2022 Benefit Guide

Amberwell
ATCHISON

Here's where to find...

At **Amberwell Atchison**, we recognize our ultimate success depends on our talented and dedicated workforce. We value the contribution every employee makes to our accomplishments, and 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 access and understand while remaining affordable. This benefits guide will help you choose the type of plan and level of coverage that are right for you.

This guide is not your only resource, of course. Any time you have questions about benefits or the enrollment process, you can contact your human resources representative. Although this guide contains an overview of benefits, for complete information about the plans available to you, please see the summary plan description (SPD).

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

The 2022 Open Enrollment for employee benefits is taking place from November 12 through November 19. Benefit elections will be effective on January 1, 2022.

Open Enrollment

Each year during Open Enrollment, you have the opportunity to reevaluate your benefit needs and adjust your coverage for the upcoming plan year. Open Enrollment provides you with the opportunity to make changes to your benefit elections without having a qualifying life event or family status change. You are allowed to add or drop your coverage or dependent coverage at this time.

For the 2022 Open Enrollment, you will enroll in benefits through Paycom.

Qualifying Life Event

The only other opportunity you have to make a change to benefit elections, outside of Open Enrollment, is if you experience a qualifying life event.

You have 63 days from the date of the event to make necessary changes to your medical and prescription drug, dental, and vision benefits. You have 30 days from the date of the event to make necessary changes to your Life, Accidental Death & Dismemberment, Critical Illness, Cancer and Accident benefits.

Qualifying Life Events include:

- Marriage.
- Divorce.
- Birth or adoption.
- Death of a dependent.
- Change in your child's dependent status.
- Change in your spouse's employment status.
- Involuntary loss of other insurance coverage.

New Hire or Newly Eligible Employees

You have 31 days from your hire date or the date you became an eligible employee to make your benefit elections and complete your enrollment. If you do not submit your enrollment information by the deadline, you will receive only the company-paid benefits. You will not be able to enroll in other plans or make changes until the next Open Enrollment (unless you experience a qualifying life event).

To achieve a wellness discount, you (and your spouse if he or she will be covered under the medical plan) may choose to complete an option as part of our wellness program. The deadline for requirements to receive the discounts is the 15th of the month prior to your coverage effective date if you are a newly hired employee. Newly hired employees and their covered spouses complete a biometric screening to earn their wellness discount. If you experience a qualifying event, you have two weeks from the date you submit your change request to complete the requirements for the discounts.

When Coverage Begins

Coverage starts on the first of the month following 30 days from your hire date or the first of the month following 30 days from the date you become a benefit-eligible employee.

Benefits are an integral part of the overall compensation package. Please take time to read this guide thoroughly.

Eligibility and Enrollment

Who Is Eligible?

As an employee of Amberwell Atchison, you are eligible for benefits if you are:

- A regular, full-time employee who is regularly scheduled to work 36 or more hours / week.
- A regular, part-time employee who is regularly scheduled to work 24-35 hours per week.

Healthcare Marketplace / Exchange and Plan Affordability

Under the Health Reform Law, you can obtain insurance through a public health insurance marketplace or exchange. In compliance with the health reform law, the Amberwell Atchison medical plan is considered qualifying and intended to be affordable to most employees.

Your Eligible Dependents

Your dependents eligible for coverage in the Amberwell Atchison benefit plans include:

- Your legal spouse.
- Your dependent children up to the end of the month during which they turn age 26 regardless of student or marital status (includes stepchildren, legally adopted children, and children for whom you are the legal guardian).
- Your dependent child, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability (child must be dependent on you for support as indicated on your federal tax return).

This means you may not qualify for a tax credit to help you purchase health insurance through the marketplace. If you purchase coverage through the marketplace, you may have to pay the full cost of coverage yourself.

Amberwell Atchison strives to offer a medical plan that is both competitive and affordable. Health reform continues to play a role in the evaluation of our benefits. While health reform has provided some positive changes to our medical plan, it has added significant new costs to the program as well.

Medical and Prescription Drug Plan

For 2022, your benefits administrator will continue to be Benefit Management, LLC (BML), and your pharmacy benefit manager will change to Elixir Solutions. The PPO network, Cigna, will remain the same.

Medical Administrator — Benefit Management LLC

You are able to register your account on the Benefit Management website. From there, you can:

- View medical claims history.
- View and print EOBs.
- View eligibility and enrollment history.
- View plan document.
- Print ID cards.
- Link to find a Cigna provider.

Register at **https://benefitmanagementllc.com** and click on "I am a Member."

Pharmacy Benefit Manager — Elixir Solutions

To find an Elixir Solutions provider, go to **elixirsolutions.com/members** or download mobile app **("Elixir Rx Solutions"). Rx Bin #800004** For customer service, call **800-771-4648**

In Atchison, Kex Rx, CVS and Walmart are in the Elixir network.

IMPORTANT: While Amberwell Atchison is considered in-network for the medical plan, the Amberwell Atchison in-house pharmacy is out-of-network for the pharmacy plan. This means that your Amberwell Atchison in-house pharmacy expenses will not go towards your Amberwell Atchison or in-network deductibles or out-of-pocket maximums.

Medical Benefits Plan			
	Core	**PPO**	**OON**
Deductible			
Individual / Family	$750 / $1,500	$1,500 / $3,000	$2,750 / $5,500
Out of Pocket Max Type			
Individual / Family	$2,000 / $4,000	$4,000 / $8,000	Unlimited / Unlimited
Coinsurance (member pays after deductible)	10%	20%	40%
Preventive Care	Covered 100%	Covered 100%	Not Covered
Primary Care Visit	$20 Copay	$40 Copay	40% after deductible
Specialist Visit	$30 Copay	$45 Copay	40% after deductible
Urgent Care	$30 Copay	$50 Copay	40% after deductible
Emergency Room (copay waived if admitted)	$250 Copay	$250 Copay then 20% after deductible	$250 Copay then 20% after deductible
Inpatient Hospital (per occurrence)	10% after deductible	20% after deductible	40% after deductible
Outpatient Surgery (hospital setting)	10% after deductible	20% after deductible	40% after deductible
Chiropractic (25 visits per year)	10% after deductible	20% after deductible	40% after deductible
Phys/Occ/Speech Therapy (visit limits may apply)	10% after deductible	20% after deductible	40% after deductible
Diagnostic Test (X-ray, blood work)	10% after deductible	20% after deductible	40% after deductible
Imaging (CT/PET scan, MRI)	10% after deductible	20% after deductible	40% after deductible
Pediatric Dental	0% after deductible (Birth up to 19 years)	0% after deductible (Birth up to 19 years)	0% after deductible (Birth up to 19 years)
Pediatric Vision	0% after deductible (Birth up to 19 years)	0% after deductible (Birth up to 19 years)	0% after deductible (Birth up to 19 years)
Prescription Drug Benefit			
Deductible Individual / Family	N/A	$50 / $100	
Out of Pocket Maximum Individual / Family	N/A	N/A	
Retail	30 Days or 90 Days	30 Days	30 Days
Tier I (Generic) / Tier II (Formulary) / Tier III (Non-Formulary)	Amberwell Atchison in-house pharmacy is considered out of network, but prescriptions are filled on a cost + 15% basis. No controlled substances or compound prescriptions are available.	$15 / $50 / $75	Non-network prescriptions will be reimbursed based on the network allowed amount less applicable deductible and copayment.
Specialty	N/A	20% up to max $200	N/A
Mail Order	N/A	90 Days	90 Days
Tier I (Generic) / Tier II (Formulary) / Tier III (Non-Formulary)	$30 / $100 / $150	$30 / $100 / $150	Non-network prescriptions will be reimbursed based on the network allowed amount less applicable deductible and copayment.

2022 Bi-Weekly Employee Medical Premiums

	Non-Wellness Premiums	Wellness Premium With Employee Discount Only	Wellness Premium With Both Employee and Spouse Discounts
Full-Time Employees Nontobacco			
Employee Only	$100.35	$60.34	$60.34
Employee + Spouse	$197.91	$157.90	$137.91
Employee + Child(ren)	$178.19	$138.19	$138.19
Employee + Family	$240.53	$200.53	$180.53
Part-Time Employees Nontobacco			
Employee Only	$141.61	$101.61	$101.61
Employee + Spouse	$279.98	$239.98	$219.98
Employee + Child(ren)	$252.08	$212.08	$212.08
Employee + Family	$342.62	$302.62	$282.62
Full-Time Employees Tobacco			
Employee Only	$169.68	$129.68	$129.68
Employee + Spouse	$267.25	$227.24	$207.25
Employee + Child(ren)	$247.53	$207.52	$207.52
Employee + Family	$309.86	$269.86	$249.86
Part-Time Employees Tobacco			
Employee Only	$210.95	$170.95	$170.95
Employee + Spouse	$349.32	$309.31	$289.32
Employee + Child(ren)	$321.42	$281.42	$281.42
Employee + Family	$411.96	$371.96	$351.96

2023 Wellness Program – Complete one option for discount

Option #1
Wellness Visit

Wellness Exam by Primary Care Provider

Option #2
Preventative Screening Exams

Complete 3 of the preventative exams below to qualify for the discount

Mammogram
PAP Smear
Low Dose CT Scan Chest-Smokers >50
Colonoscopy – Screening
Prostate Exam
DEXA Scan – Screening
Skin Cancer Screening by Physician
Dental Visit
Colorectal Screening
Cardiac Stress Test – Screening
Sleep Study
EKG – Screening
Annual Eye Exam with Eye Doctor
Lipid Panel

Option #3
Physical Activity

Complete the following steps requirement and provide proof to earn the wellness discount

215,000+ Steps / Month
(2/3 of the months you are enrolled in the insurance plan)

Example:
12 months enrollment = 8 months of 215,000 +/month
6 months enrollment = 4 months of 215,000 +/month
4 months enrollment = 2.5 months of 215,000 +/month
2 months enrollment = 1.25 months of 215,000 +/month

Option #4
Give Back

Complete 24 hours of Community Service throughout the year and return the signed Community Service form to Occupational Health Services.

Fill out your Community Service Form each time you complete Community Service. Have the organization sign off. Once you complete all 24 hours submit your form.

One of the four options need to be completed with proof turned into Occupational Health Services by October 31, 2022.

Preventative Exams need to be completed between November 1, 2021 and October 31, 2022.

Amberwell

Dental Plan

Delta Dental will continue to administer the dental plan. Delta Dental has two networks, Delta Dental PPO and Delta Dental Premier. With your Delta Dental plan, you are free to see the dentist of your choice. However, you may experience greater benefits and more cost savings by visiting a Delta Dental PPO or Premier provider. The example below shows that you may save the most by selecting a dentist in the Delta Dental PPO network.

Example:

Network			
Crown	**PPO**	**Premier**	**Out-of-Network**
Dentist Charges	$1,000	$1,000	$1,000
Max Allowed Fee	$644	$738	N/A
Benefit	50%	50%	50%
Delta Dental Pays	$322	$369	$268
Patient Pays	$322	$369	$732

For illustration only, actual fees may vary. Example assumes deductible has been met.

Below is a summary of the key features of the dental plan. Please refer to your Summary Plan Description for additional details about coverages and exclusions.

Benefit	Delta Dental PPO	Delta Dental Premier	Non-participating
Deductible	$50 Per Person, up to $150 Family Maximum		
Annual Maximum	$1,250 Per Person		
Preventive Services — Includes routine exams, X-rays and cleanings	Covered at 100% (no deductible)	Covered at 100% (no deductible)	Covered at 100% of R&C (no deductible)
Basic Services — Includes periodontics and oral surgery	Covered at 80% after deductible	Covered at 80% after deductible	Covered at 80% of R&C after deductible
Major Services — Includes bridges, crowns, and dentures	Covered at 50% after deductible	Covered at 50% after deductible	Covered at 50% of R&C after deductible

Reasonable & Customary (R&C): The amount of money that is determined to be the normal or acceptable range of charges for a specific dental-related service or procedure. If your dental provider submits higher charges than what the dental plan considers normal or acceptable, you may have to pay the difference.

2022 Bi-Weekly Employee Dental Premiums

(24 Pay Periods. Refer to Calendar on Page 15)

Delta Dental	
Employee Only	$13.53
Employee + Spouse	$27.08
Employee + Child(ren)	$26.12
Employee + Family	$42.10

Vision Plan

VSP Signature Network

Benefit	Description	Copay	Frequency
Well Vision Exam Copay	Focuses on your eyes and overall wellness	$25 for exam and glasses	Every calendar year
Prescription Glasses			
Frame	• $140 featured frame brands allowance • $120 frame allowance • 20% off amount over your allowance	Combined with exam	Every other calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Combined with exam	Every calendar year
Lens Options	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 35%-40% off other lens options	$0 $80-$90 $120-$160	Every calendar year
Contacts *(Instead of glasses)*	• $120 allowance for contacts (no copay) • Contact lens exam	$0 Up to $60	Every calendar year
Extra Savings and Discounts	• 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam. • **Laser Vision Correction:** Average of 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities. • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		

Your Coverage With Other Providers	
Visit **www.vsp.com** for details; if you plan to see a provider other than a VSP doctor. VSP will reimburse you for your vision expenses up to the amounts listed here.	
Exam — up to $50 **Single Vision Lenses** — up to $50 **Lined Trifocal Lenses** — up to $100 **Frame** — up to $70	**Lined Bifocal Lenses** — up to $75 **Contacts** — up to $105

2022 Bi-Weekly Employee Contributions

Employee Contribution	
Employee Only	$4.51
Employee + Spouse	$7.18
Employee + Child(ren)	$7.35
Employee + Family	$11.83

Flexible Spending Accounts

A great way to plan ahead and save money over the course of the year is to participate in the Flexible Spending Account (FSA) programs. These programs will be administered by Benefit Management LLC for 2022.

Participation in the Healthcare or Dependent Care FSA program must be elected each year during Open Enrollment for the following calendar year. If you participated in the FSA program in 2021, your elections will NOT automatically carry over to 2022.

These accounts allow you to redirect a portion of your salary on a pre-tax basis into reimbursement accounts. Pre-tax means the dollars used for eligible expenses are not subject to Social Security tax, federal income tax, and in most cases, state and local income tax.

The FSA Grace Period is an extended period of coverage at the end of every plan year that allows you extra time to incur expenses to use your remaining Flexible Spending Account balance after the close of the plan year. The Grace Period is 2 ½ months (through March 15th, 2023).

Healthcare FSA

The Healthcare FSA enables you to be reimbursed with pre-tax dollars for many expenses not paid by your medical, dental, or vision plans, as well as other eligible expenses. You can be reimbursed for eligible healthcare expenses for yourself and eligible family members. Family members' expenses may be reimbursed even if you do not cover these individuals under your healthcare plan. The maximum annual amount you may elect to have deposited in 2022 is $2,750. Because your medical, dental, and vision premiums are paid on a pre-tax basis, they cannot be reimbursed by your Healthcare FSA.

Dependent Care FSA

The Dependent Care FSA allows you to be reimbursed with pre-tax dollars related to the care of children under age 13, or dependents of any age that are unable to care for themselves because of a mental or physical disability. Eligible dependents are those for whom you can claim a tax exemption. The services must be necessary to allow you, or your spouse if you are married, to work or attend school full-time. The maximum annual amount you may elect to have deposited is $5,000 ($2,500 if you are married and file separate tax returns).

Managing your benefits is easy as 1.2.3.

1. Log on to **www.benefitmanagementllc.com/member** Click on FSA-HRA-HSA login
2. 24/7 access to check balance, view claims and payment details, file claims, submit receipts and more.
3. Using your username and password for the portal, you can access the Mobile App (search "Benefit Management LLC" in the App Store) to submit claims and receipts using your device's camera, receive account balances via text message and more.

Life and Disability Benefits

Life and Disability insurance are very important to those who depend on you for financial security. For your peace of mind and the financial protection of your family, Amberwell Atchison provides you with Basic Life Insurance, Accidental Death and Dismemberment Benefit, Long Term Disability, and Short Term Disability plans at no cost to you. OneAmerica will be the provider of these benefits for 2022. Please see the OneAmerica plan document for more details.

Life and Accidental Death & Dismemberment (AD&D)

Hospital-paid Life and AD&D volume is one times annual salary rounded up to the nearest $1,000, up to a maximum of $150,000. Dependent Term Life of $2,000 is provided for spouses under the age of 70 and for dependent children age six months to age 19 (or 25 if full-time student). Dependent Term Life of $1,000 is provided for dependent children up to six months old.

Disability

Amberwell Atchison provides Short Term Disability benefits at 60% of covered weekly earnings, up to $1,250 per week; reduced by other income benefits as outlined in the certificate. The waiting period is 60 days for illness and injury. The maximum benefit duration is 17 weeks. Amberwell Atchison provides Long Term Disability benefits at 60% of covered monthly earnings, up to $10,000 per month; reduced by other income benefits as outlined in the certificate.

You May Purchase Additional Voluntary Life and AD&D

You may elect Voluntary Life insurance up to a guaranteed issue of $150,000, or apply for life insurance of up to five times your annual salary, not to exceed $500,000, when you are first eligible. If you have chosen to waive coverage in the past, or wish to increase your current coverage, you may apply during this Open Enrollment by going through evidence of insurability. Employees with Voluntary Life coverage may increase their Life insurance amount by $10,000 at Open Enrollment with no evidence of insurability required.

You may also elect Voluntary Accidental Death & Dismemberment insurance of up to five times annual salary, not to exceed $500,000, when you are first eligible or during annual Open Enrollment. You must enroll in Voluntary Life in order to enroll in Voluntary AD&D.

Voluntary Dependent Term Life and AD&D is also available for spouses ($5,000 / $10,000 / $20,000), dependent children age six months to age 19 (or 25 if full-time student) ($2,500 / $5,000 / $10,000) and for dependent children up to six months ($1,000). Employees must enroll in 2 times the spouse coverage amount or 4 times the child coverage amount in order to enroll in Voluntary Life for dependents.

Other Voluntary Benefits

Guardian will provide the voluntary benefit program options for supplemental Critical Illness coverage, supplemental Accident coverage and supplemental Cancer coverage. Changes due to qualifying life events must be submitted within 30 days of the event.

Guardian Critical Illness

Treatment of critical illnesses such as cancer, heart attack and stroke can lead to unexpected expenses that create an additional financial burden. Critical Illness insurance helps fill in the gaps that medical insurance doesn't cover. This may include travel to treatment centers, ongoing household bills, copays to experimental treatment, and everyday expenses like groceries, rent and mortgage.

Choose the level of coverage — $10,000, $20,000 or $30,000 — that works best for you and your family. As an actively at-work employee, you, your spouse and your children can be covered. At your initial eligibility or at Open Enrollment, you and your family under age 70 are guaranteed coverage with no medical questions, although coverage for preexisting conditions is excluded. Eligible dependent children are covered at 25% of your coverage for no additional premium.

Guardian Accident

Guardian Accident insurance helps offset the costs associated with both minor and major on and off-the-job accidents:

- For every covered accident, Guardian can pay a benefit based on the injury you sustain and the various treatments and/or services received, regardless of what is covered by medical insurance.
- Plus, Guardian Accident insurance will increase covered benefits by 20% for a child who has an accident while playing organized sports.

At your initial eligibility and at Open Enrollment, you and your family under age 70 are guaranteed coverage with no medical questions.

Guardian Cancer

- Guardian Cancer insurance pays you in addition to your medical insurance, no matter what type of plan you have.
- Guardian pays you cash benefits based on diagnosis, certain procedures, screenings and treatments.
- The cash benefits are paid directly to you — you decide how to use them.

At your initial eligibility and at Open Enrollment, you and your family under age 70 are guaranteed coverage with no medical questions, although coverage for preexisting conditions is excluded.

Critical Illness

Bi-Weekly Premiums

(24 Pay Periods. See Calendar on page 15)

EMPLOYEE					
	18-34	35-49	50-59	60-69	70+*
$10,000	$1.61	$5.52	$11.61	$13.21	$17.42
$20,000	$3.22	$11.04	$23.22	$26.42	$34.84
$30,000	$4.83	$16.56	$34.83	$39.63	$52.26
SPOUSE					
	18-34	35-49	50-59	60-69	70+
$10,000	$1.61	$5.52	$11.61	$13.21	$17.42
$20,000	$3.22	$11.04	$23.22	$26.42	$34.84
$30,000	$4.83	$16.56	$34.83	$39.63	$52.26

RATE NOTES

Spouse receives the same benefit amount as the employee. All dependent children up to age 26 can be covered for 25% of the employee amount at no additional premium. Premiums listed are for issue age and will not increase due to an insured's age. Spouse premium is based on employee's age bracket. Benefits reduce by 50% upon reaching age 70.

*70+ rate takes the 50% reduction into account. The coverage amount will be 50% of the line listed, although the employee would still enroll in the total amount. Employees age 70 and older must complete health questions to qualify for coverage.

Accident

Bi-Weekly Premiums

(24 Pay Periods. See Calendar on page 15)

Employee	$7.65
Employee + Spouse	$15.58
Employee + Children	$13.16
Employee + Family	$21.10

Cancer Bi-Weekly Premiums

24 Pay Periods. See Calendar on Page 15

	Low	High
Employee Only	$7.62	$11.68
Employee + Spouse	$10.53	$17.69
Employee + Children	$10.12	$15.87
Family	$13.03	$21.87

Amberwell Atchison Retirement Plan

As an employee of Amberwell Atchison, you have the opportunity to save for your retirement through our 401(k) Plan, which allows both pre-tax and Roth (after-tax) employee deferrals.

- You may elect to begin deferrals on the first pay date if you meet the Plan's minimum age requirement of 20 years.
- Employer matching contributions may be made effective on the first of the month following one year of service. The matching amount is 50% of your deferral percentage of up to 6% (for a maximum match of 3% of your eligible compensation). The annual deferral maximum is also limited by IRS rules.
- Vesting is based on anniversary years of service. No vesting is credited for the first anniversary year as there is no matching that year. For anniversary years 2 through 6, a 20% vesting is given for each additional anniversary year of service.
- The Plan's record keeper is TIAA (Plan #407145) and the Plan's investment advisor is Two West. Detail on investment options can be found at **www.TIAA.org/atchison**. Click on Investment Options and select View all investments.

Please contact **800.842.2252** or visit **TIAA.org/Atchison** for questions.

2022 Paydates

3/31 and 9/29 are non-benefit deduction paydates

January

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	[6]	7	8
9	10	11	12	13	14	15
16	17	18	19	[20]	21	22
23	24	25	26	27	28	29
30	31					

February

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	[3]	4	5
6	7	8	9	10	11	12
13	14	15	16	[17]	18	19
20	21	22	23	24	25	26
27	28					

March

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	[3]	4	5
6	7	8	9	10	11	12
13	14	15	16	[17]	18	19
20	21	22	23	24	25	26
27	28	29	30	(31)		

April

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	[14]	15	16
17	18	19	20	21	22	23
24	25	26	27	[28]	29	30

May

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	[12]	13	14
15	16	17	18	19	20	21
22	23	24	25	[26]	27	28
29	30	31				

June

Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	[9]	10	11
12	13	14	15	16	17	18
19	20	21	22	[23]	24	25
26	27	28	29	30		

July

Su	Mo	Tu	We	Th	Fr	Sa
					1	2
3	4	5	6	[7]	8	9
10	11	12	13	14	15	16
17	18	19	20	[21]	22	23
24	25	26	27	28	29	30
31						

August

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	[4]	5	6
7	8	9	10	11	12	13
14	15	16	17	[18]	19	20
21	22	23	24	25	26	27
28	29	30	31			

September

Su	Mo	Tu	We	Th	Fr	Sa
				[1]	2	3
4	5	6	7	8	9	10
11	12	13	14	[15]	16	17
18	19	20	21	22	23	24
25	26	27	28	(29)	30	

October

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	[13]	14	15
16	17	18	19	20	21	22
23	24	25	26	[27]	28	29
30	31					

November

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	[10]	11	12
13	14	15	16	17	18	19
20	21	22	[23]	24	25	26
27	28	29	30			

December

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	[8]	9	10
11	12	13	14	15	16	17
18	19	20	21	[22]	23	24
25	26	27	28	29	30	31

(○) Indicates non-benefit deduction paydate

[□] Indicates benefit deduction paydate

Contacts

Amberwell Atchison Human Resources	**Jill Wenger** 913.360.5583 jwenger@amberwellhealth.org
	Jolleen Graf 913-360-2582 jgraf@amberwellhealth.org
	Kinzie Albright 913.360.5819 kalbright@amberwellhealth.org
	Elaine Laurie 913-360-5582 elaurie@amberwellhealth.org
To Verify Medical Benefits	**Benefit Management** Member services and Pre-certification: 800.290.1368 www.benefitmanagementllc.com/member
To Find a Doctor	**Cigna** Member services: 800.990.9058 www.mycigna.com
Prescription Drugs	**Elixir Solutions** Customer service: 800.771-4648 answers@elixirsolutions.com
Flexible Spending Accounts	**Benefit Management** Member services: 888.922.4622. www.benefitmanagementllc.com/member
Dental	**Delta Dental of Kansas** Member services: 800.234.3375 www.deltadentalks.com
Vision	**VSP** Customer service: 800.877.7195 www.vsp.com
Life and Disability	**OneAmerica** Customer service: 800.553.5318 Life claims: 800.553.3522 Disability claims: 866.258.8744 or 855.517.6365
Accident | Critical Illness | Cancer	**Guardian** Customer Service: 800-268-2525 Website: www.guardianlife.com
Retirement Plan	**TIAA** Customer Service: 800.842.2252 Website: TIAA.org/Atchison

Annual Notices

HIPAA Special Enrollment Rights

Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the **AMBERWELL ATCHISON** Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction, where required).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

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 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 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).

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.

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 after the marriage, 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 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.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact **JILL WENGER** at **913-360-5583.**

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

AMBERWELL ATCHISON is committed to the privacy of your health information. The administrators of the **AMBERWELL ATCHISON** (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting **JILL WENGER** at **913.360.5583.**

Women's Health and Cancer Rights Act Notice

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.

If you would like more information on WHCRA benefits, please contact **JILL WENGER** at **913-360-5583.**

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

General Notice of COBRA Continuation Coverage Rights

****Continuation Coverage Rights Under COBRA****

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?

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

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

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **https://www.medicare.gov/medicare-and-you**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement

Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

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

Plan contact information

AMBERWELL ATCHISON, JILL WENGER, 800 Ravenhill Drive, Atchison, KS 66002, 913.360.5583

[1]https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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 **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 **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 October 15, 2021. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 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: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, ext. 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 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 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.maine.gov/dhhs/ofi/applications-forms 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/info-details/masshealth-premium-assistance-pa 800.862.4840

MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/oii/hipp.htm 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/ 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075
PENNSYLVANIA – Medicaid
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org 800.250.8427
VIRGINIA – Medicaid and CHIP
https://www.coverva.org/en/famis-select https://www.coverva.org/hipp/ Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
http://mywvhipp.com/ 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since October 15, 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
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2023)

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 1/31/2023)

NOTICE REGARDING WELLNESS PROGRAM

Amberwell Atchison's voluntary wellness program is available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. In order to earn their wellness points, newly hired employees will be asked to complete a biometric screening, which will include a blood test for Cholesterol, HDL, Triglycerides, VLDL, and A1C.

Employees who choose to participate in the wellness program will receive an incentive of $80 monthly premium discount for employee wellness discount. Additional $40 per month for spouse premium discount with completion of one of four options.

The information from your screenings will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Amberwell Atchison may use aggregate information it collects to design a program based on identified health risks in the workplace, Amberwell Atchison Wellness Benefit will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are those such as "a registered nurse," "a doctor," or "a health coach" in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Jill Wenger at **913-360-5583**

Creditable (Drug) Coverage Notice

Important Notice from AMBERWELL Atchison 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 **AMBERWELL ATCHISON** 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. AMBERWELL ATCHISON has determined that the prescription drug coverage offered by the AMBERWELL ATCHISON medical 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 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 **AMBERWELL ATCHISON** medical and prescription drug coverage will not be affected. As long as you remain an active employee who is eligible for benefits at **AMBERWELL ATCHISON** the medical and prescription drug plans will continue to be primary, with Medicare benefits being secondary. Unless you decide to terminate your medical and prescription drug coverage that is available to you through **AMBERWELL ATCHISON** and replace it with only Medicare coverage, your prescription drug coverage under the **AMBERWELL ATCHISON** plan will not be changed.

If you do decide to join a Medicare drug plan and terminate your current **AMBERWELL ATCHISON** coverage, be aware that you and your dependents will be able to get this coverage back, but not until the next period of Open Enrollment or unless you have a special enrollment period due to a qualifying life 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 **AMBERWELL ATCHISON** 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 **JILL WENGER** at **913.360.5583.**

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 AMBERWELL ATCHISON 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. You can call 24 hours a day, 7 days a week.

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	1/1/2022
Name of Entity/Sender:	AMBERWELL ATCHISON
Contact/Position:	**JILL WENGER**
Address:	800 Ravenhill Drive, Atchison, KS 66002
Phone Number:	**913.360.5583**

Notes

Notes

All changes must be made by Friday, November 19th!

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

22BG2-AMBa