AMERICAN
HEALTH PARTNERS

2022 Benefit Guide

2022 Benefit Guide

At American Health Partners, we're in the business of caring for others. We believe your health and wellness are just as precious as the well-being of our patients. We want to help you live well by providing affordable health coverage and other important benefits for 2022. Our investments in these benefits support you through the many events and milestones in your life. Whether you're a current employee or a new employee enrolling for the first time, this guide will help you and your family choose your benefits for 2022. We encourage you to keep this guide on hand to answer any benefits questions that arise during the year.

Table of Contents

AMERICAN HEALTH PARTNERS

2022 Benefit User Guide

Coverage	Partner	Contact Information
Medical	BlueCross BlueShield of Tennessee Group #: 130464	**1-800-565-9140 • BCBST.com** **Pre-Enrollment Line: 1-800-973-0613**
Pharmacy	CVS caremark RxBenefits	**1-800-334-8134 • Caremark.com**
Dental	DELTA DENTAL Group #: 4198	**1-800-223-3104 • DeltaDentalTN.com**
Vision	Humana Group #: 668970	**1-866-537-0229 • HumanaVisionCare.com**
Telemedicine	98point6	**1-866-657-7991 • 98point6.com/contact-us/**
Health Savings/ Flexible Spending Accounts	wex	**1-866-451-3399 • wexinc.com**
Health Reimbursement Arrangement	HealthEquity	**1-866-375-1323 • HealthEquity.com**
401(k) Retirement Saving Plan	Fidelity INVESTMENTS Group Plan #: 88324	**1-800-835-5097 • 401k.com**
Employee Assistance Program (EAP)	GuidanceResources® Group #: 09-LF0122	**1-888-628-4824 • GuidanceResources.com** **Username:** LFGsupport • **Password:** LFGsupport1
Hospital Indemnity, Accident and Critical Illness Insurance	VOYA FINANCIAL Group #: 70774-1	**1-877-236-7564 • Voya.com/claims**
Disability Insurance	Lincoln Financial Group Group #: 09-LF0122	**1-800-713-7384 • MyLincolnPortal.com** **Code:** AmericanHealth
Life & AD&D Insurance	Lincoln Financial Group Group #: 09-LF0122	**1-888-787-2129 • GroupLifeClaims@lfg.com**
Diabetes Program	TrueLifeCare	**1-888-788-4925 • trulifecare.com/ahp**
Benefits Support/Enrollment Center Dependent Verification	cleartrackhr	**1-866-581-0475 • Clearify.ClearTrackHR.com** **1-844-395-8833 Fax**

Got questions? 1-866-581-0475 • AskBenefits@AmHealthPartners.com

Get Ready to Enroll in Your Benefits

Getting the most value from your benefits depends on how well you understand your plans and how you use them. This guide can familiarize you with American Health Partners' benefit options. Please review carefully as you prepare to enroll.

- Consider your benefit coverage needs for the upcoming year. For example, is your family financially protected if you can't work due to an accident or illness?
- Consider other available coverage.
- Gather information you'll need. If you are covering dependents, you will need their dates of birth and Social Security numbers. In addition, you may need to provide legal documentation verifying their eligibility, such as a marriage license or birth certificate.

Have questions about which options are best for you?

Call the Benefit Support Call Center at 1-866-581-0475 to discuss your situation with a benefits enrollment counselor. You may also enroll online if you already know what you'd like to do.

Your Enrollment Options

For your convenience, you have three easy ways to enroll. You can schedule an appointment with an enrollment counselor, enroll by phone during call center business hours or enroll online 24/7.

Schedule an Enrollment Appointment

1. Go to Schedule.AmHealthPartners.com
2. Complete the form and choose an appointment time
3. You will receive an email confirmation and another email reminder the day before your appointment, as well as a text reminder approximately one hour before your appointment.
4. At your appointed time, you will receive a call from an American Health Partners' enrollment counselor.

Enroll by Phone

1. Call the American Health Partners Benefit Support Call Center at 1-866-581-0475.
2. Benefit enrollment counselors are available Monday-Friday from 7am to 7pm CST.

Enroll Online

1.Go to enroll.AmHealthPartners.com.
2.Log in to your account (for password reset, email Askultipro@AmHealthPartners.com).
3.Begin the benefits enrollment process.

- For Open Enrollment click on Myself then choose Open Enrollment
- For New Hires and Newly Eligible click on Myself then Life Events then choose Newly Eligible

4.Elect the benefits you want.
5.Save or submit your elections and print a copy for your records.

Benefits Eligibility and COBRA

Employees who work an average of at least 30 hours per week are eligible for the benefits described in this guide.

Benefits are effective on the first of the month following 60 days of active employment. You will need to enroll in benefits prior to your effective date. The following dependents are eligible:

- Your legal spouse
- Your children up to age 26
- Your children of any age who become totally and permanently disabled before age 19 while covered by the plan
- Dependents covered under a Qualified Medical Child Support Order

Dependent Verification

American Health Partners requires dependent verification. This will keep our benefit plan costs low while also allowing us to better comply with the administrative and pretax status of our plans. You will be required to provide verification documents such as marriage certificates, birth certificates, etc., for any dependents you cover on the plan. This is managed by the third party vendor, Clearify.

When Coverage Ends

When you terminate employment, your coverage ends on the last day of the month in which you terminate. You may be able to continue, port, or convert your voluntary plans. Contact your benefits administrator for details.

COBRA Coverage

When your coverage ends, you may be able to continue your medical/prescription drug, dental, vision, FSA and HRA coverage through COBRA coverage. COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985.

Your eligibility for COBRA coverage is based on a "qualifying event." A qualifying event is one that occurs when you (or a covered dependent) are no longer eligible for coverage under a group health plan, such as ending employment.

Any dependents enrolled in your plan on the day prior to the qualifying event also have the independent right to continue coverage.

Since COBRA is a continuation of benefits, your coverage/benefits remain the same as they were prior to the qualifying event. However, the cost is higher because it is not subsidized by the employer and is subject to an administrative fee. For COBRA questions, contact your COBRA benefits administrator (Wex 1-866- 451-3399).

Qualifying Life Events

Generally, you may only make or change elections as a new hire or during the annual open enrollment period. However, you may change your benefit elections during the year if you experience one of these events:

- Marriage, divorce, legal separation or annulment
- Birth, adoption or placement for adoption of a child (Even if you already have family coverage you must notify your Benefits Administrator regarding your new addition in order for the child to be covered throughout the plan year.)
- Your child's gain or loss of eligibility status
- Your spouse's or dependent's gain or loss of employment
- A gain or loss of coverage through your employer
- Changes due to your spouse's or dependent's open enrollment
- A change in work schedule that affects eligibility (e.g., full-time to part-time)
- Your spouse's or dependent's plan sponsor no longer makes contributions to the plan
- Your COBRA coverage under a prior plan ends

Qualifying Life Events Eligibility

You have 31 days from a qualifying life event to make changes to your coverage. You will need to provide proof of the event, such as a marriage license. If you do not make the changes within 31 days of the qualifying event, you will have to wait until the next open enrollment period to make changes unless you experience another qualifying life event.

Medical and Pharmacy Plan Overview

We offer the choice of three medical plans through BlueCross BlueShield of Tennessee. All of the medical options include coverage for prescription drugs through Caremark CVS. To select the plan that best suits your family, you should consider the key differences between the plans, the cost of coverage (including payroll deductions), and how the plan covers services throughout the year. **Your medical and pharmacy benefit is a pretax benefit that is partially paid by American Health Partners and partially by you.**

Understanding How Your Plan Works

Deductible

You pay out-of-pocket for most medical and pharmacy expenses until you reach the deductible. You can pay for these expenses from your Health Savings Account (HSA).

Coverage

Once your deductible is met, you and the plan share the cost of covered medical and pharmacy expenses with coinsurance. The plan pays a percentage of each eligible expense, and you pay the rest.

Out-of-pocket-maximum

When your deductibles and co-pays for health care expenses reach your out-of-pocket maximum, the plan pays 100% of covered medical and pharmacy expenses for the rest of the plan year.

What is the difference between aggregate and embedded deductibles and out-of-pocket maximums?

Under an aggregate approach, there is one family limit that applies to all of you. When one or a combination of family members has expenses that meet the family deductible or out-of-pocket maximum, it is considered to be met for all of you. Then, the plan will begin paying its share of eligible expenses for the whole family for the rest of the year.

Under an embedded approach, each person only needs to meet the individual deductible and the out-of-pocket maximum before the plan begins paying its share for that individual. (And, once two or more family members meet the family limits, the plan begins paying its share for all covered family members.)

Medical and Pharmacy Plan Overview

Getting the most out of your plan also depends on how well you understand it. Keep these important tips in mind when you use your plan.

In-network providers and pharmacies

- You will always pay less if you see a provider within the medical and pharmacy network.

Preventive care

- In-network preventive care is covered at 100% (no cost to you). Preventive care is often received during an annual physical exam and includes immunizations, lab tests, screenings and other services intended to prevent illness or detect problems before you notice any symptoms.

Preventive drugs

- Many preventive drugs and those used to treat chronic conditions like diabetes, high blood pressure, high cholesterol and asthma are designated on the CVS Preventive Drug List. These prescriptions are covered at 100% (no cost to you) when you use an in-network pharmacy.

Pharmacy coverage

- Medications are placed in categories based on drug cost, safety and effectiveness.

These tiers also affect your drug coverage.

Generic

- A drug that offers equivalent uses, doses, strength, quality and performance as a brand-name drug, but is not trademarked.

Brand preferred

- A drug with a patent and trademark name that is considered "preferred" because it is appropriate to use for medical purposes and is usually less expensive than other brand-name options.

Brand non-preferred

- A drug with a patent and trademark name. This type of drug is "not preferred" and is usually more expensive than alternative generic and brand preferred drugs.

Specialty

- A drug that requires special handling, administration or monitoring. Most can only be filled by a specialty pharmacy and have additional required approvals.

Mail-order pharmacy (maintenance drugs)

- If you take a maintenance medication on an ongoing basis for a condition like high cholesterol or high blood pressure, you can use the mail-order pharmacy to save on a 90-day supply.

90 day retail (maintenance drugs)

- If you take a maintenance medication on an ongoing basis for a condition like high cholesterol or high blood pressure, you can save on a 90-day supply of your medication by filling it at an approved CVS location.

BlueAccess Portal at BCBST.com

By electing medical coverage you will have access to your health benefits at BCBST.com. Logging in is easy with BCBST.com on your computer or tablet device. If it's your first time visiting, click 'Log In/Register' and 'Register Now'. Make sure you have your ID card handy and follow the steps to get started. Log in to your account to:

- Check your benefits and see what's covered
- Look up what you owe and how much you've paid
- Find a doctor in your network
- Learn about medical conditions and your treatment options
- Access tools and trusted resources to help you live a healthier life

Medical and Pharmacy Plan Overview

In-Network Benefits	Core Plan (HRA)	Deluxe Plan	Supreme Plan (HSA)
Calendar Year Deductible**	Embedded	Embedded	Aggregate
American Health Partners contribution to HRA/HSA (Individual/Family)	$500/$1,000	N/A	$500/$1,000
Annual Deductible (Individual/Family)	$5,500/$11,000	$4,000/$8,000	$1,500/$3,000
Out-of-Pocket Maximum (Includes Deductible)	$6,500/$13,000	$5,000/$10,000	$3,000/$6,000
Preventive Care	100% Covered	100% Covered	100% Covered
Primary Care Provider Office Visit	$35 Copay	$30 Copay	20% After Deductible
Specialist Office Visit	$75 Copay	$60 Copay	20% After Deductible
X-Ray and Lab	30% After Deductible	20% After Deductible	20% After Deductible
Inpatient Hospital Services	30% After Deductible	20% After Deductible	20% After Deductible
Outpatient Hospital Services	30% After Deductible	20% After Deductible	20% After Deductible
Telemedicine Visit/98point6	$0 Copay	$0 Copay	$0 Copay Subject to change
Urgent Care	$100 Copay	$75 Copay	20% After Deductible
Emergency Room	$300 Copay, then Coinsurance	$200 Copay, then Coinsurance	20% After Deductible
Retail Pharmacy			
Generic	$7 Copay	$5 Copay	20% After Deductible
Brand Preferred	30% After Deductible	20% up to Rx OPM $500 Max Brand Drugs	20% After Deductible
Brand Non-Preferred	30% After Deductible	30% up to Rx OPM $500 Max Brand Drugs	20% After Deductible
Speciality	30% After Deductible	20% or 30% up to Rx OPM	20% After Deductible $500 Max Brand Drugs
Preventive Rx (30-day Supply)			
Generic	$5 Copay	$5 Copay	$5 Copay
Brand Preferred	$25 Copay	$25 Copay	$25 Copay
Brand Non-Preferred	$50 Copay	$50 Copay	$50 Copay
Mail Order Pharmacy (90-day Supply)			
Generic	$14 Copay	$10 Copay	20% After Deductible
Brand Preferred	30% After Deductible	$25 Copay	20% After Deductible
Brand Non-Preferred	30% After Deductible	$40 Copay	20% After Deductible

Medical and Pharmacy Plan Rates

Your per-pay-period payroll contributions for medical and pharmacy benefits are shown here.

Choosing the Best Network for You

Your medical plan offers two networks. Network P has the most participating providers. Network S has fewer providers, but offers lower premiums and deeper discounts that may save you money. It's important to choose the right network to get the maximum benefits from your coverage. Here's how:

- Make a list of all of the doctors and hospitals you and your covered family members visit on a regular basis, including primary care physicians, pediatricians and specialists.
- Search the Find a Doctor tool at BCBST.com to check if your physicians and facilities are in the network you're considering.

Medical	Core Plan Pay Period Deductions (26)		Deluxe Plan (Pay Period Deductions (26)		Supreme Plan Pay Period Deductions (26)	
Network	P	S	P	S	P	S
Employee	$42.84	$30.57	$84.84	$68.76	$113.55	$95.76
Employee + Spouse	$200.38	$155.17	$316.27	$259.44	$402.73	$339.36
Employee + Children	$162.60	$126.26	$253.35	$207.92	$324.42	$273.62
Employee + Family	$252.85	$195.39	$409.93	$332.16*	$512.74	$431.54

*Price was listed incorrectly on the printed guide book. This is the accurate price as of 11/8/2021

Spousal Surcharge

We have a spousal surcharge that is intended to encourage working spouses to review all medical plan options available to them and to keep our costs reasonable for everyone.

If your spouse is eligible for medical coverage through their employer, and you cover them on our medical plan, you will be required to pay a surcharge of $100 per month in addition to your regular medical premiums.

Nicotine / Tobacco Surcharge

Staying free of nicotine and tobacco is one of the most important steps you can take to maintain good health. If you enroll in our medical plan and use tobacco/nicotine, you will be required to pay a tobacco surcharge of $75 per month in addition to your regular medical premiums. If you complete the tobacco cessation program through BlueCross BlueShield, you can receive a refund of the surcharge. Contact your benefit administrator for more details.

(See page 12 for info on tobacco cessation)

Pharmacy Benefit Details

Rx Delivery By Mail (Maintenance Drugs)

Why get your Rx delivered by mail? Not only is delivery by mail a safe and secure way to get the medications you take regularly (like medication for asthma or high blood pressure) — you'll probably save money, too.

Want more convenience?
With delivery, you have one less thing to worry about. Your 90-day supplies will arrive at your door from CVS Caremark® Mail Service Pharmacy.

Like to save?
Filling your Rx in 90-day supplies usually comes with savings. Plus, there's no extra cost for shipping.

Looking to stay safe?
Contactless delivery keeps you and your loved ones safe. And our secure, nondescript packaging protects your privacy.

90 Day Retail (Maintenance Drugs)

If you take a maintenance medication on an ongoing basis for a condition like high cholesterol or high blood pressure, you can save on a 90-day supply of your medication by filling it at an approved CVS locations.

Mobile App

We make it easy to keep track of your Rx, check for savings and more from your mobile device.

Our mobile app gives you a secure, simple way to manage your prescription benefits and member information. You'll find easy-to-use tools that help you save time, get organized and stay on your path to better health. Find a nearby pharmacy no matter where you are. Learn about your medication and get information you can trust day or night. Do all this – and much more – at your convenience.

Customer Support

RxBenefits' experienced, high-performing call center team delivers a superior level of service.

Member Services assists you with questions or concerns regarding your pharmacy benefits such as:

- Benefit Details
- Claims Status
- Pharmacy Network
- Coverage Determination/Inquiries
- Mail and Specialty Scripts
- Pharmacy Information

As plan members, you and your dependents can call for questions related to:

- Coverage Questions
- Clinical Programs
- Copay
- Deductible Issues

Contact Info:
Call 800.334.8134 or email
CustomerCare@rxbenefits.com

Hours of Operation:
7:00 AM to 8:00 PM CT
Monday – Friday

Health & Wellness Resources

Telemedicine for All Employees

98point6 offers text-based health care for minor illness through a secure mobile app. It's available at no cost to all employees and to dependents covered by our health plan*. Through this service, you can initiate a virtual visit with a board-certified physician at your convenience. No appointment needed.

Physicians provide text-based primary care, diagnosis and treatment, including ordering prescriptions or lab work. Download the 98point6 app from the App Store or Google Play to get started.

*The cost for telemedicine is subject to change pending changes to the CARES ACT. If you are enrolled in the Supreme medical plan or not currently enrolled in one of the company offered medical plans, your cost may go up to $5.00 per visit.

BlueCross BlueShield Smoking Cessation Program

Staying free of nicotine and tobacco is one of the most important steps you can take to maintain good health. Break your tobacco habit by accessing a smoking cessation program through BlueCross BlueShield at no cost to employees on our health plan! When you commit to quit, you will be connected with the resources you need such as:

- Health coaching to help you meet your goals
- Self-directed courses to guide you
- Personalized advice

For more information call 1-866-498-9806.

Wellness Rewards – Up to $100

American Health Partners cares about your well-being and wants to reward you for being healthy. Employees on our health plan can start earning incentives today by getting a preventive care visit or completing an online Personal Health Assessment (PHA). You can earn one $50 gift card of your choice for each activity, totaling $100 in rewards!

Earn incentives between
January 1 – October 31, 2022.

Follow the instructions below to start earning today:

1. Log in to BlueAccess from BCBST.com/member
2. Select 'Managing Your Health'
3. Choose 'Member Wellness Center' to take your PHA
4. Under the 'Rewards Catalog", click 'Redeem!' to claim your gift cards.

To find out more call 1-844-269-2583 or email help@bcbstrewards.com

TrueLife Care Diabetes Management Program

This program helps individuals diagnosed with diabetes or pre-diabetes make daily behavior and self-care choices that will improve their health. Each participant has access to a RN certified health coach, receives a glucometer with Bluetooth, free test strips, and a blood pressure meter/cuff.

Please call 888-788-4925 for more information.

Savings and Reimbursement Accounts

American Health Partners offers several accounts that enable you to pay for eligible health care and dependent care expenses tax-free. For additional information, open the QR code on the next page.

Health Savings Account

A Health Savings Account (HSA) is a savings account that belongs to you that is paired with the Supreme health plan, which is considered a high-deductible health plan or HDHP. The HSA allows you to make tax-free contributions to a savings account to pay for current and future medical expenses for you and your dependents. Your HSA is offered through Discovery Benefits. Call the Discovery Benefits support line for questions about your spending accounts prior to enrollment at 1-844-561-1337.

Eligibility Details:

- If you are age 55 or older, you can contribute an additional $1,000 per year.
- You cannot have an HSA if you are enrolled in any other health coverage, including Medicare, or if you are claimed as a dependent on someone else's tax return.
- You cannot participate in the Health Care Flexible Spending Account (FSA) if you have an HSA. Your spouse also cannot have a Health Care FSA.

Health Reimbursement Arrangement

A Health Reimbursement Arrangement (HRA) is an account funded by American Health Partners for you to use to pay for qualified health care expenses. Your HRA is paired with the Core health plan, which is considered a high-deductible health plan or HDHP. The HRA is offered through Health Equity.

Qualified Health Care Expenses Include:

- Medical copays will be covered beginning January 1st, 2022
- Prescription medications

Flexible Spending Accounts

A Flexible Spending Account (FSA) helps you pay for health care or dependent care using tax-free dollars. Your FSAs are offered through Discovery Benefits. Call the Discovery Benefits support line for questions about your spending accounts prior to enrollment at 1-844-561-1337.

Please plan your contributions carefully. Any unused money remaining in your account(s) will be forfeited. This is known as the "use it or lose it" rule and it is governed by Internal Revenue Service regulations. Note that FSA elections do not automatically continue from year to year; you must actively enroll each year.

Savings and Reimbursement Accounts

	HSA	HRA	FSA
Does American Health Partners contribute? Amount for full-year 2022	✓ Employee: $500 Employee +1 or Family: $1,000	✓ Employee: $500 Employee +1 or Family: $1,000	✗
Can I contribute my own savings?	✓	✗	✓
What is the maximum I can contribute annually?	✓ Employee: $3,650 Family: $7,300 Those 55 and older can contribute an additional $1,000 annually.	✗	✓ Health Care: $1,200 Dependent Care: $5,000
Will my savings roll over each year?	✓ Unlimited	! 50% of your balance, capped at $500 to be used the following year	✗ Funds do not roll over to the following year
Will I earn interest on my savings?	✓	✗	✗
Are the savings tax-free?	✓	✓	✓
Will I get a debit card?	✓	✓ Employee: $500 Employee +1 or Family: $1,000	✓
Do I keep the money if I leave American Health Partners?	✓	! Option to continue through COBRA	! Option to continue through COBRA
Can I also have a Flexible Spending Account (FSA)?	! Dependent Care FSAs only	✓	N/A

Dental Plans

It's important to have regular dental exams and cleanings so problems are detected before they become painful and expensive. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and is an important part of maintaining your overall health. We offer two dental plan options through Delta Dental of Tennessee.

American Health Partners partially subsidizes your dental premiums!

Plan Provisions	Supreme Plan*	Core Plan
Annual Deductible (Individual/Family)	$50 per person	$50 per person
Calendar Year Maximum	$2,000	$1,000
Diagnostic and Preventive Services (e.g., X-rays, cleanings, exams)	100%, no deductible	100%, no deductible
Basic and Restorative Services (e.g., fillings)	80%, after deductible	80%, after deductible
Major Services (e.g., dentures, crowns, bridges)	50%, after deductible	Not covered
Orthodontia Orthodontia Lifetime Maximum	50%, no deductible $1,500 / person (for children & adults)	Not covered
Dental	**Pay-Period Deductions**	**Pay-Period Deductions**
Employee	$10.57	$ 7.46
Employee + Spouse	$21.62	$15.40
Employee + Children	$22.59	$16.33
Employee + Family	$35.08	$25.20

***WAITING PERIODS APPLY TO THE SUPREME PLAN**

Major Services: 6-month waiting period applies

Orthodontia: 6-month waiting period applies

Vision Plan

The vision plan provides coverage for routine eye exams and pays for all or a portion of the cost of glasses or contact lenses. You can choose any provider; however, you always save money if you see in-network providers. When you use the Humana Insight Network you can go to EyeMed and Humana providers.

Plan Provisions	In-Network	Out-Of-Network
Exam	$10 copay	$30 copay
Frames*	Plan pays up to $150; 20% off balance over $150	$65 copay
Lenses* • Single Vision Lenses • Bifocal Lenses • Trifocal Lenses	 $10 copay $10 copay $10 copay	 Plan pays up to $75 Plan pays up to $40 Play pays up to $60
Medically Necessary Contact Lenses	Plan pays 100%	Plan pays up to $200
Elective Contact Lenses in lieu of frames/lenses**	Plan pays up to $130	Plan pays up to $104
Frequency • Exam • Frames • Lenses • Contact Lenses	 Every 12 months Every 24 months Every 12 months Every 12 months	 Every 12 months Every 24 months Every 12 months Every 12 months

*Only one copay is required when you buy frames and lenses together. Your frames copay applies to frames of your choice, up to $150 retail allowance. You pay the difference for more expensive frames.
**The allowance shown above applies strictly to contact lens materials. For standard contact lens fittings/evaluations, the member will pay no more than a $55 copay. For premium contact lens fittings/evaluations, the member will receive 10% off the retail cost of the visit.

No ID Card Needed

Although you may download an ID card online, in-network providers do not require them. All you need to do in order to access benefits is give your SSN to your provider and tell them you have Humana EyeMed Vision and they can verify benefits and process your claim.

Vision	Pay-Period Deductions (26)
Employee	$3.37
Employee + Spouse	$6.37
Employee + Children	$6.95
Employee + Family	$8.94

Life Insurance and Disability

American Health Partners provides basic life and accidental death and dismemberment (AD&D) insurance for employees and offers voluntary insurance options for employees and their dependents.

Basic Life and AD&D Insurance

American Health Partners provides Basic Life/AD&D coverage at no cost to you through Lincoln Financial. The employee life insurance benefit is $50,000 for full-time employees and $15,000 for part-time and PRN employees (eligibility rules apply). The AD&D benefit pays a lump sum if you lose a limb or die in an accident. The maximum AD&D benefit will be equivalent to your Basic Life benefit. Life and AD&D benefits are reduced to 65% of you coverage amount at age 65 and to 50% at age 70.

Voluntary Life and AD&D Insurance

You may purchase additional life and AD&D coverage for yourself & your dependents at affordable group rates. Rates are based on age & the coverage level chosen.

Voluntary Life and AD&D Insurance

Employee

- Increments of $10,000 up to 4x your base annual salary
- Up to a $400,000 maximum
- Guaranteed issue up to $250,000

Spouse

- Increments of $5,000 (not to exceed 50% of your voluntary life and AD&D coverage)
- Up to a $200,000 maximum
- Guaranteed issue up to $25,000

Children

- Flat $10,000 per child
- Must be added within 31 days of birth

Electing life coverage during open enrollment:
Employees and spouses are allowed to increase up to 5 levels or to the guaranteed issue amount without answering medical questions. Anything above 5 levels or above the guaranteed issue amount will require evidence of insurability. An evidence of insurability will also be required for all increases that have previously surpassed 5 levels or the guaranteed issue amount.

Electing life coverage for new hires:
You may elect coverage of up to 4 times your salary or $400,000 (rounded to the next higher multiple of $1,000); whichever is less, in increments of $10,000. AD&D coverage equals the amount of your elected life insurance amount. Example: If your salary is $35,000 annually you can elect 4 times your salary totaling $140,000 in life insurance coverage.

Disability Insurance

Disability insurance provides income replacement should you become disabled and unable to work due to a non-work-related illness or injury.

Short-term & long-term disability are both subject to the pre-existing exclusion.

Coverage	Benefit
Short-Term Disability	• Benefits begin on the 8th, 15th, or 31st day of not working due to an accident or illness. Pay will begin after the elimination period you choose is satisfied. • Benefits are paid based on an election of coverage in $50 increments up to 60% of your income. Be sure to elect what you would need as a weekly benefit. • Benefits generally continue for up to 11 weeks.
Long-Term Disability	• Benefits begin after 90 days of total disability. • The plan replaces 60% of your earnings, up to $10,000/month and this is a monthly paid benefit. • Benefits are paid until the Social Security Normal Retirement Age.

*Includes earnings at this employer, any other employer, any other work for pay or profit, bonuses and commissions. Limits may apply. Please Note: If you are age 63 or older when your covered disability begins, your benefits duration may differ. See the official plan documents.

Pre-existing Conditions and Benefit Limits

For new enrollees, benefits will not be paid for any disability resulting from a pre-existing condition until the employee has been covered by the plan at their current coverage level for 12 months. Pre-existing condition means a sickness or injury for which an employee has incurred expenses, received medical services including diagnostic measures, took prescribed drugs, or for which a reasonable person would have consulted a physician in the three months prior to the benefit effective date.

Family Medical Leave Act (FMLA)

If you have been with American Health Partners for 12 months, you may be eligible for up to 12 work weeks of unpaid leave per year under the Family and Medical Leave Act (FMLA). FMLA can be used for an illness of your own, family member or newborn, or when other qualified medical needs arise.

Voluntary Plans from Voya

Accident Insurance

Accident insurance provides benefits to help cover the costs associated with unexpected bills due to covered accidents, regardless of any other insurance you have. If you purchase coverage and are hurt in a covered accident, you will receive a cash benefit for covered injuries that you may spend as you like.

Examples of covered injuries:

- Broken bones
- Torn ligaments
- Cuts repaired by stitches
- Eye injuries
- Ruptured discs
- Concussion
- Burns

How to File a Claim

1. Visit Voya.com/claims and click on 'Start A Claim.'
2. Complete the questionnaire to generate a custom claim form package.
3. Download your claim from package then submit completed and signed forms along with supporting documentation.

If you have questions about the claim process, call 1-877-236-7564

Critical Illness Insurance

Critical illness insurance provides cash to help pay for both medical expenses not covered by your medical plan as well as day-to-day expenses that may start to add up — like rent, mortgage, car payments, etc. — while you are ill. With critical illness insurance, if you are diagnosed with a covered illness, you get a lump-sum cash benefit, even if you receive other insurance benefits.

Examples of covered illnesses:

- Heart attack
- Major organ failure
- End-stage renal (kidney) failure
- Coronary artery bypass graft surgery
- Stroke
- Cancer

Hospital Indemnity Insurance

Hospital indemnity insurance provides a fixed lump-sum payment that can help cover hospital expenses not covered by insurance, or to pay for expenses while you, your spouse and/or dependents are in the hospital.

- Hospital: The benefit payment is $200, up to 30 days per confinement.
- Critical care unit: The benefit payment is $400, up to 15 days per confinement.
- Rehabilitation facility: The benefit payment is $100, up to 30 days per confinement.
- Initial confinement benefit: This provides an additional payment of $2,000 after confinement in a hospital, critical care unit, and or rehabilitation facility.

Retirement Plan

To enjoy a financially secure retirement, most Americans need personal savings to supplement Social Security. Participating in a company-provided retirement account is a great way to help you get into the savings habit. Payroll deductions make it easy to pay yourself first. Over time, even small contributions can add up to a significant nest egg. Get started today!

401(K) Retirement Savings Plan

The 401(k) Profit Sharing Plan is a smart, tax-effective way to save for your future. The 401(k) plan is administered by Fidelity Investments. The 401(k) plan offers a variety of investment options, each with a different level of risk and returns potential. You may invest your contributions in any or all of the investment funds. You can change your fund choices for future contributions and/ or move your existing balances from one fund to another by calling Fidelity at 1-800-835-5097, or visiting www.401k.com.

You are eligible to join the 401(k) plan when you reach age 18 and complete 60 consecutive days of service. You may enroll at any time by going to NetBenefits at www.401k.com or by calling 1-800-835-5097. The effective date of enrollment will be determined according to eligibility. Please refer to the plan documents for more details.

You can contribute as little as 1% or as much as 100% of your pay, up to 2021 IRS limits, on a pre-tax basis. If you are age 50 or older during 2020 and reach the 2021 IRS contribution limits, you may make additional "catch-up contributions." You are always 100% vested in your own contributions.

Although the 401(k) is designed to help you accumulate money for the future, you do have access to some of your funds while you're still working through special withdrawals. Keep in mind if you withdraw your money before age 59.5 you may have to pay taxes and penalties. See your Fidelity materials for more information about withdrawals and distributions. If you have an existing qualified retirement plan, 401(k), 403(b), 457 or an IRA account with a prior employer, you may roll over (or transfer) funds into your 401(k) account once you meet eligibility requirements.

American Health Partners currently matches 100% of the first 2% of your salary you contribute to the 401(k) plan. The match has a 6-year vesting schedule, you earn 20% vest after year two and earn an additional 20% each year after. Once you complete 6 years of active service you will become 100% vested in your employer match.

If you earn $50,000 per year, a contribution of 2% of your annual salary = $1,000. Under our new plan, the company will match it, making your total annual contribution $2,000. This is a great way to quickly build up your retirement account. *You can contribute a higher percentage of your salary to the 401K but amounts over 2% will not be matched. *The match discretionary and subject to change based on company performance.

Employee Assistance Program (EAP)

Provided by Lincoln Financial, our EAP program offers 24/7 support, resources, and information.

Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Employees and their family members are eligible for up to five FREE sessions per incident per year.

Work-Life Solutions

Our specialists provide qualified referrals and resources for tasks like finding child or eldercare, planning events, moving or hiring home repair contractors.

Legal Guidance

Talk to our attorneys for practical assistance with your most pressing legal issues, including divorce, adoption, family law, wills, trusts and more.

Need representation? Get a free 30-minute consultation and a 25% reduction in fees.

Financial Resources

Our financial experts can assist with a wide range of issues including retirement, taxes, mortgages, budgeting and more. For additional guidance, we can refer you to a local financial professional and arrange to reimburse you for the cost of an initial one-hour in-person consult.

Help for New Parents

Parent Guidance supports you through the process of becoming a biological or adoptive parent, including:

- Preparing for the baby emotionally and financially
- Finding child care
- Planning for back-to-work and other issues

Free Online Will Preparation

Estate Guidance lets you quickly and easily create a will online.

Get Help or Resources Anytime

Call: 1-888-628-4824

Online: www.guidanceresources.com

Username: LFGsupport

Password: LFGsupport1

Glossary

Brand preferred drugs
- A drug with a patent and trademark name that is considered "preferred" because it is appropriate to use for medical purposes and is usually less expensive than other brand-name options.

Brand non-preferred drugs
- A drug with a patent and trademark name. This type of drug is "not preferred" and is usually more expensive than alternative generic and brand preferred drugs.

Calendar Year Maximum
- The maximum benefit amount paid each year for each family member enrolled in the medical and dental plan.

Coinsurance
- The sharing of cost between you and the plan. For example, 80 percent coinsurance means the plan covers 80 percent of the cost of service after a deductible is met. You will be responsible for the remaining 20 percent of the cost.

Copay
- A fixed amount (for example $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
- The amount you have to pay for covered services before your health plan begins to pay.

Elimination Period
- The time period between the beginning of an injury or illness and receiving benefit payments from the insurer.

Flexible Spending Account (FSA)
- FSAs allow you to pay for eligible health care and dependent care expenses using tax-free dollars. The money in the account is subject to the "use it or lose it" rule which means you must spend the money in the account before the end of the plan year.

Generic drugs
- A drug that offers equivalent uses, doses, strength, quality and performance as a brand-name drug, but is not trademarked.

Health Savings Account (HSA)
- An HSA is a personal health care account for those enrolled in a High Deductible Health Plan (HDHP). You may use your HSA to pay for qualified medical expenses such as doctor's office visits, hospital care, prescription drugs, dental care, and vision care. You can use the money in your HSA to pay for qualified medical expenses for you, your spouse, and dependents, even if they are not covered by the HDHP.

Health Reimbursement Arrangement (HRA)
- A fund you can use to help pay for eligible medical costs not covered by your medical plan. Funds are contributed to the HRA by the American Health Partners.

High Deductible Health Plan (HDHP)
- A qualified High Deductible Health Plan (HDHP) is defined by the Internal Revenue Service (IRS) as a plan with a minimum annual deductible and a maximum out-of-pocket limit. These minimums and maximums are determined annually and are subject to change.

In-network
- A designated list of health care providers (doctors, dentists, etc.) with whom the health insurance provider has negotiated special rates. Using in-network providers lowers the cost of services for you and American Health Partners.

Inpatient
- Services provided to an individual during an overnight hospital stay.

Mail-Order Pharmacy
- Mail-order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail-order pharmacies offer the convenience of shipping directly to your door.

Out-of-network
- Health care providers that are not in the plan's network and who have not negotiated discounted rates. The cost of services provided by out-of-network providers is much higher for you and American Health Partners. Additional deductibles and higher coinsurance will apply.

Out-of-pocket maximum
- The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year. Your annual deductible is included in your out-of-pocket maximum.

Outpatient
- Services provided to an individual at a hospital facility without an overnight hospital stay.

Primary Care Provider (PCP)
- A doctor (generally a family practitioner, internist or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions.

Reasonable & Customary Charges (R&C)
- Prevailing market rates for services provided by health care professionals within a certain area for certain procedures. Reasonable and customary rates may apply to out-of-network charges.

Specialist
- A provider who has specialized training in a particular branch of medicine (e.g., a surgeon, cardiologist or neurologist).

Specialty drugs
- A drug that requires special handling, administration or monitoring. Most can only be filled by a specialty pharmacy and have additional required approvals.

Important Required Notices

HIPAA SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact American Health Partners Benefits Department.

HIPAA PRIVACY NOTICE - PROTECTING YOUR HEALTH INFORMATION PRIVACY RIGHTS

THIS NOTICE DESCRIBES HOW YOU MAY OBTAIN A COPY OF THE PLAN'S NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES THE WAYS THAT THE PLAN USES AND DISCLOSES YOUR PROTECTED HEALTH INFORMATION.

American Health Partners insurance plan (the "Plan") provides health benefits to eligible employees of American Health Partners (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information. To receive a copy of the Plan's Notice of Privacy Practices you should contact American Health Partners Benefits Department.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTIFICATION

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 states 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 the plan. Therefore, your deductible and coinsurance apply as according to your employer-sponsored medical insurance plan.

If you would like more information on WHCRA benefits, call your plan administrator at 1-800-826-9781.

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

IMPORTANT NOTICE FROM AMERICAN HEALTH PARTNERS 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 American Health Partners 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. American Health Partners has determined that the prescription drug coverage offered by the BCBST 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 American Health Partners coverage may be affected. Please see plan SPD for more information about your prescription drug coverage provisions/options. If you do decide to join a Medicare drug plan and drop your current employer-sponsored coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with American Health Partners 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 the person listed below for further information. 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 American Health Partners. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 10/13/20
Name of Entity/Sender: American Health Partners
Contact Position/Office: Andrew Sims, Senior Benefit Administrator
Address: PO Box 682669, Franklin, TN 37068
Phone Number: (731) 847-1441

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility.

ALABAMA – Medicaid

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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

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

ALASKA – Medicaid

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

FLORIDA – Medicaid

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

ARKANSAS – Medicaid

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

GEORGIA – Medicaid

Website:
https://medicaid.georgia.gov/healthinsurancepremium-payment-program-hipp
Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid

Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 916-440-5676

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

MONTANA – Medicaid

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

KANSAS – Medicaid

Website:
http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

LOUISIANA – Medicaid

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

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/childrenand-families/health-care/health-care-programs/programsand-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

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

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

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

PENNSYLVANIA – Medicaid

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

NEW HAMPSHIRE – Medicaid

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

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

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

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP UTAH – Medicaid

UTAH – Medicaid and CHIP

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

VERMONT– Medicaid

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

VIRGINIA – Medicaid and CHIP

Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

RHODE ISLAND – Medicaid and CHIP	WASHINGTON – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/ badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/ programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

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

AMERICAN
HEALTH PARTNERS

Our Mission

Our mission is to enhance the well-being of our patients and residents by providing compassionate, high-quality healthcare and outstanding service that consistently exceeds expectations.

Our Values

Respect
Integrity
Teamwork
Excellence
Compassion
Professionalism

Our Vision

To model a culture of excellence and community leadership that positions us as a premier healthcare provider and preferred employer in every market we serve.

About this Guide

This benefit summary provides selected highlights of the American Health Partners benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. American Health Partners reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.