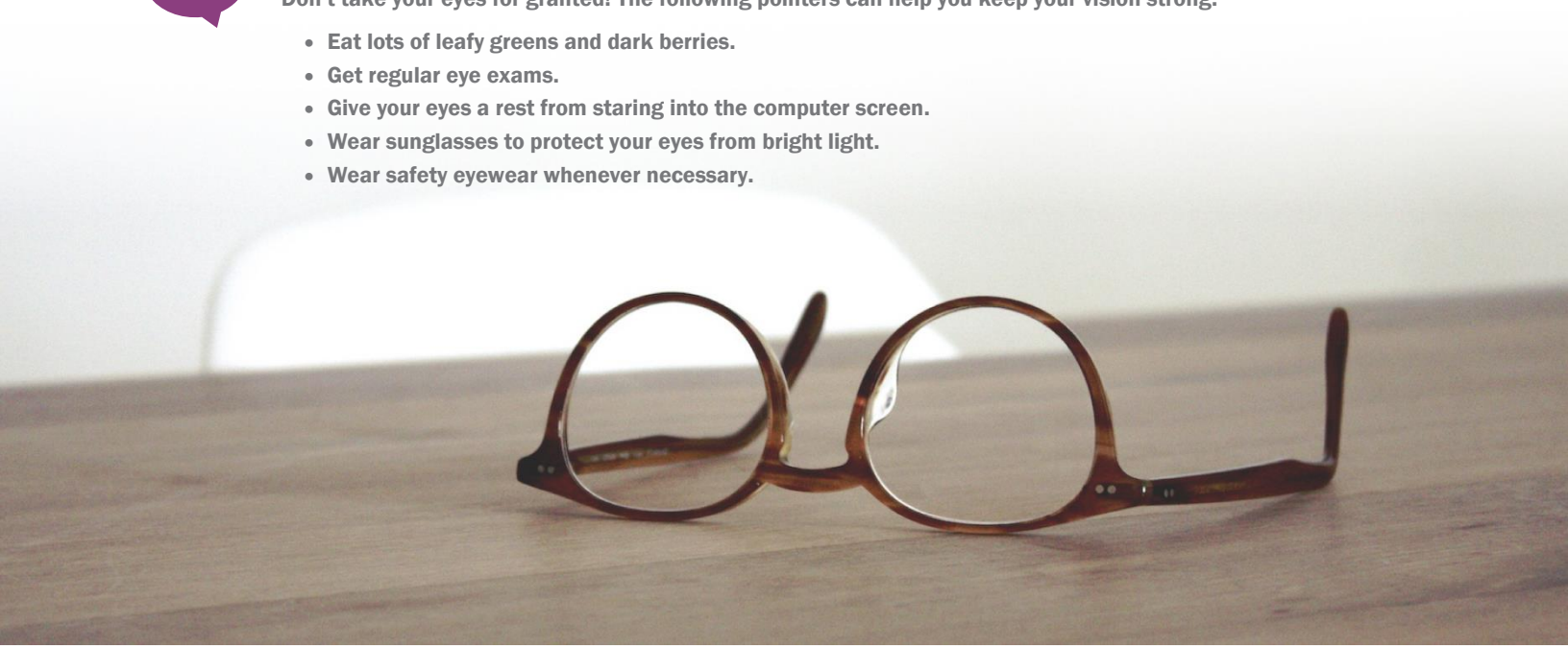
The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

TIP

Five Tips for Superior Vision

Don't take your eyes for granted! The following pointers can help you keep your vision strong:

- **Eat lots of leafy greens and dark berries.**
- **Get regular eye exams.**
- **Give your eyes a rest from staring into the computer screen.**
- **Wear sunglasses to protect your eyes from bright light.**
- **Wear safety eyewear whenever necessary.**



BASIC LIFE AND AD&D

Protect your loved ones

In the event of your death, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Your coverage

Paid for in full by Playworks, the benefits outlined below are provided by MetLife:

- Basic Life Insurance of 1x annual earnings up to $250,000.
- AD&D of 1x annual earnings up to $250,000.
- Please note, benefits may reduce when you reach age 65.

IRS Regulation: Employees can receive employer paid life insurance up to $50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of $50,000 will trigger taxable income for the "economic value" of the coverage provided to you. This taxable income will appear as an equivalent offset deduction and earning on your paystub.

TIP

Required! Are Your Beneficiaries Up to Date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- **You can change your beneficiary designation at any time.**
- **You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated. Please note that in some states like California, your spouse must be your beneficiary unless we have signed written permission for alternate beneficiary. Also if a child under the age of 18 is named as a beneficiary, the benefit will be paid to his/her guardian.**
- **You can select or change your beneficiary through UltiPro or contact your HR Partner.**

VOLUNTARY LIFE AND AD&D

If you would like to supplement your employer paid insurance, additional Life and AD&D coverage for you and/or your dependents is available for purchase.

- **For employees:** Increments of $10,000 up to a maximum of 5x your salary to $500,000. Guarantee Issue: $100,000.
- **For your spouse / state registered domestic partner:** Increments of $5,000 up to a $100,000 maximum. Guarantee Issue: $25,000.
- **For your child(ren):** Minimum flat benefit of $1,000; up to a $10,000 maximum. Additional limits on infants under six months old may apply. Guarantee Issue: $10,000
- **Optional AD&D:** No requirements for a medical questionnaire and coverage is available for purchase in the same amounts as optional life insurance amounts above.

Any amounts of insurance over the guarantee issue benefit are subject to review of good health by the insurance company. Insurance amounts subject to review will not be effective until the insurance company approves.

If you do not enroll in the plan within the initial enrollment period (at time of hire), **any** amount of supplemental life insurance will require proof of good health (Evidence of Insurability), which is subject to approval by MetLife before the insurance is effective. For more information regarding this plan, review the plan summary detail.

Please note: Benefits coverage may reduce when you reach age 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.

COST OF EMPLOYEE & SPOUSAL SUPPLEMENTAL LIFE INSURANCE COVERAGE

Age of Insured	Monthly Rate per $1,000
Less than 25	$0.09
25–29	$0.09
30–34	$0.10
35–39	$0.12
40–44	$0.16
45–49	$0.24
50–54	$0.36
55–59	$0.55
60–64	$0.82
65–69	$1.30
70–74	$2.43
AD&D	**Included**

DEPENDENT CHILD LIFE INSURANCE COVERAGE

Benefit Amount	Monthly Premium
$1,000	$0.29
$2,000	$0.58
$4,000	$1.16
$5,000	$1.46
$10,000	$2.91
AD&D	**Included**

LONG TERM DISABILITY & VOLUNTARY SHORT TERM DISABILITY INSURANCE

Added protection

Should you experience a non-work related illness or injury including child birth and your doctor certifies that you are unable to work, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings.

A note on pre-existing conditions: If you are treated for a health condition prior to the effective date and become disabled as a result of that condition, pre-existing condition limitations may apply.

Long term disability insurance coverage is provided to all regular Playworks employees at no cost to the employee. In states where short-term disability is not mandated and paid for through a mandated payroll tax deduction, employees may purchase voluntary short-term disability insurance coverage. At this time the states of California, New York, and New Jersey have state-mandated short-term disability insurance paid through mandatory payroll taxes. Contact your HR Partner for more information about Disability Benefit Coverage.

YOUR PLANS	COVERAGE DETAILS
Long-Term Disability Coverage (LTD)	• If your inability to work due to a medically-certified illness or injury disability extends beyond 90 days, the LTD coverage through MetLife can replace 60% of your earnings, up to maximum of $7,000 per month. • Your benefits may continue to be paid until you reach social security normal retirement age as long as you meet the definition of disability.
Voluntary Short-Term Disability (STD) This benefit is **not** available for employees in California (where coverage is provided by the state)	• Administered by MetLife, STD coverage provides a benefit equal to 60% of your earnings, up to $1,252 per week for a period up to 12 weeks. • The plan begins paying these benefits at the time of disability/after you have been absent from work for 7 consecutive days. • The employee cost for this insurance depends on age and wage replacement benefit amount as shown in chart below. Contact your HR partner for more information. To calculate your premium use this formula: Your Annual Salary/52 weeks = $ times 60% = your weekly benefit amount divided by 10 times the age-based rate in chart below = $premium amount per month.
State-mandated Disability Insurance	• The state you reside in may provide a partial wage-replacement disability insurance plan. • Applies to employees who reside in: CA, NY, NJ, RI, HI as of 7/1/2018 • For more information regarding statutory disability programs, contact Human Resources.

Tax considerations

Because long-term disability coverage is an employer-paid benefit and is available for employees at no cost, any disability payments made to you will be taxable.

Please note: Consult your tax advisor for additional taxation information or advice.

COST OF VOLUNTARY SHORT-TERM DISABILITY

Age of Insured	Weekly Rate per $10 of benefit	Age of Insured	Weekly Rate per $10 of benefit
Less than 30	$0.903	50-54	$1.397
30-34	$0.924	55-59	$1.712
35-39	$0.924	60-64	$1.806
40-44	$0.945	65+	$2.027
45-50	$1.124		

FLEXIBLE SPENDING ACCOUNTS (FSA)

This plan is based on the calendar year (January – December). Elections can be made in January, at time of hire or at time of a qualifying life event such as marriage, birth of child, etc. Open enrollment is not considered a qualifying life event for changes to FSA plans.

A flexible spending account lets you use pre-tax dollars to cover eligible health care, dependent care, and transit/parking expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA TYPE	DETAIL
 Health Care FSA	• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance. • Maximum contribution for 2019 is $2,700.
 Dependent Care FSA	• Can be used to pay for qualified child care and/or caregivers for a disabled family member in the household, who is unable to care for themselves. • Maximum contribution for 2019 is $5,000.
 Commuter Spending Account	• Can be used to cover qualified transit passes, vanpooling, payments for transportation in a commuter highway vehicle, and qualified parking costs. • Parking maximum contribution for 2019 is $265 per month. • Transit maximum contribution for 2019 is $265 per month. • Cash reimbursement is not allowed. You must use the FSA Debit card for all parking and transit purchases.

What are the benefits?

- Your taxable income is reduced and your spendable income increases!
- Save money while keeping you and your family healthy.

How do I use it?

You must enroll in the FSA program within 30 days of your hire date or during annual calendar year open enrollment. At this time, you must establish an annual contribution amount within the maximum limit. Once enrolled, you will have online access to view your FSA account at our FSA Plan administrator's online portal: www.discoverybenefits.com

Receiving Reimbursements

You will have until March 31, 2020 to submit a reimbursement request for claims incurred between January 1 and December 31, 2019. If you do not receive automatic reimbursement by using your debit card, you can submit a manual reimbursement request by contacting Discovery Benefits. Any unclaimed funds remaining in your account after March 31, 2019 will be forfeited.

A few rules you need to know:

- A **Health Care FSA** can reimburse for health care expenses that are not covered, or are only partially covered, by your medical, dental and vision insurance plans including other eligible expenses. You will have immediate access to the entire annual contribution amount from the last day of the benefit year, before all scheduled contributions have been made. Only those who are eligible to participate in the Playworks' major medical coverage are eligible to participate in the Health Care FSA
- The **Dependent Care FSA** can be used to pay for qualified child care/or caregivers for a disabled family member living in the household who is unable to care for themselves. Unlike the Health Care FSA, you can only access the money that is currently in the account.

The plan administrator is Discovery Benefits.

- Contributions are deducted from your paycheck in equal amounts during the year before federal, state and social security taxes are taken out.
- Since you are not paying federal, state or social security taxes on the contributions, your taxable income is reduced and your spendable income actually increases.
- Additionally, **Commuter Benefit** plans such as **Mass Transit** and **Parking** benefit can be reimbursed for eligible commuting expenses also on a pre-tax basis.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Playworks understands that you and your family members might experience a variety of personal or work-related challenges. Through the EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

PROGRAM COMPONENT	COVERAGE DETAILS
Who Can Utilize	All employees, dependents of employees, and members of your household
Topics May Include	• Childcare. • Eldercare. • Legal services. • Identity theft. • Marital, relationship or family problems. • Bereavement or grief counseling. • Substance abuse and recovery. • Financial support. • Educational materials.

TIP

How to Access:

- **By Phone: 888.319.7819.**
- **Online: metlifeeap.lifeworks.com**
- **User Name: metlifeassist**
- **Password: support**

RETIREMENT OPTIONS

Your 401(k) Plan Option

Administered by Fidelity, the 401(k) plan allows you to plan for your future by investing a portion of each paycheck. Once you become eligible, you may elect to have a percentage of your paycheck withheld and invested in your 401(k) account, subject to federal law and plan guidelines. See Human Resources to confirm eligibility and enrollment dates.

Enrollment & Account Access

- To enroll in the 401(k) plan, please visit www.401k.com to enroll online or contact Human Resources.
- Check your 401(k) account balance, view your contributions, change your investments and more by visiting www.401k.com. For login or password assistance, please contact Fidelity at 800.343.3548.

Additional 401(k) Information

Contribution Limits: For 2019 the IRS annual contribution limits are $19,000 for everyone under age 50 or $25,000 for anyone that is age 50 or over prior to December 31, 2019. If you have multiple employers during the year, these limits are combined for all plans that you contribute to during the year. Restrictions may apply to these limits based on plan documents and annual testing requirements.

Contribution Changes: Check with Human Resources for frequency and process for changing your contributions. You may also stop your contribution entirely at any time. Requests to change or stop your contributions must be made through the provider website or in writing to Human Resources.

Loans & Hardship Withdrawals: If allowed by the plan document, please see Human Resources for information and requirements for either option.

Rollover Contributions: If you have an outside qualified retirement plan or account such as a 401(k), 403(b), 457(b) or IRA, you may be able to transfer that account into your new plan. Please contact Fidelity or Human Resources for additional information.

Termination of Employment: Upon termination of employment from our organization, regardless of reason, you will be entitled to request a full distribution of your vested account balance. This may be done as a rollover to another plan or IRA. You may also request a lump-sum cash payment to yourself. Please be aware of possible taxes and penalties which may apply to any payment other than a rollover.

TIP

Your Target Retirement

Are you wondering how much you should save for retirement? Learn more by accessing a free retirement planning calculator at http://www.mmaretirement.com/calculators.cfm

Marsh & McLennan Insurance Agency LLC does not serve as advisor, broker-dealer or registered investment advisor for this plan. All of the terms and conditions of your plan are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

COST BREAKDOWN

The rates below are effective August 1, 2019 – July 31, 2020.

Coverage Level	Total Cost	Payroll Deduction	Payroll Deduction
	Monthly	Employee Monthly	Employee Semi-Monthly
Aetna Silver PPO			
Employee Only	$322.95	$16.15	$8.07
Employee and Spouse/Registered Domestic Partner	$678.18	$193.76	$96.88
Employee and Child(ren)	$613.60	$161.47	$80.74
Employee and Family	$968.84	$339.09	$169.55
Aetna Gold PPO			
Employee Only	$391.05	$84.25	$42.13
Employee and Spouse/Registered Domestic Partner	$821.20	$336.78	$168.39
Employee and Child(ren)	$743.00	$290.87	$145.44
Employee and Family	$1,173.14	$543.39	$271.70
Aetna Platinum PPO			
Employee Only	$480.06	$173.26	$86.63
Employee and Spouse/Registered Domestic Partner	$1,008.12	$523.70	$261.85
Employee and Child(ren)	$912.11	$459.98	$229.99
Employee and Family	$1,440.17	$810.42	$405.21
Aetna Dental PPO			
Employee Only	$35.52	$17.76	$8.88
Employee and Spouse/Registered Domestic Partner	$74.96	$47.34	$23.67
Employee and Child(ren)	$78.53	$50.02	$25.01
Employee and Family	$117.97	$79.60	$39.80
VSP Vision PPO			
Employee Only	$5.19	$2.59	$1.30
Employee and Spouse/Registered Domestic Partner	$8.89	$5.36	$2.68
Employee and Child(ren)	$9.08	$5.51	$2.76
Employee and Family	$14.64	$9.68	$4.84

DIRECTORY & RESOURCES

Below, please find important contact information and resources for Playworks.

INFORMATION REGARDING	GROUP / POLICY #	CONTACT INFORMATION	
Enrollment & Eligibility			
Playworks People Team/Human Resources National HQ, Oakland, California		Help Desk: https://www.playworks.org/about/contact-us/admin/help-desk-ticket/ Or contact PeopleTeam@playworks.org	People Team site/Benefits
Medical Coverage			
Aetna • Platinum • Gold • Silver	231836	877.204.9186	www.aetna.com
Dental Coverage			
Aetna • Dental PPO	231836	877.238.6200	www.aetna.com
Vision Coverage			
VSP • Vision PPO	30015056	800.877.7195	www.vsp.com
Life, AD&D and Disability			
Met Life • Life / AD&D • LTD • Voluntary STD	 KM 05715228 G KM 05715228 G	800.275.4638	www.metlife.com
FSA, COBRA, Transit & Commuter			
Discovery Benefits		866.451.3399	www.discoverybenefits.com
Employee Assistance Plan and Grief Counseling Program			
MetLife LifeWorks Counselors • Relationship Problems • Family Issues and Life Changes • Funeral Assistance Services • Elder Care Services • Confidential Assistance		888.319.7819	metlifeeap.lifeworks.com User Name: metlifeassist Password: support
401(k) Retirement Plan Adviser			
Fidelity Member Services Marsh & McLennan Insurance Agency LLC	Retirement Services Division	800.343.3548 925.482.9300	www.401k.com https://www.marshmma.com/offerings/retirement-services
Benefits Broker			
Marsh & McLennan Insurance Agency LLC 1340 Treat Blvd., Ste. 250 Walnut Creek, CA 94597	Employee Health & Benefits	925.482.9300	www.MarshMMA.com

PLAN GUIDELINES AND EVIDENCE OF COVERAGE

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

MEDICARE PART D NOTICE

Important Notice about Your Prescription Drug Coverage and Medicare

Model Individual CREDITABLE Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area.

If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact Human Resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Your medical benefits brochure contains a description of your current prescription drug benefits.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your employer and don't join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For More Information about Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: **Keep this Creditable Coverage notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

LEGAL INFORMATION REGARDING YOUR PLANS

Required Notices

Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

"HIPAA Special Enrollment Opportunities" include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage [1]
- Acquisition of a new spouse or dependent through marriage [1], adoption [1], placement for adoption [1] or birth [1]
- Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) [1]
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

"Change in Status" Permitted Midyear Election Changes

- Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved "change in status" as defined by the IRS.
- Examples of permitted "change in status" events include:
- Change in legal marital status (e.g., marriage [2], divorce or legal separation)
- Change in number of dependents (e.g., birth [2], adoption [2] or death)
- Change in eligibility of a child
- Change in your / your spouse's / your registered domestic partner's employment status (e.g., reduction in hours affecting eligibility or change in employment)
- A substantial change in your / your spouse's / your registered domestic partner's benefits coverage
- A relocation that impacts network access
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment
- Qualified Medical Child Support Order or other judicial decree
- A dependent's eligibility ceases resulting in a loss of coverage [3]
- Loss of other coverage [2]
- Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage
- You enroll, or intend to enroll, in a Qualified health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

You must notify Human Resources within 30 days of the above change in status, with the exception of the following which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

Important Information on how Health Care Reform Affects Your Plan

Primary Care Provider Designations

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- Your HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Human Resources office

For plans and issuers that require or allow for the designation of a primary care provider for a child:

- For children, you may designate a pediatrician as the primary care provider

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

- You do not need prior authorization from your insurance provider or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, 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 your Human Resources office.

Grandfathered Plans

If your group health plan is grandfathered then the following will apply. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator.

Prohibition on Excess waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan. State law may require shorter waiting periods for insured group health plans. California law requires fully-insured plans to comply with the more restrictive waiting period limitation of no more than 60-days.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended

Continuation Coverage Rights under COBRA

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

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

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

[1] Indicates that this event is also a qualified "Change in Status"
[2] Indicates this event is also a HIPAA Special Enrollment Right
[3] Indicates that this event is also a COBRA Qualifying Event

Continuation Coverage Rights under COBRA (continued)

What is COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan.

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

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

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

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

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child.

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to anyone covered under the Plan who are spouses, dependent children, or anyone else eligible for COBRA continuation coverage under the Plan.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

How is COBRA continuation coverage provided? (Continued)

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Cathy Ramer, SPHR/SHRM-SCP, Head of People Team
Playworks National Office
638 3rd Street, Oakland, CA 94607
P: 510.250.7778, catherine.ramer@playworks.org

For More Information

This notice doesn't fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact your Human Resources Representative.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.healthcare.gov.

Employee Rights & Responsibilities under the Family Medical Leave Act

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness [1]; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. [1]

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months [2], and if at least 50 employees are employed by the employer within 75 miles.

[1] The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition"

[2] Special hours of service eligibility requirements apply to airline flight crew employees

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TYY: (877) 889-5627 www.wagehour.dol.gov

Uniformed Services Employment & Reemployment Rights Act Notice of 1994, Notice of Right to Continued Coverage under USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You do not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Reporting to Work / Applying for Reemployment

Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible
181 days or more	Submit an application for reemployment within 90 days after completion of your service
Any period if for purposes of an examination for fitness to perform uniformed service	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definitions

For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency
- "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

HIPAA Privacy Notice

Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to provide information about the legal protections that apply to your health information. HIPAA includes numerous provisions that are designed to maintain the privacy and confidentiality of your Protected Health Information (PHI). PHI is health information that contains identifiers (such as your name, address, social security number, or other information that identifies you) and information related to your past, present or future health condition and treatments.

This notice is for participants in the Company Health & Welfare Plan (referred to as the "Plan"), including its component plans.

Required by Law

- The Plan must make sure that health information that identifies you is kept private.
- The Plan must give you this notice of our legal duties and privacy practices with respect to health information about you.
- The Plan must obtain written authorization from you for the use and disclosure of your PHI related to psychotherapy notes; when for purposes of marketing; and/or for disclosures constituting a sale of PHI.
- The Plan must follow the terms of the notice that are currently in effect.

Permitted Plan use of Your Health Information

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact the Plan Privacy Officer.

You have both the right and choice to tell us to: share information with your family, close friends, or others involved in payment for your care; share information in a disaster relief situation; and contact you for fundraising efforts.

If you are not able to tell us your preference, for example if you are unconscious, the Plan may go ahead and share your information if it believes it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety.

The Plan will never share your information unless you give us written permission for: marketing purposes and the sale of your information.

Treatment: The Plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the Plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees. We may also use and disclose your information to run our organization and contact you when necessary. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. The Plan is also not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Payment for Health Services and Administration of the Plan: The Plan can use and disclose your health information when paying for your health services. For example, the Plan may share information about you with your dental plan to coordinate payment for your dental work. The Plan may disclose your health information to your health plan sponsor for plan administration. For example, where your company contracts with an insurer to provide a health plan, and the Plan provides your company with certain statistics to explain the premiums charged.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy rules and HIPAA security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law (this includes the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law).

To Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director: We may share health information about you with organ procurement organizations; and may share health information with a coroner, medical examiner, or funeral director when an individual dies.

Workers' Compensation: We may release health information about you for workers' compensation programs or claims or similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement and other Government Requests: We may disclose your health information for law enforcement purposes or with a law enforcement official, in response to a valid subpoena or other judicial or administrative request/order, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services.

Public Health and Research: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation). Additionally we may share health information about you when: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety or for purposes of health research.

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information where concerning a service already paid for.
- Obtain a paper copy of the notice of health information practices promptly (even if you have agreed to receive the notice electronically) by requesting it from the Plan Privacy Officer.
- Ask to see or get a copy of your health and claims records and other health information we have about you. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Inspect and obtain a copy of your PHI contained in a "designated record set." A designated records set includes medical and billing records; enrollment, payment, billing, claims adjudication and case or medical management record systems; or other information used in whole or in part by or for the covered entity to make decisions about individuals. A written request to access your PHI must be submitted to your company Privacy Officer. Requested information will be provided within 30 days if maintained on site or 60 days if maintained off site.
- Request an amendment/correction to your health information: you can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- Obtain an accounting of disclosures of your PHI during the preceding six years, who we shared it with, and why, with the exception of disclosures made for purposes of treatment, payment or health care operations, and certain other disclosures (such as any you asked us to make); made to individuals about their own PHI; or, made through use of an authorization form. A reasonable fee may be charged for more than one request per year.
- Request confidential communications of your health information be sent in a different way (for example, home, office or phone) or to a different place than usual (for example, you could request that the envelope be marked "confidential" or that we send it to your work address rather than your home address). We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.
- Receive notification within 60 days (5 day for California residents) for any breaches of your unsecured PHI.
- Assign someone as your medical power of attorney or your legal guardian, who can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Plan Responsibilities

The Plan is required to maintain the privacy of PHI and to comply with the terms of this notice. The Plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you within 60 days of the effective date of any material change to the rights and duties listed in this notice. The Plan is required to:

- Maintain the privacy and security of your health information.
- Make reasonable efforts not to use, share, disclose or request more than the minimum necessary amount of PHI needed to accomplish the intended purpose, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- Follow the duties and privacy practices described in this notice with respect to information we collect and maintain about you and provide you a copy of the notice.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction, amendment or other request.
- Notify you of any breaches of your protected health information that may have compromised the privacy or security of your information within 60 days (5 days for California residents).
- Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA. The plan is prohibited from using or disclosing PHI that is genetic information of an individual for any purposes, including underwriting.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Your Right to File a Complaint

If you believe your privacy rights have been violated, you can file a formal complaint with the Plan Privacy Officer; or with the U.S. Department of Health and Human Services (by mail or email). We will not retaliate against you and you will not be penalized for filing a complaint.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Contact Person

If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the Plan Privacy Officer. All requests must be submitted in writing to the address shown below.

Playworks
Attention: Cathy Ramer
Head of People Team
638 3rd Street, Oakland, CA 94607
Oakland, CA 94607
(510) 250-7778

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid	**KANSAS – Medicaid**
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid and CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

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

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

NOTES

Marsh & McLennan Insurance Agency LLC
www.MarshMMA.com
CA Insurance Lic: 0H18131