Watson Truck & Supply, Inc.

DENTAL COST ANALYSIS	GUARDIAN Voluntary Guardian Indemnity Dental Plan	
Rates**	Monthly	Per Payday
Employee Only	28.36	13.09
Employee + Spouse	57.29	26.44
Employee + Child(ren)	68.25	31.50
Employee + Family	97.19	44.86
Summary of Dental Benefits	Indemnity Plan	
Calendar Year Deductible	$50	
Waived for Preventive	Yes	
Annual Maximum	$1,000*	
Preventive	100%	
Basic	80%	
Major	50%	
UCR %	90th %	
Endodontics/Periodontics	50%	
Orthodontia	N/A	
Orthodontia Lifetime Maximum	N/A	
Waiting Period	Late Entrants -- Basic 6 mths; Major 12 mths	
Dental Network	None (See any dentist)	

* Subject to maxiumum rollover (Threshold $500; Rollover amount $250)

**Rates guaranteed for 1 year

1/1/2018

VISION COST ANALYSIS	GUARDIAN Voluntary Full Feature Vision Plan	
Rates**	Monthly	Per Payday
Employee Only	7.74	3.57
Employee + Spouse	13.01	6.01
Employee + Child(ren)	13.27	6.13
Employee + Family	21.01	9.70
Summary of Vision Benefits	In-Network	Out of Network
Co-pay		
Exams	$10 Co-pay (every 12 months)	$39 max after $10 co-pay (every 12 months)
Materials		
Lenses Single Vision	$25 Co-pay (every 12 months)	$23 max after $25 co-pay (every 12 months)
Bifocal	$25 Co-pay (every 12 months)	$37 max after $25 co-pay (every 12 months)
Trifocal	$25 Co-pay (every 12 months)	$49 max after $25 co-pay (every 12 months)
Lenticular	$25 Co-pay (every 12 months)	$64 max after $25 co-pay (every 12 months)
Contact (medically necessary)	$25 Co-pay (every 12 months)	$210 max after $25 co-pay (every 12 months)
Contact (elective)	$25 Co-pay (every 12 months)	$100 max after $25 co-pay (every 12 months)
Frames	$130 retail + 20% off balance after $25 Co-pay (every 24 months)	$46 max after $25 co-pay (every 24 months)
Network	VSP CHOICE	N/A
Rate guarantee	1 year	

Basic Life/AD&D: Only those on medical are eligible for basic life & AD&D

1/1/2018

SALARY REDIRECTION AGREEMENT

EMPLOYER: Watson Truck & Supply, Inc. CAFETERIA PLAN YEAR: 1/1/2019 thru 12/31/2019

NAME: (Last) _____ (First) _____ (Middle Initial) _____

Address: _____ City/State: _____ Zip: _____

Social Security Number: _____ Hire of Date: _____ Effective Date: _____

On a separate benefit enrollment form(s), I have enrolled for certain insurance coverage(s) and understand that my insurance premiums election amount will be deducted from my paycheck by my employer. Unless this agreement is amended or terminated, these deductions will be continuous and in an equal amount to the insurance premiums amount for each payroll throughout the plan year. The amount of my required contribution is set forth on a schedule that has been provided to me. In the event of a rate change, I authorize a corresponding change in the amount deducted from my salary without signing a new Salary Redirection Agreement. If the rate change is brought on by the third-party carrier (insurance company), the premium increase or decrease can be deducted pre-tax. "Employer-provided" non-elective benefits (if any) will not be deducted from my paycheck. In addition, pre=tax contributions reduce compensation for Social Security tax purposes; therefore, my Social Security benefits could be decreased. I elect to receive the following coverage(s) the Benefits Plan as elected in the pre-tax column. Any previous election and Salary Redirection Agreement under the Benefits Plan relating to the same benefits selected below are hereby revoked. My employer's deduction of premium/contribution amounts hereunder shall evidence acceptance of this agreement.

Check the desired coverage(s) below:

Coverage	*Provider*	*EE Election Pre-Tax*	*Premium Pre-Tax*	*EE Election Post Tax*	*Premium Post Tax*
Medical Health Ins	Insurance Mgmt. Ser.				
Dental Insurance	Guardian Life Ins.				
Vision Insurance	Guardian Life Ins.				
Accident Insurance					
Cancer Insurance					
Short-Term Disability					
Hospital Indemnity					
Term Life insurance					
Whole Life Insurance					
Other:					

Total Pre-Tax _____ Total Post-Tax _____

I understand and agree to the following (initial all):

_____ On or after the first day of the plan year, I cannot change or revoke this Salary Redirection Agreement with **respect to pre-tax premiums before the next anniversary date of the plan** unless a "change in family status" occurs (as defined under the Internal Revenue Code), and the change is caused by and consistent with the "change in family status." **I understand that I cannot revoke any pre-tax election based on a Right to Examine provision as may be contained in any insurance plan or policy issued to me.**

_____ Execution of this Salary Redirection Agreement does not begin coverage under the component benefit plans or policies. The terms and conditions and actual coverage effective date of the underlying coverage will be determined under the separate benefit plans or insurance policies. Prior to the anniversary date each year, I will be offered the opportunity to add, drop, or change coverage for the following plan year. If I do not complete and return a new Salary Redirection Agreement from at that time, benefit plans or policies currently in effect will continue.

_____ In addition to and without limiting in any way any rights my employer, the plan, the service provider and its respective agents, employees, subcontractors, and assigns may have under applicable state or federal law or regulation, I hereby specifically authorize those parties to use my personal information (including by not limited to benefit elections, wages, employment status, number of dependents, marital status, and health and dependent child-care information) as is reasonably required to administer the plan (including evaluating and processing requests for payment of claims) and detecting and preventing fraud or misrepresentation. I further authorize my employer, the plan, the service provider and its respective agents, employees, subcontractors, and assigns to further disclose any such personal information as is reasonably required for such purposes. I hereby expressly waive and release any claims related to the use, disclosure, or release of such information so long as the information is used tin furtherance of plan administration or to detect or prevent fraud or misrepresentation.

_____ Paying for coverage on a pre-tax basis may cause insurance claim payments under health and medical coverage to be subject to federal and state taxes if claim payments (combining the total from all health and medical policies/plans) are in excess of medical expenses. Paying for disability income policies with pre-tax premiums will cause the benefits payable thereunder to be taxable. Such coverage may be funded on an after-tax basis to preserve the excludability of policy benefits.

WAIVER OF PRE-TAX BENEFITS UNDER THE BENEFITS PLAN:

_____ I certify that the features and benefits under the Benefits Plan have been explained to me completely. I elect to **waive all pre-tax benefits** under the plan and understand that the **benefits may be elected on an after-tax basis.** Except for a change in family status, I understand that I cannot elect pre-tax benefits until the next anniversary date, and that any after-tax coverage shall be outside the plan.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

Group Health Insurance Enrollment Form

01-01-2019 thru 12-31-2019

Employee Information:

Name: _____

Address: _____

_____

Birth Date: _____ Marital Status: _____

SSN: _____ Sex: _____

Email Addr: _____

Phone: _____

Are you covered by any other insurance, including Medicare? _____

If so please fill out the following information:

Insurance Carrier Name: _____

Policy Number: _____

Phone Number: _____

If applicable, IMS will not pay claims until other insurance information is provided.

Employment Information: (To be completed by employer)

Group Name: Watson Truck & Supply, Inc.

IMS Group Number: SWT0906

Department/Division: _____

Enrollment Type: _____

Payroll ID: _____

Class: _____

Annual Earnings: _____

Occupation: _____

Employment Date: _____

Effective Date: _____

Minimum Hours Worked Per Week: _____

Group Health Coverage Options:

	None	Employee Only	Employee & Child	Employee & Spouse	Employee & Family
Medical Plan					

Spouse's Information

NAME:	
ADDRESS:	
CITY, STATE, & ZIP CODE	
PHONE:	BIRTH DATE:
SSN:	SEX:

Spouse's Employer

EMPLOYER:
ADDRESS:
CITY, STATE, & ZIP CODE
PHONE:
OTHER INSURANCE COVERAGE: MEDICAL ____ DENTAL ____ VISION ____ INDEMNITY ____

Spouse's Insurance

INSURANCE COMPANY:
ADDRESS:
CITY, STATE, & ZIP CODE
PHONE:
POLICY NUMBER:

Dependent Children Information – Complete this section for all dependents you want covered.

NAME:	SOCIAL SECURITY NUMBER:	RELATIONSHIP TO INSURED:	BIRTH DATE:	SEX:

Is this dependent covered by other insurance, including Medicare/Medicaid? _____ If so we need the following information:

Name of Insurance Carrier: _____ Policy Number: _____ Phone Number: _____

NAME:	SOCIAL SECURITY NUMBER:	RELATIONSHIP TO INSURED:	BIRTH DATE:	SEX:

Is this dependent covered by other insurance, including Medicare/Medicaid? _____ If so we need the following information:

Name of Insurance Carrier: _____ Policy Number: _____ Phone Number: _____

Dependent Children Information – (Continued)

NAME:	SOCIAL SECURITY NUMBER:	RELATIONSHIP TO INSURED:	BIRTH DATE:	SEX:

Is this dependent covered by other insurance, including Medicare/Medicaid? ________ If so we need the following information:

Name of Insurance Carrier: ____________________ Policy Number: ________________ Phone Number: ______________

NAME:	SOCIAL SECURITY NUMBER:	RELATIONSHIP TO INSURED:	BIRTH DATE:	SEX:

Is this dependent covered by other insurance, including Medicare/Medicaid? ________ If so we need the following information:

Name of Insurance Carrier: ____________________ Policy Number: ________________ Phone Number: ______________

NAME:	SOCIAL SECURITY NUMBER:	RELATIONSHIP TO INSURED:	BIRTH DATE:	SEX:

Is this dependent covered by other insurance, including Medicare/Medicaid? ________ If so we need the following information:

Name of Insurance Carrier: ____________________ Policy Number: ________________ Phone Number: ______________

NAME:	SOCIAL SECURITY NUMBER:	RELATIONSHIP TO INSURED:	BIRTH DATE:	SEX:

Is this dependent covered by other insurance, including Medicare/Medicaid? ________ If so we need the following information:

Name of Insurance Carrier: ____________________ Policy Number: ________________ Phone Number: ______________

I AUTHORIZE any physician, dentist, medical practitioner, hospital, pharmacy or other provider of health care, any insurance company, government agency or consumer reporting agency to disclose to Insurance Management Services or my employer all information and records relating to diagnosis, treatment, medical history, physical or mental condition and evaluation, or any other information relating to me, my spouse, or my dependent children. I understand that any information obtained will not be released to any person or organization except re-insurers, other persons or organizations performing business or legal services in conjunction with my coverage, or as required by law, or as I may authorize. A photocopy of this authorization remains valid for the term of coverage. I have the right to receive a copy of this authorization upon request.

Employee Signature ____ Date ____________________

REFUSAL OF GROUP HEALTH COVERAGE

This is to certify I have been given an opportunity to apply for group health coverage available to me through my Employer, and I have decided to not apply coverage for:

_______ Myself _______ Spouse _______ Child(ren)

REASON FOR REFUSAL

______ Other Coverage ______ Other Reason ______________________________

Employee Signature ____ Date ____________________

SPECIAL ENROLLMENT RULES

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependent in this Plan, provided that you request enrollment within 30 days after your coverage ends. 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, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

GUARDIAN®

Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer Name: **WATSON TRUCK & SUPPLY, INC.**	Group Plan Number: **00483632**	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX Initial Enrollment Re-Enrollment Add Employee/Dependents Drop/Refuse Coverage Information Change
Increase Amount Family Status Change

Class: ALL OTHER ELIGIBLE EMPLOYEES NOT ENROLLING IN MEDI Division:_____ Subtotal Code:_____ **(Please obtain this from your Employer)**

About You:
First, MI, Last Name:

Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address	City	State	Zip

Gender: M F Date of Birth (mm-dd-yy): ____ - ____ - ____ Phone: ( ) -

Email Address:
Are you married or do you have a spouse? Yes No Date of marriage/union:____-____-_____
Do you have children or other dependents? Yes No Placement date of adopted child: ____-____-_____

About Your Job: Hours worked per week: _____ Job Title:

Work Status:
Active Retired Cobra/State Continuation

Date of full time hire: _____ - _____ - _____

About Your Family: Please include the names of the dependents you wish to enroll for coverage. Additional information may be required for non-standard dependents such as a niece or a nephew.

Spouse (First, MI, Last Name) Address/City/State/Zip: Phone: ( ) -		Gender M F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	Add Drop	Gender M F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	Add Drop	Gender M F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER
DATE FORM PUBLISHED: Oct 11, 2017

Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	Add Drop	Gender M F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	Add Drop	Gender M F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent

Drop Coverage:

Drop Employee Drop Dependents

The date of withdrawal cannot be prior to the date this form is completed and signed.

Last Day of Coverage: _____-_____-_____

Termination of Employment Retirement

Last Day Worked: _____-_____-_____

Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Dropped:

Dental	Employee	Spouse	Child(ren)
Vision	Employee	Spouse	Child(ren)

Loss Of Other Coverage:

I and/or my dependents were previously covered under another insurance plan. Loss of coverage was due to:

Termination of Employment: _____-_____-_____

Divorce _____-_____-_____

Death of Spouse _____-_____-_____

Termination/Expiration of Coverage _____-_____-_____

Coverage Lost Dental Vision

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:

Covered under another insurance plan

Other _____

(additional information may be required)

Dental Coverage: **You must be enrolled to cover your dependents. Check only one box.**

Your Monthly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Indemnity	$28.36	$57.29	$68.25	$97.19

I do not want this coverage. If you do not want this Dental Coverage, please mark all that apply:

I am covered under another Dental plan

My spouse is covered under another Dental plan

My dependents are covered under another Dental plan

Vision Coverage: **You must be enrolled to cover your dependents. Check only one box.**

Your Monthly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Full Feature	$7.74	$13.01	$13.27	$21.01

I do not want this coverage. If you do not want this Vision Coverage, please mark all that apply:

I am covered under another Vision plan

My spouse is covered under another Vision plan

My dependents are covered under another Vision plan

Signature

An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.

I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.

I understand that the premium amounts shown above are estimations and are for illustrative purposes only.

Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.

If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.

Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.

I hereby apply for the group benefit(s) that I have chosen above.

I understand that I must meet eligibility requirements for all coverages that I have chosen above.

I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.

I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.

I attest that the information provided above is true and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

The laws of New York require the following statement appear: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE X _____ **DATE** _____

Enrollment Kit 00483632, 0004, EN

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut, Iowa, Nebraska, and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

INSURANCE MANAGEMENT SERVICES
NOTICE OF PRIVACY PRACTICES

Insurance Management Services ("IMS") provides this notice to describe our privacy practices and our commitment to protecting the privacy and security of your personal and protected health information.

In order to effectively administer claims, provide quality customer service and other services on behalf of your group health plan, it is necessary for IMS to receive and or disclose personal and protected health information. IMS may disclose to employers, plan administrators, health care providers, other group health plans, insurers, service providers and/or business associates. Such information may be made available through enrollment forms, medical claims, medical reports, coverage history and other sources and forms necessary to effectuate claim administration, treatment, payment and health care operations.

The information IMS may receive and/or disclose may include your name, Social Security number, address, date of birth, telephone number, marital status, gender, dependent information, claim information and employment information. While this list is not all inclusive, it gives you an idea of the type of information we are referring to in this notice.

HIPAA Compliance

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), in part, establishes new standards for healthcare privacy and security. IMS does receive protected health information ("PHI") from, and on behalf of, our customers that are subject to HIPAA. IMS is committed to protecting the privacy and security of personal and protected health information in a manner that is consistent with our customer's legal obligations. IMS has developed a privacy and security compliance program for our personnel that take into account HIPAA privacy and security standards and reasonable practices in the healthcare industry.

Our Security Procedures

IMS understands that storing and transmitting data in a secure manner is essential. IMS stores your personal and protected health information using industry standard physical, technical and administrative safeguards to secure data against foreseeable risks, such as unauthorized use, access, disclosure, destruction and modification. Certain information containing personal and protected health information that is displayed or received via Internet Web browser technology is transmitted in a secured environment using 256-bit SSL encryption. You have a right to be notified if a breach of your unsecured PHI occurs.

Our Commitment to You

- We will safeguard, according to strict standards of security and confidentiality, any information shared with us. We will limit the collection and use of information to the minimum required to provide superior quality customer service.
- We may disclose personal and protected health information to business associations of your group health plan.
- We may disclose personal and protected health information to service providers.
- We may disclose personal and protected health information reasonably necessary to assist in detecting or preventing criminal activity, fraud, misrepresentation or non-disclosure in a health benefit or insurance transaction/function.
- We may disclose personal and protected health information to another person or entity in order to administer your group health plan or for purposes of allowing the other person or entity to administer a health benefit plan including, but not limited to, payment and health care operations.
- We may disclose personal and protected health information to an insurance regulatory authority, to an insurance commissioner, law enforcement or other governmental authority as required tor permitted by law.
- We may disclose personal and protected health information to comply with any law or legal process to which we are subject, including a facially valid administrative or judicial order, search warrant, subpoena or lawful discovery request.
- We may disclose personal and protected health information for the purpose of conducting an audit.
- We may disclose personal and protected health information to a professional peer review organization for the purpose of reviewing the service or conduct of a medical care institution or a medical care professional.
- We may disclose personal and protected health information to other non-affiliated third parties as permitted by law.
- We may disclose personal and protected health information not presently disclosed, but only as permitted by law.

In certain circumstances, IMS may be required by law to obtain from you separate, written authorization in order to disclose personal and protected health information, such as uses and disclosures of psychotherapy notes.

IMS will **never** sell or rent any of your personal information to third parties for marketing purposes and only share your personal information with third parties as described in this policy.

Revisions and Contact Information

IMS reserves the right to amend this Privacy Policy. It may be revised from time-to-time as new features and services are added, as laws change and as the healthcare industry and privacy and security practices evolve.

For additional information about the IMS Privacy Policy, please contact us at 1-806-373-5944, or at IMS, Attention: Privacy Officer, PO Box 15688, Amarillo, Texas 79109.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, 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

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