Benefit Summary for the Employees of

Advantage Home Health Care
Field Staff (Class II)

Effective Date:

January 1, 2022

This memorandum has been prepared to help you review the key factors that are associated with our benefit plans. This memorandum does not provide all of the contractual provisions, limitations or exclusions included in our policies and should be considered only as a summary of our current benefits. If any differences exist between this summary and the official contracts, the contracts shall prevail.

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Procedure:
If you WANT Health Insurance:

1) Complete in full the application sections that you are applying for Health Insurance (Anthem or Reliance Standard plan(s)
2) Complete in full and sign the Premium Savings Plan Participation if you want to participate. Return the application, the Payroll Election Form, and the participation form to the Muncie office for processing.

If you DO NOT WANT Health Insurance:

1) Complete in full the Payroll Election Form marking waive coverage and return your form to Muncie.

If you WANT **Voluntary** Dental/Vision Insurance:

1) Complete in full the Guardian Dental/Vision application, the premium savings plan participation form and complete the Payroll Election form and return with application to Muncie.

If you DO NOT WANT Dental/Vision insurance:

1) Please check waiver section, sign and date at the bottom of the Dental/Vision application(s) and return with the Payroll Election form to Muncie for processing.

Your Benefits Plan

Advantage Home Health Care is pleased to offer a comprehensive benefits program to our valued employees.

In the following pages, you will learn more about the benefits Advantage Home Health Care offers. You will also see how choosing the right combination of benefits can help protect you and your family's health and financial future.

Eligibility

Effective today, eligibility in the Group Medical Plan of Advantage will be open to those individuals that are designated as, perform duties of, and are recognized by payroll as Class II "Field Staff Employees."

Advantage Office Group Medical Plan requirements for eligibility:

- Has worked as a field staff employee averaging 30 hours per week during the measurement period.
- Meets new hire eligibility criteria.

When Can you Enroll?

You can sign up for Benefits at any of the following times:

- After completing initial eligibility period:
    - Enrollment for full-time eligible new hires is on the first day of the month following a 60-day waiting period.
- During the annual open enrollment period
- Within 30 days of a qualified family-status change

If you do not enroll at the above times, you must wait for the next annual open enrollment period or .

All terminations from the group plan are the last day of the month, regardless of the circumstances and will be paid by the employee accordingly.

Making Changes

Generally, you can only change your benefit elections during the annual benefits enrollment period. However, you may be able to change some of your benefit elections upon the occurrence of certain change in status events, provided you properly notify your Employer and another change is permitted under the plan terms. Examples of these change in status events may include:

- Your marriage
- Your divorce or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her benefits
- Change in your work status that affects your benefits
- Change in residence or work site that affects your eligibility for coverage
- Change in your child's eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

If you have a family status change, you must timely notify (within 30 days) your HR Manager and complete the necessary forms. For more information refer to your benefits booklet.

MEDICAL

Advantage Home Health Care offers the choice between the HSA plan through Anthem or the Reliance Standard Essential Plan (Minimum Essential Coverage Plan). The Basic Advantage Indemnity offering is also available in 2022.

If you and your eligible dependents are enrolled in one of our sponsored medical plans, you have "minimum essential coverage." For more information, visit Healthcare.gov. The company has made the employee cost of the single rate of the Anthem HSA plan no more than 9.61% of an employee's annual earnings. The 9.61% is required by the Affordable Care Act.

Advantage will pay 100% of the employee cost for the Essential Plan through Reliance Standard. These medical plans and the contribution schedule may change at renewal (annually in January) or with a 30-day notice.

Effective January 1, 2022, all Advantage employees who averaged 30 hours or more weekly in the mandated "look Back" period from 11/1/20 – 11/1/21 will be offered a choice of an "Essential Plan", which provides preventive health care services. The employee will also have the option of purchasing additional benefit services with the Basic Advantage Total Plan or electing the Anthem HSA Full Comprehensive Coverage Plan. All qualified employees must complete the Advantage Class II Payroll Enrollment form indicating Election of the Coverage or the Waiving of Coverage.

If you enroll in the Essential Plan:

- There is no cost for employee only coverage, Advantage is paying 100% of the single rate.
- Accepting this plan disqualifies the employee for any exchange subsidy.
- The Essential Plan is NOT a comprehensive major medical plan.

If you enroll in the Basic Advantage Total Plan:

- The Basic Advantage coverage provides additional daily hospital, office visits and emergency room coverage. This is a limited liability plan.
- The Basic Advantage Plan is NOT a comprehensive medical plan.

If you enroll in the Anthem HSA Plan:

- The HSA plan satisfied the individual mandate for the employee and is affordable and has an actuarial plan value of 60%.
- This plan IS a comprehensive major medical coverage.

MEDICAL

	*Anthem HSA Plan	Reliance Standard Essential Plan *(Covers only preventive)*	Reliance Standard Basic Advantage Plan
Annual Deductible/Coinsurance			
Per Person / Per Family *Deductible applies unless otherwise noted*	$6,200 / $12,400	$0 / $0	$0 / $0
Coinsurance (In/Out)	100% / 70%	0%	Schedule Plan
Annual Out-of-Pocket Maximum			
Per Person / Per Family	$6,350 / $12,700	N/A	N/A
Professional Services			
Physician Office Visit	Ded / Coins	$0	Schedule Plan
Specialist Visit	Ded / Coins	$0	Schedule Plan
Hospital/Facility			
Emergency Room	Ded / Coins	N/A	Schedule Plan
Urgent Care	Ded / Coins	N/A	Schedule Plan
Pharmacy Benefit			
Deductible (Per Individual)	Combined with medical ded.	N/A	N/A
Pharmacy Benefit	Ded / 100%	N/A	Schedule Plan
Employee Contributions (Weekly)			
Employee	**$31.26**	**$0.00**	**$23.19**
Employee + Spouse	**$208.42**	**$2.29**	**$48.93**
Employee + Child	**$169.35**	**$4.57**	**$34.78**
Employee + Children	**$169.35**	**$9.59**	**$58.67**
Employee + Family	**$341.29**	**$11.86**	**$77.91**

***Embedded Deductible:** The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum.

Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO HSA

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$6,200 person / $12,400 family	$18,600 person / $37,200 family
Out-of-Pocket Limit	$6,350 person / $12,700 family	$22,225 person / $44,450 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Mental Health and Substance Abuse care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	0% coinsurance after deductible is met	

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	0% coinsurance after deductible is met	
Specialist Care	0% coinsurance after deductible is met	
Visits in an Office		
Primary Care (PCP)	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist Care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Retail Health Clinic	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Surgery	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Freestanding Lab/Reference Lab	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Facility Visit		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and Other Services		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 120 visits per benefit period. Limits are combined for all home health services.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 40 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.*		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Pulmonary rehabilitation *Coverage is limited to 20 visits per benefit period.*		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	0% coinsurance after deductible is met	Covered as In-Network
Durable Medical Equipment	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the **Essential** drug list appear below. Drugs not included on the Essential drug list will not be covered. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*		

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
Home Delivery Pharmacy *Maintenance medication are available through IngenioRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	0% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $42

Notes:

- Dependent age: to end of the month in which the child attains age 26.

- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

RSL BasicCare® Program

Draw on the protection provided by your benefits.

Important **protection** made available by your employer for **you** and **your dependents** through easy payroll deduction. Your acceptance is **guaranteed**…you cannot be turned down, as long as you sign up during your open enrollment period.

The BasicAdvantage Total Plan described in this brochure is not a substitute for comprehensive health insurance and does not qualify as minimum essential health coverage under the Affordable Care Act. It is intended to provide you, and your covered dependents, with basic insurance coverage.

The Essential Plan described in this brochure is not a substitute for comprehensive health insurance; however, it is intended to provide minimum essential coverage under the Affordable Care Act.

BasicAdvantage Total Plan

- **Visit any doctor or hospital.**
- **Enrolled dependents receive the same coverage as you.**
- **No pre-existing conditions exclusions or limitations.**
- **BasicAdvantage Total Plan enrollees also receive these added non–insurance benefits:**
  - ✓ **Prescription Drug Card offering discounts at participating pharmacies.**
  - ✓ **VSP Access Plan membership offering discounts on eye exams and prescription glasses at network doctors.**
  - ✓ **On Call Travel Assistance.**
  - ✓ **24-Hour Telemedicine Services. Services are available after a$30 per-consultation fee has been paid. A credit card is required.**
  - ✓ **Teletherapy Services. Services are available after a $69 per consultation fee has been paid. A credit card is required.**

This is a supplemental plan that is not intended to provide the minimum essential coverage required by the Affordable Care Act ("ACA"). You may be subject to a federal tax penalty unless you have another plan (such as major medical coverage) that provides minimum essential coverage in accordance with the ACA. The benefits provided by this plan cannot be coordinated with the benefits provided by other coverage. Please review the benefits provided by this plan carefully to avoid duplication of coverage.

INPATIENT HOSPITAL BENEFITS	
Hospital Room & Board Benefits:	
Daily Benefit for the Treatment of Mental & Nervous Conditions Number of Daily Benefits Per Coverage Year	$100 per day 25
Daily Benefit for the Treatment of Alcohol & Substance Abuse Number of Daily Benefits Per Coverage Year	$100 per day 25
Daily Benefit for the Treatment of All Other Covered Conditions Number of Daily Benefits Per Coverage Year	$500 per day 90
Hospital Admission Benefit For Specified Conditions:	
Daily Benefit for Cancer (Malignant Neoplasm) Number of Daily Benefits Per Coverage Year	$4,000 per day 1
Daily Benefit for Heart Attack (Myocardial Infarction) OR Daily Benefit for Heart Disease[1] Number of Daily Benefits Per Coverage Year	$3,000 per day $1,500 per day 1
Daily Benefit for Accidental Injury Number of Daily Benefits Per Coverage Year	$2,000 per day 1
Daily Benefit for Stroke (Cerebrovascular Accident - CVA) Number of Daily Benefits Per Coverage Year	$1,500 per day 1
Daily Benefit for Childbirth Number of Daily Benefits Per Coverage Year	$1,500 per day 1
Surgery / Anesthesia Benefits:	
Daily Benefit for Inpatient Surgery Number of Daily Benefits Per Coverage Year Daily Benefit for Anesthesia administered during Inpatient Surgery Number of Daily Benefits Per Coverage Year	$500 per day 3 $100 per day 3
*The Hospital Admission Benefit is payable for either Heart Attack or Heart Disease during a coverage year, but not both.	
OUTPATIENT BENEFITS	
Doctor Visit Benefits:	
Daily Benefit for a New Patient Office Visit Number of Daily Benefits Per Coverage Year	$75 per day 1
Daily Benefit for an Established Patient Office Visit Number of Daily Benefits Per Coverage Year	$70 per day 5
Daily Benefit for a Consultation Office Visit Number of Daily Benefits Per Coverage Year	$100 per day 1
Daily Benefit for an Emergency Room Doctor Visit Number of Daily Benefits Per Coverage Year	$75 per day 1
Radiology Benefits:	
Daily Benefit for a Magnetic Resonance Imaging (MRI) Number of Daily Benefits Per Coverage Year	$150 per day 1
Daily Benefit for a Computerized Tomography (CT) Scan Number of Daily Benefits Per Coverage Year	$75 per day 1
Daily Benefit for all other Radiology Services Number of Daily Benefits Per Coverage Year	$40 per day 6
Pathology Benefits:	
Daily Benefit for all Pathology Services Number of Daily Benefits Per Coverage Year	$40 per day 6
Urgent Care Benefits:	
Daily Benefit for an Urgent Care Facility Visit Number of Daily Benefits Per Coverage Year	$50 per day 1
Emergency Room Visit Benefits:	
Daily Benefit for the treatment of an Accidental Injury Number of Daily Benefits Per Coverage Year	$500 per day 2
Daily Benefit for the treatment of a Sickness Number of Daily Benefits Per Coverage Year	$50 per day 3
Surgery / Anesthesia Benefits:	
Daily Benefit for Outpatient Surgery Number of Daily Benefits Per Coverage Year Daily Benefit for Anesthesia administered during Outpatient Surgery Number of Daily Benefits Per Coverage Year	$250 per day 3 $50 per day 3
Prescription Drug Benefits:	
Daily Benefit per Generic Drug Prescription (filled or refilled) Number of Daily Benefits Per Coverage Year	$25 per day 18

Essential Plan

The Essential Plan is intended to provide minimum essential coverage under the Affordable Care Act. It provides you and your enrolled dependents with **preventive care only** and helps you meet the requirements of the Affordable Care Act.

General Information - (Preventive Care Only)

Co-pays: ..... $0 ($50 co-pay for brand name contraceptives)
Deductible: $0
Benefit percentage paid by plan: ..... 100% of covered expenses (Covered expenses are the lesser of the actual or usual & customary charges)
Plan Annual Maximum: ..... Unlimited
Plan Lifetime Maximum: ..... Unlimited

Summary of Covered Services

Below are a few of the common preventive health services the plan covers. The plan may also cover a service that is not listed, as long as the service is a covered preventive health service as described in the policy.

Covered Services for Children & Adolescents

Well Child Exams – physical exams & vision acuity
Assessments – developmental & behavioral
Immunizations – diphtheria, tetanus and pertussis
Screenings – hearing loss, lead poisoning and depression

Covered Services for Adults

Annual Preventive Care Visits – physicals & history
Immunizations – hepatitis & influenza
General Health Screenings – blood pressure, cholesterol & diabetes
Prescription contraceptives for women

Questions & Answers

Who can be covered? In addition to covering yourself, dependent coverage is offered in the BasicAdvantage Total and Essential Plans. Your eligible dependents are your lawful spouse and your children through age 25, or through any age if disabled and unable to earn a living.

When does my coverage begin and end? Your coverage begins on the first day of the month after you enroll, provided you are eligible and the required premium has been paid. Coverage for all of your benefits under the program will end if (1) the required premiums are not paid; (2) you are no longer an eligible employee; (3) the insurance policies terminate; or (4) you enter an Armed Service on full-time active duty.

When does dependent coverage begin and end? Your dependents' coverage begins when yours does, unless you enroll them later. If you do, their coverage will become effective after the enrollment is approved and the premiums have been paid. Their coverage ends when yours does or when the dependent is no longer eligible.

Do I have to use certain doctors or hospitals? No. You are free to use any licensed doctor or any certified hospital. However, under the BasicAdvantage Total Plan, you can save money by using a network provider. Rest, nursing or old age homes, or facilities for the treatment of alcoholism, drug addiction or mental disorders are not hospitals.

How does the BasicAdvantage Total Plan's Hospital Admission Benefit work? It pays a single daily benefit when you are admitted as an inpatient to the hospital for treatment of any of the conditions shown. The daily benefit amount varies by condition and is payable based on the first diagnosis code listed on the claim form for the hospital admission.

When will I receive ID cards and full coverage information? You will receive a Summary Plan Description after you enroll. ID cards will be included.

Does the BasicAdvantage Total Plan cover maternity? Yes. Maternity care is covered.

Are visits to a chiropractor covered under the BasicAdvantage Total Plan? Yes, chiropractic office visits are covered; however, spinal adjustments and manipulations, or modalities are not covered.

Exclusions & Limitations

The following is just a summary. Please see your Summary Plan Description (SPD) for a more complete description of these items.

What is not covered under the BasicAdvantage Total Plan…

- outpatient treatment of mental or nervous conditions;
- outpatient treatment of alcoholism, or substance abuse;
- intentionally self-inflicted injuries, suicide or attempted suicide while sane or insane;
- acts of declared or undeclared war;
- the covered person's commission of a felony;
- work-related injury or sickness;
- normal health checkups;
- eye examinations for glasses, any kind of eye glasses, or prescriptions therefore;
- hearing examinations or hearing aids;
- brand name drugs and drugs not requiring a prescription;
- dental care or treatment except covered events rendered in connection with the care of sound, natural teeth and gums required on account of an accidental injury that happens while covered, and rendered within 6 months of the accident;
- reading or interpreting the results of any diagnostic pathology or radiology tests;
- cosmetic surgery, except covered events rendered in connection with cosmetic surgery needed for breast reconstruction following a mastectomy or an accident that happens while covered. The surgery needed for an accident must be performed within 90 days of the accident;
- treatment rendered while outside the United States of America; and
- services rendered by an immediate family member or provided by your employer.

What is not covered under the Essential Plan…

- injury or self-inflicted bodily harm;
- sickness or disease of any kind;
- acts of declared or undeclared war;
- the covered person's commission of a felony;
- charges in excess of usual, customary & reasonable charges;
- preventive health services not meeting the requirements of the Affordable Care Act;
- dental care, treatment or supplies, except those specifically included as a covered preventive health service for a child;
- laboratory, radiology, or cardiovascular tests performed for the diagnosis or treatment of sickness, disease or injury; and
- preventive health services rendered by an immediate family member or provided by your employer.

The BasicAdvantage Total Plan and Essential Plan are underwritten by Reliance Standard Life Insurance Company, Philadelphia, Pennsylvania under group policy form series: LRS-9497-0613, et al and LRS-9499-0913, et al, or LRS-9167-1103, et al; respectively.

Refer to the accompanying materials for information on premiums.

Every effort has been made to ensure the accuracy of this enrollment brochure. The information described applies to the residents of most states, however state laws do vary. The laws of your state may affect this benefit program, but these differences generally do not reduce your benefits. This brochure is not a legal document. The contractual terms and conditions of coverage are set forth in the group policies. In the event of a discrepancy, the policies would be the determining factor. Insurance products are provided through Reliance Standard Life Insurance Company, which is licensed in all states (except New York), the District of Columbia, Puerto Rico, & the U.S. Virgin Islands. Reliance Standard Life Insurance Company reserves the right to change the premiums it charges for its plans.

VSP Access Plan discounts from Vision Service Plan. Telemedicine and Teletherapy from Broadreach Medical Resources, Inc. On Call Travel Assistance from On Call International. The suppliers of these services are not affiliated with Reliance Standard Life Insurance Company, which is not responsible for the content of the services and cannot be held liable for any services provided or not provided by these suppliers.

VOLUNTARY DENTAL INSURANCE

Benefits eligible employees and their dependents may enroll in the dental benefits through Guardian. The employee is responsible for the full cost of this coverage.

	Guardian
Benefit Maximum	
Yearly Benefit Maximum	$1,500
Annual Deductible	
Per Person / Per Family	$100 / 3x individual deductible
Deductible waived for Preventive?	Yes
Dental Services	
Preventive & Diagnostic Care	100%
Basic Restorative Care	80%
Endodontic Treatment	80%
Periodontics Treatment	50%
Major Restorative Care	50%
Implants	50%
Orthodontia	
Benefits	50%
Lifetime Orthodontia Maximum	$1,000
Employee Contributions (Weekly)	
Employee	$10.11
Employee + Spouse	$21.64
Employee + Child(ren)	$28.37
Employee + Family	$39.32

VOLUNTARY VISION INSURANCE

Vison benefits are available for you and your eligible dependents through Guardian. The employee is responsible for the full cost of coverage.

	Guardian
Plan Copays	
Routine Eye Exam	$10
Hardware	$25
Benefit Frequency	
Exam / Lenses / Frames / Contacts (months)	12 / 12 / 24 / 12
Benefit Details	
Lenses (Single Vision)	100%
Contact Lenses* (Elective)	$130
Frames	$130
Employee Contributions (Weekly)	
Employee	$2.28
Employee + Spouse	$3.84
Employee + Child(ren)	$3.91
Employee + Family	$6.19

Guardian®

Your dental coverage

PPO plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	**PPO**	
Your Network is	DentalGuard Preferred	
Your Weekly premium	**$10.11**	
You and Spouse	$21.64	
You and Child(ren)	$28.37	
You, Spouse and Child(ren)	$39.32	
Lifetime deductible	*In-Network*	*Out-of-Network*
Individual	$100	$100
Family limit	3 per family	
Waived for	Preventive	Preventive
Charges covered for you (co-insurance)	*In-Network*	*Out-of-Network*
Preventive Care	100%	100%
Basic Care	80%	80%
Major Care	50%	50%
Orthodontia	50%	50%
Annual Maximum Benefit	$1500	$1500
Maximum Rollover	Yes	
Rollover Threshold	$700	
Rollover Amount	$350	
Rollover In-network Amount	$500	
Rollover Account Limit	$1250	
Lifetime Orthodontia Maximum	$1000	
Dependent Age Limits	26	

Guardian®

Your dental coverage

A Sample of Services Covered by Your Plan:

		PPO *Plan pays (on average)*	
		In-network	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	100%	100%
	Frequency:	Once Every 6 Months	
	Fluoride Treatments	100%	100%
	Limits:	Under Age 19	
	Oral Exams	100%	100%
	Periodontal Maintenance	100%	100%
	Frequency:	Once Every 3 Months	
	Sealants (per tooth)	100%	100%
	X-rays	100%	100%
Basic Care	Anesthesia*	80%	80%
	Fillings‡	80%	80%
	Simple Extractions	80%	80%
	Surgical Extractions	80%	80%
Major Care	Bridges and Dentures	50%	50%
	Inlays, Onlays, Veneers**	50%	50%
	Perio Surgery	50%	50%
	Repair & Maintenance of Crowns, Bridges & Dentures	50%	50%
	Root Canal	50%	50%
	Scaling & Root Planing (per quadrant)	50%	50%
	Single Crowns	50%	50%
Orthodontia	Orthodontia	50%	50%
	Limits:	Child(ren)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

Guardian

Your dental coverage

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date..

Find A Dentist:

Visit www.GuardianAnytime.com
Click on "Find A Provider"; You will need to know your plan, which can be found on the first page of your dental benefit summary.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00469257

Please call the Guardian Helpline if you need to use your benefits within 30 days of plan effective date. Please note, self-serve options over the phone or online at Guardian Anytime are not available until the case is fully implemented, please wait to speak to a live agent when calling the Guardian Helpline.

EXCLUSIONS AND LIMITATIONS

Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred Network PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DG2000 et al. **PPO and or Indemnity Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000

Guardian®

Watch our video
How vision insurance can help you see clearly as you get older.

Vision insurance

Vision insurance helps protect the health of your eyes by providing coverage for benefits that often aren't covered by regular medical insurance.

Protecting your eyesight means allowing for routine visits to the optometrist for eye exams, as well as coverage for glasses and contacts. Make sure your eyes remain in great shape at any age – no matter how much time you spend staring at digital screens.

Who is it for?

Even if you have perfect eyesight, it's important to have regular eye exams to make sure you're still seeing clearly. Most of us may eventually need vision correction, which is why we offer vision insurance to cover some of the costs.

What does it cover?

Vision insurance covers benefits not typically included in medical insurance plans. It covers things like routine eye exams, allowances towards the purchase of eyeglasses and contact lenses, as well as discounts on corrective Lasik surgery.

Why should I consider it?

Regular eye exams can detect more than failing eyesight, they can also pick up diseases like glaucoma and diabetes. Vision problems are one of the most prevalent disabilities in the United States, making vision insurance especially useful for anyone who regularly needs to purchase eyeglasses or contacts, or anyone who simply wants to help protect their eyesight and general health.

You will receive these benefits if you meet the conditions listed in the policy.

20/20 coverage

David notices that his vision is deteriorating. He goes in for an eye exam, and is diagnosed with myopia, which means he needs glasses.

Average cost of vision exam: **$171**

Average cost of frames and lenses: **$350**

Total cost: **$521**

With a Vision policy from Guardian, David pays just **$10** for his eye exam. After **$25** in copay, his lenses are fully covered, and he pays **$96** for his frames.

David's total out-of-pocket expense is **$131**, saving him **$390**.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

ADVANTAGE HOME HEALTH CARE
ALL ELIGIBLE EMPLOYEES
2020-104313 (07/22)

Your benefits as of 12/16/2020
Group number: 00469257

Guardian®

Your vision coverage

Option 1: Significant out-of-pocket savings available with your **Full Feature** plan by visiting one of VSP's network locations.

Your Vision Plan	**Full Feature**	
Your Network is	VSP Choice Network	
Your Weekly premium	**$ 2.28**	
You and Spouse	$ 3.84	
You and Child(ren)	$ 3.91	
You, Spouse and Child(ren)	$ 6.19	
Copay		
Exams Copay	$ 10	
Materials Copay *(waived for elective contact lenses)*	$ 25	
Sample of Covered Services	*You pay (after copay if applicable):*	
	In-network	*Out-of-network*
Eye Exams	$0	Amount over $39
Single Vision Lenses	$0	Amount over $23
Lined Bifocal Lenses	$0	Amount over $37
Lined Trifocal Lenses	$0	Amount over $49
Lenticular Lenses	$0	Amount over $64
Frames	80% of amount over $130[1]	Amount over $46
Contact Lenses *(Elective)*	Amount over $130	Amount over $100
Contact Lenses *(Medically Necessary)*	$0	Amount over $210
Contact Lenses *(Evaluation and fitting)*	15% off UCR	No discounts
Cosmetic Extras	Avg. 20-25% off retail price	No discounts
Glasses *(Additional pair of frames and lenses)*	20% off retail price**	No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price	No discounts
Service Frequencies		
Exams	Every calendar year	
Lenses *(for glasses or contact lenses)*‡‡	Every calendar year	
Frames	Every two calendar years‡‡‡	
Network discounts *(glasses and contact lens professional service)*	Limitless within 12 months of exam.	
Dependent Age Limits	26	
	Visit www.GuardianAnytime.com and click on "Find a Provider"	

VSP

- ‡‡Benefit includes coverage for glasses or contact lenses, not both.
- ** For the discount to apply your purchase must be made within 12 months of the eye exam.
- Charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use. The only exception would be if a member purchases contact lenses from an out of network provider, members can use the balance towards additional contact lenses within the same benefit period.

Your vision coverage

- [1]Extra $20 on select brands
- Members can use their in network benefits on line at Eyeconic.com.
- ‡‡‡.*The VSP system considers contact lenses to be the equivalent of a full pair of eyeglasses (lenses and frames) so while the member can obtain contact lenses one year and standard eyeglass lenses the next year, the frames benefit would not be available until 24 months or two calendar years, depending on the plan design, after the date the member obtained the contact lenses.*

EXCLUSIONS AND LIMITATIONS

Important Information: This policy provides vision care limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Coverage is limited to those charges that are necessary for a routine vision examination. Co-pays apply. The plan does not pay for: orthoptics or vision training and any associated supplemental testing; medical or surgical treatment of the eye; and eye examination or corrective eyewear required by an employer as a condition of employment; replacement of lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available or a warranty exists). The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, tinted lenses, progressive multifocal lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses; U-V protected lenses and optional cosmetic processes.

The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract #GP-1-VSN-96-VIS et al.

Laser Correction Surgery:

Discounts on average of 10-20% off usual and customary charge or 5% off promotional price for vision laser Surgery. Members out-of-pocket costs are limited to $1,800 per eye for LASIK or $1,500 per eye for PRK or $2300 per eye for Custom LASIK, Custom PRK, or Bladeless LASIK.

Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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. Therefore, the following deductibles and coinsurance apply:
HSA Plan: Deductible In-Network $6,200/$12,400, Max Out of Pocket In-Network $6,350/$12,700

NEWBORNS ACT DISCLOSURE - FEDERAL

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).

NOTICE OF 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.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

PATIENT PROTECTION MODEL DISCLOSURE

Anthem generally required the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Anthem designated on for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Anthem at anthem.com

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Anthem or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Anthem at anthem.com

MICHELLE'S LAW DISCLOSURE

Under the ACA, dependent children are covered by the group health plan until age 26. Advantage Home Health Care group health plan extends dependent coverage beyond the ACA requirements, to age 26, so long as the child is covered as a student. If your child has extended coverage as a student but loses their student status because they take a medically necessary leave of absence from school your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This is available if, immediately before the first day of the leave of absence, your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).
To obtain more information, contact person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $156 per day (up to a $1,566 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Chris Jones
4008 Wheeling Ave., Muncie, IN 47304
765-284-1211
cjones@advantagehhc.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:

Marketing purposes

Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- 01/01/2022
- Advantage Home Health Care

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

Important Notice from Advantage Home Health Care 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 Advantage Home Health Care 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. **Advantage Home Health Care has determined that the prescription drug coverage offered by the PPO 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 15thto 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.

CMS Form 10182-CC **Updated April 1, 2011**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

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We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- 01/01/2022
- Advantage Home Health Care

OMB 0938-0990

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

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 Advantage Home Health Care coverage will not be affected.

	Anthem Bronze HDHP	Reliance Standard Essential Plan Covers only preventive	Reliance Basic Advantage
Pharmacy Benefit			
Deductible (Per Individual)	Deductible (Per Individual)	Combined with medical ded.	N/A
Pharmacy Benefit	Pharmacy Benefit	Ded / 100%	N/A

If you do decide to join a Medicare drug plan and drop your current Advantage Home Health Care 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 Advantage Home Health Care 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 Advantage Home Health Care changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC **Updated April 1, 2011**

OMB 0938-0990

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

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:	1/1/2022
Sender:	Advantage Home Health Care
Contact--Position/Office:	Human Resources
Address:	4008 North Wheeling Ave. Muncie, In 47304
Phone Number:	765-284-1211

CMS Form 10182-CC **Updated April 1, 2011**

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 October 15, 2021. Contact your State for more information on eligibility –

ALABAMA Medicaid	CALIFORNIA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA Medicaid	**COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS Medicaid	**FLORIDA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA Medicaid

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

INDIANA Medicaid

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

IOWA Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS Medicaid

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

KENTUCKY Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

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: https://www.mass.gov/info-details/masshealth-premium-assistance-pa

Phone: 1-800-862-4840

MINNESOTA Medicaid

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

MISSOURI Medicaid

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

MONTANA Medicaid

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

NEBRASKA Medicaid

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

NEVADA Medicaid

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

NEW HAMPSHIRE Medicaid

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

NEW JERSEY Medicaid and CHIP	SOUTH DAKOTA Medicaid
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	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK Medicaid	**TEXAS Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA Medicaid	**UTAH Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA Medicaid	**VERMONT Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA Medicaid and CHIP	**VIRGINIA Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON Medicaid	**WASHINGTON Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA Medicaid	**WEST VIRGINIA Medicaid**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND Medicaid and CHIP	**WISCONSIN Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA Medicaid	**WYOMING Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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 October 15, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
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)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one–stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost–sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer–offered coverage. Also, this employer contribution –as well as your employee contribution to employer–offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after–tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Advantage Home Health Care	4. Employer Identification Number (EIN) 35-1911151	
5. Employer address 4008 North Wheeling Avenue	6. Employer phone number 765-284-1211	
7. City Muncie	8. State IN	9. ZIP code 47304
10. Who can we contact about employee health coverage at this job? Christopher Jones		
11. Phone number (if different from above)	12. Email address cjones@advantagehhc.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [x] All employees. Eligible employees are:

    All full time employees working 30+ hours a week
  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:

    All legal spouses and dependent children
  - [ ] We do not offer coverage.

[ ] If checked, this coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

* An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Premium Savings Plan form

The POP plan was established by Section 125 of the Internal Revenue Code. It allows you to pay for certain insurance benefits before taxes, which saves you money. The taxes you save are returned to you as increased take home pay. You may use Basic Flex POP on employer-sponsored benefits which you pay a share of the premium cost. These may include medical, dental, vision, Health Savings Accounts (HSAs), or other qualified benefits under Section 125.

Example of POP Benefit:

Without POP Option		**With POP Option**	
Gross Taxable Wage	$400.00	Gross Taxable Wage	$400.00
Federal, FICA & State Tax	-71.00	Insurance Prem. co-pay	- $25.00
Insurance premium co-pay	-25.00	Taxable Wage	$375.00
		Federal, FICA & State Tax	- $62.00
Weekly Take Home Pay	$304.00	Weekly Take Home Pay	$313.00
		Annual Tax Savings	$468.00

Fill out form below and return page with Insurance application

- -

Employer Name: ____ADVANTAGE HOME HEALTH CARE_____

Participant Name: _____SS#:_____

___Open Enrollment__ New Hire (Hire Date __/___/___) ___Key Employee (Officer or Owner) ___Change Status

___ **I elect to participate** (the amount of salary reduction needed to pay premiums under the insured portions of the Plan will be determined by my employer. This amount will be changed as necessary, if the premium changed by the insurance company changes.)

Check all that apply:

_____Anthem Bronze PPO

_____**I decline to participate**.

I request that my periodic paychecks for the plan year be reduced on a pro rata pre-tax basis by sum of my premium contributions to the plan, such amount to be allocated among the benefits I selected above. I understand this election form cannot be revoked or changed during the plan year, unless there is a change in my status (e.g marriage, divorce, death of spouse or child, birth or adoption of child, and change of employment of spouse) which justifies the revocation or change. I have examined this agreement and to the best of knowledge, it is true, correct and complete.

Employee Signature:_____**Date**: _____

Employee Enrollment Application
For 51+ employee groups
Indiana

Anthem AnthemLife

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.
To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Please complete electronically or in blue or black ink only.

Employer name	Group no.	Subsection
ADVANTAGE HOME CARE	W11329	M002

Section 1: Employee information

Last name	First name	M.I.	Social Security no.* (required)

Birthdate (MM/DD/YYYY)	Home address

City	County	State	ZIP code

Sex	Marital status	Primary phone no.
☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner	

Employee email address

Employment status	Hire date (MM/DD/YYYY)	No. of hours worked per week
☐ Full time ☐ Part time ☐ Disabled ☐ Retired		

Primary Care Physician (PCP) name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Section 2: Reason for application – Select one

☐ New enrollment
☐ Annual open enrollment (not applicable to life and disability)
☐ New hire
☐ Rehire – Rehire date: (MM/DD/YYYY)
☐ Marriage – Date of marriage: (MM/DD/YYYY)
☐ Birth of child
☐ Add dependent (Fill in section 4)
☐ Loss of eligibility for other coverage – Date previous coverage ended: (MM/DD/YYYY)
☐ COBRA – Select qualifying event
- ☐ Left employment
- ☐ Reduction in hours
- ☐ Death
- ☐ Medicare
- ☐ Loss of dependent child status
- ☐ Divorce or legal separation
- ☐ Covered employee's Medicare entitlement

Qualifying event date: (MM/DD/YYYY)

☐ Waiver (To decline ALL coverage skip to section 8.)

*Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Reset Form Save and Print

Social Security no.* (required)

Section 3: Type of coverage

Medical coverage

Large Group 51–99 options

- ☐ Blue Access (PPO)
- ☐ Blue Access PPO HRA
- ☐ Blue Access PPO HSA
- ☐ HealthSync (HMO)
- ☐ HealthSync HMO HSA
- ☐ HealthSync (POS)
- ☐ HealthSync (POS - 3Tier)
- ☐ HealthSync POS HSA
- ☐ HealthSync (POS - 3Tier) HSA

Large Group 100+ options

- ☐ Anthem Essential (PPO)
- ☐ Blue Access (PPO)
- ☐ Blue Preferred (HMO)
- ☐ Blue Preferred (POS)
- ☐ Blue Access PPO HSA
- ☐ Blue Access PPO HRA
- ☐ Blue Access PPO HRA (with Copay)
- ☐ Blue Access PPO Deductible First HRA
- ☐ Blue Access PPO HIA Plus
- ☐ HealthSync (HMO)
- ☐ HealthSync (POS)
- ☐ HealthSync (POS - 3Tier)
- ☐ HealthSync HMO HSA
- ☐ HealthSync POS HSA
- ☐ HealthSync (POS - 3Tier) HSA
- ☐ HealthSync (POS - 3Tier) HRA

Member medical coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Flexible Spending Account (FSA) coverage – More than one plan may be selected, depending on employer offerings.

- ☐ Healthcare FSA (excluded if you have an HSA plan)
- ☐ Limited-Purpose FSA (for dental and vision services)
- ☐ Dependent Care FSA
- ☐ Commuter Parking
- ☐ Commuter Transit
- ☐ No FSA coverage at this time

Dental coverage

☐ Prime Essential Choice ☐ Prime Consumer Choice ☐ Complete Essential Choice ☐ Complete Consumer Choice
☐ Other: _____

Member dental coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Vision coverage

☐ Vision

Member vision coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Life and disability coverage

If you select life and/or disability coverage over the guaranteed issue amount or are a late entrant an Evidence of Insurability form may be sent to you to complete.

- ☐ Basic Life
- ☐ Basic Life and Accidental Death and Dismemberment
- ☐ Basic Dependent Life
- ☐ Optional Supplemental/Voluntary Life and Accidental Death and Dismemberment . . . . . $_____ (employee amount)
- ☐ Optional Supplemental/Voluntary Dependent Life Spouse . . . . . $_____ (spouse amount)
- ☐ Optional Supplemental/Voluntary Dependent Life Child . . . . . $_____ (child amount)
- ☐ Voluntary Accidental Death and Dismemberment . . . . . $_____ (employee amount)
- ☐ Voluntary Accidental Death and Dismemberment Family Plan (Spouse and Child coverage)
- ☐ Voluntary Accidental Death and Dismemberment Spouse Only (no Child coverage)
- ☐ Voluntary Accidental Death and Dismemberment Child Only (no Spouse coverage)
- ☐ Short Term Disability
- ☐ Long Term Disability
- ☐ Voluntary Short Term Disability
- ☐ Voluntary Long Term Disability

Current annual income – For employer/Anthem use	Occupation	Life and disability class no. – For employer/Anthem use
$_____		

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Life and disability coverage — Continued

Primary beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Contingent beneficiary — If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed.

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally.

Spousal consent for community property states only (Note: The insurance company is not responsible for the validity of a spouse's consent for designation.)
If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following. I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse/Domestic Partner signature **X**	Spouse/Domestic Partner name	Date (MM/DD/YYYY)

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Voluntary Accident, Critical Illness, and Hospital Indemnity Insurance

☐ **Voluntary Accident Insurance –** Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Accident plan offered please select: ☐ Low Plan ☐ High Plan

☐ **Voluntary Critical Illness Insurance –** Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Critical Illness plan offered please select: ☐ Low Plan ☐ High Plan
Have you smoked or used tobacco products in the last 12 months? ☐ No ☐ Yes, explain product used: _____

☐ **Voluntary Hospital Indemnity Insurance –** Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Hospital Indemnity plan offered please select: ☐ Low Plan ☐ High Plan

If any person to be covered by a Critical Illness or Hospital Indemnity plan is a resident of CA, GA, NY or CO, please answer the following question:

Will all applicants who reside in CA, GA, NY, or CO , when such coverage is to become effective, be enrolled in comprehensive health benefits from an individual or group health insurance policy, an employer sponsored health plan, or an HMO that provides essential health benefits? ☐ Yes ☐ No (Please note that if the response is No, such applicants are not eligible for coverage)

Voluntary Accident, Critical Illness, and Hospital Indemnity Insurance beneficiary designation

Primary beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Contingent beneficiary – If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed.

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.* (required)	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally.

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 4: Coverage information — All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your spouse or domestic partner, your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.

Please read the Genetic Information Non-discrimination Act (GINA) information on page 3 of the application, under Section 7, Significant Terms, Conditions and Authorizations, prior to answering the questions in Section 4.

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner
PCP name		PCP ID no.	Existing patient? ☐ Yes ☐ No

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ______
PCP name		PCP ID no.	Existing patient? ☐ Yes ☐ No

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, please enter: ______

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ______
PCP name		PCP ID no.	Existing patient? ☐ Yes ☐ No

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, please enter: ______

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ______
PCP name		PCP ID no.	Existing patient? ☐ Yes ☐ No

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, please enter: ______

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 5: Prior and other group coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If yes, give name: ______________________________

Medicare ID no.	Part A effective date (MM/DD/YYYY)	Part B effective date (MM/DD/YYYY)	Medicare eligibility reason (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date: ______ (MM/DD/YY)

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date (MM/DD/YYYY)

Are you or a family member previously or currently covered by a Medicare, medical and/or dental plan? ☐ Yes ☐ No

If yes, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Policyholder name	Dates (if applicable) (MM/DD/YY)
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 6: Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

Genetic Information Non-discrimination Act (GINA): When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

Health Savings Account Notice: I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield (Anthem) facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem at any time.

1. I understand that I may not assign any payment under my Anthem program.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
4. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.
5. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

I have read and accept the Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

I certify each Social Security Number listed on this application is correct.

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

I'm signing here because I want to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Section 7: Signature — Required if you are applying for coverage. Please review your application for errors or omissions.

Read section 6 carefully before signing.

I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature	Date (MM/DD/YYYY)
X	

Important Accident Insurance eligibility information:

The following notice applies to all Accident and Voluntary Accident coverage presented on this form:

ACCIDENT INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Important Critical Illness Insurance eligibility information:

The following notice(s) apply to all Critical Illness and Voluntary Critical Illness coverage presented on this form:

CRITICAL ILLNESS INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Important Hospital Indemnity Insurance eligibility information:

The following notice applies to all Hospital Indemnity and Voluntary Hospital Indemnity coverage presented on this form:

HOSPITAL INDEMNITY INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 8: Waiver/Declining coverage

Medical coverage

Medical coverage declined for – check all that apply: ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's/domestic partner's group coverage
- ☐ Enrolled in other insurance – Please provide company name and plan: _____
- ☐ Enrolled in individual coverage
- ☐ Spouse covered by employer's group medical coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Dental coverage

Dental coverage declined for – check all that apply: ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's/domestic partner's group coverage
- ☐ Enrolled in other insurance – Please provide company name and plan: _____
- ☐ Enrolled in individual coverage
- ☐ Spouse covered by employer's group medical coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Vision coverage

Vision coverage declined for – check all that apply: ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:

- ☐ Covered by spouse's/domestic partner's group coverage
- ☐ Enrolled in other insurance – Please provide company name and plan: _____
- ☐ Enrolled in individual coverage
- ☐ Spouse covered by employer's group medical coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

Life and disability coverage

***Life/AD&D** coverage declined for: ☐ Myself
Spouse, Domestic Partner and dependent coverage not available if life coverage is waived/declined.

Dependent Life coverage declined for: ☐ Spouse/domestic partner and dependents

Optional Supplemental/Voluntary coverage declined for: ☐ Myself

Optional Supplemental/Voluntary Dependent Life coverage declined for: ☐ Spouse/domestic partner and dependents

Voluntary Short Term Disability coverage declined for: ☐ Myself

Voluntary Long Term Disability coverage declined for: ☐ Myself

Reason for declining coverage – check all that apply:

- ☐ Life/AD&D declined for religious reasons
- ☐ Do not elect to enroll in Dependent Life
- ☐ Do not elect to enroll in Optional Supplemental/Voluntary coverage
- ☐ Do not elect to enroll in Optional Supplemental/Voluntary Dependent Life coverage
- ☐ Do not elect to enroll in Voluntary Short Term Disability
- ☐ Do not elect to enroll in Voluntary Long Term Disability

*I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Sign here only if you are declining coverage.

Signature of applicant	Printed name	Social Security no.	Date (MM/DD/YYYY)
X			

*Anthem is required by the Internal Revenue Service to collect this information.

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

BasicCare Program

Enrollment Form
Class II

You must complete Sections A and B. Complete Section C only if you are enrolling dependents. Make a copy of your completed Enrollment Form for your records. Please print neatly and firmly within the boxes.

SECTION A — INFORMATION ABOUT YOU

Social Security Number | First Name | Middle Initial | Last Name

Mailing Address: Street | City

State | Zip | Home Phone Number | Birth Date: Month Day Year | Sex: ☐ M ☐ F

ADVANTAGE HOME

Name of Employer | Work Phone Number

SECTION B — ENROLLMENT SELECTION

It is important that you follow the directions when making your elections; otherwise, your enrollment may be delayed. And if you are enrolling any of your dependents (spouse or children), please be sure to include their information in Section C; otherwise, their enrollment may be delayed. Costs listed below are **weekly** amounts.

Make your selection by putting an [X] in the box next to the selection you want. You must mark a box in each section. You may elect both BasicAdvantage Total and Essential plans. List your Dependents on the back of this form.

	BasicAdvantage Total Plan	Essential Plan*
Employee Only	☐ $23.19	☐ $0
Employee + Spouse	☐ $48.93	☐ $2.29
Employee + One Child	☐ $34.78	☐ $4.57
Employee + Children	☐ $58.67	☐ $9.59
Employee + Family	☐ $77.91	☐ $11.86
DECLINE COVERAGE	☐	☐

* The costs shown may include amounts paid for Affordable Care Act taxes and fees that are in addition to the Essential plan's premium.

I wish to participate in the benefit plan(s) that I've selected above and I authorize my employer to deduct the required costs from my paycheck.

Your Signature

Today's Date: Month Day Year

(OVER PLEASE)

RS-2202.BAT3(IN)EP
Advantage Home Health Care 2020

SECTION C — WHICH DEPENDENTS WILL BE COVERED?

1. First Name | Middle Initial | Last Name

Sex: ☐ M ☐ F Enrolled in the following plans: ☐ BasicAdvantage Total Plan ☐ Essential Plan

Birth Date: Month Day Year

Social Security #: — —

Relationship: ☐ Your Spouse ☐ Your Child

If over 25, is your child: ☐ Disabled

Check the box here ☐ if living at a different address and list below.

---

2. First Name | Middle Initial | Last Name

Sex: ☐ M ☐ F Enrolled in the following plans: ☐ BasicAdvantage Total Plan ☐ Essential Plan

Birth Date: Month Day Year

Social Security #: — —

Relationship: ☐ Your Spouse ☐ Your Child

If over 25, is your child: ☐ Disabled

Check the box here ☐ if living at a different address and list below.

---

3. First Name | Middle Initial | Last Name

Sex: ☐ M ☐ F Enrolled in the following plans: ☐ BasicAdvantage Total Plan ☐ Essential Plan

Birth Date: Month Day Year

Social Security #: — —

Relationship: ☐ Your Spouse ☐ Your Child

If over 25, is your child: ☐ Disabled

Check the box here ☐ if living at a different address and list below.

---

4. First Name | Middle Initial | Last Name

Sex: ☐ M ☐ F Enrolled in the following plans: ☐ BasicAdvantage Total Plan ☐ Essential Plan

Birth Date: Month Day Year

Social Security #: — —

Relationship: ☐ Your Spouse ☐ Your Child

If over 25, is your child: ☐ Disabled

Check the box here ☐ if living at a different address and list below.

Address of Dependent not living with you:

First Name | Middle Initial | Last Name

Mailing Address: Street | City | State | Zip

If you have additional dependents or addresses for those dependents not living with you, please record all requested information on a separate sheet and attach it to this form.

There may be events that will allow you to enroll yourself and your eligible dependents outside of the Open Enrollment Periods. Please ask your employer for a Life Event Change Form which must be used for the additions or changes to benefits (including Special Enrollments), outside of an Open Enrollment Period.

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

Please print clearly and mark carefully.

Employer Name: ADVANTAGE HOME HEALTH CARE	Group Plan Number: 00469257	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX Initial Enrollment Add Employee/Dependents Drop/Refuse Coverage Information Change

Class:_____ Division:_____ Subtotal Code:_____ (Please obtain this from your Employer)

About You:

First, MI, Last Name:

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

Address	City	State	Zip

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

Phone (indicate primary): Home (____) ____ - ____
Work (____) ____ - ____
Mobile (____) ____ - ____

Email Address (indicate primary) Home _____ Work _____

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

About Your Job: Job Title:

Work Status:
Active Retired Cobra/State Continuation
Hours worked per week: _____

Date of full time hire: _____ - _____ - _____

About Your Family: Please include the names of the dependents you wish to enroll for coverage. If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse (First, MI, Last Name)		Gender M F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1:	Add Drop	Gender M F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Disabled Non standard dependent
Child/Dependent 2:	Add Drop	Gender M F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Disabled Non standard dependent
Child/Dependent 3:	Add Drop	Gender M F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Disabled Non standard dependent
Child/Dependent 4:	Add Drop	Gender M F	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Disabled Non standard dependent

Drop Coverage:

Drop Employee Drop Dependents

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

Last Day of Coverage: _____-_____-_____

Termination of Employment Retirement

Last Day Worked: _____-_____-_____

Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Dropped:

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

Loss Of Other Coverage:

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

Termination of Employment: _____-_____-_____

Divorce/Separation _____-_____-_____

Death of Spouse _____-_____-_____

Termination/Expiration of Coverage _____-_____-_____

Coverage Lost Dental Vision

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

Covered under another insurance plan

Other _____

(additional information may be required)

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

Your Weekly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
PPO	$10.11	$21.64	$28.37	$39.32

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

I am covered under another Dental plan

My spouse is covered under another Dental plan

My dependents are covered under another Dental plan

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

Your Weekly Premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Full Feature	$2.28	$3.84	$3.91	$6.19

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

I am covered under another Vision plan

My spouse is covered under another Vision plan

My dependents are covered under another Vision plan

Signature

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

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

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

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

I understand that if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my request.

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

I understand that my coverage will not be effective until approved by Guardian or its designated underwriter.

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

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

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

Guardian Group Plan Number: 00469257 Please print employee name:

I consent to electronic communication from Guardian, such as emails and text messages, regarding my coverage(s). I may change this election only by providing (thirty) 30 days prior written notice.

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

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

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

SIGNATURE OF EMPLOYEE X _____ DATE _____

Enrollment Kit 00469257, 0002, EN

Fraud Warning Statements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Advantage Home Health – Class II
2022 Payroll Election Form

For Employer Use Only					
Employee #:		Effective Date:		Date of Hire/Mgmt Status:	

Employee Data (Please PRINT clearly)	
Full Name:	SS#:
Street Address:	Date of Birth:
City, State, Zip:	Marital Status:
Email Address:	Work Location:

Medical Payroll Pre-Tax Deduction (Weekly) – 2022

Plan	Single	Employee + Spouse	Employee + Child(ren)	Family	Waive
Choice 1: Anthem HSA Plan	☐ $31.26	☐ $208.42	☐ $169.35	☐ $341.29	☐ I decline
HSA Contribution *(ONLY if enrolled in the HSA)*	Annual: $_____ **OR** Per Paycheck: $_____ *2022 HSA Maximum Contributions: $3,650 (individual) or $7,300 (family)*				

	Single	Employee + Spouse	Employee + Child	Employee + Children	Family	Waive
Choice 2: Reliance Essential Plan	☐ $0.00	☐ $2.29	☐ $4.57	☐ $9.59	☐ $11.86	☐ I decline
Choice 3: Reliance Basic Advantage Plan	☐ $23.19	☐ $48.93	☐ $34.78	☐ $58.67	☐ $77.91	☐ I decline

Dental/Vision Payroll Pre-Tax Deduction (Weekly) – 2022

Plan	Single	Employee + Spouse	Employee + Child(ren)	Family	Waive
Dental - Guardian *(Critical Illness Rider included)*	☐ $10.11	☐ $21.64	☐ $28.37	☐ $39.32	☐ I decline
Vision – Guardian	☐ $2.28	☐ $3.84	☐ $3.91	☐ $6.19	☐ I decline

BY SIGNING BELOW, I AM INDICATING THAT I HAVE READ AND UNDERSTAND THE TERMS

Employee Signature: _____

Print Name: _____

Date: _____ SS#:_____