Employee Benefits Guidebook

January 1, 2027 to December 31, 2027

Benefits Website:
professionalplastics.benefitsmap.com



CA EMPLOYEES

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For Questions About	Carrier	Call	Visit/Email	Plan/Group ID
Medical	Anthem	(800) 888-8288	anthem.com/ca	L04099
Dental	Anthem	(877) 567-1804	anthem.com/ca	L04099
Vision	Anthem	(866) 723-0515	anthem.com/ca	L04099
Life/AD&D	Standard	(800) 552-2137	standard.com	L04099
Disability	Standard	(800) 232-0113	standard.com	09-L04099
Supplemental Insurance (Accident/Hospital/Critical Illness)	Anthem	(800) 604-4381	anthem.com/ca	L04099
Pet Discount Program	United Pet Care	(888) 781-6622	unitedpetcare.com	00001493
Legal Assistance	MetLife	(800) 821-6400	members.legalplans.com	5386746
Employee Assistance Program	Standard	(888) 209-7840	carelonwellbeing.com/resourceadvisor	L04099
Flexible Spending Accounts	Igoe	(800) 633-8818 option #1	goigoe.com Login Code: IGOPROPLA	ProPlas
Benefit Advocacy Team	SCM	(833) 693-7089	proplasticsbenefits@sullicurt.com	N/A

If you have Medicare, or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 26 for more details.

Letter From Dave Kietzke & Mark Casey

Professional Plastics Family,

Welcome to the 2027 Employee Benefits Enrollment Guide!

As we begin our enrollment season, we want to sincerely thank you for the outstanding effort you bring to the company every day. Your contributions are the foundation of our continued success, and we remain committed to supporting your health and well-being with a comprehensive and competitive benefits program.

Looking ahead to 2027, we are pleased to share that there are no changes to our benefit plan options. This is our fifth consecutive year with Anthem Blue Cross, providing Team ProPlas with reliable coverage and continued access to the doctors, specialists, and support services you know and trust. Maintaining consistency allows you and your family to continue receiving the care you rely on without disruption.

Like many employers across the country, we continue to face rising healthcare and insurance costs. Increased provider costs and broader market trends have contributed to higher premiums and benefit expenses. While these factors are beyond our control, we want you to know that we carefully evaluate every renewal and work hard to manage employee out-of-pocket costs. Our goal remains the same: to provide strong benefits while keeping them as affordable as we can for our team.

We believe that quality healthcare coverage is an important investment in our people. That is why we continue to offer a benefits package designed to support the diverse needs of our team and your families – providing protection today while helping you prepare for the future with confidence.

We encourage you to review your benefit elections carefully during enrollment to ensure they continue to meet your personal and family needs. In addition to medical, dental, and vision coverage, we offer a variety of supplemental benefits and voluntary options that may provide additional protection and peace of mind.

Thank you for everything you do to make Professional Plastics successful. We are grateful for your commitment and proud of what we continue to accomplish together.

We look forward to another outstanding year and wish you and your family a healthy and rewarding 2027.



Dave Kietzke
CEO & Chairman of the Board



Mark Casey
President – North America

A Healthy Year Starts Here!

Making decisions about you and your family's health isn't always easy. But choosing your benefits can be simplified with this helpful guide to your 2027 healthcare options. Simply review the enclosed information and choose from the flexible benefit options that provide the right balance of cost and features for you and your family.

Don't Forget

Your enrollment period is your one opportunity to review and/or elect the benefits you would like to participate in for the 2027 plan year, unless you experience a qualifying life event (i.e. birth, marriage, adoption, divorce). If any of these changes occur, it is your responsibility to alert Human Resources to make changes within 30 days of the date of the qualifying event.

Please review this guide and all materials provided carefully as you consider your benefit needs.

Plan Costs

Premium contributions are deducted from your paycheck on a pre-tax basis.

	2025 Deductions	2026 Deductions	2027 Deductions
	Anthem Value Deductible HMO		
Employee Only	$67.09	$83.01	$93.80
Employee + Spouse	$151.58	$182.63	$206.37
Employee + Child(ren)	$123.41	$149.42	$168.84
Employee + Family	$214.95	$257.33	$290.78
	Anthem Solution PPO		
Employee Only	$90.13	$110.18	$124.50
Employee + Spouse	$202.28	$242.40	$273.91
Employee + Child(ren)	$164.90	$198.33	$224.11
Employee + Family	$286.40	$341.56	$385.96
	Anthem Dental DHMO		
Employee Only	$6.11	$6.11	$6.35
Employee + Spouse	$12.21	$12.21	$12.70
Employee + Child(ren)	$13.13	$13.13	$13.65
Employee + Family	$20.88	$20.88	$21.72
	Anthem Dental PPO High Option		
Employee Only	$14.05	$14.62	$15.35
Employee + Spouse	$28.47	$29.61	$31.09
Employee + Child(ren)	$31.59	$32.85	$34.50
Employee + Family	$46.11	$47.96	$50.36
	Anthem Dental PPO Low Option		
Employee Only	$10.95	$11.39	$11.95
Employee + Spouse	$22.16	$23.05	$24.20
Employee + Child(ren)	$24.57	$25.56	$26.83
Employee + Family	$35.82	$37.25	$39.11
	Anthem Vision		
Employee	$3.21	$3.21	$3.21
Employee + 1	$4.98	$4.98	$4.98
Employee + 2 or more	$7.90	$7.90	$7.90

Ready to Enroll?

Professional Plastics covers a significant amount of your benefit costs. Your contributions for medical, dental, and vision benefits are deducted on a pre-tax basis, which reduces the amount you're required to pay taxes on. Employee contributions vary depending on the level of coverage you select — typically, the more coverage you have, the more you'll pay up-front for it.

Enrollment Action Items

Update your personal information.

Confirm your mailing address and phone number are up to date.

Update your dependents & beneficiaries.

Update dependent information so your family can be covered. Update beneficiaries, as their contact info may not be the same as yours.

Review available plan options.

Review the differences between plans and choose the options that best meet your needs.

Benefits Website

Visit our employee benefits website, an online destination for you to find benefits information, carrier forms, educational resources and enrollment information. This site will allow you to quickly access the information you need to make an informed decision about choosing your benefit plans.

professionalplastics.benefitsmap.com

Scan for the benefits website

Eligibility & Enrollment

Eligibility

If you are a full-time employee of Professional Plastics, you are eligible to participate in medical, dental, vision, life and disability plans, and additional benefits. If you're enrolling as a new employee, you become eligible for benefits on the first of the month following 60 days of employment and must enroll within 30 days of your date of hire to have coverage for the rest of the plan year. Benefits cannot be changed until the next enrollment period unless you experience a Qualifying Life Event.

Do I Need to Enroll?

Before deciding whether you need to enroll, keep in mind that there are many good reason to take a close look at all the benefits and options Professional Plastics offers you — even if you're already covered.

For instance, you may experience changes from year to year and there likely will be changes to what you pay for coverage each year. So, it's a good idea to make sure your benefits still fit you—and that you're not paying for more coverage than you need.

Passive enrollment – Benefits will carry over into the new plan year. FSA enrollment must be re-elected every year.



You must enroll if you want to:

- Change your medical, dental, or vision coverage for next year.
- Change your optional Employee Life Insurance, Spouse/Domestic Partner Life Insurance, Supplemental Life Insurance, Long-Term Disability Insurance, or Short-Term Disability Insurance choices.

To enroll, visit benefits.plansource.com.

Dependents

Dependents eligible for coverage include:

- Your legal spouse/domestic partner.
- Children under the age of 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom you or your spouse/domestic partner have legal guardianship).
- Dependent children 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability (periodic certification may be required).

You'll be required to provide proof of eligibility for any new dependent you want to add to your coverage.

Domestic Partners - Tax Considerations

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

You can update your benefits when you start a new job or during Open Enrollment each year. But changes in your life called Qualifying Life Events determined by the IRS can allow you to enroll in health insurance or make changes outside of these times.

What Are Qualifying Life Events?

When a Qualifying Life Event occurs, you have 30 days to request changes to your coverage. Your change in coverage must be consistent with your change in status.

Qualifying Life Events include:

- A change in the number of dependents (through birth or adoption or if a child is no longer an eligible dependent)
- A change in your legal marital status (marriage, divorce, or legal separation)
- A change in a spouse/domestic partner's employment status (resulting in a loss or gain of coverage)
- Entitlement to Medicare or Medicaid
- Eligibility for coverage through the Marketplace (Healthcare.gov)
- Changes in address or location that may affect coverage
- Turning 26 and losing coverage through a parent's plan
- A change in employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility
- Death in the family (leading to change in dependents or loss of coverage)
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)

Reach out to Human Resources with questions regarding specific life events and your ability to request changes. Don't miss out on a chance to update your benefits!





Medical Benefits

Medical benefits are provided through Anthem Blue Cross. Consider the physician networks, premiums, and out-of-pocket costs for each plan when making a selection. Keep in mind your choice is effective for the entire 2027 plan year unless you have a Qualifying Life Event.

NOTE
To get the most value out of your medical plan, be sure to visit in-network providers whenever possible.

How to Find a Provider

Visit findcare.anthem.com and follow the instructions below:

1. Click on "Basic search as a guest"
2. Under "Select the type of plan or network," select "Medical Plan or Network"
3. Under "Select the state where the plan or network is offered," select "California"
4. Under "Select how you get health insurance," select "Medical (Employer-Sponsored)"
5. Select a plan or network:
   - "Select HMO" for the Anthem Value Deductible HMO Plan
   - "Prudent Buyer PPO" for the Anthem Solution PPO

You can also call Customer Care at (866) 207-9878 for a list of Anthem Blue Cross network providers.

Healthcare Cost Transparency

There are so many different providers and varying costs for healthcare services — how do you choose? Online services called healthcare cost transparency tools can help. Available through most health insurance carriers, these tools allow you to compare costs for services, from prescriptions to major surgeries, to make your choices simpler. Visit www.anthem.com/ca to learn more.

How You Pay For Health Care Costs

You share the cost of services with your employer and the insurance plans you select. As you review your plan options, you should consider the following types of costs:

Premium

A premium is the total cost of your health insurance. You and your employer share this cost. You pay your portion of medical, dental, and vision premiums through pre-tax payroll deductions.

Copay

A copay is a set payment you make for a specific service.

Out-of-Pocket Maximum

The annual out-of-pocket maximum protects you from major medical expenses. This is the most you would pay, including your deductible, for eligible expenses during a plan year. Once you reach the out-of-pocket maximum, the plan pays 100% of the usual, customary, and reasonable charges for covered services.

Deductible

A deductible is the amount you must pay before the medical plan begins sharing the cost of services. You pay this full amount, if required by your plan, before the plan pays benefits.

The individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will also be applied toward the "per family" deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the "per family" deductible amount. The same typically applies for the out-of- pocket maximum.

Coinsurance

When you are paying coinsurance, you are sharing a percentage of the cost of services with the medical plan.

Your Total Cost of Care

Remember, your total healthcare cost for the year is the combination of the premium contributions you make for coverage and your out-of-pocket expenses when you access medical care.

Premiums
+ Out-of-Pocket Costs

= Total Cost of Health Care

Depending on your personal situation, the plan with the lowest deductible may not be the best plan for you. Be sure to take a good look at the total cost of your expected care before making your plan decisions for 2027.

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Medical Plan Summary

This chart summarizes the 2027 medical coverage provided by Anthem Blue Cross. All covered services are subject to medical necessity as determined by the plan. Please note that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

**Note: ID Card available*

	Anthem Value Deductible HMO
	In-Network
Calendar Year Deductible	
Individual **Family**	$1,500 $3,000
Calendar Year Out-of-Pocket Maximum**	
Individual **Family (includes deductible)**	$3,500 $7,000
Coinsurance/Copays	
Preventive Care **Primary Care** **Specialist** **Urgent Care** **Outpatient Hospitalization** **Inpatient Hospitalization** **Emergency Room**	No charge $25 copay $50 copay $25 copay 25% after deductible 25% after deductible $200 then 25% after deductible
Retail Rx (30-Day Supply)	
Tier 1a/1b: Generic **Tier 2: Preferred** **Tier 3: Non-Preferred** **Tier 4: Specialty**	$5/$20 copay $30 copay $50 copay 30% up to $250

***Includes all deductible and coinsurance.*

Please refer to your carrier Summary(ies) of Benefits and Coverage (SBCs) for more detailed benefit information. In the event of a discrepancy, plan documents will govern.

Preventive Care

Routine checkups and screenings are considered preventive, so they're generally paid at 100% by your insurance. Common covered services include:

- Wellness visits, physicals, and standard immunizations
- Screenings for blood pressure, cancer, cholesterol, depression, obesity, and diabetes
- Pediatric screenings for hearing, vision, obesity, and developmental disorders
- Anemia screenings, breastfeeding support, and pumps for pregnant and nursing women
- Iron supplements (for infants at risk for anemia)

Preventive vs. Diagnostic

It's important to take advantage of these covered services. But remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. So, if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

What vaccines are covered 100% under preventive care?

Many vaccines are covered under preventive care when delivered by a doctor or provider in your plan's network. These include chickenpox, flu, shingles, and tetanus. For a full list, visit www.healthcare.gov/preventive-care-adults.

**Note: ID Card available*

	Anthem Solution PPO	
	In-Network	**Out-of-Network**
Calendar Year Deductible		
Individual **Family**	$3,000 $6,000	
Calendar Year Out-of-Pocket Maximum**		
Individual **Family (includes deductible)**	$6,300 $12,700	$13,000 $26,000
Coinsurance/Copays		
Preventive Care **Primary Care** **Specialist** **Urgent Care** **Outpatient Hospitalization** **Inpatient Hospitalization** **Emergency Room**	No charge $30 copay $30 copay $30 copay 20% after deductible $100 + 20% after deductible $100 + 20% after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible $100 + 50% after deductible Covered as in-network
Retail Rx (30-Day Supply)		
Tier 1: Generic **Tier 2: Preferred** **Tier 3: Non-Preferred** **Tier 4: Specialty**	$10 copay $35 copay $75 copay 30% up to $250	In-network copay In-network copay In-network copay Not covered

***Includes all deductible and coinsurance.*

Please refer to your carrier Summary(ies) of Benefits and Coverage (SBCs) for more detailed benefit information. In the event of a discrepancy, plan documents will govern.



Pharmacy Benefits

NOTE
Apps and prescription discount programs such as GoodRx, Amazon Prime Rx Savings, Optum Perks, and Cost Plus Drug Company let you compare prices of prescription drugs and find possible discounts. However, using these programs and their discounts may result in prescription costs not applying toward the deductible.

Prescription Drug Coverage

Our Prescription Drug Program is coordinated through Anthem Blue Cross. That means you will only have one ID card for both medical care and prescriptions. Information on your benefits coverage and a list of network pharmacies is available online at www.anthem.com/ca or by calling the Customer Care number on your ID card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Preferred, Non-Preferred, or Specialty Drugs.

Generic Drugs

Want to save money on meds? Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety, and strength. Because they are the same medicine, generic drugs are just as effective as the brand names, and they are held to the same rigid FDA standards. But generic versions cost 80% to 85% less on average than the brand-name equivalent. To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

Where to Go For Care

You're feeling sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new prescription, but the pharmacy is closed. Or you're on vacation and are under the weather. Instead of rushing to the emergency room or relying on questionable information from the internet, consider all of your site-of-care options.



Nurse Line

Find the number on the back of your ID card



Telemedicine

Through the Sydney app or LiveHealth Online



Primary Care Center



Urgent Care Center



Emergency Room

WHEN TO USE

You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.

You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

TYPES OF CARE

Answers to questions regarding symptoms, self-care, home treatments, medications / side effects and when to seek care.

Cold & flu symptoms, bronchitis, urinary tract infection, sinus problems.

Routine checkups, immunizations, preventive services, managing your general health.

Strains, sprains, minor broken bones (e.g., finger), minor infections, minor burns.

Heavy bleeding, chest pain, major burns, severe head injury.

COST/TIME CONSIDERATION

Usually available 24 hours a day, 7 days a week. Typically free as part of your medical insurance.

Usually a first-time consultation fee and a flat fee or copay for any visit thereafter. Typically immediate access to care. Prescriptions through telemedicine or virtual visits not allowed in all states.

Often requires a copay and/or coinsurance. Normally requires an appointment. Short wait time with scheduled appointment.

Copay and/or coinsurance usually higher than an office visit. Walk-in patients welcome, but urgency determines order seen and wait time

Often requires a much higher copay and/or coinsurance. Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first. Ambulance charges, if applicable, will be separate and may not be in-network.



Flexible Spending Accounts

Take control of your spending! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses.

Healthcare Flexible Spending Account

You can contribute up to the IRS limit for the next year annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them — no waiting for reimbursement.

Account Rollover

If you have money left in your Health Care FSA at the end of 2027, you may carry over up to the IRS limit for the next year.

Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — even if you don't elect any other benefits. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is currently deposited in your account.

- With the Dependent Care FSA, you can set aside up to $7,500 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent day care expenses that are necessary for you and your legal spouse/domestic partner to work or attend school full time. Eligible expenses include:

- In-home babysitting services (not provided by a dependent)
- Care of a preschool child by a licensed nursery or day care provider
- Before- and after-school care
- Day camp
- In-house dependent day care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

Using the Account

Use your FSA debit card at doctor and dentist offices, pharmacies, and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you use the card at an ineligible location.

Submit a claim form along with the required documentation. Contact Igoe with reimbursement questions. If you need to submit a receipt, Igoe will notify you. Always save receipts for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any FSA debit card charges in case you need to prove an expense was eligible. Without proof an expense was valid, your card could be turned off and the expense deemed taxable.

NOTE
The Dependent Care FSA is not to be used for medical expenses, nor is it the same as electing medical coverage for dependents.

General Rules

The IRS has the following rules for Healthcare and Dependent Care FSAs:

- Expenses must occur during the 2027 plan year.
- Funds cannot be transferred between FSAs.
- You are not permitted to claim the same expenses on both your federal income taxes and Dependent Care FSA.
- You must “use it or lose it” — any unused funds will be forfeited.
- You cannot change your FSA election in the middle of the plan year without a Qualifying Life Event.
- Terminated employees have ninety (90) days following termination to submit FSA claims for reimbursement.
- Those considered highly compensated employees (family gross earnings were $155,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more info.





Virtual Care

When you're under the weather, there's no place like home, and if you're busy with work and family, scheduling an in-person doctor's appointment can be a pain. Virtual medicine is a convenient and easy way to connect with a doctor on your time.

Professional Plastics provides a virtual medicine benefit through Anthem Blue Cross for you and your dependents. Virtual Care offers on-demand access to board-certified doctors through online video consultations.

Virtual Care doctors can share information with your primary care physician with your consent. Please note that some states do not allow physicians to prescribe medications via telemedicine. For more information, visit anthem.com/ca.

Virtual doctors can treat many medical conditions, including:

- Cold & flu
- Allergies
- Bronchitis
- Respiratory infection
- Pink eye
- Sore throat
- Bladder infection / urinary tract infection
- Stomachache
- Sinus problems

Access Virtual Visits

Visit anthem.com/ca or the Sydney app and choose Care, and then Virtual Care to request a virtual visit. After you register and request an appointment, you'll enter a virtual waiting room. During your visit, you can talk to a doctor about your health concerns, symptoms, and treatment options.

NOTE
Your primary care physician may also offer virtual visits - check with them for availability and cost.

Dental Benefits

Like brushing and flossing, visiting your dentist is an essential part of your oral health. Professional Plastics offers affordable plan options from Anthem for routine care and beyond.

Dental Plan Summary

This chart summarizes the dental coverage provided by Anthem for 2027.

Stay in Network

If your dentist doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C).

How to Find a Provider

1. Go to findcare.anthem.com
2. Click on "Basic search as a guest"
3. Under "Select the type of plan or network," select "Dental Plan or Network"
4. Under "Select the state where the plan or network is offered," select "California"
5. Under "Select how you get health insurance," select "Dental"
6. Select a plan or network:
   - "Dental Net HMO" for the Anthem DHMO Plan
   - "Dental Complete (PPO)" for the Anthem Dental PPO Plan

**Note: ID Card available*

	Anthem DHMO	Anthem Low PPO		Anthem High PPO	
	In-Network	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible					
Individual **Family** **Waived for Preventive and Basic?**	None None N/A	$50 $150 Yes	$100 $300 No	$50 $150 Yes	$50 $150 Yes
Calendar Year Maximum					
Per Person	None	$1,000		$1,500	
Covered Services					
Preventive Services	Most require no copay	20%	30%	No charge	20%
Basic Services	See copay schedule	20%	40%	20%	20%
Major Services	See copay schedule	50%	50%	50%	50%
Orthodontics Child Adult	 $1,695 $1,895	 Not covered Not covered	 Not covered Not covered	 Not covered Not covered	 Not covered Not covered



Vision Benefits

Getting your eyes checked regularly is important even if you don't wear glasses or contacts. We provide quality vision care for you and your family through Anthem.

Vision Plan Summary

This chart summarizes the vision coverage provided by Anthem for 2027.

How to Find a Provider

1. Go to findcare.anthem.com
2. Click on "Basic search as a guest"
3. Under "Select the type of plan or network," select "Vision Plan or Network"
4. Under "Select the state where the plan or network is offered," select "California"
5. Under "Select how you get health insurance," select "Vision"
6. Select a plan or network:
   - "Blue View Vision" for the Anthem Blue View Vision Plan

**Note: ID Card NOT available*

	Vision Choice Plan		
	In-Network	**Out-of-Network**	**Frequency**
Copay			
Exam **Materials**	$10 $25	Up to $42 reimbursement N/A	Every 12 months
Lenses			
Single Vision **Bifocal** **Trifocal**	No charge after copay No charge after copay No charge after copay	Up to $40 reimbursement Up to $60 reimbursement Up to $80 reimbursement	Every 12 months
Contacts (In Lieu of Lenses and Frames)			
Elective **Medically Necessary**	$130 allowance + 15% off balance No charge after copay	Up to $105 reimbursement Up to $210 reimbursement	Every 12 months
Frames			
Allowance	$130 allowance + 20% off balance	Up to $45 reimbursement	Every 24 months

Voluntary Worksite Benefits



Professional Plastics offers several ways to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and offered at discounted group rates.

Hospital Indemnity Coverage

Hospital Indemnity Coverage provides an extra layer of financial protection that pays cash benefits for covered hospital or critical care unit (ICU) stays. This insurance pays a cash benefit to help cover medical and everyday expenses while you recover.

Plan highlights include:

- Benefits are payable for pregnancy on the first day of coverage
- Coverage is guaranteed issue; no medical questions

Hospital Indemnity	
Hospital Confinement	First day: $500 Daily benefit: $100 up to 31 days
Intensive Care Unit Confinement	Daily benefit: $200 up to 31 days

Monthly Contributions	
Employee	$10.01
Employee + Spouse	$20.77
Employee + Child(ren)	$15.51
Employee + Family	$27.05

Accident Coverage

Accidents happen. You can't always prevent them, but you can take steps to reduce the financial impact. Accident coverage, available through Anthem, provides benefits for you and your covered family members if you have expenses related to an accident that occurs outside of work. Health insurance helps with medical expenses, but this coverage is an additional layer of protection that can help you pay deductibles, copays, and even typical day-to-day expenses such as a mortgage or car payment. Benefits under this plan are payable to you, to use as you wish.

Accident Coverage	
Ground Ambulance	$300
Emergency Room	$200
X-ray	$150
Concussion	$200
Laceration (6-inch +)	$300
Follow-up Treatment	$75

Monthly Contributions	
Employee	$6.83
Employee + Spouse	$10.74
Employee + Child(ren)	$11.30
Employee + Family	$17.82



Critical Illness Coverage

Critical Illness coverage through Anthem pays a lump-sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like; for example: to help pay for expenses not covered by your medical plan, lost wages, child care, travel, home health care costs, or any of your regular household expenses.

Plan Highlights

- Guaranteed issue coverage (no medical questions).
- Benefits are payable based on the date of the covered event occurring or the date of diagnosis. Illnesses or occurrences prior to the effective date of coverage will not be payable events.

Coverage Amounts

- Employee: $10,000 or $20,000
- Spouse: 50% of employee benefit
- Children: 50% of employee benefit (at no additional cost)
- Annual Health Screening Benefit of $50
- Employee and Spouse rates are determined by age and the amount of coverage selected.

Critical Illness Coverage	
Benign Brain Tumor	100%
Coma	100%
Coronary Disease	100%
Heart Attack	100%
Invasive Cancer	100%
Major Organ Transplant	100%
Stroke	100%



Life Insurance Benefits

It's hard to think about, but it's important to have a plan in place to provide for your family if something were to happen to you. Survivor benefits provide financial protection for your loved ones in the event of an unexpected event.

Basic Life and Accidental Death & Dismemberment Insurance

Professional Plastics provides employees Basic Life and Accidental Death and Dismemberment (AD&D) insurance as part of your basic coverage through The Standard, which guarantees that your spouse/domestic partner or other designated survivor(s) continue to receive benefits after death.

Your Basic Life and AD&D insurance benefit is $25,000. If you are a full-time employee, you automatically receive Life and AD&D insurance even if you waive other coverage.

Buy-Up Voluntary Life Insurance

You may wish for extra coverage for more peace of mind. Eligible employees may purchase additional Buy-Up Voluntary Life insurance. Premiums are paid through payroll deductions.

Naming a Beneficiary

Your beneficiary is the person you designate to receive your Life Insurance benefits in the event of your death. This includes any benefits payable under Basic Life. You receive the benefit payment for a dependent's death under The Standard insurance.

Name a primary and contingent beneficiary to make your intentions clear. Indicate their full name, address, Social Security number if available, relationship, date of birth, and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches age 18. Contact Human Resources or your own legal counsel with any questions.

Basic Life/AD&D	
Coverage Amount	Flat $25,000 for you
Who Pays	The Standard
Evidence of Insurability (EOI) Required?	No
Buy-Up Voluntary Employee Life	
Coverage Amount	You may purchase coverage for yourself in increments of $10,000
Who Pays	Employee
Maximum Benefit	Up to $200,000 or 5x annual earnings (whichever is less)
Evidence of Insurability (EOI) Required?	Yes, for any amount over $100,000 or after initial election period
Buy-Up Voluntary Spouse/ Domestic Partner Life	
Coverage Amount	Benefits are available in increments of $5,000
Who Pays	Employee
Maximum Benefit	50% of the employee benefit up to a maximum of $100,000
Evidence of Insurability (EOI) Required?	Yes, for any amount over $10,000 or after initial election period
Buy-Up Voluntary Child Life	
Coverage Amount	Benefits are available in increments of $2,000
Who Pays	Employee
Maximum Benefit	$10,000
Evidence of Insurability (EOI) Required?	No EOI is required





Long Term Disability

You and your loved ones depend on your regular income. That's why Professional Plastics offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury or illness. A portion of your income is protected until you can return to work or you reach retirement age.

Voluntary Long-Term Disability

Long-Term Disability (LTD) pays a portion of your income if you are unable to work for an extended period of time. To qualify, you must be disabled for 90 days. LTD benefits provide you with 60% of your monthly salary up to a $5,000 monthly maximum.

Voluntary Long-Term Disability	
Monthly Maximum Benefit	$5,000
Percentage of Monthly Income	60%
Elimination Period	90 days
Maximum Benefit Period	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

Voluntary Long-Term Disability Monthly Premium	
Age	Employee Cost per $100 of Covered Payroll
Under 25	$0.14
25-29	$0.18
30-34	$0.22
35-39	$0.31
40-44	$0.48
45-49	$0.80
50-54	$1.14
55-59	$1.29
60-99	$0.91

Mental Health

You visit your doctor when you're feeling sick, and you exercise and eat healthy to keep your body strong. But your mental health is just as important. How do you stay healthy mentally? Where can you go when you need help? Whether you need assistance with work-life balance or anxiety, there are resources available to help you out.

Employee Assistance Program

We're here for you when you need help. Our Employee Assistance Program (EAP) provided by The Standard helps you and your family manage your total health, including mental, emotional, and physical. And there's no cost to you — whether or not you're enrolled in a company-sponsored medical plan.

Through the EAP, you have access to mental health assistance and legal and financial help from professionals. You also have 24-hour access to helpful resources by phone and a designated number of face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with Professional Plastics. You may access information, benefits, educational materials, and more by phone at (888) 628-4824 or online at www.carelonwellbeing.com/resourceadvisor.

The EAP provides referrals to help with:

- Emotional health and wellbeing
- Job pressures
- Stress, anxiety, depression
- Alcohol or drug dependency
- Grief and loss
- Marriage or family problems
- Financial or legal advice

The Big Five of Emotional Wellness



Practice Mindfulness

Practice deep breathing, walk, enjoy nature, and stay present in the moment.



Strengthen Social Connections

Reach out to a friend or family member daily — even if it's just a call or text.



Get Quality Sleep

Keep a consistent sleep schedule and limit use of electronics before bed.



Improve Your Outlook

Treat people with kindness, including yourself.



Deal with Stress in Healthy Ways

Think positively, exercise regularly, and set priorities.

Mental Health and Your Medical Plan

When your covered EAP services run out, your medical plan network of mental health providers covers multiple mental health benefits to support both short and long term issues.

An important aspect of your overall wellbeing is emotional wellness — the ability to successfully adapt to changes and challenges as they arrive and handle life's stresses. The five actions above have been shown to improve emotional wellness.

Other Mental Health Resources

No matter your problem, whether you're a manager or entry-level employee, don't be afraid to ask for help. There are resources available 24/7.

NOTE
According to the Centers for Disease Control, nearly 24% of adults received help for mental health in 2026.

Call 911 or go to the nearest emergency room if you or someone you know is in immediate danger.

988 Suicide & Crisis Lifeline

Dial 988 to be connected with 24/7/365 emotional support.

Free, confidential crisis counseling, including appropriate follow-up services, is available no matter where you live in the United States.

Crisis Text Line

Text "HOME" to 741741

Send a text 24/7 to the Crisis Text Line to speak with a crisis counselor who can provide support and information. Standard text messaging rates may apply.

War Vet Call Center

Veterans and their families call 877-WAR-VETS (877-927-8387) to talk about their military experience and/or readjustment to civilian life.





Additional Benefits

Norton LifeLock Identity Theft Protection

Protect your identity and personal information with Norton LifeLock Identity Theft Protection. This program helps monitor for signs of identity theft, fraud, and unauthorized use of your personal information.

If your identity is compromised, dedicated U.S.-based Identity Restoration Specialists can help guide you through the recovery process. With Norton LifeLock, you can enjoy added peace of mind knowing you have tools and support to help protect your identity and finances.

The cost for individual coverage is $5.30 per pay period and $10.14 per pay period for family coverage.

United Pet Care Pet Discount Program

United Pet Care makes it easier and more affordable to care for your furry family members. This voluntary pet healthcare discount program helps you save approximately 20–50% on eligible veterinary services when you visit a participating veterinarian. Discounts may apply to routine wellness visits, vaccinations, diagnostic testing, dental care, treatments, and other veterinary services.

Unlike traditional pet insurance, United Pet Care provides savings directly at the time of service, with no deductibles, claim forms, or waiting periods. Pets are eligible regardless of age, breed, or pre-existing conditions, making the program a flexible option for pet owners.

For more details and to enroll, call **(888) 781-6622** or visit www.unitedpetcare.com.

MetLife Legal Plan

Life can bring unexpected legal needs, from buying or selling a home to preparing a will or navigating family matters. The MetLife Legal Plan provides access to a network of experienced attorneys who can help you and your eligible family members with a variety of personal legal matters. Covered services include estate planning, family law, real estate matters, consumer protection, debt issues, identity theft, and elder law.

With this voluntary benefit, you can access legal guidance and representation for covered matters for a predictable monthly cost.

Log in to www.members.legalplans.com or call **(800) 821-6400** for assistance to review your coverages, select an attorney, and schedule an appointment.

Important Notices & Disclosures

The Women's Health and Cancer Rights Act of 1998—Important Notice

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications in all stages of mastectomy, including lymphedemas.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

HIPAA Privacy Notice—Important Notice about Your Health Information

The HIPAA Notice of Privacy Practices applies to Protected Health Information associated with the Group Health plan provided to our employees, employee's dependents and, as applicable, retired employees. The Notice describes that Professional Plastics may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide individuals covered under our group health plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of the Notice so long as it remains in effect. We reserve the right to change the terms of the Notice as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all policyholders then covered by the Group Health plan. Copies of our current Notice may be obtained by contacting Human Resources.

Newborns' and Mothers Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Patient Protection Disclosure

The Anthem Blue Cross HMO health plan generally requires/allows 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. Until you make this designation, Anthem Blue Cross designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Anthem Blue Cross at (800) 888-8288.

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

You do not need prior authorization from Anthem Blue Cross 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 Anthem Blue Cross at (800) 888-8288.

HIPAA Special Enrollment Rights

If you are declining for yourself or your dependent (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependent's other coverage).

However, you must request enrollment within 30 days after your or your dependent's other coverage ends (or after the employer stops contributing towards the other coverage). Note: if the change is due to Medicaid/CHIP eligibility, there is a 60 day window for Medicaid/CHIP eligibility changes only.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services - If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center - When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Medicare Notice of Creditable Coverage

Important Notice from Professional Plastics About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this

coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Professional Plastics has determined that the prescription drug coverage offered by the Anthem Blue Cross plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

- If you decide to join a Medicare drug plan, your current Professional Plastics coverage may be affected.
- If you do decide to join a Medicare drug plan and drop your current Professional Plastics coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Professional Plastics and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact Human Resources for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Professional Plastics 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 Social Security on the web at www.socialsecurity.gov, or call them 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 drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2027
Name of Entity/Sender: Joe Daigneault
Phone Number: (714) 866-7857

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIP (855-692-7447)
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecover y.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2
INDIANA – Medicaid
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338 8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/ Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website:https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 / Lincoln: 402-473-7000 / Omaha: 402-595-1178
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program- hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs- services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium- assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium- assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website:https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 5/31/2029)

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