Growing Stronger Together

2021-2022

EMPLOYEE BENEFITS GUIDE

in this guide

Acenda Integrated Health strives to offer you and your dependents a competitive and comprehensive benefits package. This year is no exception. We encourage you to take the time to educate yourself about the benefit options available to you.

The benefits you elect will be effective through September 30, 2022.

Once you have made your elections, you will not be able to change them until the next Open Enrollment period, unless you experience a qualified change in status (see page 2 of this guide for more information).

ACENDA

IMPORTANT ENROLLMENT INFORMATION

Who is Eligible?

If you are an Acenda Integrated Health full-time employee (working 30 or more hours per week) you are eligible to enroll in the benefits described in this Guide the first of the month following 30 days of continuous employment. Please remember that only eligible dependents can be enrolled. Eligible dependents include all of the following:

- Your spouse (with proof of marriage), domestic partner or civil union partner (documentation required)
- Your child(ren), step-child(ren), grandchild(ren) (proof of guardianship required), adoptive child(ren), child(ren) placed with you in anticipation of adoption, child(ren) for whom you are the legal guardian, child(ren) who is an alternate recipient under a qualified medical support order. Your eligible dependents can be covered until they reach age 26. All child(ren) dependents require proof of eligibility.
- A child(ren) who is totally disabled and relies on you for care and is covered under the Plan as an eligible dependent at the time he or she reaches age 26, may be covered beyond age 26.
- Individuals losing other coverage. An employee or dependent who is eligible, but not enrolled in this Plan, may enroll if they experience a qualified change in status.

How to Enroll

Login to your e3 account to select and/or waive your benefit elections. Please contact Human Resources if you need assistance.

Making Plan Changes

Unless you experience a qualified change in status, you cannot make changes to the benefits you elect until the next Open Enrollment period.

Qualified status changes include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you, your spouse, commencement or termination of adoption proceedings, or change in your spouse's benefits or employment status.

If an eligible dependent had other coverage and such coverage is lost, the eligible dependent may be eligible for enrollment during a "special enrollment period," which is usually the 31-day period following the date that other coverage was lost, due to a qualified change in status.

You must notify Human Resources within 31 days of experiencing a qualified status change.

MEDICAL PLANS: AETNA

Eligible employees and their eligible family members have the option of three plans from Aetna.

	OPEN ACCESS MANAGED CHOICE #1	OPEN ACCESS MANAGED CHOICE #2	OPEN ACCESS MANAGED CHOICE HDHP WITH HRA
MEDICAL BENEFITS	**IN-NETWORK**	**IN-NETWORK**	**IN-NETWORK**
Plan Year Deductible	None	$500 individual / $1,000 family	$2,500 individual / $5,000 family
HRA Funding	N/A	N/A	$500 Single Coverage $1,000 All Other Tiers
Out-of-Pocket Maximum	$3,000 individual / $6,000 family	$3,000 individual / $6,000 family	$4,500 individual / $6,750 family
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 100%
PCP Office Visit	$20 copay	$20 copay	Plan pays 80%*
Specialist Office Visit	$40 copay	$40 copay	Plan pays 80%*
Diagnostic Lab and X-ray	Plan pays 100%	Plan pays 90%*	Plan pays 80%*
Advanced Radiology Imaging Services (MRI, MRA, PET, CT-Scan and Nuclear Medicine)	$75 copay	Plan pays 90%*	Plan pays 80%*
Inpatient Hospital	$300 a day (up to 5 days) then Plan pays 100%	Plan pays 90%*	Plan pays 80%*
Outpatient Surgery	Plan pays 100%	Plan pays 90%*	Plan pays 80%*
Emergency Room	$100 copay (waived if admitted)	$100 copay (waived if admitted)	Plan pays 80%*
Urgent Care Center	$50 copay	$50 copay	Plan pays 80%*
OUT-OF-NETWORK BENEFITS			
Deductible	$7,500 individual / $15,000 family	$7,500 individual / $15,000 family	$5,000 individual / $10,000 family
Out-of-Pocket Maximum*	$30,000 individual / $60,000 family	$30,000 individual / $60,000 family	$10,000 individual / $20,000 family
Coinsurance (% Plan Pays)	Plan pays 50%*	Plan pays 50%*	Plan pays 60%*

*After deductible

Blood pressure
Cholesterol
Diabetes
Breast cancer
Colorectal cancer
Prostate cancer
Thyroid disease
Glaucoma

*Don't Forget: **Preventive Care Services** are covered 100% in-network—no copays or coinsurance!*

The screenings to the left represent just some of the preventive care screenings available through our medical plans. Don't guess when it comes to your health—make the most of your healthcare investment and take advantage of the preventive care services that are covered 100% in-network.

HEALTH REIMBURSEMENT ACCOUNT: FLEX

A Health Reimbursement Account (HRA) is an employer-funded account that is designed to pay for qualified medical expenses before the employee incurs any out-of-pocket expenses. The HRA works in conjunction with plans like the Aetna Open Access Managed Choice HDHP, thereby reducing premium costs while encouraging employees to spend wisely. ***Please Note: The HRA is not available to employees who enroll in the Aetna Open Access Managed Choice Plan.***

How much does the company contribute to the HRA?

Acenda Integrated Health will pre-fund the HRA based on the tier you elect for your coverage.
If you elect the Aetna Open Access Managed Choice HDHP, the company will contribute:

- **$500** for employees enrolled in Single coverage
- **$1,000** for employees enrolled for all other tiers (Employee +Spouse/Partner, Employee + Child(ren) or Family)

By staying "in-network", medical expenses incurred are paid at the reduced, pre-negotiated Aetna rates. This stretches your HRA dollars further and reduces any out-of-pocket expenses. For example, a typical doctor's office visit for illness may cost $150.00. However, if the physician participates in the Aetna network, the in-network rate could be less than half that amount (approximately $75.00).

What happens if I do not use my entire HRA during the Plan Year?

Any amount unused will roll-over to the next Plan Year! Please note, you must re-enroll to receive the roll-over funds. In any Plan Year, you may have up to a maximum of two (2) years of company-funded HRA contributions in your account.

The company is not permitted to refund any part of the balance to you. These amounts may never be used for anything but reimbursements for qualified medical expenses.

What are qualified medical expenses under the HRA?

Qualified medical expenses are specified in the plan document. Examples include amounts paid for office visits and necessary hospital services.

What happens once my HRA account is exhausted?

The purpose of providing you with a company-funded HRA account is to encourage you to critically look at the healthcare expenses you incur for illness and injury (i.e. the consumerism concept) to determine if there are more economical alternatives to receiving the medical care. For instance, the cost for an urgent care center visit versus an emergency room (ER) visit is very different - only you can decide whether an ER visit is necessary.

Once you exhaust your company-funded HRA, you will be responsible for any copays, coinsurance and deductible amounts (up to the annual out-of-pocket maximum) when you or your covered dependent seek care.

PRESCRIPTION DRUG PLANS: AETNA

If you are enrolled in one of the medical plans, you are automatically enrolled in the prescription drug plan through Aetna.

	OPEN ACCESS MANAGED CHOICE #1	OPEN ACCESS MANAGED CHOICE #2	OPEN ACCESS MANAGED CHOICE HDHP WITH HRA
PRESCRIPTION TYPE	**IN-NETWORK**	**IN-NETWORK**	**IN-NETWORK**
Retail Pharmacy (Up to a 30-day supply)			Copays apply after deductible
Generic	$15 copay	$20 copay	$10 copay
Formulary Brand Name	$35 copay	$40 copay	$35 copay
Non-Formulary Brand Name	$50 copay	$60 copay	$50 copay
Mail-Order Pharmacy (Up to a 31-90-day supply)			Copays apply after deductible
Generic	$30 copay	$40 copay	$20 copay
Formulary Brand Name	$70 copay	$80 copay	$70 copay
Non-Formulary Brand Name	$100 copay	$120 copay	$100 copay

Save on your prescriptions with Mail Order

Using the mail order program for your maintenance medications will save you money. You will receive **up to a 90-day (3-month) supply** for two retail copays. In addition to the savings, your prescriptions will be delivered right to your home.

To begin, visit www.aetnanavigator.com or **888-792-3862** to complete an order form. Submit the **form and your original written prescription** to the following address:

Aetna Rx Home Delivery
PO Box 417019
Kansas City, MO 64179-7019

How much can you save when you use Mail Order? *Compare for yourself…*

Retail Pharmacy	Mail Order	Annual Savings
Preferred Brand-Name Copay **$35**	Preferred Brand-Name Copay **$70**	**$140**
Annual cost *($35 per month x 12 fills)* **$420**	Annual cost *($70 per order x 4 fills per year)* **$280**	

TELADOC®: AETNA

Teladoc gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone, video, or mobile app visits. It's an affordable alternative to costly urgent care and ER visits when you need care now.

How to get started:

- Go to **www.teladoc.com/aetna** to set up your account, or
- Call **1-855-Teladoc (835-2362)**
- Complete your profile and your medical history form– be sure to include any medication(s) you are on and any allergies
- Add dependents, spouses, if applicable

So many reasons to use Teladoc!

- Talk to a doctor anytime, anywhere you happen to be
- Receive quality care via phone or online video
- Prompt treatment, average call back in 16 minutes or less
- A network of doctors that can treat children of any age as well as adults
- Secure, personal and portable electronic health record (EHR)
- No limit on consults, so take your time

When can I use Teladoc?

- When you need care now
- If your doctor is unavailable
- If you're considering the ER or urgent care center for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

Get the care you need

Teladoc doctors can treat many medical conditions, including:

- Cold & Flu symptoms
- Allergies
- Bronchitis
- Skin problems
- Respiratory infection
- Sinus problems and more!

Download the Teladoc app!

Log into your account on your mobile device and complete the "Medical History" section. Visit Teladoc.com/mobile to download the app.

Talk to a doctor anytime for $40 or less!

DENTAL PLANS: AETNA

Eligible employees and their eligible family members have the option of two Aetna Dental plans, which include 100% coverage for preventive services.

	DMO	PPO
	IN-NETWORK ONLY	IN-NETWORK AND OUT-OF-NETWORK
Deductible	None	$50 individual / $150 family
Plan Year Maximum	None	$2,000
Preventive and Diagnostic	Plan pays 100%	Plan pays 100%
Basic Services	Subject to DMO Fee Schedule	Plan pays 80%
Orthodontia	Subject to DMO Fee Schedule	$2,000 lifetime maximum (child only—to age 19)
Major Services	Subject to DMO Fee Schedule	Plan pays 50%

VISION PLAN: AETNA

If you utilize the services of a provider listed in the Preferred Provider Directory, your benefits include routine vision exams for a $10 copay and preferred pricing on a large selection of brand-name, designer frames, lenses and lens options.

Please note: This is a voluntary benefit. Employees pay 100% of the cost.

	AETNA VISION PLAN
SERVICES	**IN-NETWORK**
Exam	$10 copay
Prescription Glasses	$25 copay
Frames	Copay included in Prescription Glasses: $150 allowance for any frames including prescription sunglasses 20% off remaining balance over allowance
Lenses	Copay included in Prescription Glasses: Single vision, lined bifocal and lined trifocal lenses Polycarbonate lenses for dependent children - $40
Lens Enhancements Standard Progressive Lenses Premium Progressive Lenses	 $90 20% discount off retail minus $120 plan allowance plus $90 copay = member out-of-pocket
Contacts Conventional Disposable Medically Necessary	 $150 allowance and additional 15% off balance over allowances $150 allowance $0
Frequency Frames Lenses Exam Contacts	 Every 24 months Every 12 months Every 12 months Every 12 months

FLEXIBLE SPENDING ACCOUNTS: FLEX

A Flexible Spending Account (FSA) allows you to set aside money, on a pre-tax basis, for eligible out-of-pocket medical, dental, vision, and dependent care expenses.

You can save approximately 25% of each dollar spent on these expenses when you participate in a Flexible Spending Account (FSA).

You must enroll/re-enroll in the plan to participate for the new Plan Year (October 1, 2021 through September 30, 2022).

Healthcare FSA

The Healthcare FSA is used to reimburse you for eligible medical, dental and vision expenses incurred by you and your dependents. Eligible employees may contribute up to $2,750.

Dependent Care FSA

A Dependent Care FSA reimburses you for expenses that allow you and your spouse (if married) to work while your dependents are being cared for. You may contribute up to $5,000 per year if you are a single employee or married filing jointly, or $2,500 if you are married and filing separately.

How much should you contribute to the FSAs?

You should contribute the amount of money you expect to pay out-of-pocket for eligible expenses for the plan period.

FSA Roll Over

Acenda Integrated Health will offer the option to roll over up to $500 unused FSA funds at the end of the plan year.

How do I enroll?

You **must** login to e3 to enroll/re-enroll in the FSA program. Once enrolled, please visit **www.myflexaccount.com** to create your online account.

Questions?

Visit **www.myflexaccount.com** or call Customer Service at **888.345.7990**.

COMMUTER BENEFITS: FLEX

Acenda is pleased to provide our employees with the opportunity to enroll in a spending account specific to work-related transit expenses.

Transit and parking pre-tax reimbursement accounts allow you to pay for eligible work-related transit commuter expenses through pre-tax payroll deductions from your paycheck.

You are able to make a monthly pre-tax election **up to $270** for both transit and parking accounts. You are able to make changes to your pre-tax election amount on a month to month basis. Once you make your election, you will receive a debit card that can be used to pay for work-related transit expenses.

Your debit card is loaded with your pre-tax deductions each time a deduction is taken from your paycheck. Each time you use your debit card to pay for transit purchases, the funds are automatically debited from your transit account.

Carryover and Eligible Expenses

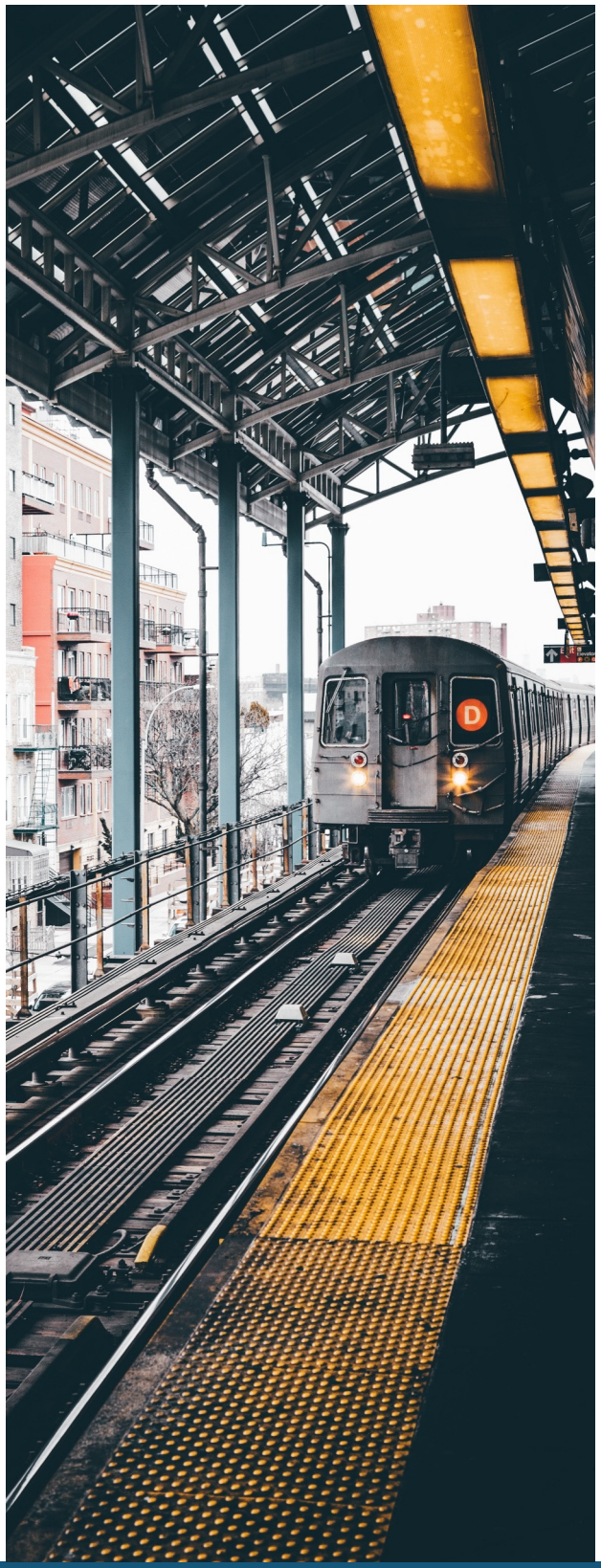
There is no annual "use it or lose it" rule. While unused amounts cannot be cashed out, they do not need to be forfeited, and can be carried over to provide transit benefits in subsequent years.

Eligible work-related transit expenses include: bus, subway, ridesharing (uberPOOL, Lyft Line), ferry, streetcar, and train.

Eligible work-related parking expenses include: parking at or near work, parking at or near public transportation to get to work and park and ride expenses.

Questions?

Visit **www.myflexaccount.com** or call Customer Service at **888.345.7990**.



LIFE AND DISABILITY BENEFITS: CIGNA

Life and Accidental Death and Dismemberment (AD&D) insurance through Cigna provides protection to those who depend on you financially, in the event of your death or an accident that results in death or serious injury. With ***Long-Term Disability insurance****, you have a plan in place to help cover your daily living expenses, while you are out of work, should you become ill or injured.*

Basic Term Life and AD&D Insurance

All active, full-time employees working at least 40 hours per week are eligible for the basic life and accidental death & dismemberment (AD&D) plan. This plan is available to employees at no cost – Acenda pays 100% of the basic life and AD&D premium.

Basic Term Life and AD&D Plan	
Benefit Amount	1 times annual compensation rounded to the next higher $1,000 not to exceed $250,000

Long-Term Disability Insurance

All active, full-time employees regularly working at least 40 hours per week are eligible for the long-term disability (LTD) plan. This plan is available to employees at no additional cost – Acenda pays 100% of the LTD premium.

Long-Term Disability (LTD) Plan	
Percentage of Income Replaced	60%
Minimum Benefit	The greater of $100 or 10% of your Monthly Benefit prior to any reductions for Other Income Benefits
Maximum Benefit	$8,000 per month up to SSNRA
Elimination Period	180 days
Pre-Existing Condition	3 / 12
Definition of Disability	Regular occupation

EMPLOYEE CONTRIBUTIONS

*The following charts show the **weekly contributions effective October 1, 2021.***

Medical & Prescription Drug Plan

Enrollment Tiers	Open Access Managed Choice #1	Open Access Managed Choice #2	Open Access Managed Choice HDHP with HRA
Single	$76.77	$49.61	$19.97
Employee + Spouse/Partner	$297.13	$233.11	$150.85
Employee + Child(ren)	$134.94	$75.38	$24.11
Family	$334.86	$249.38	$159.34

Dental Plans

Enrollment Tiers	DMO	PPO
Single	$0.50	$6.17
Employee + Spouse/Parter	$2.71	$13.89
Employee + Child(ren)	$0.94	$14.93
Family	$3.19	$22.62

Vision Plan

Enrollment Tiers	
Single	$1.47
Employee + Spouse/Partner	$2.80
Employee + Child(ren)	$2.94
Family	$4.33

ADDITIONAL BENEFIT RESOURCES

Member Advocacy
Conner Strong & Buckelew

We know it is often difficult to fully understand your health benefits and use them properly, especially when insurance companies make more and more changes to the way plans are administered and how claims are paid.

Contact the Conner Strong & Buckelew Member Advocacy Team for assistance if you:

- Believe your claim was not paid properly
- Need clarification on information from the insurance company
- Have a question regarding a bill from a doctor, lab or hospital
- Are unclear on how your benefits work
- Need information about adding or deleting a dependent
- Need help to resolve a problem you've been working on

You can contact Member Advocacy by phone at **800-563-9929** Mon – Fri, 8:30am – 5:00pm (EST), or submit a request online at **www.connerstrong.com/memberadvocacy**.

BenePortal
Online Benefits Resource

Acenda offers employees a website dedicated to benefits. This online portal houses key information regarding all the plans and is available to you 24 hours a day, 7 days a week!

BenePortal is a valuable online resource that houses all of your benefit information, including:

- All benefits-related information and downloads, including benefit summaries and detailed plan documents
- Quick links to carrier websites
- Enrollment forms and wellness forms
- And much more….

You and your family can access BenePortal anytime at **www.acendabenefits.com**.

LEGAL NOTICES

Patient Protection and Affordable Care Act

Please note: The Acenda Integrated Health medical plans are considered compliant with the Patient Protection and Affordable Care Act.

Acenda Integrated Health reserves the right to modify, amend, suspend, or terminate any plan, at any time, and for any reason without prior notification. The plans described in this guide are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this guide as accurate as possible. However, should there be a discrepancy between this guide and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern.

Notice Regarding Special Enrollment

Loss of other Coverage (excluding Medicaid or a State Children's Health Insurance Program)

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage (including COBRA coverage) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within [30 days or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage. Coverage will be effective the first of the month following your request for enrollment.

Loss of coverage for Medicaid or a State Children's Health Insurance Program

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program (CHIP). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

New dependent by marriage, birth, adoption, or placement for adoption

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within [30 days or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

To request special enrollment or obtain more information, contact Human Resources at 609.987.3985.

Newborns' and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act

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 benefits. If you have any questions, please speak with Human Resources.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.
If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets.

Important Notice 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 the Acenda Integrated Health Health Benefit Plan 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. Acenda Integrated Health has determined that the prescription drug coverage offered by the Acenda Integrated Health Health Benefit Plan 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

LEGAL NOTICES

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 Acenda Integrated Health coverage will not be affected. If you elect Medicare Part D coverage, the Acenda Integrated Health coverage will coordinate with Part D coverage.
If you do decide to join a Medicare drug plan and drop your current Acenda Integrated Health coverage, be aware that you and your dependents will not be able to get this coverage back during the year without a qualifying event.

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

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

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

Please note that you will get this notice each year. You also may request a copy of this notice at any time.

More Information About Your Options Under Medicare the 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 users should call 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:	October 2021
Sender:	Acenda Integrated Health
Contact:	Human Resources
Address:	42 South Delsea Drive Glassboro, NJ 08028
Phone Number:	844.422.3632

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Acenda Integrated Health offers a series of health coverage options. You should receive a Summary of Benefits and Coverage (SBC) during Open Enrollment. These documents summarize important information about all health coverage options in a standard format. Please contact Human Resources if you have any questions or did not receive your SBC.

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, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - Medicaid
Website:
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health First Colorado
Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

LEGAL NOTICES

INDIANA – Medicaid
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)
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

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA – 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

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA - Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS - Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/
https://www.coverva.org/en/famis-select
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, 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

ACENDA

Acenda Integrated Health | 42 South Delsea Drive | Glassboro, NJ 08028