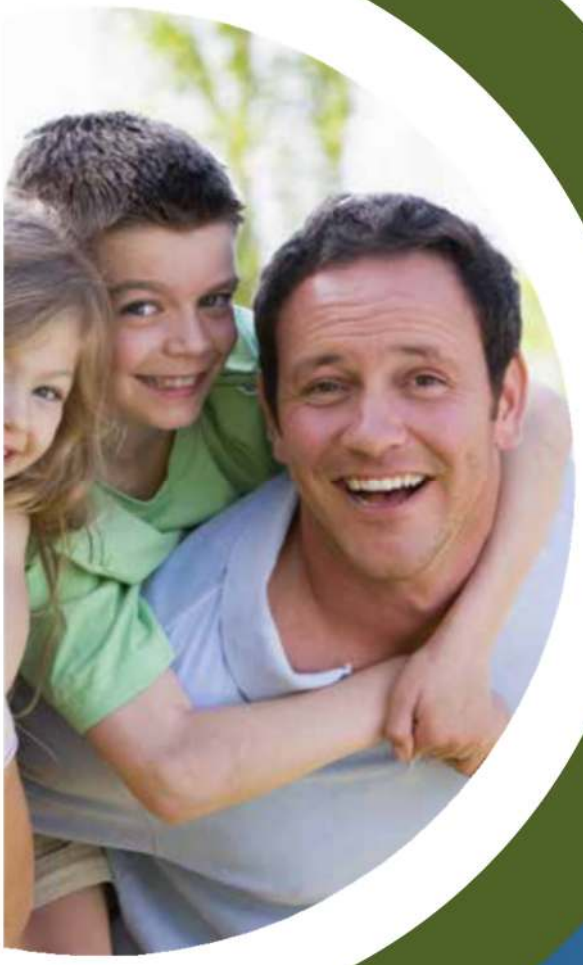
GOODWILL INDUSTRIAL SERVICES CORPORATION

GISC



2024
Employee Benefit Guide
Full-Time SCA Employees

(Workers under Federal Government Contract)

If you (and/or your dependents) 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 25 for more details.

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*Mountain, Pacific, and Alaskan Standard Time

The BRC team is equipped to answer your questions in languages other than English.

Welcome!

At GISC, we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

Eligibility

Eligible Employees:

You are automatically eligible for the benefits described in the benefit guide when:
You are assigned to McNamara O'Hara Service Contract Act (SCA) and average 30+ hours per week.

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. Eligible dependents include your spouse or domestic partner, and dependent children up to age 26 for medical; up to age 19 for dental (24 if a full-time student). If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, stepchildren and children obtained through court- appointed legal guardianship, as well as children of same sex state-registered domestic partners. If you elect dependent coverage, the premium will be paid through bi-weekly payroll deductions. Health and Welfare dollars are for employee coverage only and cannot be used to pay for dependent coverage.

When Coverage Begins:

The effective date for your benefits is 01/01/2024. Employees designated as Full-Time by their supervisors are eligible to participate beginning **first of the month following 60 days of employment**. All elections are in effect for the entire plan year and can only be changed during Open Enrollment, unless you experience a family status event.

Qualifying Life Events:

A change in qualifying life event is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some qualifying life events include:

- Change of legal marital status (i.e., marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e., birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If you experience a qualifying life event, and need to change your benefit elections, you must make the changes to your benefits within 30 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change. Please contact the Goodwill Benefits Team to make these changes.

Default Coverage:

Full-Time employees who do not take action will be automatically enrolled in the following benefits:

☐ Cigna PPO (Mandatory Benefit unless you provide proof of other medical insurance coverage)
☐ Direct Primary Care (DPC) PeakMed (Mandatory Benefit if you are enrolled for Cigna PPO Medical Plan Coverage)
☐ MetLife Dental (Option to opt out of this benefit)
☐ MetLife VSP Vision (Option to opt out of this benefit)
☐ MetLife Short Term Disability (Mandatory Benefit)
☐ MetLife Group Term Life $25,000 (Mandatory Benefit)
☐ The Contractors Plan Retirement Plan (Mandatory Benefit)

Waiving coverage –

- You may waive major medical only with proof of other employer-sponsored group major medical coverage, Medicare, Medicaid or Tricare.
- You may waive the dental, or vision coverage.
- You may NOT waive the Life Insurance, Short Term Disability or Retirement benefits.

Medical Insurance

GISC will continue to offer medical coverage with Cigna. The chart on the following page is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

	CIGNA PPO - $1500
Benefits Coverage	Schedule of Benefits In Network / Out-of-Network
Annual Deductible	
Individual	$1,500 In Network / $3,000 Out of Network
Family	$3,000 In Network / $6,000 Out of Network
Coinsurance	80% In-Network / 50% Out of Network
Maximum Out-of-Pocket	
Individual	$5,500 In Network / $10,000 Out of Network
Family	$11,000 In Network / $20,000 Out of Network
Physician Office Visit	
Primary Care	$20 copay / PeakMed PCP $0 copay / 50% after deductible
Specialty Care	$40 copay / 50% after deductible
Preventive Care	
Adult Periodic Exams	100% Deductible Waived
Well-Child Care	100% Deductible Waived
Diagnostic Services	
X-ray and Lab Tests	$20 copay / 50% after deductible
Complex Radiology	80% after deductible / 50% after dedcutible
Urgent Care Facility	$100 copay / 50% after deductible
Emergency Room Facility Charges	$300 copay waived if admitted – In or Out of Network
Inpatient Facility Charges	80% after deductible
Outpatient Facility and Surgical Charges	80% after deductible
Mental Health / Substance Abues	
Inpatient	80% after deductible / 50% after deductible
Outpatient	$40 copay / 50% after deductible
Retail Pharmacy (30 Day Supply)	
Generic (Tier 1)	$10 copay
Preferred (Tier 2)	$35 copay
Non-Preferred (Tier 3)	$60 copay
Preferred Specialty (Tier 4)	$100 copay
Mail Order Pharmacy (90 Day Supply)	
Generic (Tier 1)	$20 copay
Preferred (Tier 2)	$70 copay
Non-Preferred (Tier 3)	$120 copay
Preferred Specialty (Tier 4)	$200 copay

Medical Insurance Cost

Mandatory Benefit (unless you provide proof of other medical insurance coverage)

Employee Medical Contributions per Pay Period (26 Pay Periods/year)	
Employee	$0.00
Employee & Spouse	$337.98
Employee & Child(ren)	$235.71
Employee & Spouse & Child(ren) (Family)	$558.02

To Find a Doctor: Go to www.cigna.com, across the top of the page, select "Find a Doctor," then click on the box that says for plans offered through work or school. Type in your location and then select medical plan and "PPO" for the network.

PeakMed Direct Primary Care (DPC)

Mandatory Benefit if you are enrolled for Cigna PPO Medical Plan Coverage!

- PeakMed – Direct Primary Care (DPC) is a **$0.00 Primary and Urgent Care cost shares for covered members.**
- PeakMed is not medical insurance, however, the doctors treat anything a Primary Care Physician (PCP) or urgent care would.
- Free to an employee if they carry the GISC Cigna PPO Medical Plan coverage.
- You will have access 24/7/365 to board-certified doctors and mid-levels. As your primary care physician, they will diagnose, treat, and prescribe medication.
- Get the care you need, when you need it, in person, via online video, phone, secure email. The service is secure, confidential, and compliant with all medical privacy regulations.
- PeakMed DPC provides: Better Access | No Cost for Care | More Personalized Care
  To learn more about PeakMed, use this QR code

Employee PeakMed Contributions per Pay Period (26 Pay Periods/year)	
Employee	$0.00
Employee & Spouse	$35.54
Employee & Child(ren)	$22.62
Employee & Spouse & Child(ren) (Family)	$58.15

IMPORTANT INFORMATION – PeakMed is not health insurance, it is health care. As such, it is not subject to COBRA continuation should you leave GISC, however, you may elect to continue your PeakMed membership via a direct pay arrangement if you so choose.

PEAKMED

ACCESS TO YOUR DOCTOR 24/7/365

It is simple, affordable, and convenient

PeakMed Direct Primary Care (DPC) –

When should I use PeakMed?

- ✓ For **ALL** your primary care needs
- ✓ Your primary care physician is not available
- ✓ If you're considering the ER or urgent care for a non-emergency medical issue
- ✓ At home, traveling, or at work
- ✓ 24/7/365 M.D. access (including holidays)

What can be treated?

- ✓ Hypertension
- ✓ Diabetes
- ✓ Cholesterol
- ✓ Allergies
- ✓ Asthma
- ✓ Bronchitis
- ✓ Cold and flu
- ✓ Ear infections
- ✓ Joint aches and pain
- ✓ Respiratory infection
- ✓ Sinus problems
- ✓ And more!

PeakMed can treat conditions related to:

- ✓ Chronic conditions (e.g., high blood pressure, diabetes etc.)
- ✓ Adult physicals
- ✓ School physicals
- ✓ Sleep disorders
- ✓ Smoking addiction
- ✓ Other personal challenges
- ✓ And more!

Who are PeakMed's providers?

Our providers practice primary care, pediatrics, family, and urgent care.

We incorporate technology and longer appointment times into our practices to provide convenient access to quality care.

Who is eligible?

If you are an eligible GISC employee, you can elect to have access to PeakMed for your dependents (subject to payroll deductions). However, if you want a child seen, a parent or guardian must be present during registration and any consults involving minors.

Your Copay Cost Is

$0 per visit

Subject to eligibility

Convenience

Visit https://www.peakmed.com for a list of all Colorado locations available to you.

PeakMed –Tejon Life Center
421 S Tejon St.
Colorado Springs, CO 80903
Phone: (719) 623-3068

PeakMed –Tutt Life Center
6915 Tutt Blvd, Suite 100
Colorado Springs, CO 80923
Phone: (719) 380-7325

PeakMed - North Gate Life Center
13271 Bass Pro Dr., Suite 140
Colorado Springs, CO 80921
Phone: (719) 394-8664

Dental Insurance

Goodwill Industrial Services offers dental coverage to full-time employees through MetLife. Employees will automatically be enrolled in the coverage unless they choose to waive the coverage. The dental plan covers a full range of dental services, including orthodontia.

The plan's $50 individual and $150 family deductibles are calculated on a calendar year basis. Both In-Network and Out-of-Network (or Non-Network) dental expenses apply towards the $1,500 annual maximum.

To find an In-Network provider, go to www.metlife.com:

- Click "Find a Dentist"
- Click "PDP Plus Network"

The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

Plan Year Benefits	In-Network *% of MAC*	Out-of-Network *% of MAC*
Annual Maximum (Applies Both In and Out-of-Network)	$1,500 per Member	
Reimbursement Levels		
Type A – Diagnostic & Preventive Care Oral Exams Routine Cleanings and X-rays Fluoride Application Sealants Space Maintainers (limited to non-orthodontic) Emergency Care to Relieve Pain	Amount YOU Pay: 0%, No Deductible	0%, No Deductible
Type B – Basic Restorative Care Fillings Oral Surgery – Simple Extractions Oral Surgery – All Except Simple Extractions Surgical Extractions of Impacted Teeth General Anesthesia Minor and Major Periodontics Root Canal Therapy / Endodontics Relines, Rebases and Adjustments Repairs – Bridges / Crowns/ Dentures and Inlays	20% after Deductible	20% after Deductible
Type C – Major Restorative Care Bridges / Crowns / Dentures / Implants / Inlays / Onlays	50% after Deductible	50% after Deductible
Type D – Orthodontia - Dependent children to age 19 Diagnostic, Active, Retention Treatment	50% Covered, No Deductible $1,000 Lifetime Maximum per Child	
This summary of benefits is provided for informational purposes only. In the event of a conflict between this benefits summary and the Summary Plan Description (SPD), the SPD will prevail.		

Employee Dental Contributions per Pay Period (26 Pay Periods/year)	
Employee	$0.00
Employee & Spouse	$18.81
Employee & Child(ren)	$19.63
Employee & Spouse & Child(ren) (Family)	$43.94

You will be enrolled unless you waive the coverage.

Vision Insurance

Goodwill Industrial Services offers vision coverage to full-time employees through MetLife. Your vision is very important to your overall health. Whether your vision is 20/20 or less than perfect, every-one should receive regular vision care.

Did you know that regular comprehensive eye exams can spot symptoms of many underlying health problems, such as diabetes, hypertension, high cholesterol, glaucoma, and cataracts? We partner with a network providers where members receive comprehensive vision care.

To find an In-Network provider, go to www.Metlife.com:

- Click “Find a vision provider”
- Click “MetLife Vision PPO network”.

Covered Services	In-Network	Out-of-Network
Frequencies		
Exam	Once Every 12 Months	
Lenses	Once Every 12 Months	
Frames	Once Every 12 Months	
Routine Vision Examination	$10 Copay	Covered Up to $45 allowance
Frames	Covered In-Full Up to $130 Allowance COSTCO: Covered in-Full Up to $70 Allowance	Up to $70 Allowance
Lenses		
Single Vision	Covered In-Full	Up to $30 Allowance
Lined Bifocal Vision		Up to $50 Allowance
Lined Trifocal Vision		Up to $65 Allowance
Contact Lenses (Elective)	Covered Up to $130 Allowance	Covered Up to $105 Allowance

This summary of benefits is provided for informational purposes only. In the event of a conflict between this benefits summary and the Summary Plan Description (SPD), the SPD will prevail.

*Either glasses (base lenses and frames) or contact lenses allowed per frequency – not both.

Employee Vision Contributions per Pay Period (26 Pay Periods/year)	
Employee	$0.00
Employee & Spouse	$2.40
Employee & Child(ren)	$3.53
Employee & Spouse & Child(ren) (Family)	$4.75

You will be enrolled unless you waive the coverage.

Life and AD&D

We believe we should offer our employees the opportunity to provide for their family's future rather than leaving it to chance. Life insurance can provide your dependents with a lifetime of financial security and upon your death, can be used to pay off your debts – such as credit cards and your mortgage – or other expenses that could burden your family.

That's why Goodwill Industrial Services provides Basic Life and Accidental Death & Dismemberment (AD&D) insurance.

MetLife provides $25,000 Basic Life insurance coverage and an Accidental Death & Dismemberment (AD&D) policy for your family or designated beneficiary in the event of your death. AD&D benefits are payable if you pass away, lose a limb, or have a loss of speech, hearing, or eyesight because of a covered accident (either on or off-the-job) and the loss occurs within one year of the covered accident.

BASIC LIFE AND AD&D BENEFITS *(available to employees only)*	
Basic Life: *Provides a benefit in the event of your death.*	**$25,000 Flat Amount**
Accidental Death & Dismemberment (AD&D): *Provides an additional benefit in the event of your death or dismemberment as the result of a covered accident.*	**$25,000 Flat Amount**
Age Reduction Formula: *Benefits begin to reduce once you reach a certain age.*	**35% at age 65** **50% at age 70**
This summary of benefits is provided for informational purposes only. In the event of a conflict between this benefits summary and the Certificate of Coverage, the Certificate will prevail. Please refer to your Certificate of Coverage for further details.	

Important Reminder!

A primary beneficiary is defined as the person, organization, trust, or entity you name to receive any benefits in the event of your death. Keep in mind that changes in your family situation (such as marriage, divorce, birth or adoption) do not automatically alter or revoke beneficiary designations.

Make sure that the designated beneficiary for your life insurance is up-to-date!

Short-Term Disability Insurance

All active full-time employees meeting minimum eligibility requirements will be automatically enrolled in the Short-Term Disability (STD) benefits plan provided by MetLife.

Mandatory Benefit: per pay period premium comes out of fringe dollars.

The STD plan provides covered employees with monthly benefits for disability due to sick-ness and off-the-job accidents. Coverage is not provided for on-the-job accidents (refer to GISC's workers' compensation policies for additional information regarding work-related accidents).

SHORT-TERM DISABILITY (STD) INSURANCE	
Elimination Period	Accident – 14 days Sickness – 14 days
Weekly Benefit Percentage	60% of Your Covered Earnings
Maximum Weekly Benefit	$600
When Your STD Benefits Start	Begins on the 15th Day
Pre-Existing Condition Limitation	Twelve (12) Months Prior
How Long You May Receive Benefits	Up to 13 Weeks (including the elimination period)
This summary of benefits is provided for informational purposes only. In the event of a conflict between this benefits summary and the Certificate of Coverage, the Certificate will prevail.	

Cobra Continuation

Under certain circumstances, you may continue your benefit coverage when it would otherwise end. This is called COBRA continuation coverage.

Group health insurance coverage for COBRA participants is usually more expensive than health coverage for active employees because your company pays a significant portion of its employees' insurance premiums each month. Under COBRA you pay the full monthly premium for continuing coverage plan an additional 2% administrative fee.

COBRA continuation applies to your Medical, Dental and Vision coverage.

If you have any questions about COBRA continuation, please contact the Human Resources Department.

CONTINUATION OF COVERAGE FOR 18 MONTHS	CONTINUATION OF COVERAGE FOR 29 MONTHS	CONTINUATION OF COVERAGE FOR 36 MONTHS
• Employee's Termination of Employment • Employee's Reduction of Hours	• Termination of Disabled Employee (coverage beyond 18 months is subject to verification of disability)	• Death of Covered Employee • Divorce / Legal Separation / Annulment • Ineligibility of Dependent Child

How Health & Welfare (H&W) Dollars work

Health & Welfare (H&W) dollars – (based on hours worked/paid), also referred to as fringe dollar are contributed by Goodwill Industrial Services Corporation (GISC) to help pay for your benefit coverage as required by the Service Contract Act (SCA).

You earn an H&W allowance for every hour worked up to 40 hours per week (excluding PTO and holidays), or for every hour you are paid (excluding overtime), as defined by your Wage Determination. This H&W allowance is utilized to pay for employee-only benefits with any excess H&W dollars added to a Reserve Account, which is set up for each employee.

H&W dollars will be allocated as follows, and in this order:

1. H&W dollars are first to be used to pay for your first month of employee-only benefits. Benefits will begin January 1, 2024; December 2023 hours will pay for January's benefits.
2. After all employee-only premiums are paid for each month, any remaining H&W dollars will be funded to a Reserve Account which is tracked on a per employee basis.
3. Once there are enough H&W dollars to cover two months of employee-only premiums for all benefits held in an employee Reserve Account, any leftover H&W dollars will then be funded to their 401k retirement account on a quarterly basis.
4. Extra H&W dollars fund your 401k retirement savings account.

H&W dollars can only be used to pay for employee-only benefit coverage. If you choose to enroll an eligible dependent, the additional cost to cover your dependent(s) will be paid for with additional payroll deductions.

What if I work fewer hours in a month?

If you do not work enough hours to cover the cost of your benefits in a given month, H&W dollars in your Reserve Account will be used to cover the shortage and keep your coverage active. When you start working enough hours to sufficiently cover the cost of benefits, any extra H&W dollars will be funded back to your Reserve Account until it is satisfied again.

If in the event that the amount of H&W dollars in your reserve combined with the number of hours worked is not enough to cover the cost of a full month's mandatory employee-only benefits, Goodwill Industrial Services will cover the payment shortage.

Dependent premiums are payroll deducted and not covered with H&W dollars. You will be required to arrange payment for these benefits in the event of a shortage.

Retirement Savings Plan

Goodwill Industrial Services is pleased to offer you a unique investment platform offering investment choices through two investment approaches. You will be asked to make a decision on your investment options during your enrollment and conducting a little research ahead of time will make the process easier.

Please note that the Retirement Savings Plan is offered through The Contractors Plan. If you have questions regarding your retirement plan, please contact Member Services at 1-800-933-3863.

Any H&W dollars not used for health benefits or to fund your reserve will be placed into a retirement plan for your future benefit. You can choose your own mix of funds, or you can leave the investment allocations to us.

IRS Limits

Tax law limits the amount you can contribute on a pre-tax basis to the plan each year. Tax law also limits the amount of compensation that is considered eligible for the plan. You cannot defer any portion of your compensation above that limit in the plan.

In 2024, you can contribute up to $23,000 ($30,500 if age 50 or older) of your salary for your retirement.

Vesting

Vesting refers to the portion of your retirement plan account balance to which you care entitled under the plan rules. Each contribution is 100% vested in the plan.

TAX Considerations

You pay no taxed-on contributions or investment returns until you withdraw funds from the plan.

Account Access and Investment Options

Once enrolled you can log in to your account and view your benefits, change information and request information. Please call the Contractors Plan Retirements Member Services at 1-800-933-3863. Or go online to www.MyContractorsPlan.com to enroll and for ongoing account access. You will be provided a Transamerica Retirement Plan enrollment kit during your enrollment.

DISCLAIMER

Reconciliation

In adherence of the Code of Federal Regulations 29CFR4.175(d)1, GISC will perform no less than quarterly reconciliation of worked / paid hours. Based upon the reconciliation if here is excess H&W Fringe, the excess will be deposited into the Retirement Savings Plan.

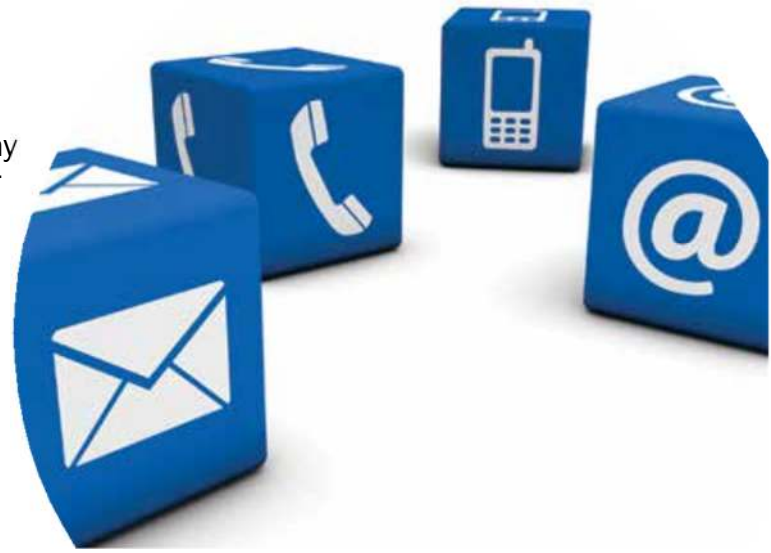
Termination

Upon termination of employment, the aforementioned process will apply. Depending upon a cycle of no less than quarterly reconciliation, distribution for the Retirement Savings Plan cannot be performed until the reconciliation is completed.

Contact Information

Carrier Customer Service

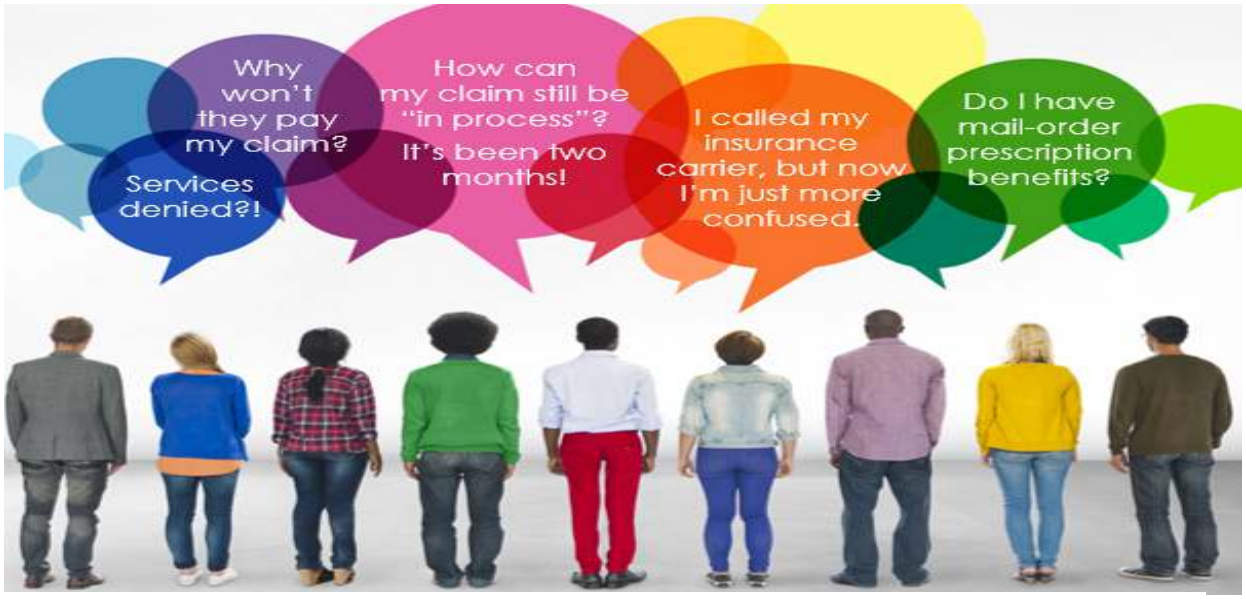
Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.



PLAN ADMINISTRATORS	
The Contractors Plan	Visit: www.thecontractorsplan.com Call: 855-433-2981
Goodwill Benefits Team	Sara Nelson: 303-412-4786 Carla Headley: 719-442-2074 Sally Thomas: 720-738-1073
USI's Benefit Resource Center – your one-call benefits information specialists and advocates! **The BRC team is equipped to answer your questions in languages other than English.**	855-874-0742
PeakMed Direct Primary Care (DPC)	Visit: www.peakmed.com Call: 844-673-2563, Option 2

Benefit Resource Center (BRC)

Call the Benefit Resource Center ("BRC"), We're Here To Help!



We speak insurance. Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution
- Medicare basics with your employer plan
- Coordination of benefits
- Finding in-network providers
- Access to care issues
- Obtaining case management services
- Group disability claims
- Filing claims for out-of-network services

USI

Benefit Resource Center

855-874-0742 (Toll-Free)

BRCMT@usi.com

Monday - Friday 8:00 AM - 5:00 PM*

Call for assistance with:

- Benefit Elections
- Eligibility
- Change in Family Status
- Benefit Plan/Policy Questions
- Claim Issues with Carriers
- Plan Contact Information

Your one-call benefits information hotline

*Mountain, Pacific, and Alaskan Standard Time

The BRC team is equipped to answer your questions in languages other than English.

USI Partners with Language Line Services©

USI is pleased to announce our partnership with Language Line Services© to provide over the phone interpretation for employees and their dependents who are non-English Speaking or speak English as their second language.

Upon calling, simply indicate to the Agent who answers the call what language needs you have, and we will bring an interpreter onto the line.

There is no charge to you for utilizing this service. This is just another way USI is committed to providing quality customer service, regardless of what language is spoken.

Below are the languages that have over-the-phone interpretation available by calling 1-855-874-0742:

Acholi	French	Latvian	Romanian
Afrikaans	French Canadian	Lingala	Russian
Akan	Fukienese	Lithuanian	Samoan
Albanian	Fula	Luganda	Serbian
Amharic	Fulani	Lusoga	Shanghainese
Armenian	Fuzhou	Luxembourgeois	Shona
Assyrian	Gaddang	Maay	Sicilian
Azervaijani	Gaelic	Macedonian	Sinhalese
Azeri	Georgian	Malagasy	Sindhi
Bajuni	Gorani	Malayalam	Slovenian
Bambara	Greek	Maltese	Somali
Basque	Gujarati	Mandarin	Sorani
Behdini	Haitian Creole	Mandingo	Spanish
Belorussian	Hakka	Mandinka	Sudanese Arabic
Bengali	Hakka – China	Mankon	Swahili
Berber	Hausa	Marathi	Swedish
Bosnian	Hebrew	Marshallese	Sylhetti
Bravanese	Hindi	Mien	Szechuan
Bulgarian	Hmong	Mina	Tagalog
Burmese	Hungarian	Mirpuri	Taiwanese
Cantonese	Ibanag	Mixteco	Tajik
Catalan	Ibo	Moldovan	Tamil
Chaldean	Icelandic	Mongolian	Telugu
Chaochow	Igbo	Navajo	Thai
Chamorro	Ilocano	Neapolitan	Tibetan
Chavacano	Indonesian	Nepali	Tigre
Cherokee	Italian	Nigerian Pidgin English	Tigrinya
Chuukese	Jakartanese	Norwegian	Toishanese
Croatian	Japanese	Nuer	Tongan
Czech	Karen	Oromo	Tshiluba
Dakota	Kashmiri	Pahari	Turkish
Danish	Khmer (Cambodian)	Pampangan	Twi
Dari	Kinyarwanda	Pangasinan	Ukrainian
Dinka	Kirundi	Papiamento	Urdu
Dutch	Korean	Pashto	Vietnamese
Estonian	Kosovan	Patois	Visayan
Ewe	Krio	Pidgin English	Welsh
Farsi	Kurdish	Polish	Yiddish
Fijian Hindi	Kurmanji	Portuguese	Yoruba
Finnish	Lakota	Portuguese Creole	Yupik
Flemish	Laotian	Punjabi	

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; 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.

NEWBORNS ACT DISCLOSURE - FEDERAL

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

NOTICE OF 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, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance. To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Sara Nelson
1460 Garden of the Gods Road
Colorado Springs, CO 80907
303-412-4786
snelson@goodwillcolorado.org

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- 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.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

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.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person 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.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

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, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, 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

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

- In these cases we never share your information unless you give us written permission:

Marketing purposes

Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are 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.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- 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

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here 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.

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

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 (if applicable), and we will mail a copy to you.

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

Important Notice from Goodwill Industrial Services Corporation 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 Goodwill Industrial Services Corporation 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. **Goodwill Industrial Services Corporation has determined that the prescription drug coverage offered by the Cigna is, 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 Goodwill Industrial Services Corporation coverage will not be affected. If you joined a Medicare drug plan after a COBRA qualified event, your COBRA coverage may end.

If you do decide to join a Medicare drug plan and drop your current Goodwill Industrial Services Corporation coverage, be aware that you and your dependents will 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 [Insert Name of Entity] 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…

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 Goodwill Industrial Services Corporation 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:	01/01/2024
Name of Entity/Sender:	Sara Nelson
Contact--Position/Office:	Benefits Manager
Address:	1460 Garden of the Gods Road, Colorado Springs, CO 80907
Phone Number:	303-412-4786

CMS Form 10182-CC **Updated April 1, 2011**

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, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – 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	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: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2023, 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 1/31/2026)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Sara Nelson, Benefits Manager, snelson@goodwillcolorado.org, 303-412-4786.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name – Goodwill Industrial Services Corporation		4. Employer Identification Number (EIN) - 84-0513404
5. Employer address - 1460 Garden of the Gods Road		6. Employer phone number – 719-635-4483
7. City – Colorado Springs	8. State - CO	9. ZIP code - 80907
10. Who can we contact about employee health coverage at this job? – Sara Nelson		
11. Phone number (if different from above) – 303-412-4786	12. Email address – snelson@goodwillcolorado.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [X] All employees. Eligible employees are:

    Full-time = 30 hours per week
  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [X] We do offer coverage. Eligible dependents are:

    Legal Spouse
    Children to age 26 or beyond if proved to be mentally or physically disabled
  - [ ] We do not offer coverage.

[X] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

This brochure summarizes the benefit plans that are available to GISC eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.