Let’s get ready for Annual Enrollment.

Here is your Decision Guide, so let’s get started!

CONTRACTORS GUIDE

What's Inside

**This guide is designed to assist you in making benefit election choices and represents only a brief summary of available plans. This booklet is not intended as an official interpretation of the plans. For more detailed information, please refer to the Certificate of Coverage or Summary Plan Description. Should any question arise, the Certificate of Coverage or Summary Plan Description will be the final authority in determining the benefits provided by your plans. CorTech, LLC Inc. reserves the right to modify, amend or terminate the plan at any time.*

Dear Valued Employee:

CorTech, LLC recognizes that our employees are the most valuable asset a company can have. We are committed to your wellbeing and realize that each person's needs are unique. Our objective is to provide a benefits package that is comprehensive, affordable, diverse, mindful of our unique corporate culture, and sensitive to our business needs. In consideration of this, we strive to offer a variety of benefits with highly rated carriers and vendors designed to offer you opportunities to mitigate your risks and provide peace of mind to you and your family.

To fulfill these objectives, we are committed to:

- Continuously evaluating how we choose our healthcare coverage, how we are using healthcare services, and how we can help our employees manage their personal health decisions.
- Providing affordable opportunities for our employees to mitigate their financial risks.
- Communicating with and educating you about the benefits and resources available to you.

As benefits represent an important component of your total compensation package, we are pleased to provide you with the 2021 benefit offerings included in this guide. Please review this enrollment guide for a summary* of the benefits that are available to you and your family for enrollment along with tips and resources that will help you maximize the value of the coverage you elect. This guide will summarize who is eligible to enroll, when you are eligible to enroll, what coverage options are available to you and the cost of coverage. It will also provide you contact information in case you have detailed questions or need more information.

Regards,
Vincent Rossy, CEO

ELIGIBILITY

Eligibility for You and Your Dependents

You are eligible to participate in the group benefit plans if you are an active full-time employee and scheduled to work 30 or more hours per week. Employees are eligible to enroll after their New Hire Waiting Period. Certain dependents of eligible team members can enroll in the medical, dental, vision, and voluntary benefits.

Eligible Dependents Include:

- Your legally married spouse
- Your natural children, legally adopted children, step children and children for whom you assume legal guardianship up to age 26
- Children age 26 or older incapable of self-support due to a mental or physical condition incurred prior to age 26. You may be required to complete a Handicapped/Disabled Certification form prior to the child attaining age 26

Qualifying Life Events

The choices you make during your New Hire period or Annual Open Enrollment period are irrevocable until either the next Annual Open Enrollment period or unless you experience a qualifying life event. Qualifying life events include changes to your legal marital status, giving birth or adopting a child, a change in you or your spouse's employment status or your entitlement to Medicare.

If you anticipate any of these changes, please see Human Resources in advance of the event to verify your right to change plan coverage(s). You must elect your change in benefits within 30 days of the qualified life event. If you do not notify Human Resources within 30 days of a qualifying event, you will have to wait until the next annual open enrollment period to make benefit changes unless you have another qualifying event.


Loss of Essential Coverage


Loss of COBRA Benefits


Marriage or Divorce


Permanent Relocation


Birth, adoption or new dependent


Aged off of Parent's Plan


Change in Citizenship


Change in Employment Status


Death in Family


Change in Government Assistance Eligibility

HOW TO ENROLL

If you will be electing coverage this year, you will need to follow these directions to complete the process. If you have trouble enrolling, contact a member of our Human Resources department.

All benefit eligible employees will be required to login to the **"ease"** enrollment system and make enrollment elections.

Step 1: Log In

Go to www.employeenavigator.com and click Login

- Returning users: Log in with the username and password you selected. Click Reset a forgotten password.
- First time users: Click on your Registration Link in the email sent to you by your admin or Register as a new user. Create an account, and create your own username and password.

Step 2: Welcome!

After you login click Let's Begin to complete your required tasks.

Step 3: Onboarding (For first time users, if applicable)

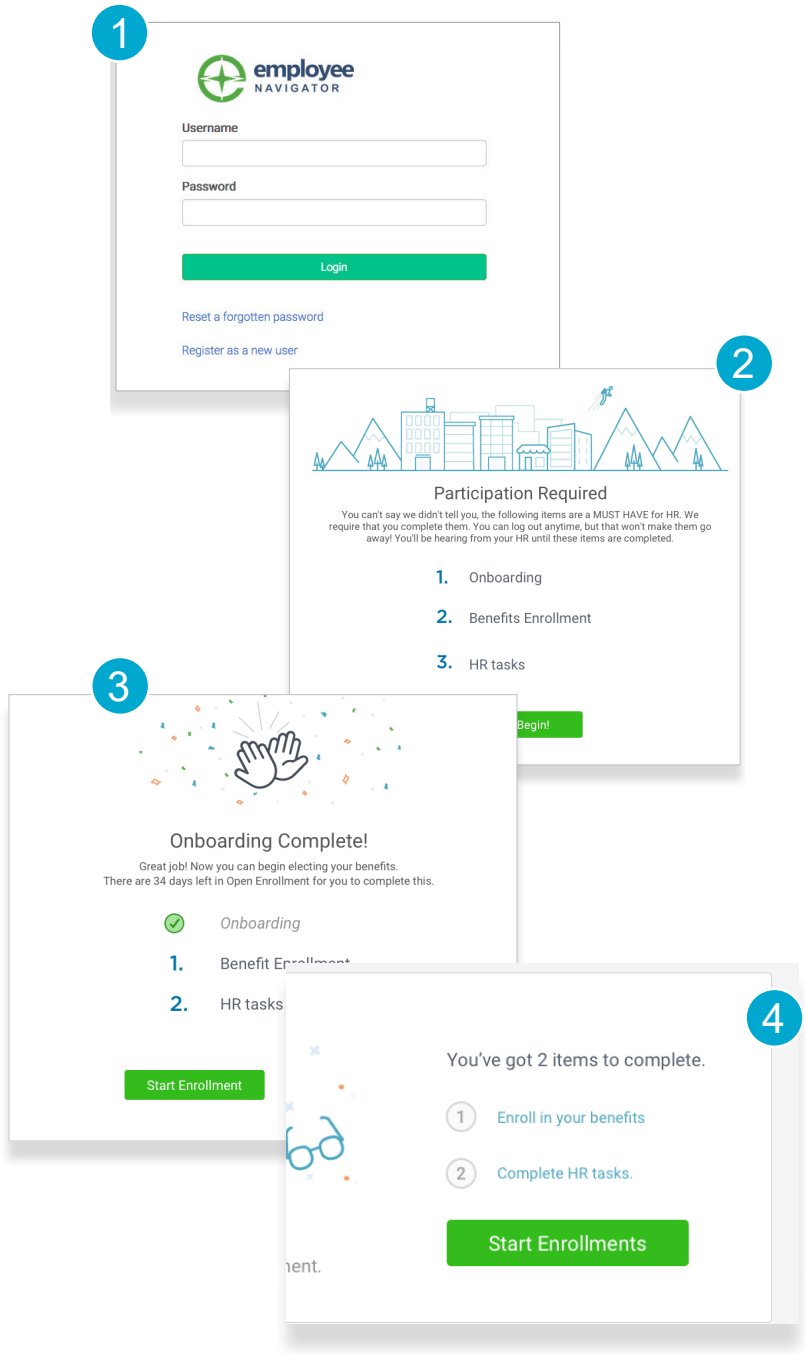
Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks click Start Enrollment to begin your enrollments.

TIP: if you hit "Dismiss, complete later" you'll be taken to your Home Page. You'll still be able to start enrollments again by clicking "Start Enrollments"

Step 4: Start Enrollments

After clicking Start Enrollment, you'll need to complete some personal & dependent information before moving to your benefit elections.

TIP: Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.



HOW TO ENROLL

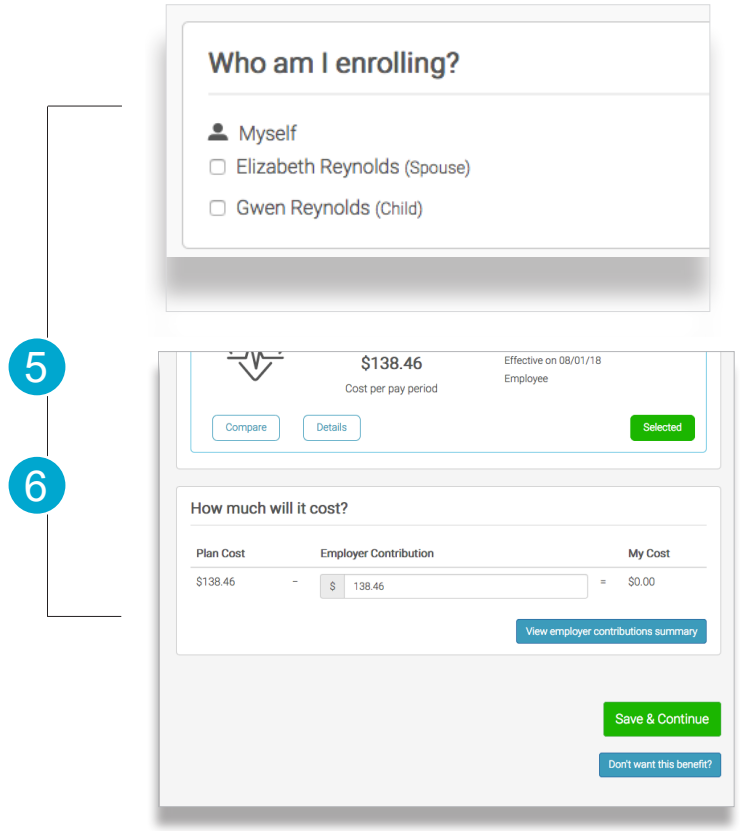
Step 5: Benefit Elections

To enroll dependents in a benefit, click the checkbox next to the dependent's name under Who am I enrolling?

Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click Select Plan underneath the plan cost.

Click Save & Continue at th elections.

If you do not want a benefit, click Don't want this benefit? at the bottom of the screen and select a reason from the drop-down menu.



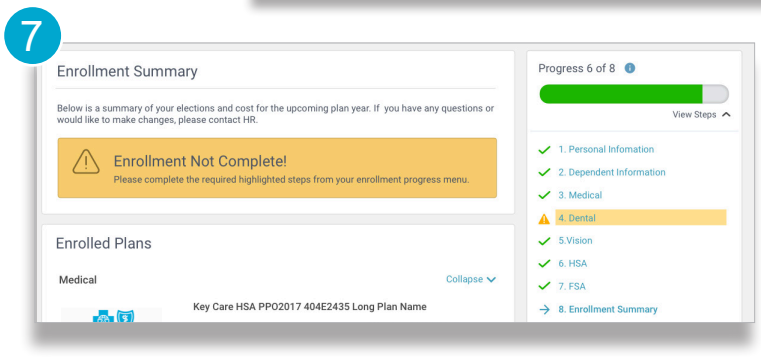
Step 6: Forms

If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.

Step 7: Review & Confirm Elections

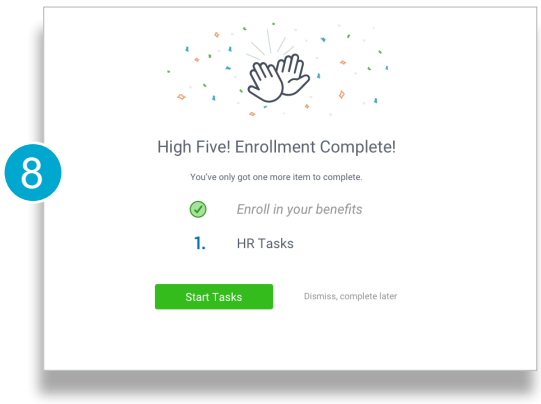
Review the benefits you selected on the enrollment summary page to make sure they are correct then click Sign & Agree to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.

TIP: If you miss a step you'll see Enrollment Not Complete in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.



Step 8: HR Tasks (if applicable)

To complete any required HR tasks, click Start Tasks. If your HR department has not assigned any tasks, you're finished!



CONTACT INFORMATION

Medical
GPA
Group #: H880166
1-800-827-7223
www.gpatpa.com

Pharmacy
CVS Caremark
1-866-475-0056
www.caremark.com

Dental
MetLife
Group #: 0218342
1-800-942-0854
www.MetLife.com

Vision
MetLife
Group #: 0218342
1-855-638-3931
www.MetLife.com

Voluntary Life Insurance
Anthem Blue Cross Blue Shield
800-552-2137
greatergeorgialife@anthem.com

Short Term Disability
Anthem Blue Cross Blue Shield
800-232-0113
greatergeorgialife@anthem.com

Worksite Benefit Insurance
Anthem Blue Cross Blue Shield
888-828-2432
greatergeorgialife@anthem.com

Marsh & McLennan Agency Broker Contacts
Agent Customer Service Hotline:
1-844-679-7737

Stefanny Hernandez
Benefits Advisor
Office: 770-622-7224
Stefanny.Hernandez@MarshMMA.com

Dee Ann Pierce
Senior Account Executive
Office: 770-295-1113
Cell: 470-415-9553
Dee.Ann.Pierce@MarshMMA.com

MOBILE APPS

Put your smartphone to work for you! Download these free apps from Google Play or Apple store.

CleverRx

Partnering with Pharmacies saves you money!

Features:

- Download your Clever RX App to unlock exclusive savings.
- Present your Clever RX App or Clever RX card to your pharmacist.
- Save up to 80% off prescription drugs and beat copay prices for FREE.

Q&A

Can you explain the meaning of some of the key terms in this guide?

- *Deductible:* a set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual basis.
- *Coinsurance:* the money that an individual is required to pay for services after the deductible has been met. It is often a specified percentage of the charges.
- *Copayment (aka Copay):* an arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his/her share when services are rendered. Copayments are usually a set dollar amount.
- *Out-of-pocket Maximum:* the total amount paid each year by the member for the deductible, coinsurance, copayments and other covered health care expenses, excluding the premium. After reaching the out-of-pocket maximum, the plan pays 100% of the allowable charges for covered services the rest of that year.

Will I receive new medical/dental/vision ID cards?

Anyone making changes to their plan or enrolling for the first time will receive new ID cards. If you are not making changes to your plan, you can still use your existing cards.

How much life insurance do I need?

Many people decide based on an income replacement calculation, between 5 and 10 times the amount of your current income. Think about your personal circumstances: Is yours the sole income in your household? Are there other expenses, such as college tuition, that may arise in the future? Don't forget to include potential medical and funeral costs. Above everything, you want to be sure your family does not get stuck with bills, debts or expenses that they cannot afford. Depending on your needs, you may want to consider buying supplementary coverage beyond what offers.

Why might I want Accident coverage if I am enrolled in a major medical plan?

This plan is not intended to replace major medical coverage. This plan complements medical plans by eliminating the concern of having to pay for a high deductible or other out-of-pocket expenses in the event of applicable catastrophic events. This plan can serve as an affordable way to fill in a gap in coverage and help reduce your financial risks.

What Network does the Medical Plan use?

All Medical Plans use the PHCS network of Doctors. To search for Providers, go to www.phcs.com and click on "Find a Physician."

HEALTHCARE BENEFITS

MEDICAL | DENTAL | VISION

MEDICAL

GPA

You have four medical plan options to choose from:

GPA MEC Plan	GPA Enhanced MEC Plan	GPA HDHP Plan	GPA MVP Plan
Annual Deductible: N/A Individual N/A Family	**Annual Deductible:** N/A Individual N/A Family	**Annual Deductible:** $4,500 Individual $9,000 Family	**Annual Deductible:** $4,200Individual $8,400 Family
Out-of-Pocket Maximum: $7,900 Individual $15,800 Family	**Out-of-Pocket Maximum:** $7,900 Individual $15,800 Family	**Out-of-Pocket Maximum:** $6,650 Individual $13,300 Family	**Out-of-Pocket Maximum:** $6,600 Individual $13,200 Family
Office Visits: N/A for Primary Care N/A for Specialist	**Office Visits:** $25 copay for Primary Care and Specialist	**Office Visits:** 80% after deductible for Primary Care and Specialist	**Office Visits:** $50 copay for Primary Care $75 copay for Specialist

Your Medical Coverage

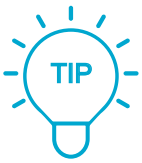
When choosing a health plan, you want to know what's available and how various benefit plan options fit your needs. You need to consider costs and benefits and then choose with confidence, knowing you have made the right decision for yourself and family. Please take as much time as necessary to review all your choices before you enroll. However, you must enroll by the stated deadline or you may miss your opportunity for coverage.

CorTech, LLC is pleased to offer you a choice of 4 health plans with different levels of costs and benefits. Before enrolling in a plan, consider what you want and need. Step back and look at how you and your family use health care and how much you pay for it. For example:

- Are you paying for coverage you don't need or use?
- Do you need more coverage than you have?
- How many prescription drugs do you and your family take?
- How much do you pay when you have a prescription?
- Does anyone in your family need ongoing medical care?

When choosing a health benefits plan, the most important question is: Will it provide the right amount of coverage for you and your family? After deciding how much coverage you need, consider the costs – and when you pay them.

*The MEC Plan is not a Creditable coverage for the state of Massachusetts.



You will receive your medical ID cards 2-3 weeks after you enroll. If you need care before you receive your card please call GPA.

This page is a summary only. For a complete list of benefit restrictions, limitations and exclusions, please refer to your Certificate of Coverage.

Medical Summary of Benefits

GPA Medical Plan Highlights				
Plan Type	**MEC Plan**	**Enhanced MEC Plan**	**HDHP Plan**	**MVP Plan**
In-Network				
Employee Deductible	N/A	N/A	$4,500	$4,200
Family Deductible	N/A	N/A	$9,000	$8,400
Employee Out-of-Pocket	$7,900	$7,900	$6,650	$6,600
Family Out-of-Pocket	$15,800	$15,800	$13,300	$13,200
Coinsurance	N/A	N/A	80% after ded	70% after ded
Preventive Services	100%	100%	100%	100%
Primary Care Copay	N/A	$25	80% after ded	$50
Specialist Copay	N/A	$25	80% after ded	$75
Inpatient Hospital Copay	N/A	N/A	80% after ded	70% after ded
Urgent Care	N/A	$25	80% after ded	$100
Emergency Room Copay	N/A	N/A	80% after ded	70% after ded

Semi-Monthly Monthly Payroll Deductions				
Plan Type	**MEC Plan**	**Enhanced MEC Plan**	**HDHP Plan**	**MVP Plan**
Employee Only	$35.00	$64.25	$293.61	$356.70
Employee + Spouse	$60.00	$110.00	$551.41	$712.70
Employee + Child(ren)	$54.00	$97.25	$491.91	$634.95
Family	$79.50	$144.00	$811.28	$1,052.20

If the monthly Employee Only Premium on the MVP or HDHP exceeds 9.61% of your monthly pay, you may be eligible for a cost subsidy from CorTech. Contact CorTech's HR Team for the details if you think you qualify.

*The MEC Plan is not a Creditable coverage for the state of Massachusetts.

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Prescription Medication Coverage

Our medical coverage through GPA includes a Prescription Drug Program. The cost of each prescription is determined by the tier it falls under. The three tiers are Generic, Preferred Drugs, and Non-Preferred drugs. You can find in-network pharmacies and a list of covered prescriptions at www.caremark.com.

Generic Drugs

To get more out of your health care plan, choose Generic drugs when possible. Generic drugs are the chemical equivalent of their more expensive brand name drug counterparts. Even if your doctor prescribes you a brand name drug, you can always ask for the Generic equivalent.

Preferred Drugs

Preferred brand drugs are prescriptions that your pharmacy benefit plan has selected as the most effective and cost efficient to treat certain conditions or illnesses. These brand name drugs are often more expensive than their generic counterpart.

Non-Preferred Drugs

Non-preferred brand drugs treat conditions or illnesses that can also be treated by a preferred brand or generic prescription. These drugs typically have a higher copayment.

Prescription Drug Tier Pricing		
In-Network Retail Rx (30 day supply)	**MEC Plan**	**Enhanced MEC Plan**
Generic	$2 or 20% (whichever is greater)	$2 or 20% (whichever is greater)
Preferred Brand Name	N/A	N/A
Non-Preferred Brand Name	N/A	N/A
Specialty	N/A	N/A
Mail Order (90 Day Supply)	**MEC Plan**	**Enhanced MEC Plan**
Generic	$2 or 20% (whichever is greater)	$2 or 20% (whichever is greater)
Preferred	N/A	N/A
Non-Preferred	N/A	N/A
Preferred Specialty	N/A	N/A

Prescription Drug Tier Pricing		
In-Network Retail Rx (30 day supply)	**HDHP Plan**	**MVP Plan**
Tier 1	$10	$10
Tier 2	$30	$30
Tier 3	$50	$50
Mail Order (90 Day Supply)	**HDHP Plan**	**MVP Plan**
Tier 1	$30	$30
Tier 2	$90	$90
Tier 3	$150	$150

WHAT IS ELAP?

If you are enrolled into the HDHP, Core or Buy-Up Plan, you will also have access to ELAP Services. ELAP works with you and your employer to ensure that you pay fair, **often times drastically reduced**, prices for your healthcare.

They are experts in:

- Cost reduction
- Employee advocacy services
- Legal defense for the plan and individual plan members

ELAP audits facility claims

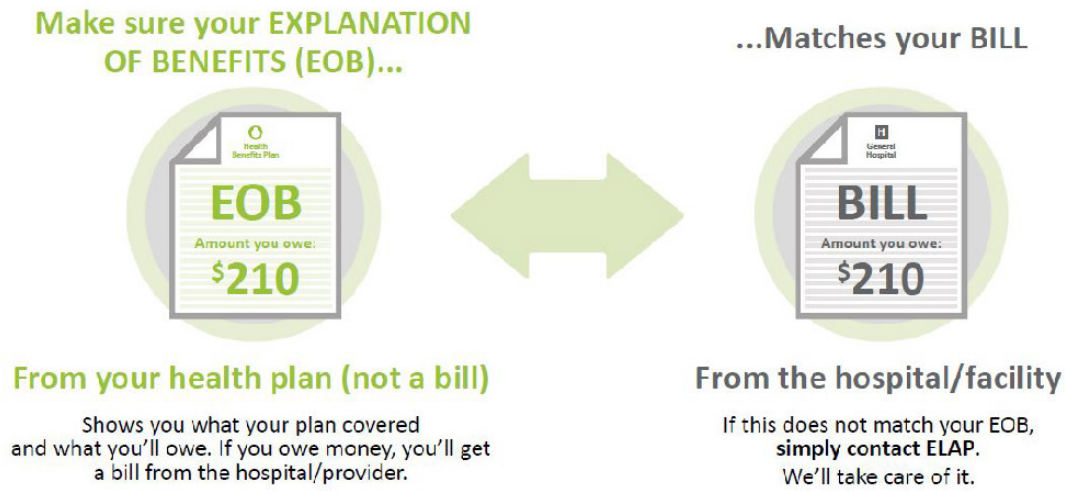
- Hospital
- Medical Center
- Surgery Center
- Rehab Center

Important steps after you receive a balance bill

1. Review your Explanation of Benefits to determine your out of pocket (OOP) expenses or co-pays. This amount is due to the provider.
2. If the amount is more than your OOP, send in your balance bill to ELAP.
3. An intake specialist will confirm the receipt of your bill and assign a personal member services advocate who will assist you throughout the entire process.

How ELAP Works

1. Member receives care at the facility/hospital
2. Claim goes to GPA and forwarded to ELAP for an Audit
3. ELAP determines reimbursement per Plan Limits
4. Facility receives Audit and payment
5. GPA sends member EOB and “Heads up” letter



How to Contact ELAP
1-800-977-7381
balancebills@elapservices.com

Enroll Today! Call 1-877-217-3381 or log into www.employeenavigator.com/benefits/Account/Login 10

DENTAL

MetLife

You have one dental plan option through MetLife. Although you can use an out-of-network dentist, you will save the most money out of your pocket by using MetLife dentists who have agreed to give you negotiated rates. To see what dentists are in the network, call 1-800-942-0854 or visit www.metlife.com.

You have two dental plan options:

MetLife Low Plan

COVERED AT 100% — Preventive Services: x-rays, cleanings, exams

COVERED AT 80% — Basic Services: fillings, oral surgery

COVERED AT 50% — Major Services: implants, crowns, bridges, prosthetics

MetLife High Plan

COVERED AT 100% — Preventive Services: x-rays, cleanings, exams

COVERED AT 80% — Basic Services: fillings, oral surgery

COVERED AT 50% — Major Services: implants, crowns, bridges, prosthetics

Dental Summary of Benefits	MetLife Dental	
	Low Plan	High Plan
Calendar Year Benefit Maximum	$1500	$1500
Calendar Year Deductible *(applies to Basic & Major Only)*	$50/$150	$50/$150
Preventive Services	100%	100%
Basic Services	80%	80%
Major Services	50%	50%
Orthodontics *(for children up to age 19)*	N/A	50%
Orthodontia Lifetime Max	N/A	$1,500

Semi-Monthly Payroll Deductions	MetLife Dental	
Plan Type	**Low Plan**	**High Plan**
Employee Only	$17.27	$22.19
Employee + Spouse	$34.64	$44.53
Employee + Child(ren)	$42.54	$59.78
Family	$59.89	$82.45

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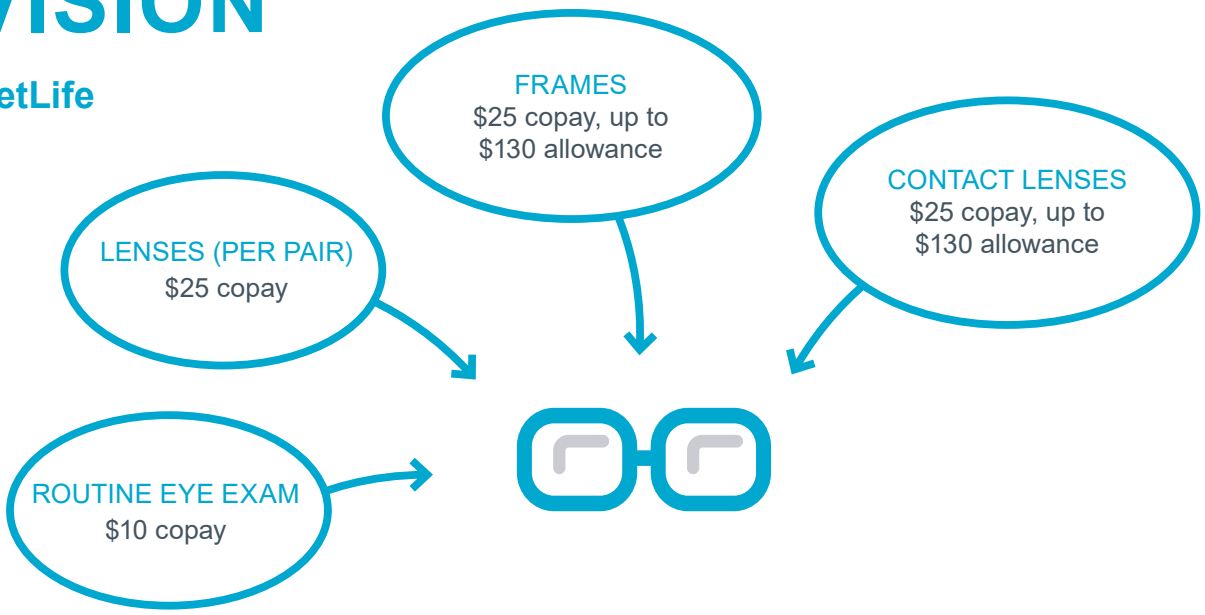
VISION

MetLife



Whether you have glasses, contacts, or even 20/20 vision, CorTech, LLC offers a comprehensive vision benefit provided by MetLife. Vision insurance is the key to maintaining good eye health, as annual exams may detect early warning signs of various health conditions.

Discovering Your Provider Network

For your convenience, this plan utilizes the MetLife Vision Network. When looking for a provider, please make sure they participate in the MetLife Network.

Additional Discounts

Additional discounts may be available for Laser Surgery and additional materials. Please refer to the plan summary for a complete listing.

Vision Summary of Benefits	
	VSP
Routine Eye Exam *(once every 12 months)*	$10
Lenses *(once every 12 months)*	
Single	$25
Bifocal	$25
Trifocal	$25
Frames *(once every 24 months)*	$25 copay, up to $130 allowance
Contact Lenses *(in lieu of glasses)*	$25 copay, up to $130 allowance

Semi-Monthly Payroll Deductions	
Plan Type	**VSP**
Employee Only	$3.27
Employee + Spouse	$6.53
Employee + Child(ren)	$5.71
Family	$8.98

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YOUR LIFE.
YOUR WORK.

LIFE INSURANCE | DISABILITY

VOLUNTARY LIFE

Anthem BCBS

Voluntary life insurance is available to supplement your employer paid life benefit. You can elect increments of $10,000 up to a max of $300,000. There is a Guaranteed Issue amount of $100,000 if you are a new enrollee or if this is a special enrollment period.

What does "Guaranteed Issue" mean?

Guaranteed issue is a term used in health insurance to describe a situation where a policy is offered to any eligible applicant without regard to health status.

Voluntary Life Summary of Benefits		
	Benefit Amount	**Guarantee Issue***
Employee Life and AD&D Benefit	$300,000	$100,000
Spouse Life and AD&D Benefit	$150,000	$30,000
Child(ren) Life Benefit	$10,000	$10,000

** The amount of coverage permitted without completing a health questionnaire for new hires.*

Employee – Monthly Rate for each $1,000 of Voluntary Life											
<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-99
$0.050	$0.060	$0.080	$0.090	$0.119	$0.186	$0.282	$0.453	$0.757	$1.27	$2.06	$4.63

Spouse – Monthly Rate for each $1,000 of Voluntary Life											
<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-99
$0.050	$0.060	$0.080	$0.090	$0.119	$0.186	$0.282	$0.453	$0.757	$1.27	$2.06	$4.63

Child Coverage – Monthly Rate for each $10,000 of Child Voluntary Life	
Per $10,000	$1.98

Understanding Voluntary Life Benefits:
https://www.brainshark.com/1/player/mmawest?pi=zJqznaelFzUxwmz0&r3f1=&fb=0

DISABILITY

Anthem BCBS

Voluntary Short Term Disability

CorTech offers full-time employees Short Term disability income benefits on a voluntary basis.

Accidents and illnesses happen every day. How long would your money last if your paycheck suddenly stopped? Thankfully, there is insurance that pays you an income if you become temporarily or permanently disabled.

Short Term Disability, STD, provides you with a specified percentage of your pre-disability income on a weekly basis. Conditions that can trigger Short Term Disability are usually temporary in nature, such as pregnancy, broken bones, sprains, or minor surgery. Most people use accumulated sick time to cover the waiting period.

Short Term Disability Summary of Benefits	
Elimination Period	8/8
Duration of Benefit	13 weeks
Percentage of Income Replacement	60%
Maximum Benefit	$1,000 Weekly
Pre-Existing Conditions	12/12

Short Term Disability Monthly Rates			
Age	**Rate**	**Age**	**Rate**
< 25	$0.57	50-54	$0.40
25-29	$0.57	55-59	$0.54
30-34	$0.55	60-64	$0.71
35-39	$0.39	65-69	$0.71
40-44	$0.34	70-74	$0.71
45-49	$0.36	74+	$0.71

Rates are per $10 of weekly benefit

How to Calculate Your Short Term Disability Bi-Weekly Premium

Martha

Example:

Martha is 33 years old and earns $48,000 per year. Below is how she would calculate her bi-weekly Short Term Disability premium:

$48,000 ÷ 52 ÷ 10 x 0.60 x $XX x 12 ÷ 26 = $XXX

Martha's salary — *Rate from table based on her age* — *Her bi-weekly premium*

Calculate your Short Term Disability premium:

Your salary = _____
Your rate based on your age (see table) = _____

$_____ ÷ 52 ÷ 10 x 0.60 x ____ x 12 ÷ 26 = _____

Your salary — *Rate from table based on your age* — *Your bi-weekly premium*

ADDITIONAL BENEFITS

CRITICAL ILLNESS | ACCIDENT
ANTHEM BCBS WORKSITE PRODUCTS
MEDICARE BACKOFFICE

CRITICAL ILLNESS

Anthem BCBS

Group Critical Illness Insurance

Critical Illness insurance pays a benefit upon the diagnosis and/or treatment of a named critical illness or certain category of major surgery. Plan options let you choose the amount of coverage you need.

The reasoning behind a critical illness policy is that someone with employer provided health care coverage and disability coverage could still incur a large amount of costs in copayment, deductibles, coinsurance, and non-covered items in the event of a critical illness.

Critical illness policies help to pay these expenses, and assist someone during their recovery by paying the insured a cash benefit. Depending on your carrier, you can choose $5,000-$10,000 of coverage. This money would be paid to you in cash for you to use as you see fit.

	$10,000 Benefit	$20,000 Benefit
Employee Coverage Amount	$10,000	$15,000
Spouse Coverage Amount	$5,000	$7,500
Child Coverage Amount	$5,000	$7,500
Rate Basis Type	Attained Age	Attained Age
Cancer Benefits		
Invasive Cancer	100% of Coverage Amount	100% of Coverage Amount
Non-Invasive Cancer	25% of Coverage Amount	25% of Coverage Amount
Benign Brain Tumor	100% of Coverage Amount	100% of Coverage Amount
Vascular Benefits		
Heart Transplant	100% of Coverage Amount	100% of Coverage Amount
Heart Attack	100% of Coverage Amount	100% of Coverage Amount
Stroke	100% of Coverage Amount	100% of Coverage Amount
Coronary Artery By-Pass Surgery	25% of Coverage Amount	25% of Coverage Amount
Other Specified Illness Benefits		
Coma	100% of Coverage Amount	100% of Coverage Amount
Paralysis	100% of Coverage Amount	100% of Coverage Amount
Major Organ Transplant	100% of Coverage Amount	100% of Coverage Amount
End Stage Renal Disease	100% of Coverage Amount	100% of Coverage Amount
Loss of Hearing	100% of Coverage Amount	100% of Coverage Amount
Loss of Speech	100% of Coverage Amount	100% of Coverage Amount
Loss of Vision	100% of Coverage Amount	100% of Coverage Amount
Recurrence Benefits		
Recurrence Waiting Period	6 months	6 months
Invasive Cancer	50% of Previously Covered Benefit	50% of Previously Covered Benefit
Benign Brain Tumor	50% of Previously Covered Benefit	50% of Previously Covered Benefit
Heart Transplant	50% of Previously Covered Benefit	50% of Previously Covered Benefit
Heart Attack	50% of Previously Covered Benefit	50% of Previously Covered Benefit
Stroke	50% of Previously Covered Benefit	50% of Previously Covered Benefit
Coma	50% of Previously Covered Benefit	50% of Previously Covered Benefit
Major Organ Transplant	50% of Previously Covered Benefit	50% of Previously Covered Benefit
Additional Benefits		
Health Screening Benefit	$50 per person, per year	$50 per person, per year
Skin Cancer Benefit	$500	$500
Pre-Existing Condition Limitations	None	None

CRITICAL ILLNESS

Anthem BCBS

Anthem Critical Illness with Cancer				
Age	$10,000 Benefit - $50 Be Well (Monthly Rates)			
	EE Only	EE+SP	EE+CH	Fam
18-24	$2.81	$4.67	$5.24	$7.51
25-29	$3.37	$5.56	$5.80	$8.39
30-34	$3.79	$6.21	$6.22	$9.04
35-39	$4.84	$7.81	$7.27	$10.64
40-44	$6.65	$10.57	$9.08	$13.40
45-49	$9.99	$15.59	$12.42	$18.43
50-54	$14.06	$21.65	$16.49	$24.48
55-59	$19.74	$30.08	$22.17	$32.91
60-64	$27.94	$42.28	$30.37	$45.11
65-69	$37.58	$56.75	$40.01	$59.58
70-74	$50.05	$75.31	$52.48	$78.14
75-79	$66.28	$99.60	$68.71	$102.43
80-84	$76.24	$114.46	$78.67	$117.29

Anthem Critical Illness with Cancer				
Age	$20,000 Benefit - $75 Be Well (Monthly Rates)			
	EE Only	EE+SP	EE+CH	Fam
18-24	$4.74	$7.56	$8.32	$11.74
25-29	$5.77	$9.17	$9.35	$13.35
30-34	$6.56	$10.38	$10.14	$14.55
35-39	$8.62	$13.50	$12.20	$17.67
40-44	$12.13	$18.80	$15.72	$22.98
45-49	$18.67	$28.56	$22.25	$32.74
50-54	$26.67	$40.43	$30.25	$44.60
55-59	$37.85	$56.95	$41.44	$61.13
60-64	$54.03	$80.91	$57.61	$85.08
65-69	$73.01	$109.26	$76.59	$113.43
70-74	$97.72	$145.98	$101.31	$150.15
75-79	$129.99	$194.18	$133.57	$198.35
80-84	$149.86	$223.78	$153.44	$227.95

ACCIDENT

Anthem BCBS

Accidents happen. Accident Insurance can help.

Accident coverage is one of the more common benefits people choose to elect. Any guesses why? It's because accidents are a leading cause of injury for people under age 40, and because they occur more randomly than sickness. Accident insurance pays you with cash benefits for expenses that may not be fully covered by your comprehensive health insurance, including:

- Treatment for an injury
- Ambulance cost for transportation to a hospital
- X-ray or lab exams
- Hospital confinement

Accident Insurance Semi-Monthly Payroll Deductions	
Employee Only	$3.79
Employee + Spouse	$5.96
Employee + Child(ren)	$6.27
Family	$9.88

		Medium 24 Hour Plan
Coverage Features	Pre-Existing Conditions Limitation	None
	Extended Continuation	Up to Age Limit
	Termination Age	Age 85
	Underwriting	Guaranteed Issue
	Eligibility Requirements	Must be Actively At Work
	Contribution Type	Voluntary
	On the Job Accidents	Covered

Hospital and Emergency Benefits	Once/accident within 90 days	Hospital Admission	$1,000
	Up to 365 days/lifetime (total daily and ICU)	Daily Hospital Confinement	$200
	Up to 30 days/accident (subject to 365 days/lifetime)	Daily Icu Confinement	$400
	Once/accident within 72 hours	Ambulance – Air	$1,000
	Once/accident within 90 days	Ambulance – Ground	$300
	Once/accident within 90 days	Blood/Plasma/Platelets	$300
	Once/accident within 72 hours	Emergency Room	$200
	Once/accident within 90 days	Diagnostic Exam	$150
	Once/accident within 72 hours	Urgent Care	$150
	Once/accident within 90 days	X-Ray	$150

ACCIDENT

Anthem BCBS

			Medium 24 Hour Plan
Hospital and Emergency Benefits	Up to 3 treatments/accident within 90 days	Accident Follow-Up	$75
	Up to 10 visits/accident within 365 days	Acupuncture	$25
	Up to 30 days/accident while insured is confined	Child Care	$25
	Up to 10 visits/accident within 365 days	Chiropractic Care	$25
	Up to 3 trips/accident	Transportation	$300
	Once/accident within 90 days	Initial Physician Office Visit	$75
	Up to 30 nights/lifetime	Lodging	$125
	Once/accident within 90 days	Medical Appliance	$150
	Up to 10 visits/accident within 90 days	Physical Therapy	$50
	Up to 15 days/lifetime within 90 days	Rehabilitation Facility	$150
Specified Injury & Surgery Benefits	ABDOMINAL/THORACIC SURGERY		$1,000
	ARTHROSCOPIC SURGERY		$300
	CONCUSSION		$200
	EMERGENCY DENTAL – CROWN		$300
	EMERGENCY DENTAL – EXTRACTION		$100
	EYE INJURY – OBJECT REMOVAL		$150
	EYE INJURY – SURGERY		$450
	KNEE CARTILAGE – WITH REPAIR		$750
	KNEE CARTILAGE – WITHOUT REPAIR		$150
	LACERATION – 2” TO 6”		$150
	LACERATION – 6” OR GREATER		$300
	RUPTURED DISC		$750
	TENDON/LIGAMENT/CUFF – SINGLE		$750
	TENDON/LIGAMENT/CUFF – 2 OR MORE		$1,000
Catastrophic Benefits	COMA (≥ 168] CONTINUOUS HOURS)		$10,000
	BURN – 2ND DEGREE (≥ 34% OF BODY SURFACE)		$1,000
	BURN – 3RD DEGREE (≥ 18 Sq. In. OF BODY SURFACE)		$10,000
	BURN – SKIN GRAFT (FOR 3RD DEGREE BURN)		25% of 3rd Degree Burn Benefit
	HOME HEALTH CARE		$50
	PARALYSIS – QUADRIPLEGIA		$10,000
	PARALYSIS – PARAPLEGIA		$5,000
	PROSTHESIS – SINGLE		$750
	PROSTHESIS – 2 OR MORE		$1,500

ACCIDENT

Anthem BCBS

Accidental Death & Dismemberment

Accidental Death and Dismemberment Schedule

- Death or dismemberment must occur within 90 Days of the Accident
- Spouse benefit payable at 50% of employee benefit
- Child(ren) benefit payable at 25% of employee benefit

	Medium 24 Hour Plan
Accidental Death	$50,000
Common Carrier Death	$150,000
Both Hands Or Both Feet	$50,000
Sight – Both Eyes	$50,000
Speech & Hearing (Both Ears)	$50,000
1 Hand & 1 Foot	$25,000
1 Hand/Foot & Sight Of 1 Eye	$50,000
1 Hand Or 1 Foot	$25,000
Sight – 1 Eye	$25,000
Speech Or Hearing (Both Ears)	$25,000
Thumb & Index Finger (Same Hand)	$5,000

Dislocation Schedule

Dislocation Benefit Schedule

- Payable for either Open or Closed/Non-Surgical Dislocation
- Benefit for dependent spouse is 100% of the amount shown
- Benefit for dependent child(ren) is 100% of the amount shown
- Incomplete dislocations and dislocation without anesthesia are 25% of the benefit shown
- Multiple dislocations and fractures are payable up to 200% of the highest benefit

Ankle, Foot Bones (Except Toes)	$1,400
Collarbone – Acromio/Separation	$320
Collarbone – Sternoclavicular	$320
Elbow	$640
Finger, Toe	$320
Hip	$3,800
Knee	$1,800
Lower Jaw	$640
Shoulder (Glenohumeral)	$1,400
Wrist	$1,400
Hand Bones (Except Fingers)	$640

ACCIDENT

Anthem BCBS

Fractures Schedule

Fracture Benefit Schedule

- Amount shown is payable for either Open or Closed Frac-ture
- Benefit for dependent spouse is 100% of the amount shown
- Benefit for dependent child(ren) is 100% of the amount shown
- Chip fracture is payable at 25% of the benefit shown
- Multiple dislocations and fractures are payable up to 200% of the highest benefit

	Medium 24 Hour Plan
Ankle	$1,800
Foot Bones (Except Toes)	$1,800
Coccyx	$320
Collarbone/Clavicle Or Sternum	$1,800
Finger, Toe	$320
Forearm – Radius Or Ulna	$1,800
Hip, Thigh/Femur	$4,000
Kneecap/Patella	$1,800
Lower Jaw/Mandible (Exc. Alv. Process)	$1,400
Lower Leg – Fibula Or Tibia	$2,200
Nose, Facial Bones (Except Jaw Bones)	$640
Pelvis (Except Coccyx)	$3,600
Vertebrae – Processes	$640
Rib	$320
Shoulder Blade/Scapula	$1,800
Skull – Depressed	$3,600
Skull – Non-Depressed/Simple	$640
Upper Arm/Humerus	$1,800
Upper Jaw/Maxilla (Exc. Alveolar Process)	$1,400
Vertebrae – Body	$3,600
Wrist, Hand Bones (Except Fingers)	$1,800

HOSPITAL INDEMNITY

Anthem BCBS

Hospitalization is unplanned.

Even with your employer's medical insurance, the cost of a hospital stay can be overwhelming. According to HealthCare.gov, the average price for a three-day hospital stay is $30,000.

Voluntary hospital indemnity coverage pays a fixed, pre-determined dollar amount for each day the insured is confined to a hospital for either sickness or injury. The plan pays benefits without regard to actual medical expenses and do not decrease if benefits are paid by other coverage. It can also cover unforeseen expenses such as travel, child care during hospital visits, and home maintenance expenses.

To purchase a hospital indemnity plan, you must be enrolled first in comprehensive health care coverage, as per the Affordable Care Act.

Anyone who is concerned about the cost of hospitalization or the potential impact on personal finances would be a good candidate for this type of policy.

HOSPITAL CARE		
Hospital Confinement	First Day Benefit	$2,000
First Day Hospital Confinement	Annual Max	1 Day
Hospital Confinement	Daily Benefit	$100
Daily Hospital Confinement	Annual Max	31 Days
Intensive Care Unit Confinement	Daily Benefit	$200
Daily Intensive Care Unit Confinement	Annual Max	31 Days

Hospital Indemnity Semi-Monthly Payroll Deductions	
Employee Only	$11.28
Employee + Spouse	$23.54
Employee + Child(ren)	$17.26
Family	$30.31

MEDICARE BACKOFFICE

Medicare BackOfficeTM can help you navigate the Medicare maze to find a plan that is right for you. Your Insurance Agent referred you to Medicare BackOffice™ because of our trusted Medicare expertise. Our dedicated insurance agents are licensed, contracted and certified in all 50 states to provide Medicare advice and products. We'd be happy to help you find an "A"-rated or better insurance carrier at a competitive rate.

Here is how our process works and what you can expect.

1. You call Medicare BackOfficeTM at 1-877-385-8083 to speak to a Licensed Insurance Agent.
2. You provide the name of your Insurance Agent to Medicare BackOffice™.

   Your Insurance Agent is: **Andrea Jordan**
3. You discuss with Medicare BackOffice™:
   - Your existing insurance coverage
   - The four parts of original Medicare and how it works
   - Types of coverage including Medigap, Medicare Advantage and prescription drug coverage
   - Which of those plans might work the best for you
4. You enroll, either by:

   a. having Medicare BackOffice™ help you enroll immediately

   OR

   b. having Medicare BackOffice™ email or mail the policy materials for you to review and enrolling at a later date.
5. You receive your new insurance policy ID card in the mail.

This is a free service offered to employees and their immediate family members, including spouses, parents and children.

LEGAL NOTICES

IMPORTANT NOTICES

Women's Health & Cancer Rights Act of 1998

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, 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 the other medical and surgical benefits provided under this plan. For more information, contact Human Resources.

Newborn's and Mother's Health Protection Act (Newborn Act)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice for Outcomes-based Wellness Programs

Our program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for total cholesterol + HDL + TC/HDL risk ratio, glucose, blood pressure and pulse, weight, height, waist circumference, body mass index (BMI). You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of $100 for completion of the HRA and Biometric screening. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive this incentive. Additional incentives may be available for employees who have completed the biometric screening and HRA AND participate in certain health-related activities; preventative exams, completing a coaching or health management program, utilizing a Center of Excellence for orthopedic, cardiac, childbirth or fertility surgery and/or procedure. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources.

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

IMPORTANT NOTICES

Protections from Disclosure of Medical Information

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

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

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources.

IMPORTANT NOTICES

Who is Eligible for CHIP/Children's Medicaid?

Texas families with uninsured children may be eligible for health insurance through Children's Medicaid and the Children's Health Insurance Program (CHIP). Both programs offer healthcare benefits, including regular check-ups and dental care. You can apply online at www.chipmedicaid.org, or by phone 800-647-6558. If you qualify for CHIP, you may be subject to a yearly enrollment fee of $0, $35 or $50 based on your monthly income.

CHIP and Children's Medicaid both offer a lot of benefits:

- choice of doctors, regular checkups and office visits
- dentist visits, cleanings and fillings
- prescription drugs and vaccines
- access to medical specialists and mental health care
- hospital care and services
- medical supplies, x-rays and lab tests
- treatment of special health needs
- treatment of pre-existing conditions

A child must be 18 or younger, a Texas resident and a U.S. citizen or legal permanent resident.

Any adult who lives more than half the time with an uninsured child may apply. This includes: parents, step-parents, grandparents, other relatives, legal guardians or adult brothers or sisters.

Income Guidelines must be met to be eligible:

CHIP Yearly Enrollment Fees

1. Find your family size on the left side of this chart.
2. Follow that row to the right and find your monthly income range.* The amount to the right will show what you will need to pay for your one-year enrollment fee if your children are approved for CHIP.

Find your family size here

1 Family Members (Adults plus children)	2 Monthly Income = Yearly Fee	Monthly Income = Yearly Fee	Monthly Income = Yearly Fee
1 **	$0 to $1,530 = $0	$1,531 to $1,874 = $35	$1,875 to $2,021 = $50
2	$0 to $2,072 = $0	$2,073 to $2,536 = $35	$2,537 to $2,736 = $50
3	$0 to $2,613 = $0	$2,614 to $3,199 = $35	$3,200 to $3,451 = $50
4	$0 to $3,153 = $0	$3,154 to $3,860 = $35	$3,861 to $4,163 = $50
5	$0 to $3,694 = $0	$3,695 to $4,523 = $35	$4,524 to $4,878 = $50
6	$0 to $4,235 = $0	$4,236 to $5,186 = $35	$5,187 to $5,593 = $50
7	$0 to $4,775 = $0	$4,776 to $5,847 = $35	$5,848 to $6,306 = $50
8	$0 to $5,316 = $0	$5,317 to $6,509 = $35	$6,510 to $7,020 = $50

*Income is money you get paid before taxes are taken out.
**A family of one might be a child who does not live with a parent or other relative.

IMPORTANT NOTICES

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 January 31, 2020. Contact your State for more information on eligibility –

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

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

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

CALIFORNIA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-800-541-5555

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child- health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
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: http://www.indianamedicaid.com
Phone 1-800-403-0864

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

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
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
Website: http://www.maine.gov/dhhs/ofi/public- assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

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

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/medical-assistance.jsp
[Under ELIGIBILITY tab, see "what if I have other health insurance?"]
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
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

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

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

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

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

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

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

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

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

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

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

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

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

MEDICARE PART D

This notice has information about your current prescription drug coverage with CorTech, LLC and 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.

Please Note: If you are not Medicare eligible, and none of your covered family members are Medicare eligible, no action is required on your part.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- 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.
- CorTech, LLC has determined that the prescription drug coverage offered by GPA is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare Drug Plan? If you decide to join a Medicare drug plan, your current CorTech, LLC coverage will not be affected. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current Flournoy 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 CorTech, LLC 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: 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 CorTech, LLC changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare Prescription Drug Coverage: More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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).

SPECIAL ENROLLMENT NOTICE FROM CORTECH, LLC

This notice is being provided to insure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive 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 because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our 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 by CorTech, LLC, 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 by CorTech, LLC, your children received health coverage under CHIP and you did not enroll them in our 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 Human Resources.

**This guide is designed to assist you in making benefit election choices and represents only a brief summary of available plans. This booklet is not intended as an official interpretation of the plans. For more detailed information, please refer to the Certificate of Coverage or Summary Plan Description. Should any question arise, the Certificate of Coverage or Summary Plan Description will be the final authority in determining the benefits provided by your plans. CorTech, LLC Inc. reserves the right to modify, amend or terminate the plan at any time.*