2025 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).

Use the HR email, **humanresources@amberwellhealth.org** to message the HR Team directly with any questions you may have.

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.

Benefit elections will be effective on January 1, 2025.

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 2025 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 30 days from the date of the qualifying life event to make necessary changes to your benefits.

Qualifying Life Events include:

- Marriage.
- Divorce.
- Birth or adoption.
- Death of a spouse or 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 30 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).

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, which includes common law marriage.
- 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

Your benefits administrator continues to be Auxiant, and your pharmacy benefit manager will be SmithRx. The PPO network continues to be Aetna.

Medical Administrator — Auxiant

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

- View medical claims status.
- View and print EOBs.
- View eligibility and enrollment history.
- View plan document.
- Print ID cards.

Register at **Auxiant.com.** Click on **Register** > Select **Plan Member Registration** from the dropdown > Complete the **Member Registration Form** (Group #A1188) > Create your username and password. You can also download the Auxiant Health mobile app. For questions, contact Auxiant at **800.788.7569**.

To locate a provider:

1. Log into your account by going to **www.auxiant.com**.
2. On the left side of the screen, click on Auxiant Health. For PPO information, click on Provider Directory. For PBM information, click on Prescription Benefits.
3. The page will display a link to the network online provider search, as well as their phone number. For questions, call the foll free number on the front of your ID card.

Pharmacy Benefit Manager — SmithRx

Member Portal

Once you receive your ID card, you can create an account at **smithrx.com/portal**. There you can find the pharmacy search tool, track total spends against your plan deductible and out-of-pocket limits, print ID cards, FAQs and more.

Getting prescriptions at the pharmacy

Provide your benefits card and ask them to update your insurance profile. They will need the BIN, PCN, Member ID and RxGroup number located on your card.

Member Services and Questions:

Live chat from smithrx.com
Call Member Support: 844.454.5201
Email: help@smithrx.com

IMPORTANT: While Amberwell Atchison is considered in-network for the medical plan, the contracted retail pharmacy charges do not count toward deductible or out-of-pocket maximums.

	PPO Plan		
	Amberwell Atchison Services/Providers	**In-Network Aetna**	**Out-of-Network**
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%	30%	50%
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	Not Applicable	$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
Physical / Occupational / 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 Tier 1 Generic / Tier 2 Preferred Brands / Tier 3 Non-Preferred Brands	$4 / $10 / $20	**30-Day** $15 / $50 / $75 after deductible	Non-network prescriptions will be reimbursed based on the network allowed amount less applicable deductible and copayment.
Specialty Tier 4 Preferred / Tier 5 Non-Preferred	$60 / $80	20% up to $500 after deductible	N/A
Mail Order / Retail 90 Tier 1 Generic / Tier 2 Preferred Brands / Tier 3 Non-Preferred Brands	$12 / $30 / $60	**90-Day** $30 / $100 / $150 after deductible	Non-network prescriptions will be reimbursed based on the network allowed amount less applicable deductible and copayment.

	HDHP (High Deductible Health Plan)		
	Amberwell Health Atchison Services / Providers	**In-Network Aetna**	**Out-of-Network**
Benefit Period	Calendar Year		
Deductible Type			
Individual / Family	$3,300 / $6,600	$3,800 / $7,600	$6,600 / $13,200
Out-of-Pocket Max			
Individual / Family	$6,650 / $13,300	$7,150 / $14,300	Unlimited/Unlimited
Coinsurance (member pays after deductible)	20%	30%	50%
Preventive Care	Covered 100%	Covered 100%	Not covered
Primary Care Visit	20% after deductible	30% after deductible	50% after deductible
Specialist Visit	20% after deductible	30% after deductible	50% after deductible
Urgent Care	Not applicable	30% after deductible	Paid at In-Network Level
Emergency Room (copay waived if admitted)	20% after deductible	30% after deductible	Paid at In-Network Level
Inpatient Hospital (per occurrence)	20% after deductible	30% after deductible	50% after deductible
Outpatient Surgery (hospital setting)	20% after deductible	30% after deductible	50% after deductible
Chiropractic (visit limits may apply)	Not covered	30% after deductible (30 visits)	50% after deductible (30 visits)
Phys/Occ/Speech Therapy (visit limits may apply)	20% after deductible (combined 40 visits)	30% after deductible (combined 40 visits)	50% after deductible (combined 40 visits)
Diagnostic Test (X-ray, blood work)	20% after deductible	30% after deductible	50% after deductible
Imaging (CT/PET scan, MRI)	20% after deductible	30% after deductible	50% after deductible
Prescription Drug Benefit			
Retail Tier 1 Generic / Tier 2 Preferred Brands / Tier 3 Non-Preferred Brands	$4 / $10 / $20 after deductible	**30 days** $ 15 / $50 / $75 after deductible	N/A
Specialty Tier 4 Preferred / Tier 5 Non-Preferred	$60 / $80 after deductible	**30 days** 20% up to $500 after deductible	N/A
Mail Order / Retail 90 Tier 1 Generic / Tier 2 Preferred Brands / Tier 3 Non-Preferred Brands	$12 / $30 / $60 after deductible	**90 days** $30 / $100 / $150 after deductible	N/A

2025 Bi-Weekly Employee Medical Premiums

PPO Plan	Non-Wellness Premiums	Wellness Premium With Employee Discount Only	Wellness Premium With Both Employee and Spouse Discounts
Full-Time Employees			
Employee Only	$111.13	$66.82	$66.82
Employee + Spouse	$219.18	$174.87	$152.73
Employee + Child(ren)	$197.34	$153.04	$153.04
Employee + Family	$266.38	$222.08	$199.93
Part-Time Employees			
Employee Only	$156.83	$112.53	$112.53
Employee + Spouse	$310.07	$265.77	$243.62
Employee + Child(ren)	$279.17	$234.87	$234.87
Employee + Family	$379.44	$335.14	$312.99

HDHP Plan	Non-Wellness Premiums	Wellness Premium With Employee Discount Only	Wellness Premium With Both Employee and Spouse Discounts
Full-Time Employees			
Employee Only	$79.60	$47.86	$47.86
Employee + Spouse	$156.99	$125.25	$109.40
Employee + Child(ren)	$141.35	$109.62	$109.62
Employee + Family	$190.79	$159.07	$143.20
Part-Time Employees			
Employee Only	$112.33	$80.60	$80.60
Employee + Spouse	$222.09	$190.36	$174.49
Employee + Child(ren)	$199.95	$168.22	$168.22
Employee + Family	$271.77	$240.04	$224.18

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 30 days from your date of hire. Newly hired employees and their covered spouses complete a biometric screening to earn their wellness discount. If you experience a qualifying event, you have 30 days from the date you submit your change request to complete the requirements for the discounts.

Ancillary Service And Hospital Discount Information

All Amberwell Health employees are eligible for a 25% prompt pay discount on medical services provided throughout the hospital. For employee accounts to be eligible for the prompt pay discount, the entire account balance must be paid in full within 6 months of the account becoming self-pay after insurance has paid their portion, or initial self-pay from the date of service. If the balance is not paid in full within the outlined 6-month timeframe, the account is subject to the standard payment plan policy of a minimum of $50.00/month, not to exceed 18 months to have account paid in full. Copays are not eligible for an employee discount.

2025 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, 2025.

Preventative Exams need to be completed between November 1, 2024 and October 31, 2025.

Amberwell

Cancer Care

CancerCARE
Right Care. Right Time. Right Place.

A Benefit Specialized In Dealing with Cancer

The CancerCARE Program is an additional benefit, provided by your health plan, that focuses on helping members diagnosed with cancer. Our passionate medical team will oversee your cancer treatment and ensure the optimal treatment path with proven results is being followed. **We are your cancer advocates and will strive to lead you and your dependents to survivorship!**

Day One Help

We are available to help you from the day of your diagnosis and beyond. You can register for the program at any point in your cancer journey to gain access to our resources and support. Registration is available through our website or by phone.

Personalized Care

Once you are part of the program, **a dedicated nurse will be with you every step of the way.** This nurse will be available to answer any questions you might have as well as make sure you are **receiving ideal treatment for your diagnosis.**

National Resources

Through CancerCARE, **you will have access to some of the best doctors, hospitals, and technology nationwide.** We will work with your local oncologist to make sure all treatment options are considered, not just local ones.

Expert Medical Team

Our medical staff has decades of experience treating cancer and we pride ourselves on staying up-to-date with the latest cancer treatments and technology. Each medical staffer has unique cancer expertise and background.

+1 877 640 9610 cancermanagement@cancercareprogram.net cancercareprogram.net

Survivorship is our goal!

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Through CancerCARE, **you will have access to some of the best doctors, hospitals, and technology nationwide.** We will work with your local oncologist to make sure all treatment options are considered, not just local ones.

Expert Medical Team

Our medical staff has decades of experience treating cancer and we pride ourselves on staying up-to-date with the latest cancer treatments and technology. Each medical staffer has unique cancer expertise and background.

To Activate Your Benefit, Visit Us Online Or Contact Us At:

+1 877 640 9610 | cancercareprogram.net | cancermanagement@cancancercareprogram.net

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.

2025 Bi-Weekly Employee Dental Premiums

(24 Pay Periods)

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

2025 Bi-Weekly Employee Premiums

(24 Pay Periods)

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

Employee Assistance Program

Employee Assistance Summary of Services

What is an EAP?

Provided by BHS, your Employee Assistance Program (EAP) provides you and your household members with **free**, **confidential**, **in-the-moment support** to help with personal or professional problems that may interfere with work or family responsibilities.

What Happens When You Call the EAP?

A Care Coordinator (master's level clinician) will confidentially assess the problem, assist with any emergencies and connect you to the appropriate resources. The Care Coordinator may resolve your need within the initial call; assess your need as a short-term issue, which can be resolved by an EAP counselor within the available sessions; assess your need as requiring long-term care and assist with connecting you to a community resource or treatment provider available through your health insurance plan.*

Common Reasons to Call Your EAP

Relationships	Life Events	Risks	Challenges
Boss/ Co-worker	Birth/Death	Burnout/Anger	Daily responsibilities
Customers	Health/ Illness	Depression/ Anxiety	Financial/Legal
Friends	Marriage/Divorce	Suicidal thoughts	Parenting
Spouse/Kids	Promotion/ Retirement	Substance abuse	Stress/ Conflict

3 counseling sessions per issue, per person, per year

PROGRAM FEATURES:

Program Cost
This benefit is provided at NO COST* to you and is paid for by your employer.

Confidentiality
BHS follows all federal and state privacy laws. When you speak with us, you can trust that your conversations and information will be kept completely confidential.

Information about your problem cannot be released without your written permission.

Available 24/7
Services are available 24-hours a day, 7-days a week via a toll-free number.

Help is just a phone call away.
Call or text to access services.
800-327-2251

MyBHS Portal

The mobile-friendly MyBHS customer portal provides access to more than 500,000 tools and resources on a variety of well-being and skill-building topics.

Features:
- ✓Program Information
- ✓Access to Services
- ✓Announcements
- ✓Assessments
- ✓Café Series Webinars
- ✓Training Center
- ✓Calculators
- ✓Legal Forms
- ✓News & Tips
- ✓And more...

Access the MyBHS Portal online or via the app.

portal.BHSonline.com
ID: ATCHISON

BHS
Download on the App Store
Google play

* If you require a referral for long-term treatment, costs may be incurred. These are often covered by your health insurance plan.

Work Life Services

CHILDCARE

BHS provides up-to-date, carefully screened, national resources and referrals for a range of childcare needs including:

- Adoption and Special Needs
- Before and After School Programs
- Family Daycare and Group Homes
- Nanny and Au Pair Services
- Nurseries and Preschools
- Summer Camps

ELDERCARE

BHS provides up-to-date, national resources and referrals for a range of eldercare needs including:

- Home-Based Services: Nutrition, Meals on Wheels, Cleaning and Repair
- Housing: Retirement Communities, Subsidized Housing
- In-Home Care: Medical and Nursing Rehabilitation Services
- Inpatient Services: Nursing Homes, Intermediate Care Facilities, Respite Care and Assisted Living Facilities
- Older Adult Services: Support/ Advocacy Groups, Volunteer Opportunities and Adult Day Care
- Transportation Services

LEGAL

When faced with a legal matter, simply contact BHS and you will be connected to an attorney with expertise specific to your needs. **Legal benefits under the program include:**

- Free 30-minute consultations
- In office or telephonic with local plan providers
- Each consultation must be over a new legal topic
- 25 percent off the attorney's hourly rate when an hourly rate is quoted for services beyond consultation

FINANCIAL

You and your household members can access unlimited telephonic financial counseling, information and education from BHS' team of highly-trained financial counselors. **Typical financial matters include:**

- Budgeting
- College Funding
- Credit Counseling
- Debt Management and Consolidation
- Retirement Funding

Locator Services

LOCATOR

BHS shall provide participants with a resource that allows for searches to be performed based on specific requirements regarding child and eldercare needs. This resource is available through the MyBHS portal.

Better begins today.
Call or text to access services.
800-327-2251

bhs™

Flexible Spending Accounts (FSA)

Administered by Auxiant

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 Auxiant.

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 2024, your elections will NOT automatically carry over to 2025.

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. We advise you to seek tax advice before enrolling.

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 minimum election amount is $200 and the maximum annual amount you may elect to have deposited is $3,300. Because your medical, dental, and vision premiums are paid on a pre-tax basis, they cannot be reimbursed by your Healthcare FSA. Entire amount of funds elected are available on effective date.

Link of eligible expenses: https://sig-is.org/eligible-product-list/eligible-product-list-criteria

Please note: If an ineligible purchase is made using the FSA card, the card will be automatically suspended until reimbursement is received for the ineligible purchase.

$660 Rollover Feature

For many, the reluctance of a flex spending account is the use or lose nature of the plan. With the rollover feature our plan offers, any funds up to $660 you have left at the end of the year will be rolled over so you can use them the following year for the Medical Flex Spending Plan.

Run Out Period

The run out period for plan year end is 90 days. (New plan year funds cannot be used to pay for previous year funds).

Filing Claims

Members have 60 days to file any claims within the time they were an active employee if they term mid-year.

FSA Account Page Instructions

1. When you access your FSA on **Auxiant.com**, that information will open on a new window/tab in your browser. you will see a page that shows the status of the FSA plan(s) you are enrolled in.
2. Click on the blue plan name for additional details or use the Accounts menu at the top of the page.
3. To file a claim online, click the "Reimburse Myself" button. If receipt is needed, it will show under the "Tasks" section of the home page. To verify reimbursement method, select Accounts/Payment Method.
4. A paper claim form should be completed for claims for the prior calendar year on or after 1/1. Placeholder for instructions.

Note: A $10 fee will be charged against your account balance for any additional or replacement Healthcare FSA debit cards. If you continue to participate in this benefit from year to year, the plan benefit level you elect each year will be added to the same card and new cards will not be re-issued until the current card expires. Please keep your FSA cards in order to avoid the $10 replacement fee.

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). Amount of funds available are what have been contributed to date. We advise you to seek tax advice before enrolling.

Submitting Claims

- Complete the Flex Claim Form and submit to Auxiant via the methods listed at the bottom of the form.
- If fees are standardized, you can fill out the Standing Dep Care form (and submit. With this option, claims will be entered on a weekly, bi-weekly, or monthly basis.
- The IRS does not allow the carryover provision on dependent care accounts; therefore claims must be submitted before plan year end to be reimbursed.

Limited Purpose FSA

The Limited Purpose Health FSA is a flexible spending account that reimburses you for eligible dental and vision expenses only. **It is only available to employees who are enrolled in the High Deductible Health Plan (HDHP) and HSA.** You can save money on taxes by using money from this account for your dental and vision expenses, while preserving your HSA funds for other purposes, including saving funds for the future.

You must actively re-enroll each year to participate in the Flexible Spending Accounts by making an annual contribution election during Open Enrollment. Once you elect a contribution amount, you cannot change that amount during the plan year unless you experience a qualifying change of status event.

Health Savings Account (HSA)

Administered by WEX

A Health Savings Account (HSA) is a tax-favored individual savings account available to those who are enrolled in the High Deductible Health Plan (HDHP). You can contribute to and use this account to pay for eligible health expenses tax-free.

Plan Highlights

As defined by the IRS, the HSA contribution limit for 2025 will be $4,300 for individual coverage and $8,550 for family coverage. Funds you withdraw from your HSA are tax-free when used to pay for qualified medical expenses including dental and vision. **The IRS defines healthcare expenses that are eligible to be paid by your HSA in IRS Publication 502 available at www.irs.gov**.

If you are going to turn 55 by the end of the 2025 calendar year, you may contribute an additional $1,000 per year as a catch-up contribution.

HSA Payroll deductions can be changed anytime during the year.

There is no "use it or lose it" philosophy. If you don't use it, save it for next year. Or better yet, for retirement. You own your HSA. All contributions roll over and remain yours, even if you change plans, retire or leave employment.

Questions before you enroll: 844.561.1337

Questions when enrolled: 866.451.3399

Email: customerservice@wexhealth.com

Live chat: wexinc.com and hover over Solutions and select Participants/Employees

Once your HSA cash balance reaches the minimum amount required, you can transfer funds to an HSA investment account, which allows you to choose from a selection of mutual funds.

You can open and fund an HSA if you are:

- Enrolled in an HSA-qualified High Deductible Health Plan (HDHP)
- Not covered by your spouse's health plan (unless it is a qualified HDHP), Healthcare FSA, or Health Reimbursement Account (HRA).
- Not eligible to be claimed as a dependent on someone else's tax return.
- Not enrolled in Medicare, TRICARE, or TRICARE for Life.

Benefits Participant Portal & Mobile App

- Visit **wexinc.com**, hover over Solutions and select Participants/Employees. This page provides login buttons for accessing your online account.
- Download the Mobile App

Download on the App Store | GET IT ON Google Play

Qualified medical expenses include, but are not limited to the following:

- Medical out-of-pocket expenses such as deductibles, coinsurance, prescription drugs and lab tests
- Dental treatment such as fillings, braces and extractions
- Hearing aids, including batteries
- Eye exams, eyeglasses and contact lenses
- Chiropractic care and acupuncture
- Premiums for qualified long term care insurance (dollar limits may apply) and COBRA
- Medicare premiums

IRS Publication 502 provides a complete list at **www.irs.gov**.

2025 Plan Year

If you plan to participate in the HSA for 2025, any balance you have in the Healthcare FSA must be zero by December 31, 2024.

How Do Tax-Favored Accounts Compare?

	Health Savings Account (HSA)	Healthcare FSA	Dependent Care FSA	Limited Purpose FSA
Who can have one?	Most employees enrolled in the HDHP	Employees ineligible for HSA Contributions	All employees	Most employees enrolled in the HDHP and HSA
Purpose of Account	Pay for eligible expenses on a pre-tax basis; also offers tax-free savings feature	Pay for eligible medical, dental and vision expenses on a pre-tax basis	Pay for eligible child or dependent care while at work on a pre-tax basis	Pay for eligible Dental and Vision expenses only on a pre-tax basis
Owner of Account	Employee	Employee and Employer	Employee and Employer	Employee and Employer
"Use It or Lose It" Provision	No	Yes	Yes	Yes
Contribution Limit	$4,300 Single $8,550 Family	$3,300	$5,000 ($2,500 if married and file separate tax returns)	$3,300
Elections / Contributions	Change in elections are permitted	Annually, unless a qualifying event	Annually, unless a qualifying event	Annually, unless a qualifying event
Investment Options	Yes, once the balance is $1,000	No options	No options	No options

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. Sun Life continues to be the provider of these benefits. Please see the Sun Life plan document for more details.

Life and Accidental Death & Dismemberment (AD&D)

We provide all eligible employees, spouse and children with Basic Life insurance as well as Accidental Death & Dismemberment (AD&D), which provides an additional payment to you or your beneficiaries if you lose a limb or die in an accident.

Employee Benefit:	1x Annual Salary rounded up to the nearest $1,000, up to a maximum of $150,000 (reduces to 65% at 65; 50% at 70; 35% at 75)
Spouse Benefit:	$2,000 (coverage ends at age 70)
Children (Greater than 6 months):	$2,000
Children (Birth to 6 months)	$1,000

Short-Term Disability

Amberwell Atchison provides Full Time and Part Time employees Short Term Disability benefits. Short-Term Disability may pay up to 60% of your weekly earnings in the event you are unable to work due to a covered illness (includes pregnancy) or non-work related injury.

Eligibility	Full-Time and Part-Time employees Eligible 1st of the month coincident with or next following 30 days of employment
Benefit Amount	60% of Covered Weekly Earnings
Maximum Weekly Benefit	$1,250
Elimination Period	Accident: 60 Days / Illness: 60 Days
Maximum Benefit Period	18 Weeks

Long-Term Disability

Amberwell Atchison provides Full Time employees Long Term Disability benefits. Long-Term Disability may pay you up to 60% of your covered monthly earnings in the event you are unable to work due to a covered illness or injury.

Eligibility	Full-Time employees Eligible 1st of the month coincident with or next following 30 days of employment
Benefit Amount	60% of Covered Monthly Earnings
Maximum Monthly Benefit	$10,000
Elimination Period	180 Days
Maximum Benefit Period	Social Security Normal Retirement Age (SSNRA)

Your Sun Life coverage includes Travel Emergency Assistance, ID Theft Protection Services and Online Will Preparation and Claimant Support Services (pages 24 - 26)

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 in $5,000 increments up to $300,000 (not to exceed 100% of employee's amount) with a guaranteed issue of $50,000; dependent children age six months to age 26 in increments of $2,000 to a maximum of $10,000 (not to exceed 50% of employee's amount) and for dependent children up to six months (a benefit of $1,000).

Do I have to answer health questions to enroll in Voluntary Life?

You will be required to answer health questions if (1) you do not elect coverage when it's first available to you and you want to elect at a later date, (2) you request an amount higher than the Guaranteed Issue amount, or (3) you want to increase coverage at a later date. You will need to fill out and submit the Evidence of Insurability application, which must be approved by Sun Life before the coverage takes effect.

If you are required to submit Evidence of Insurability (EOI), you can access the application (Policy # is 956920):

- Online: Sign into your account at **sunlife.com/account** > Select Submit Evidence of Insurability > Follow instructions on the Evidence of Insurability screen (making sure to click the Submit for review button - a Thank you page will appear.
- If you prefer not to create an account, you can submit Evidence of Insurability by visiting **sunlife.com/eoi.**
- Download at **sunlife.com/findaform**. Complete and follow instructions on the application to complete and return.
- Contact **800.247.6875**

Coverage subject to EOI is effective on the approval date or the date the application becomes effective per the contract, whichever date is later.

EOIs that are approved will not take effect/payroll deducted until the first day of the month following approval.

Sun Life provides voluntary benefit options for Critical Illness coverage, Accident Coverage and Hospital Indemnity coverage. Changes due to qualifying life events must be submitted within 30 days of the event.

Critical Illness Insurance

- **Helps protect your finances from an illness.** When you, your spouse or child is diagnosed with a covered condition, you can receive a cash benefit to help pay unexpected costs not covered by your health plan.
- **Helps cover related expenses.** You can use your benefit to help with related expenses like lost income, child care, travel to and from treatment, deductibles and co-pays.
- **Pays a cash benefit directly to you.** Critical Illness insurance can be used however you want, and it pays in addition to any other coverage you may already have.

Covered Conditions include Heart Attack, Stroke, Angioplasty, Invasive/Noninvasive Cancer, Severe Burns, Advanced Alzheimer's, Complete Blindness, Coma. Refer to the Benefit Summary for complete list, limitations and exclusions.

Choose the level of coverage - $10,000, $20,000, $30,000 or $40,000– that works best for you and your family. As an actively at-work employee, you, your spouse and your children can be covered.

Additionally, all family members on your plan are eligible for a wellness-screening benefit, also paid directly to you once each year per covered person.

Bi-Weekly Premiums (24 pay periods)

EMPLOYEE						
	Under Age 30	**30 - 39**	**40 - 49**	**50 - 59**	**60 - 69**	**70 +**
$10,000	$2.95	$4.25	$8.00	$15.40	$22.45	$39.85
$20,000	$5.90	$8.50	$16.00	$30.80	$44.90	$79.70
$30,000	$8.85	$12.75	$24.00	$46.20	$67.35	$119.55
$40,000	$11.80	$17.00	$32.00	$61.60	$89.80	$159.40

SPOUSE (Limited to 100% of employee's election)*						
	Under Age 30	**30 - 39**	**40 - 49**	**50 - 59**	**60 - 69**	**70 +**
$10,000	$2.95	$4.25	$8.00	$15.40	$22.45	$39.85
$20,000	$5.90	$8.50	$16.00	$30.80	$44.90	$79.70
$30,000	$8.85	$12.75	$24.00	$46.20	$67.35	$119.55
$40,000	$11.80	$17.00	$32.00	$61.60	$89.80	$159.40

CHILD (Limited to 50% of employee's election)	
	All Age Bands
$5,000	$ .30
$10,000	$ .60
$15,000	$ .90
$20,000	$1.20

*Spouse rates are based on the employee's age

Hospital Indemnity Insurance

Helps protect your finances. When you, your spouse or child are facing a hospital stay, you can receive a benefit to help pay unexpected expenses not covered by your plan.

Helps cover related expenses. While health plans may cover direct costs associates with an illness or injury, you can use your hospital indemnity benefits to help cover related expenses like lost income, child care, deductibles and co-pays.

Pays cash benefits directly to you. Hospital Indemnity insurance payments can be used however you want, and it pays in addition to any other coverage you may already have. Benefits are payable directly to you.

Benefits are payable for hospital stays due to Sickness, Accidents, Routine pregnancy, Complications of pregnancy, Newborn complications, Mental and nervous disorders, Substance abuse. Refer to the Benefit Summary for hospital confinement benefit amounts, limitations and exclusions.

Bi-Weekly Premiums

Employee Only	$13.64
Employee + Spouse	$28.95
Employee + Child(ren)	$22.72
Employee + Family	$38.02

Accident Insurance

Helps your finances after a mishap. When you, your spouse or child has a covered accident, like a fall from a bicycle that requires medical attention, you can receive cash benefits to help cover the unexpected costs.

Helps cover related expenses. While health plans may cover direct costs associated with an accident, you can use accident benefits to help cover related expenses like lost income, child care, deductibles and co-pays.

Pays cash benefits directly to you. Accident Insurance can be used however you want, and it pays in addition to any other coverage you may already have. Benefits are payable directly to you. There are no health questions or pre-existing conditions limitations.

You are covered for accidents such as fractures, dislocations, burns, concussion, eye injury, lacerations. Refer to the Benefit Summary for complete list, limitations and exclusions.

All family members on your plan are eligible for a wellness-screening benefit, also paid directly to you once each year per covered person.

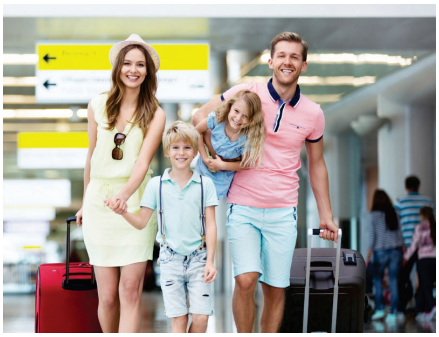
Bi-Weekly Premiums

Employee Only	$6.26
Employee + Spouse	$10.49
Employee + Child(ren)	$12.26
Employee + Family	$16.49

Travel Emergency Assistance

TRAVEL EMERGENCY ASSISTANCE

Sun Life



CONGRATULATIONS!

With your Sun Life coverage, you receive an emergency travel assistance program and ID-theft protection services provided by Assist America.

This travel emergency assistance program immediately connects you to doctors, hospitals, pharmacies and other services if you experience a medical or non-medical emergency while traveling 100 miles away from your permanent residence, or in another country. One simple phone call to Assist America will connect you to:

- A state-of-the-art 24/7 Operations Center
- Experienced, multilingual crisis management professionals
- Worldwide emergency response capabilities
- Air and ground ambulance service providers

TRAVEL ASSISTANCE SERVICES

Medical Consultation, Evaluation & Referral
Calls to Assist America's Operations Center are evaluated by medical personnel and referred to qualified doctors and/or hospitals.

Foreign Hospital Admission Assistance
Assist America fosters prompt hospital admission outside the United States by validating the member's health coverage or by advancing funds to the hospital as needed.

Emergency Medical Evacuation
If adequate medical facilities are not available locally, Assist America will use whatever mode of transport, equipment and personnel necessary to evacuate a member to the nearest facility capable of providing a high standard of care.

Medical Monitoring
Assist America's medical personnel will maintain regular communication with the member's attending physician and/or hospital and relay information to the family, as appropriate.

Medical Repatriation
If a member still requires medical assistance upon being discharged from a hospital, Assist America will repatriate them home or to a rehabilitation facility with a medical or non-medical escort, as necessary.

Prescription Assistance
If a member needs a replacement prescription while traveling, Assist America will help in filling that prescription.

Care of Minor Children
Assist America will arrange for the care of children left unattended as the result of a medical emergency and pay for any transportation costs involved in such arrangements.

Compassionate Visit
If a member is traveling alone and will be hospitalized for more than seven days, Assist America will provide economy, round-trip, common carrier transportation to the place of hospitalization for a designated family member or friend.

Return of Mortal Remains
Assist America will assist with the logistics of returning a member's remains home in the event of his or her death during travel.

Other non-medical emergency assistance services include:

- Return of Vehicle
- Lost Luggage & Document Assistance
- Legal & Interpreter Referrals
- Emergency Message Transmission
- Bail Bond & Emergency Cash Coordination
- Emergency Trauma Counseling
- Pre-trip Information

For more information, visit www.assistamerica.com.

Please cut on dotted line to remove card.

GLOBAL EMERGENCY SERVICES

assist america®

Reference # **01-AA-SUL-100101**

If you require assistance when traveling 100 miles from your permanent residence, or in another country, call Assist America's Operations Center at:

+1 609 986 1234 (outside USA - Collect Call)
+1 800 872 1414 (inside USA - Toll Free)
Or email at: medservices@assistamerica.com

DISCLAIMER

Value-added services are not available in New York. Value-added services are not insurance, are offered only on specific lines of coverage, and carry a separate charge, which is added to the cost of the insurance. The cost is included in the total amount billed. Emergency Travel Assistance is provided by Assist America®. Identity Theft Protection is provided by SecurAssist®, an Assist America program. Sun Life is not responsible or liable for care, services, or advice given by any provider or vendor of the Services. Sun Life reserves the right to discontinue any of the Services at any time. Employers who provide group insurance coverage and make available value added services within an I.R.C. Section 125 cafeteria plan should consult a tax professional to determine whether those services are Qualified Benefits for Section 125 plans. In all states except New York, group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA). GVASBCH-EE-039 SLPC 29750

ID Theft Protection Services

ID THEFT PROTECTION SERVICES

Assist America offers prevention and resolution tools to safeguard your data and restore its integrity if it is used fraudulently. These services include:

24/7 Access to Identity Protection Experts
You have 24/7 direct emergency access to ID Theft Protection experts who can provide guidance in dealing with identity fraud issues.

Credit Card and Document Registration
Register your details using our secure website to store information from credit cards, banks and other important document in a single, centralized and secured location.

Internet Fraud Monitoring
Upon registration, we use a real-time web-crawling technology to monitor any sign of your registered personal data on suspicious sites. You will receive automatic warning notifications if it is discovered that your data is being used fraudulently.

24/7 Identity Fraud Support
If you are a victim of identity fraud, a dedicated ID Theft Protection expert will guide you in mitigating the consequences of the fraud. Your caseworker will also notify credit and debit card issuers if your credit or debit card(s) is lost or stolen.

To activate these identity protection services, visit:
www.assistamerica.com/sunlife

DOWNLOAD THE MOBILE APP

Access a wide range of global emergency assistance services from your phone by downloading the FREE Assist America Mobile App for iPhone and Android.

The Mobile App's features include:

- **Tap for Help:** One-touch call to our 24/7 Operations Center
- **Pre-Trip Information:** Access detailed country-specific information to prepare your trip
- **Digital ID Card:** Your Assist America membership card is stored inside the App
- **Travel Alerts:** Receive alerts on urgent global situations that may impact travel
- **Travel Status Indicator:** This feature indicated when you are eligible for services
- **Embassy & U.S. Pharmacy Locator:** Locate the nearest embassy/consulate of 23 countries around the world and the nearest pharmacies in the U.S.
- **Available in 7 Languages:** English, Spanish, Arabic, Mandarin, Thai, Bahasa, and French

Complete the set-up process by entering your Assist America reference number **01-AA-SUL-100101**.

ANDROID APP ON Google play | Download on the App Store

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assist america® is a registered service mark of Assist America, Inc.

CONDITIONS

Assist America will not provide services in the following instances:

- Travel undertaken specifically for securing medical treatment
- Travel by a Participant's spouse when it is for the benefit of the spouse's employer (spouse business travel)
- Injuries resulting from participation in acts of war or insurrection
- Commission of unlawful act(s)
- Attempt at suicide
- Incidents involving the use of drugs unless prescribed by a physician
- Transfer of member from one medical facility to another medical facility of similar capabilities and providing a similar level of care

Assist America will not evacuate or repatriate a member:

- Without medical authorization
- With mild lesions, simple injuries such as sprains, simple fractures, or mild sickness which can be treated by local doctors and do not prevent the member from continuing his/her trip or returning home
- With a pregnancy over 28 weeks
- With mental or nervous disorders unless hospitalized

Services will not be provided for the following types of travel:

- Trips exceeding 90 days from legal residence without prior notification to Assist America (separate purchase of Expatriate Coverage is available at www.assistamerica.com/expatriate)

While assistance services are available worldwide, transportation response time is directly related to the location/jurisdiction where an event occurs. Assist America is not responsible for failing to provide services or for delays in the delivery of services caused by strikes or conditions beyond its control, including by way of example and not by limitation, weather conditions, availability of airports, flight conditions, availability of hyperbaric chambers, communications systems, or where rendering of service is limited or prohibited by local law or edict.

All consulting physicians and attorneys are independent contractors and not under the control or responsibility of Assist America.

Please cut on dotted line to remove card.

Please provide the following information when you call:

- **Your name, phone number and relationship to the patient**
- **Patient's name, age, gender**
- **The Assist America reference number**
- **Name, location and phone number of hospital or treating doctor if applicable**

Attention: This card is not a medical insurance card. All services must be provided by Assist America. No claims for reimbursement will be accepted. The holder of this card is a member of Assist America and is entitled to its medical and personal services.

Online Will Preparation & Claimant Support Services

Sun Life

Benefits you can use today

Online Will Preparation and Claimant Support Services

At Sun Life, we are pleased to offer you Online Will Preparation and Claimant Support Services through ComPsych® Corporation.

Online Will Preparation

A will is the cornerstone of any estate plan and can protect your assets and loved ones. Through an easy-to-use secure website, you and your spouse can now create and download a will in about 20 minutes. This service includes the following:

- step-by-step guidance and customization for your unique situation,glossary of legal definitions,
- ability to name an executor to carry out your wishes and a guardian(s) to care for your children,
- ability to create a living will (for an additional fee), and
- ability to create a final arrangements document (for an additional fee).

Claimant Support Services

Losing a loved one or becoming disabled can be overwhelming to say the least. With Claimant Support Services, you have access to no-cost, objective financial planning, legal information, and emotional support, if you or your family member has filed a claim with us.

You can receive the following:

- up to five telephonic professional counseling sessions per claim for legal, financial, and emotional assistance,
- 24x7 access to counseling provided by ComPsych's on-staff professionals, including clinicians, licensed attorneys, CPAs, CFPs, and other financial experts,
- assistance with topics such as inheritance taxes, loss of income, creditors, and probate, and
- support dealing with trauma, loss, and adjusting to a reduced quality of life, and other concerns.
- ComPsych's professionals do not sell financial products and do not receive commissions, so you can rest assured that you will receive the information you need to help during a difficult time.

To learn more, visit www.sunlife.com/us

Getting the help you need to face life's challenges and planning ahead to protect your loved ones can go a long way.

Remove and keep this reference card handy so you can take advantage of these services if or when you need to.

Online Will Preparation

To protect your assets and loved ones, you can go online to create and download a will at:

www.EstateGuidance.com **Promo code: SLF4VAS**

Online Will Preparation provided by ComPsych to active employees enrolled in Sun Life's Life insurance. This service is not insurance.

Claimant Support Services

If you need to talk to a counselor or need legal or financial information because of a Life or Disability insurance claim with Sun Life, you can call ComPsych for no-cost, objective assistance.

888-475-3827

Claimant Support Services provided by ComPsych to Sun Life's Life insurance claimants and beneficiaries. Up to five counseling sessions per claim. This service is not insurance.

ComPsych® GuidanceResources®

Sun Life

Retirement Plan

As an employee of Amberwell Atchison, you have the opportunity to save for retirement through our 401(k) Plan which helps you reduce taxes and invest for the future.

- Roth and Pre-Tax Options
- You may begin to contribute immediately upon hire (first pay date)
- You become eligible for employer match after 1 year and 1,000 hours of service. The entry date for matching contributions is the first day of the payroll period following the date you satisfy the eligibility conditions described. 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 for 2025 is $23,500.
- Vesting is a 5-year graded schedule. A year of service for vesting is earned upon completing 1,000 hours of service during the plan year (1/1 - 12/31).
- Participants vest as follows:
  Following year 1 – 20%
  Following year 2 – 40%
  Following year 3 – 60%
  Following year 4 – 80%
  Following year 5 – 100%

Client Care Center:
800.448.2542
www.corebridgefinancial.com

Account registration:
https://myaccount.valic.com/auth/public/login#/

Corebridge Financial Professional:
Ty Hysten
(785) 414.0969
ty.hysten@corebridgefinancial.com

Additional Benefits

Earned Time Off (ETO)

Accrual begins at hire and eligibility for use after 90 days. Accruals are based on 80 hours worked in a pay period. Six (6) holidays are included in this ETO paid time.

Years of Service	Paid hours per pay period	ETO Hours accrued on 80 hours paid	Accrual factor/ hr. for less than 80 hours	ETO accrued per year based on 80 hours	Maximum Accrual hours
Non-Exempt Staff:					
0 < 5	80	5.53	.0691	144	144
5 < 15	80	7.072	.0884	184	184
15 and >	80	8.624	.1078	224	224
Exempt Non-Director:					
0 < 5	80	5.53	.0691	144	144
5 < 15	80	7.072	.0884	184	184
15 and >	80	8.624	.1078	224	224
Director:					
0 < 15	80	7.072	.0884	184	184
15 and >	80	8.624	.1078	224	224
Executive:					
0 >	80	8.624	.1078	224	224

- You can use ETO to pay Amberwell Invoices.
- During your anniversary month each year you can:
  - » Cash out 40 hours of ETO
  - » Trade 24 hours of sick for 8 hours of ETO, if you have the max sick leave of 280 hours.

Sick Leave

Accrual begins at hire and eligibility for use after 90 days. Accrual rate is 3.69 hours per pay period. Leave balance rolls over from year to year until maximum of 280 hours is reached.

Membership Discounts

Amberwell Atchison pays 50% of the following memberships for F/T and P/T employees.

YMCA (Atchison, North KC, Platte County North & South, Olathe, Paul Henson, Cleaver, Downtown, Linwood, Bonner Springs, Providence)	SNAP Fitness (Atchison location only)
Your Cost / Bi-Weekly / Single $9.50	Your Cost / Bi-Weekly / Individual $9.50
Your Cost / Bi-Weekly / Household $13.63	Your Cost / Bi-Weekly / Household $15.00

Tuition Reimbursement

Available for the following:

- F/T and P/T employees working at least 24 hours a week
- Employed at least one year
- $1,000 available for Full-Time and $500 available for Part-Time employees each calendar year.

Requires the following:

- Approval from HR
- Must be for courses related to position at Amberwell
- Classes through an accredited institution
- Must pass class with a “C” or better

Jean Day

Employees pay $3 per pay period to wear jeans on Fridays. The proceeds are donated to a local Charity each year. You must wear Amberwell attire or attire sporting a school or sports team with jeans.

2025 Paydates

1/30 and 7/31 are non-benefit deduction paydates, with the exception of FSA, HSA and retirement deductions which come out of all 26 paychecks.

□ Indicates benefit deduction paydate

○ Indicates non-benefit deduction paydate

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
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August

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31						

September

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December

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Contacts

Amberwell Atchison Human Resources	**HR Department** **humanresources@amberwellhealth.org**
To Verify Medical Benefits	**Auxiant** **800.788.7569** **Auxiant.com**
To Find a Doctor	**Auxiant** **800.788.7569** **Auxiant.com**
Prescription Drugs	**SmithRx** Customer Service: **844.454.5201** **help@smithrx.com**
Flexible Spending Accounts (FSAs)	**Auxiant** Auxiant Flex Department: **800.475.2232** **Auxiant.com**
Health Savings Account (HSA)	**WEX** **844.561.1337** **wexinc.com** **customerservice@wexhealth.com**
Dental	**Delta Dental of Kansas** Member Services: **800.234.3375** **www.deltadentalks.com**
Vision	**VSP** Customer Service: **800.877.7195** **www.vsp.com**
Employee Assistance Program (EAP)	**BHS** **800.327.2251** **portal.BHSonline.com** ID: ATCHISON
Life and Disability	**Sun Life** Customer Service: **800.247.6875** **www.sunlife.com/us**
Travel Emergency Assistance	**Sun Life / Assist America** **609.986.1234** (Outside US - Collect Call) **800.872.1414** (Inside US) Reference #01-AA-SUL-100101 **medservices@assistamerica.com**
ID Theft Protection Services	**Sun Life / Assist America** One-Touch call from Mobile App Reference #01-AA-SUL-100101 **www.assistamerica.com/sunlife**
Online Will Preparation **Claimant Support Services**	**Sun Life / ComPsych** Promo code: **SLF4VAS** **www.EstateGuidance.com** **Sun Life / ComPsych** **888.475.3827** **www.sunlife.com/us**
Accident | Critical Illness | Hospital Indemnity	**Sun Life** Customer Service: **800.247.6875** **www.sunlife.com/us**
Retirement Plan	**Corebridge Financial** **800.448.2542** **www.corebridgefinancial.com**

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 **Human Resources** at **humanresources@amberwellhealth.org**.

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 **Human Resources** at **humanresources@amberwellhealth.org**.

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 **Human Resources** at **humanresources@amberwellhealth.org**.

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).

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 July 31, 2024. 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: https://health.alaska.gov/dpa/Pages/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 | Fax: 916.440.5676| 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.mycohibi.com/ HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program Family and Social Services Administration http://www.in.gov/fssa/dfr/ | 800.403.0864 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid 800.338.8366 Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki 800.257.8563 HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.967.4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kynect.ky.gov | 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms
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.mymaineconnection.gov/benefits/s/?language=en_US 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/masshealth/pa 800.862.4840 | TTY: 711| Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
https://mn.gov/dhs/health-care-coverage/ 800.657.3672
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 | Email: HHSHIPPProgram@mt.gov
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/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 15218 | Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 800.356.1561 CHIP: http://www.njfamilycare.org/index.html 800.701.0710 (TTY: 711) | Premium Assistance: 609.631.2392
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid and CHIP
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
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
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program 800.440.0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) https://medicaid.utah.gov/upp/ | Email: upp@utah.gov | 888.222.2542 Adult Expansion: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: https://medicaid.utah.gov/buyout-program/ CHIP: https://chip.utah.gov/
VERMONT – Medicaid
https://dvha.vermont.gov/members/medicaid/hipp-program 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid and CHIP
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 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 July 31, 2024, 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 1/31/2026)

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

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 **Human Resources** at **humanresources@amberwellhealth.org**.

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 **Human Resources** at **humanresources@amberwellhealth.org**.

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	1/1/2025
Name of Entity/Sender:	AMBERWELL ATCHISON
Contact/Position:	**Human Resources**
Address:	800 Ravenhill Drive, Atchison, KS 66002
Email:	**humanresources@amberwellhealth.org**

COBRA

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[1], 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
humanresources@amberwellhealth.org

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

Notes

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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

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