

2021-22 BENEFITS

Enrollment & Reference Guide




Achievement First

YOUR BENEFITS EFFECTIVE

JULY 1, 2021

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ABOUT THE GUIDE

This reference guide has been designed to explain the basics of the benefit plans offered by Achievement First for eligible employees. We hope this guide will help new employees understand the basics of all of AF's benefit package. We also hope that New Hires will be able to use this guide as their first stop for the basic information around their new benefit plans.

This guide contains brief descriptions of the options provided in each benefit category. These summaries are intended to help you choose among the available options under the benefits program. This guide does not take the place of the legal plan documents.

The policy document for each applicable plan is available on Many Minds. If there is a conflict between this guide and the plan documents, the plan documents will govern. If you require more detailed information, contact the AF Team Talent Operations.

AF reserves the right to modify, amend, or terminate any or all of the provision of these plans at any time for any reason.

The Health Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a Covered Benefit, or is subject to limitation or exclusion, a Covered Person still has the right and privilege to receive such medical services or supply at the Covered Person's own personal expense.

ABOUT YOUR BENEFITS

It is important to ensure that you and your family have the coverage you need when you need it most. Because different people have different needs, AF offers you a choice of benefits. AF helps you obtain these benefits and covers a significant portion of their costs. You pay for the balance through payroll deductions.

BASIC INFORMATION

- Coverage for all benefits is effective the first day of employment.
- Cigna medical ID cards will be mailed to your home address.
- Delta Dental ID cards will be mailed to your home address.
- Vision ID cards will not be mailed to you. You must print them from the carrier website.
 - Vision ID cards are available at www.guardiananytime.com

CONTACT INFORMATION

- If you are a school staff member, your DSO is always your first stop.
- If you are a NS staff member, please submit a Zendesk ticket and a Team Talent Ops member will respond in our usual speedy manner.
- If you have questions about specific levels of coverage (i.e., Is this Drug Tier Two or Three? What fertility treatments does AF's plan cover?), please reach out to our brokers at MDG. They can be reached at 888-282-1591 or by email at AFbenefits@mdgbenefits.com. If you call, simply say you're an Achievement First employee and they will get you to the right person.
- If you have specific questions for the providers:

Provider	Phone	Website	Group / Policy #
Cigna	800-244-6224	www.mycigna.com	3343586
Delta DHMO (dental)	800-422-4234	www.deltadentalins.com	79145
Delta PPO & Premier (dental)	800-452-9310	www.deltadentalct.com	04384
Guardian (vision)	877-814-8970	www.guardiananytime.com	458566
Employee Assistance Plan	800-316-2796	www.mutualofomaha.com/eap	Achievement First*
MDG (broker/advocate)	888-282-1591	www.mdgbenefits.com	Achievement First*

* When calling, simply identify yourself as having coverage through Achievement First to be routed to the correct department or contact person.

WHO IS ELIGIBLE?

For the first year of employment, all full-time regular employees regularly scheduled to work at least 30 hours per week, and their eligible dependents, may participate in the AF medical, dental, and vision benefits programs.

After completing a year of full-time employment all regular employees working at least 20 hours

per week, and their eligible dependents, may participate.

Eligible dependents include:

- A spouse or Domestic Partner
- Children up to age 26 in the medical, dental, and vision plans

ELECTING & CHANGING YOUR BENEFITS

Upon hire, you have thirty days to elect or waive your benefits. All benefits are active on your date of hire.

You should elect only the benefits plans you and your family need. You can decline the coverage that you do not need.

You can evaluate your benefit coverage and change every year during the annual Open Enrollment period.

After Open Enrollment ends, due to plan rules and IRS regulations, you cannot change your elections unless you have a “Qualified Life Event”.

A “Qualified Life Event” (QLE) is generally defined as:

- Marriage or divorce
- Birth, adoption, or placement for adoption
- Death of dependent
- Change in dependent’s employment status (new employment, change in hours or status which affect eligibility for coverage)
- Termination of dependent’s employment and subsequent loss of coverage
- Over-age child (A child can be covered until age 26 in the medical, dental and vision plans.)

If you believe you have experienced a Qualifying Life Event (QLE), reach out to your DSO or Team Talent Operations at AF_TalentOps@achievementfirst.org. We will help guide you through how to make updated elections in ADP. Please note that all QLE changes will require documentation and must be made within 30 days of the event occurring. After 30 days, you will no longer be able to make changes related to that qualifying event.

WHEN COVERAGE BEGINS

Coverage as a new hire will begin on the first day of employment. Changes made during the annual Open Enrollment period are effective July 1, 2021.

PAYING FOR YOUR BENEFITS

Benefits are an important part of your total compensation package. AF provides coverage for some benefits at no cost to you as outlined below. Your contributions – the amount you pay for your benefits – are automatically deducted from your paycheck.

Provided at no cost to you:

- Short-Term Disability Insurance
- Long-Term Disability Insurance
- Basic Life, and Accidental Death & Dismemberment Insurance
- Employee Assistance Program

Pre-Tax Options (AF shares the cost with you):

Your benefit contribution are deducted from your paycheck on a before-tax basis.

- Medical coverage for all coverage tiers
- Dental coverage for all coverage tiers
- Vision coverage for all coverage tiers
- Supplemental Life, and Accidental Death & Dismemberment Insurance

Domestic Partner coverage is post tax, per IRS guidelines.

PRE-TAX DEDUCTION AUTHORIZATION SALARY REDUCTION AGREEMENT

By enrolling in the medical, dental, and/or vision plans you are authorizing AF to make a pre-tax deduction from your paycheck each pay period. It equals your share of the insurance premium.

The authorization revokes any previous salary reduction agreement you may have. The deduction authorization remains in effect for all future Plan Years unless revoked or modified.

DOMESTIC PARTNER BENEFITS AND IMPUTED INCOME

Domestic partner coverage (and coverage for your domestic partner's dependents) is considered a taxable benefit by the IRS. The value of your domestic partner's and/or domestic partner's dependents' medical and dental coverage is subject to imputed income. Imputed Income includes the amount AF pays towards benefits that cover domestic partners, which includes any contributions toward the medical and dental benefits. The imputed income is reported on the employee's W2. For AF's definition of who qualifies as a domestic partner, please review the Employee Handbook on Many Minds.

MEDICAL PLAN SIDE-BY-SIDE COMPARISON

Cigna - Outline of In-Network Benefits (Refer to the carrier's plan summary for full details)

	PLAN A COPAY PLAN*	PLAN B HRA	PLAN C HDHPQ (HSA)
DEDUCTIBLES:			
Individual / Family Deductible	N/A	\$1,500 / \$3,000	\$2,800 / \$5,600
Coinsurance	N/A	30% after deductible	No Charge after deductible except for RX co-pays (see below)
Plan Year or Calendar Year	N/A	Plan Year	Plan Year
Individual / Family Max Out of Pocket	\$4,500 / \$8,550	\$4,500 / \$8,550	\$4,500 / \$8,550
HRA or HSA Funding	N/A	AF pays first \$700/single or \$1400/family toward deductible. Note: No one member of family would receive more than \$700.	Plan allows for Health Savings Account (HSA). A pre-tax savings account to be used for medical expenses.
Embedded or Non-Embedded	N/A	Embedded Deductible	Embedded Deductible
		When family member meets individual deductible, Cigna will begin paying according to the plans coverage for that member.	When family member meets individual deductible, Cigna will begin paying according to the plans coverage for that member.
OFFICE VISITS:			
Preventative Care	No Charge	No Charge	No Charge
Any Other Office Visits	\$30	Subject to Ded. & Coins.	Subject to Deductible
SERVICES:			
Hospitalization	\$500/day to \$1,500	Subject to Ded. & Coins.	Subject to Deductible
Outpatient Surgery	\$250	Subject to Ded. & Coins.	Subject to Deductible
Lab / Radiology (X-Ray)	\$30	Subject to Ded. & Coins.	Subject to Deductible
High Diagnostic Testing (MRI, PET)	\$75	Subject to Ded. & Coins.	Subject to Deductible
EMERGENCY CARE:			
Emergency Room	\$150	Subject to Ded. & Coins.	Subject to Deductible
Urgent Care Center	\$30	Subject to Ded. & Coins.	Subject to Deductible
Emergency Ambulance Services	No Charge	Subject to Ded. & Coins.	Subject to Deductible
PRESCRIPTION DRUGS:			
Prescription Deductible	\$100 / \$300 (Waived Tier 1)	\$100 / \$300 (Waived Tier 1)	\$2,800 / \$5,600 (combined with Medical)
Tier 1	\$5	\$5	\$5
Tier 2	\$30	\$30	\$30
Tier 3	\$60	\$60	\$60

* Plan A (Co-Pay Plan) is only available to team members hired before July 1, 2016.

NOTES: Services such as rehabilitation therapy, chiropractic care, contain visit limits. Services such as home health, skilled nursing, have day limits.

Above details are specific to in-network benefits. Plans A and C have out-of-network benefits as well. Please note that plan B does NOT have out-of-network benefit coverage.

MEDICAL PLAN HIGHLIGHTS

CIGNA PLAN A (CO-PAY PLAN)

This plan is only available to team members hired before July 1, 2016. **Teammates hired before July 1, 2016 who leave Achievement First and are rehired are no longer eligible for Plan A.**

Type of Care	In Network	Out of Network
Primary Care Doctor Visit	\$30 co-pay	subject to deductible and coinsurance
Specialist Doctor Visit	\$30 co-pay	subject to deductible and coinsurance
Preventative Visit	\$0 co-pay (see SBC for details)	subject to deductible and coinsurance
Pharmacy	\$5 Tier 1 \$30 Tier 2 \$60 Tier 3 \$100 deductible for Tier 2 and Tier 3	\$5 Tier 1 \$30 Tier 2 \$60 Tier 3 \$100 deductible for Tier 2 and Tier 3
Emergency Room	\$150 co-pay	\$150 co-pay
Hospital Stay	\$500 co-pay per day up to \$1,500	subject to deductible and coinsurance
Basic Diagnostic (X-Ray/Lab)	\$30 co-pay	subject to deductible and coinsurance
Advanced Diagnostic (MRI/CT Scan)	\$75 co-pay	subject to deductible and coinsurance
Outpatient Surgery	\$250 co-pay	subject to deductible and coinsurance
Deductible	Not applicable	\$500/\$1,250
Coinsurance	Not applicable	70%/30%
Out of Pocket Maximum (Individual/Family)	\$4,500/\$8,550	\$4,500/\$8,550

Enrollment Tier	Employee Per Paycheck Cost	Employer Cost
Employee Only	\$157.87	\$240.15
Employee + Child(ren)	\$387.84	\$440.01
Employee + Spouse	\$425.14	\$430.58
Employee + Family	\$548.22	\$590.07

Refer to certificate of insurance for complete plan details.

MEDICAL PLAN HIGHLIGHTS

CIGNA PLAN B (HRA PLAN)

Type of Care	In Network	Out of Network
Primary Care Doctor Visit	subject to deductible and coinsurance	not covered
Specialist Doctor Visit	subject to deductible and coinsurance	not covered
Preventative Visit	no cost (see SBC for details)	not covered
Pharmacy	\$5 Tier 1 \$30 Tier 2 \$60 Tier 3 \$100 deductible for Tier 2 and Tier 3	Not covered
Emergency Room	subject to deductible and coinsurance	subject to in-network deductible and coinsurance
Hospital Stay	subject to deductible and coinsurance	not covered
Basic Diagnostic (X-Ray/Lab)	subject to deductible and coinsurance	not covered
Advanced Diagnostic (MRI/CT Scan)	subject to deductible and coinsurance	not covered
Outpatient Surgery	subject to deductible and coinsurance	not covered
Deductible	\$1,500/\$3,000	not applicable
Coinsurance	70%/30%	not applicable
Out of Pocket Maximum (Individual/Family)	\$4,500/\$8,550	not applicable
Enrollment Tier	Employee Per Paycheck Cost	Employer Cost
Employee Only	\$57.90	\$247.24
Employee + Child(ren)	\$172.75	\$460.06
Employee + Spouse	\$204.29	\$448.24
Employee + Family	\$242.08	\$610.54

Refer to certificate of insurance for complete plan details.

MEDICAL PLAN HIGHLIGHTS

CIGNA PLAN C (HSA PLAN)

Type of Care	In Network	Out of Network
Primary Care Doctor Visit	subject to deductible	subject to deductible and coinsurance
Specialist Doctor Visit	subject to deductible	subject to deductible and coinsurance
Preventative Visit	\$0 copay (see SBC for details)	subject to deductible and coinsurance
Pharmacy	subject to deductible, then: \$5 Tier 1 \$30 Tier 2 \$60 Tier 3	subject to deductible, then: \$5 Tier 1 \$30 Tier 2 \$60 Tier 3
Emergency Room	subject to deductible	subject to deductible and coinsurance
Hospital Stay	subject to deductible	subject to deductible and coinsurance
Basic Diagnostic (X-Ray/Lab)	subject to deductible	subject to deductible and coinsurance
Advanced Diagnostic (MRI/CT Scan)	subject to deductible	subject to deductible and coinsurance
Outpatient Surgery	subject to deductible	subject to deductible and coinsurance
Annual Deductible	\$2,800/\$5,600	\$2,800/\$5,600
Coinsurance	Not applicable	70%/30%
Out of Pocket Maximum (Individual/Family)	\$4,500/\$8,550	\$4,500/\$8,550

Enrollment Tier	Employee Per Paycheck Cost	Employer Cost
Employee Only	\$15.00	245.04
Employee + Child(ren)	\$88.76	\$453.55
Employee + Spouse	\$115.74	\$444.87
Employee + Family	\$135.77	\$610.41

Refer to certificate of insurance for complete plan details.

HEALTH SAVINGS ACCOUNT (HSA)

HSAs are tax-advantaged savings accounts that are available to employees who are enrolled in Plan C (HDHPQ/HSA Plan). The account is employee-owned, and money may be contributed by both the employer and employee to the account. AF does not currently make contributions into the HSA. The employee owns the account and remains in control of the funds in the account. The account is portable, and you may continue to make deposits into the account as long as you are enrolled in a compliant HDHP.

The funds contributed to the account are pre-tax, which means they aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses; there is a heavy tax penalty for using HSA funds to pay for non-qualified expenses. Funds roll over year after year if you don't spend them, and can accumulate a significant balance. There is a limit to how much money can be put into an HSA every year, but no limit on how much money can be in the account.

If you are enrolled in Plan C (HDHPQ/HSA Plan), you must complete the appropriate HSA deduction that you can obtain from your DSO or from Team Talent Operations. It is also available on Many Minds.

Why would I open an HSA?

You can use your HSA to pay deductible expenses, any applicable coinsurance, and other qualified health care expenses. In addition, because contributions are made on a pre-tax basis, you are lowering your taxable income. Lastly, any unused funds that you deposit into the HSA are available for you to use year after year, since the money rolls over and can continue to be utilized if you choose to leave AF.

Can I add my own pre-tax dollars to the HSA?

Yes, you can make contributions of up to \$3,600 in Calendar Year 2021 if you have employee only coverage, or \$7,200 for all other levels of coverage. If you are over age 55, you can contribute an additional \$1,000 in 2021 as a "catch-up" contribution.

Does AF open an HSA for me?

As HSA accounts are personal banking accounts, it is the responsibility of the employee to open the account directly with a bank or credit union. Many of our employees utilize Optum Bank. You can easily open an account by visiting www.optumbank.com. At the top of the website, you will see 'Open an HSA'. Once you have opened an account, please contact your DSO or Team Talent Operations to obtain an HSA deduction form so you can start making pre-tax contributions into the HSA. You can use your HSA to pay deductible expenses, any applicable coinsurance, and other qualified health care expenses. You can also request a debit card so that you can pay for services as you receive them, or you can file a claim to get reimbursed from Optum Bank.

What happens to any money I don't use in 2021?

Your HSA funds will roll over, year after year. They belong to you.

If I leave employment, what happens to my HSA?

Your HSA is portable, so if you leave employment for any reason, your HSA goes with you.

Can I withdraw money from a HSA for non-medical expenses?

Yes, but if you withdraw funds for non-medical expenses before you turn 65, you have to pay taxes on the money and a 20% penalty. If you take money out after you turn 65, you don't have a penalty, but you must still pay ordinary income taxes on the money you withdraw for non-medical expenses.

Can I use the money in my HSA account to pay for my dependents' medical expenses?

You can use the money in the account to pay for the medical expenses of yourself, your spouse or your dependent children, whether they are covered by the AF plan or not. Please note that domestic partner expenses should not be paid using your HSA.

When can I start using my HSA dollars?

You can use your HSA dollars immediately following your HSA account activation and once contributions have been made.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

AF funds an HRA for employees who choose the Plan B (HRA Plan). Only AF may fund the HRA—employee contributions are not permitted. If there are unused funds in the account at the end of the year, they belong to AF. The HRA pays for certain medical costs you and your covered dependents incur.

	Employee Only Coverage	Employee + Dependents Coverage
AF Contributions per Plan Year:	\$700	\$1400

What are the advantages of an HRA?

Funds in the HRA are given to you by AF to help you fund the first part of your deductible expenses. Cigna administers the HRA so that any medical expenses that counts towards your deductible are paid by them up to the total amount available in the HRA. See the table above for the amounts contributed by AF into the HRA.

What expenses can be reimbursed from the HRA?

Any health care expenses that are charged to your deductible are eligible for reimbursement. Here is an example of how the HRA works:

Cigna HRA \$1500/\$3000 (Plan B)	AF Pays the First Part of the Deductible	Employee Pays the Last Part of the Deductible
Employee Only	\$700	\$800
Employee + Dependent Coverage	\$1400	\$1600

What happens to the money in the HRA if I don't spend it in the 2021-22 Plan Year?

Because the funds in the account are contributed by AF to help you pay for your deductible, any funds that are not used will be returned to AF at the end of the plan year (June 30, 2022).

Can I add my own pre-tax dollars to the HRA?

No. Per Federal Guidelines, the HRA can only be funded by AF.

Can I withdraw funds from the HRA?

No. The HRA works on a reimbursement basis and it will only pay for the medical expenses that are defined under the plan.

Can I participate in the HRA if I'm enrolled in one the other Cigna Medical Plans?

No. The HRA is only available to employees enrolled in Plan B (HRA Plan).

VALUE ADDED PROGRAMS INCLUDED WITH CIGNA

TeleHealth

An ear ache at 2:00 am. Pink eye on a Sunday morning. If you can't see your regular doctor, talking to a doctor or nurse using Cigna Telehealth Connection is a fast, reliable option to get the care you need. Cigna customers can connect 24/7 with board-certified doctors, licensed clinicians, or nurses through online video chat or phone. Cigna provides the below two options to meet your telehealth needs:

Talk to a Nurse

If you're not sure what type of care you need, talking on the phone with a nurse can help you determine the right care plan and is available at no additional cost to you. When you talk to a nurse about where to go for care, there's no additional cost share.

Or

Online Doctor Visits

You can talk directly with a board-certified doctor through the phone, or video, for help with minor, non-life-threatening conditions. When medically necessary, they can have prescriptions sent directly to your local pharmacy. Your out-of-pocket cost will be the same, or less, than a visit with your Primary Care Provider (PCP) and will usually cost less than going to an urgent care clinic, and much less than going to an emergency room.

Maternity Support Program

If you're a Cigna health plan customer, enroll in the Cigna Healthy Pregnancies, Healthy Babies® program. It's a program designed to help you and your baby stay healthy during your pregnancy and in the days and weeks following your baby's birth. Ask us anything - your health coach, who has nursing experience, is there to support you during your whole pregnancy. Get live support 24 hours a day, seven days a week.

DENTAL PLAN: DHMO

AF provides two dental plan options from Delta Dental. Teammates can choose between a Dental Health Maintenance Organization (DHMO) plan and a Preferred Provider Organization (PPO) plan. The difference is what you pay out-of-pocket. See the charts on this page and the following page for cost differences.

Preventive, basic and major services are covered under both plans. When choosing between the DHMO or the PPO, here are some things to consider:

Contracted rates with network dentists are often much lower than their regular fees. You help save money by staying in-network.

The DHMO network is much smaller than the PPO network. When visiting a DHMO provider, you should refer to the “fee schedule”, available from Delta Dental and provided on Many Minds. Each covered procedure has a set cost that you will be required to pay or will be listed as “No Cost”. You will not pay more than that amount, and Delta Dental will pay the provider any additional balance due.

For those enrolling in the DHMO, a participating dentist must be elected and documented within the Delta Dental system for claims to be processed and paid accordingly. The ADP system requires you to elect a provider upon enrollment. There is a box in ADP where you will input your 6-digit provider number. You are also allowed to change the designated DHMO dentist any time by directly calling Delta Dental.

Delta Dental DHMO	
	“In-Network Only You Pay”
Annual Maximum	Unlimited
Orthodontia Maximum	Unlimited
Deductible (Plan Year)	N/A
• Individual	N/A
• Family	N/A
Preventive	Refer to fee schedule
Basic Care	Refer to fee schedule
Major Care	Refer to fee schedule
Orthodontia	Refer to fee schedule
Basic Endodontics & Periodontics	Refer to fee schedule
	Refer to fee schedule
Enrollment Tier	Employee Per Paycheck Cost for DHMO
Employee Only	\$0.82
Employee + Spouse	\$4.46
Employee + Child(ren)	\$3.96
Employee + Family	\$6.37

See certificate of insurance for complete plan details

DENTAL PLAN: PPO

AF provides two dental plan options from Delta Dental. Teammates can choose between a Dental Health Maintenance Organization (DHMO) plan and a Preferred Provider Organization (PPO) plan. The difference is what you pay out-of-pocket. See the chart on the prior page and this page for cost differences.

Preventive, basic and major services are covered under both plans. When choosing between the DHMO or the PPO, here are some things to consider:

Contracted rates with network dentists are often much lower than their regular fees. You help save money by staying in-network.

The DHMO network is much smaller than the PPO network. The PPO network includes Delta’s PPO providers, and you also get access to the Delta Premier network, making it the most extensive dental network nationwide.

For those enrolling in the PPO Plus Premier plan, you are not required to select a provider when you enroll, and you can choose to see any provider you would like. You receive Delta PPO coverage when you see a participating PPO dentist, and Delta Premier coverage when you see a participating Premier dentist.

If you choose to see a provider who doesn’t participate in the PPO or the Premier networks, you may be subject to balance-billing from the dentist (this is when you are charged for the difference in cost between what Delta pays and what the dentist actually charges).

Delta PPO Plus Premier		
	PPO or Premier Network You Pay	Out-of-Network You Pay
Annual Maximum	\$1,500	\$1,500
Orthodontia Maximum	\$1,500	\$1,500
Deductible (Plan Year)		
• Individual	\$50	\$50
• Family	\$150	\$150
Preventive	100%	100%
Basic Care	80% after deductible	80% after deductible
Major Care	50% after deductible	50% after deductible
Orthodontia	50%	50%
Basic Endodontics	80%	80%
& Periodontics	80%	80%

Enrollment Tier	Employee Per Paycheck Cost for PPO Plus Premier
Employee Only	\$1.63
Employee + Spouse	\$7.47
Employee + Child(ren)	\$6.78
Employee + Family	\$10.54

See certificate of insurance for complete plan details

VISION PLAN

The vision plan provides discounted vision care throughout its network of over 10,000 providers, which includes those in private practice as well as retail chains. When making an appointment with a network provider, please identify yourself as a participant in the Guardian VSP plan. If purchased through the provider network, eye examinations and eyewear will result in less out of pocket cost to you and your enrolled dependents; however, the plan does provide out of network coverage as well. The high level benefits are as follows:

Type of Care	In Network	Out of Network
Exam	\$10 co-pay	\$10 co-pay
Lenses	\$20 co-pay	Varies depending on Lens Type (refer to benefit summary)
Contact Lenses	Plan pays up to \$120 and provides discounts	Plan pays up to \$120
Frames	Plan pays \$120 and provides discounts	Plan pays up to \$47

Enrollment Tier	Per Paycheck Cost
Employee Only	\$0.26
Employee + Spouse	\$0.90
Employee + Child(ren)	\$0.88
Employee + Family	\$1.42

Network Name is VSP. See certificate of insurance for complete plan details

LIFE INSURANCE & DISABILITY COVERAGE

100% EMPLOYER PAID

Mutual of Omaha Life Insurance	
Life Insurance Benefit	1.5 x annual salary to a maximum of 415,000
Accidental Death & Dismemberment	Matches life insurance
Reduction in Benefits	Begins at age 65
Employee Cost	\$0.00

See certificate of insurance for complete plan details

Mutual of Omaha Short Term Disability	
Weekly Benefit Amount	60% of weekly salary to a maximum of \$3,500
Benefit Waiting Period	0 day for accident/7 days for illness
Benefit Duration	26 weeks
Employee Cost	\$0.00

See certificate of insurance for complete plan details

Mutual of Omaha Long Term Disability	
Monthly Benefit Amount	60% of Monthly Salary to a Maximum of \$14,500
Benefit Waiting Period	180 days
Own Occupation Period	24 months
Benefit Duration	To social security/retirement age
Employee Cost	\$0.00

See certificate of insurance for complete plan details

VOLUNTARY LIFE INSURANCE COVERAGE

100% EMPLOYEE PAID

Mutual of Omaha Voluntary Life Insurance	
Life Insurance Benefit	Choose between flat \$70,000 or flat \$150,000
Accidental Death & Dismemberment	Matches life insurance
Reduction in Benefits	Begins at age 65
Employee Cost	\$0.12 per \$1,000 per month

See certificate of insurance for complete plan details

EMPLOYEE ASSISTANCE PROGRAM (EAP)

When it's difficult to cope with family, work-related, personal or substance abuse problems - at work and at home - we often turn to family or friends for support. Unfortunately, there are times when that's not enough. Sometimes you need the ear of an experienced professional, one who will keep your concerns confidential and help guide you in the right direction.

Mutual of Omaha's Employee Assistance Program is voluntary and confidential. The program is paid for by Achievement First, and includes assistance for you and your immediate dependent family members.

- Telephone assistance and referral
- Service for immediate and dependent family members
- Three face-to-face sessions with a counselor
- Call 1-800-316-2796, 24 hours a day, 7 days a week for access to EAP professionals

Mutual of Omaha's EAP can provide assistance for a variety of personal and professional matters, including:

- Stress
- Resiliency
- Depression
- Gambling and other addictive behavior
- Parenting
- Financial issues
- Life changes
- Relationships
- Drug/alcohol abuse
- Mental health
- Grief
- Balancing work and home
- This service is completely free to you and your dependents and you are automatically covered as long as your work for Achievement First.

SEARCHING FOR PARTICIPATING PROVIDER

Medical Provider Search:

1. Go to <https://hcpdirectory.cigna.com/web/public/consumer/directory/search>
2. You must either enter an address, city, or zip code near the top of the page
3. Then choose a search category below the box, such as: “Doctor by Type”, “Doctor by Name” or “Locations”
4. Enter the Type, Name, or Location you desire. You may be asked to filter your results for Primary Care Providers or Specialists
5. You will also be given the options to log in (requires you to register as a member) or select your plan
6. Select “Open Access plus” as the plan name.

Dental DHMO Provider Search:

1. Go to www.deltadentalins.com
2. Look in the right-hand column for a box titled “Find a Dentist”
3. Enter your location and select the “DeltaCare USA” network
4. At this point, you can enter a dentist’s name, or practice name, if desired. Otherwise click “Search” and the website will display participating dentists
5. YOU WILL NEED TO NOTE THE 6-DIGIT FACILITY CODE TO ENTER INTO ADP. In Connecticut, the code does not display online, but it is always “000000”.

Dental PPO Provider Search:

1. Go to www.deltadentalct.com/tools-and-resources/find-a-dentist
2. Select a specific type of dental provider or simply choose “Any” to see all results.
3. Select “Delta Dental PPO Plus Premier” network.
4. You can add a provider name to search, or enter the location you want to search from.

Vision Provider Search:

1. Go to www.guardiananytime.com
2. Click “find a provider” (can be found towards the top middle portion of page)
3. On the next page, select “Search Providers”
4. Near the top of the page, select the tab entitled “Find a Vision Provider”, then select the VSP vision network
5. Enter zip code or address
6. The next drop down box asks you to choose a Doctor Network, select “Signature”
7. You can narrow down the search by provider gender, or select services or products that are important to you in the boxes under the search entry fields. You can also narrow the search range in miles
8. Click “Search” and the website will display participating vision doctors

SEARCHING FOR PRESCRIPTIONS

1. Go to <https://www.cigna.com/individuals-families/member-resources/prescription/drug-list.html?consumerID=cigna&indicator=nonIFP&pdYearType=CD&effectiveDate=2020-01-01#/pdly>
2. From the drop down menu under Select a Drug List, select Standard 3 Tier
3. You can choose to either type in the drug name (or at least 3 letters of the name), or choose to view the entire list of drugs, in alphabetical order.
4. If you choose to view the entire list, you will have the option to download the list, or filter by the drug's first letter.
5. The results will show if the drug is covered, what Tier it is under, and any requirements or restrictions for obtaining a prescription.

PATIENT CARE ADVOCACY SERVICES

Sometimes dealing with an insurance company can be stressful. It may feel like they are speaking another language. Whether you have a question about your benefits or if you need help working with one of the insurance companies to ensure a claim is paid properly, our insurance broker MDG is here to help you.

This confidential service is available to you Monday-Friday, 8am to 5:30pm:

- Answer questions about your benefits
- Explain how to best use your plan
- Resolve claims and billing issues
- Clarify the total and out-of-pocket costs for services
- Assist with referrals and prior authorization
- Help with claim appeals
- Help you find a doctor or hospital

This service is completely free to you and your dependents and you are automatically enrolled when you participate in an AF benefit plan. For assistance, contact MDG at 888-282-1591 or email AFBenefits@mdgbenefits.com



Your benefit plan is supported by MDG – Employee Benefit Solutions
AFBenefits@mdgbenefits.com
888 282 1591 TOLL FREE
203 315 0510 FAX
www.mdgbenefits.com

403(B) RETIREMENT PLAN

After one year of continuous employment, employees are eligible to receive the company's discretionary matching contributions and discretionary contributions. AF will match 100% of your contributions to the 403(b) up to 4% for eligible employees, to a maximum of \$2,500.

You can start saving pre-tax today up to \$19,500 + and additional \$6,500 if you are over 50 years of age in the 2021 calendar year.

403(b) Employer Match

Matching contributions begin the 1st day following your 1 year anniversary of employment. Contributions are deposited annually.

Years of Service	Percent Vested in Plan
1	0%
2	0%
3	100%

To participate in the 403(b) plan, you will need to contact Transamerica by logging into the Transamerica portal website or by calling customer service at 800-755-5801. With Transamerica, you will complete a Salary Reduction Agreement online and the data will flow from Transamerica back to your payroll profile in ADP automatically. Changes to benefits elections will take 1-2 payroll cycles to go into effect.

Any questions you have regarding your 403b contributions amounts should go to Team Talent Operations via email at AF_TalentOps@achievementfirst.org. If you already have an account, you can access your account online at <http://www.af.trretire.com>.

You can also find additional information on the 403(b) plan on Many Minds.

Connecticut TRB

Connecticut staff may also be eligible for the Connecticut Teachers Retirement System. Any staff member who contributes to the TRS system will NOT be eligible for a match through Transamerica. CT staff members who are also uncertified for their role (but should be certified) are also not eligible for a match.

If you need to update your address with TRB, please do so by updating your address in ADP. Employee addresses in ADP flow over to TRB's database within one month. More information about TRB eligibility and DSO action steps can be found from Team Finance.

DEPENDENT CARE ASSISTANCE PROGRAM (DCAP)

AF offers benefit eligible employees the ability to enroll in a Dependent Care Assistance Program (DCAP) Flexible Spending Account (FSA). You can use a DCAP to pay for dependent care expenses you incur while you are working, like daycare, after school care, or summer camp.

You can deposit up to \$5,000 per year, per household pre-tax through payroll deductions into the account.

What happens to my FSA dollars if I don't use them?

Any unused funds in the DCAP FSA at the end of the year will be forfeited. Funds do not roll over. You have 60 days from the end of the plan year (which is June 30th) to submit reimbursements from the prior year to be reimbursed.

Who is in charge of my DCAP?

American Benefits Group (ABG) administers AF's plan. When you enroll in the plan, after your first payroll deduction, you will receive a welcome packet in the mail from ABG that will give you access to their online portal. Through the online portal, you can request reimbursement from the funds that are deposited in your account.

How do I use the money deposited into my DCAP?

You can only access funds that have already been deposited into your FSA account. You can submit a receipt for your eligible dependent expenses through the online portal. You can then choose to be reimbursed via direct deposit or via a paper check being mailed to you.

For additional information including what expenses are considered to be eligible for reimbursement, please visit Many Minds.

COMMUTER BENEFIT PLAN (CBP)

AF offers benefit eligible employees the ability to enroll in a transit and parking expense plan. You can use a CBP to pay for mass transit or parking expenses, including UberPOOL and Lyft Line.

You can deposit up to \$270 per month, per household pre-tax through payroll deductions into the account.

What happens to my Commuter dollars if I don't use them?

Any unused funds roll over from month to month. If you leave AF, the funds do not come with you, they would be forfeited. You cannot use more than the federal maximum of \$270 per month, even if the balance is higher.

Who is in charge of my DCAP?

Benefit Resource, Inc. (BRI) administers AF's plan. When you enroll in the plan, you will receive a Beniversal Prepaid Mastercard, which you can use to pay for qualified expenses or to add funds to your SmartLink card.

For additional information including what expenses are considered to be eligible, please visit Many Minds.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to make certain that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive health insurance coverage at this time.

Loss of Other Coverage

If you are declining coverage 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 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact your DSO.

Note: If you or your dependents enroll during a special enrollment period, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a pre-existing condition exclusion period of more than 12 months. Any pre-existing condition exclusion period will be reduced by the amount of your prior creditable health coverage. Effective for plan years beginning on or after Jan. 1, 2014, health plans may not impose pre-existing condition exclusions on any enrollees.

PATIENT PROTECTION DISCLOSURE

Cigna generally allows 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the member services department on the back of your ID card.

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

WOMENS' HEALTH & CANCER RIGHTS ENROLLMENT ACT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your Plan Administrator.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved OMB No. 1210-0149
(expires 5-31-2020)

PART A: GENERAL INFORMATION

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 your DSO if you are a school-based employee, or Team Talent Operations if you are a Network Support employee.

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		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)		12. Email address

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

•As your employer, we offer a health plan to:

Some employees. Eligible employees:

- (1) Work at least 30 hours per week
- (2) Work 20 hours per week and have previously worked for at least 30 hours per week for at least one year
- (3) or, are Temporary workers that work more than 90 days meeting the minimum hours

•With respect to dependents:

We do offer coverage. Eligible dependents are:

An individual who is the son, daughter, stepson, or stepdaughter of the subscriber;

An individual who was legally adopted by the subscriber;

An individual who is placed with the subscriber for legal adoption by the subscriber;

A child for whom the subscriber is the court-appointed guardian; or

An eligible foster child (defined as an individual who is placed with the subscriber by an authorized placement agency or by judgment, decree, or other court order).

Domestic partner, same or opposite sex

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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months? Yes (Continue) No (STOP and return this form to employee)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)

14. Does the employer offer a health plan that meets the minimum value standard*?
 Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month
 Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month
 Monthly Quarterly Yearly

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 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDRENS 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 January 31, 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

<p>GEORGIA – Medicaid</p>	<p>MASSACHUSETTS – Medicaid AND CHIP</p>
<p>Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131</p>	<p>Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840</p>
<p>INDIANA – Medicaid</p>	<p>MINNESOTA – Medicaid</p>
<p>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</p>	<p>Website: https://mn.gov/dhs/people-we-serve/children-andfamilies/health-care/health-care-programs/programs-andservices/other-insurance.jsp Phone: 1-800-657-3739</p>
<p>IOWA – Medicaid and CHIP (Hawki)</p>	<p>MISSOURI – Medicaid</p>
<p>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</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p>KANSAS – Medicaid</p>	<p>MONTANA – Medicaid</p>
<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884</p>	<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>
<p>KENTUCKY – Medicaid</p>	<p>NEBRASKA – Medicaid</p>
<p>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</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
<p>LOUISIANA – Medicaid</p>	<p>NEVADA – Medicaid</p>
<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p>Medicaid Website: http://dhcnp.nv.gov Medicaid Phone: 1-800-992-0900</p>
<p>MAINE – Medicaid</p>	<p>NEW HAMPSHIRE – Medicaid</p>
<p>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: 1-800-977-6740 TTY: Maine relay 711</p>	<p>Website: https://www.dhhs.nh.gov/oi/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>

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/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
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/providers/Providers/Pages/Medical/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 Rlte 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 January 31, 2021, or for more information on special enrollment rights, contact either:

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

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

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)

GLOSSARY OF TERMS

- **Provider:** any doctor, clinic, hospital or lab that provides medical services.
- **Coverage:** what services are actually included in the medical plan. For AF, all three of our plans offer the exact same coverage.
- **Premiums:** the fixed amount of money that is withheld from every paycheck. This is the cost of being in the plan and does not cover any services.
- **Co-pay:** the flat fee that is paid at every visit with a provider.
- **Deductible:** the amount of money you are responsible for first.
- **Co-insurance:** the split between insurance and you after you have met the deductible.
- **Out-of-Pocket Maximum:** the absolute maximum you will pay for services (co-pays OR deductible + co-insurance) in a plan year. This total does not include what you pay in premiums!
- **HRA:** Health Reimbursement Account – a plan that offers a way for your employer to “reimburse” some of your deductible
- **HDHP:** High Deductible Health Plan – a plan that includes a high-dollar deductible before insurance covers any cost. Subject to various IRS rules.
- **HSA:** Health Savings Account – a personally-owned savings account that only staff enrolled in the HDHP can contribute to pre-tax. Subject to various IRS rules.
- **FSA:** Flexible Spending Account – a use-it-or-lose-it account where staff can contribute money pre-tax. AF does not currently offer health FSAs, but we offer a Dependent Care Assistance Program, which is an FSA.