ChenMed

TEAM MEMBER NEW HIRE ENROLLMENT GUIDE

2024

New Hire Benefits Enrollment

Now is the time to focus on you.

We understand how important it is to have resources to help make the best decisions for you and your family. Review your options presented in this benefits guide, compare plans and choose what works best for you. Being an informed consumer regarding your employee benefits is important now more than ever.

You will enroll in medical/prescription drug, dental, vision and certain other benefits through the Aon Active Health Exchange™. The Aon Active Health Exchange is America's first national, large-employer, multi-insurance carrier exchange.

Your physical, emotional and financial health are important, especially during challenging times. That's why ChenMed offers a comprehensive benefits package in a vast array of plans that contribute to the present and future well-being of our employees and their families. To help promote "healthy choices," ChenMed offers premium discounts for the Medical/Rx plan for eligible employees and their eligible dependents who complete various wellness activities.

Para obtener una versión en español de esta guía, visite la intranet de ChenMed.

Take Action!

All new hires must complete the enrollment process to elect or waive benefits for the 2024 plan year. You must actively enroll within 30 days of your date of hire or you WILL NOT have ChenMed benefits in 2024. You can complete your enrollment with the help of a Benefits Counselor or online. Benefits are effective on your 1st day of employment.

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ChenMed offers a full range of coverage that protects you financially and helps you build a secure future.

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Employees:

Regular full-time employees working at least thirty (30) hours per week are eligible on their first day of employment.

Dependents:

- Your legal spouse.
- Your children under the age of 26, regardless of student status for medical, dental and vision coverage, including married dependents, but not their spouse and/or children.
- Your unmarried, dependent children who become mentally or physically incapable of earning a living, before age 26 (medical certification required) for medical, dental and vision coverage.

Proof of Eligibility:

If you are enrolling an eligible spouse during enrollment, proof such as, but not limited to, a certificate of marriage is required.

If you are enrolling an eligible dependent child during enrollment, proof is required. Examples of proof of dependency include but are not limited to: birth certificate, adoption, foster or legal medical support order indicating the participating employee as the parent. To submit proof of dependency on the **ChenMed Benefits Portal**, go to the **To-Dos** section and select **Verify Your Dependent's Eligibility for Health Benefits**.

Enrollment

Log on to **digital.alight.com/chenmed**, click the button to enroll and follow the prompts to create your account. From the ChenMed Benefits Portal, register as a new user, follow the prompts to provide the requested information and set up your username and password. If you need help, you can schedule an appointment with a Certified Benefits Counselor who can answer your questions and help you enroll in coverage. To schedule your appointment, click on the **Benefits Counselor** tile. Review your enrollment insert for more information.

The AON Active Health Exchange

The Aon Active Health Exchange creates a dynamic health coverage market for ChenMed employees. The exchange offers a menu of standardized plans with multiple insurance carriers that compete at the consumer level. This innovative structure provides employees with a broad choice of health coverage options.

The medical plans on the exchange ensure access to the Nation's top providers and are integrated with clinical programs that address acute and chronic needs. Telehealth and independent expert medical opinions deliver convenience and improved care quality.

Decision-support tools are available to help employees make confident decisions to protect those they care about the most. Employees can truly personalize their benefit choices.

The Aon Exchange provides our ChenMed employees with some unique advantages:

- **Lots of choices.** Each employee can shop and choose from several coverage levels, a variety of insurance carriers, and a range of costs. Options can vary based on where you live.
- **Competitive pricing.** The insurance carriers are competing for business, so it's in their best interests to offer their best prices. Plus, ChenMed will provide an employer contribution (credit) for employees to use toward the cost of coverage.
- **Helpful resources.** In addition to hosting employee webinars, there will be great resources to help before, during and after enrollment:
    - **Make It Yours website:** The **Make It Yours** website is a year-round resource for information about the available medical options, things to consider before enrolling and practical tips for employees to get the most out of their benefits.
    - **Insurance carrier "preview" websites:** These sites are available through the **Make It Yours** website so employees can get up to speed on each medical carrier's provider networks, prescription drug information and other programs.

Take Action!

Visit "**Make it Yours**" **chenmed.makeityoursource.com** to learn more about your medical (including prescription drug coverage) benefit options.

ChenMed Credit

Exchange plans are fully insured. That means the insurance carriers — not ChenMed — are responsible for the cost of claims. We'll show our commitment to help team members pay for health care coverage through a credit. Since the amount of the credit will not change during the year, our health care spending will be much more predictable. Offering a credit also ensures our benefits remain affordable to you. When you enroll, you'll be able to see the credit amount from ChenMed and your price options on the ChenMed Benefits Portal at **digital.alight.com/chenmed** or the Alight Mobile app. You'll also be able to access tools that give you a personalized suggestion, help compare the details of your options, let you see insurance carrier ratings and more.

Wellness Credit

Employees enrolled in one of the ChenMed medical plans must complete their **ChenMed Wellness Attestation** in order to receive the wellness credit towards the cost of their medical coverage. Your spouse does not need to complete the HRA or the Attestation to receive the credit. There is no cost to participate, and your personal health information is completely confidential.

- **ChenMed Wellness Attestation**
  Employees and their enrolled spouses who apply for the wellness credit must not use tobacco and comply with the safety items stated in the Wellness Attestation. You will complete this step during your enrollment.

The wellness credit will automatically be applied for the first month your coverage is effective. You must complete the **ChenMed Wellness Attestation** during your enrollment. Once completed, a payroll credit of $58.00 for you and $58.00 for your eligible spouse (if enrolled) will be applied to your premium payments.

Medical Plan Options

You can choose from five medical coverage plan designs **(Bronze, Bronze Plus, Silver, Gold, or Platinum)**, offered by national carriers **(Aetna, Blue Cross Blue Shield, Cigna and UnitedHealthcare)** and regional carriers **(Health Net, Dean/Prevea360, Kaiser Permanente, Geisinger Health Plan, UPMC, Medical Mutual and Priority Health)**.

The carriers available to you are based on the region in which you live, as determined by your ZIP code. Learn about each of the carriers on the **Make It Yours** website. Each plan design features different coverage levels, so you can choose the option that best suits your needs. When you enroll, you'll find plenty of tools and resources to help you select a coverage level.

Do not rely on your provider's office to know if they are in the carriers' network(s).

The Inside Scoop

You can easily navigate the **Make It Yours** microsite to get to Your Carrier Connection for plan information or click on **The Inside Scoop**, where you can find articles and videos about many essential health care topics. The Inside Scoop has tips on working the health care system, being a savvy shopper and saving money on most health care expenses.

To see whether your doctor is in-network:

- Visit Your Carrier Connection accessible from **chenmed.makeityoursource.com** to browse carriers and obtain contact information.
- When you enroll, check the networks of each insurance carrier you're considering on the ChenMed Benefits Portal. For the best results:
  - Search for your provider by name — not medical practice.
  - Check only the office location(s) you are willing to visit.
  - When searching for a facility, use the complete facility name and confirm whether the specialty of the facility is covered in-network.

Important! If you have any uncertainty (for instance, covering out-of-area dependents) or need the network name, you will need to call the insurance carrier.

California Residents

Your options may be different, depending on the insurance carrier you choose. Each insurance carrier in California can choose to offer each coverage level either as an option that offers in-network and out-of-network benefits (e.g., a PPO) or as an option that offers in-network benefits only (e.g., an HMO).

California insurance carriers may offer either the standard Gold option or a Gold II option — not both. The Gold II option offers only in-network benefits and has no deductible. Aetna, Blue Cross Blue Shield, Cigna and UnitedHealthcare offer the Gold option. Health Net and Kaiser Permanente offer the Gold II option. The regional carriers available to you depend on your home ZIP code.

Learn more about your California coverage options and insurance carriers on the **Make It Yours** website.

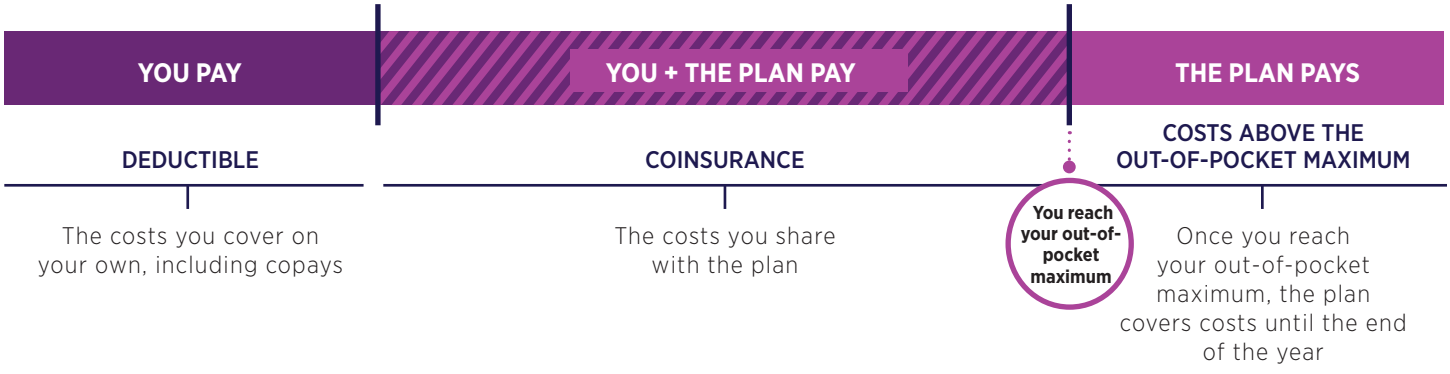
2024 Medical Plan Summary

	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
Plan Type	High-Deductible Option with HSA	High-Deductible Option with HSA	PPO	PPO	PPO that Offers Limited Benefit for Out-of-Network Care*
Annual Deductible					
In-Network (Individual/Family)	$3,300 / $6,600	$2,450 / $4,900	$1,000 / $2,000	$800 / $1,600	$250 / $500
Out-of-Network (Individual/Family)	$3,300 / $6,600	$2,450 / $4,900	$2,000 / $4,000	$1,600 / $3,200	$5,000 / $10,000
Traditional or True Family	Traditional	True Family	Traditional	Traditional	Traditional
Annual Out-of-Pocket Maximum					
In-Network (Individual/Family)	$6,400 / $12,800	$3,900 / $7,800	$5,300 / $10,600	$3,600 / $7,200	$2,300 / $4,600
Out-of-Network (Individual/Family)	$12,800 / $25,600	$11,500 / $23,000	$10,600 / $21,200	$7,200 / $14,400	$11,500 / $23,000
Traditional or True Family	Traditional	True Family	Traditional	Traditional	Traditional
In-Network Benefit					
Preventive Care	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible	Covered 100%, no deductible
Doctor's Office Visit	You pay 25% after deductible	You pay 25% after deductible	You pay $30 for PCP visit and $50 for specialist visit, no deductible	You pay $25 for PCP visit and $40 for specialist visit, no deductible	You pay $25 for PCP visit and $40 for specialist visit, no deductible
Emergency Room	You pay 25% after deductible	You pay 25% after deductible	$150 copay; then you pay 30% after deductible	You pay 25% after deductible	You pay 15% after deductible
Urgent Care	You pay 25% after deductible	You pay 25% after deductible	$50 copay	You pay 25% after deductible	You pay 15% after deductible
Inpatient Care	You pay 25% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay 25% after deductible	You pay 15% after deductible
Outpatient Care	You pay 25% after deductible	You pay 25% after deductible	If not an office visit, you pay 30% after deductible	If not an office visit, you pay 25% after deductible	If not an office visit, you pay 15% after deductible

**For some insurance carriers in CA, CO, DC, GA, MD, OR, VA, and WA, the Platinum coverage level is an HMO option that covers in-network care only.*

Remember: Getting care from an in-network medical provider always saves you money.

How Your Medical Plan Works



Prescription Benefits Comparison

When you enroll in medical coverage, you automatically have prescription drug coverage. Your prescription drug coverage depends on your medical coverage level and your medical insurance carrier. Each pharmacy benefits manager has its own rules about how prescription drugs are covered. That's why you should do your homework to find out how your medications will be covered — before choosing a medical plan and insurance carrier. Your pharmacy benefits will be managed by the carrier.

	BRONZE	BRONZE PLUS	SILVER	GOLD	PLATINUM
Preventive Drugs	**You Pay $0****	**You Pay $0****	**You Pay $0****	**You Pay $0****	**You Pay $0****
30-Day Retail Supply					
Tier 1 (Generally Lowest Cost Options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $12	You pay $10	You pay $8
Tier 2 (Generally Medium Cost Options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $50	You pay $40	You pay $30
Tier 3 (Generally Highest Cost Options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $70	You pay $60	You pay $50
90-Day Mail Order Supply					
Tier 1 (Generally Lowest Cost Options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $30	You pay $25	You pay $20
Tier 2 (Generally Medium Cost Options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $125	You pay $100	You pay $75
Tier 3 (Generally Highest Cost Options)	You pay 100% until you've met the deductible, then you pay 25%	You pay 100% until you've met the deductible, then you pay 25%	You pay $175	You pay $150	You pay $125

***Preventive drugs are determined by the insurance carrier or pharmacy benefit manager. You must have a doctor's prescription for the medication— even for products sold over the counter (OTC)—and you must use an in-network retail pharmacy or mail-order service. These charts may not take into account how each coverage level covers any state-mandated benefits, its plan administration capabilities, or the approval from the state Department of Insurance of the benefits offered by the plan. If you have questions about a specific benefit, contact the insurance carrier for additional information. Individual carriers may offer coverage that differs slightly from the standard coverage reflected here. In the event that there is a discrepancy between this document and the official plan documents, the official plan documents will control.*

This chart is a high-level listing of commonly covered benefit across carriers and coverage levels for the Aon Active Health Exchange. For a more detailed look at these and additional coverages, go to the ***ChenMed Benefits Portal****.*

Voluntary Benefits

Medical insurance does not prevent all of the financial strain of a major illness or injury. Many families don't have enough in their savings to cover the deductible and coinsurance of a major medical event. Voluntary benefits can help cover this out-of-pocket financial exposure for a reasonable cost.

The benefits are paid directly to you, allowing you to use the funds however you choose. You receive the full benefit even if you have other insurance. ChenMed offers Critical Illness Insurance, Accident Insurance and Hospital Indemnity Insurance.*

Did You Know?

Americans spend an average of **$5,000** a year on out-of-pocket health care costs.

Bureau of Labor Statistics Consumer Expenditures Survey 2020

Critical Illness Insurance

You can protect yourself from the unexpected costs of a serious illness.

Even the most generous medical plan does not cover all of the expenses of a serious medical condition like a heart attack or cancer. Critical Illness Insurance pays a full lump sum benefit directly to you if you are diagnosed with a covered illness that meets the plan criteria. The benefit is paid in addition to any other insurance coverage you may have.

Covered Illnesses include:

- Heart Attack
- Stroke
- Cancer
- Major Organ Transplant
- End Stage Renal (Kidney) Failure
- Coronary Artery Bypass Surgery**

Plan Features

Employee-Paid Coverage Options: You may choose a benefit amount of $5,000, $10,000, $15,000, $20,000, $25,000 or $30,000. Spouse and children will be offered 50% of the employee's issued benefit amount.

Guaranteed Acceptance: There are no health questions or physical exams required.

Portable Coverage: You can take your policy with you if you change jobs or retire.

Wellness Benefit

The plan provides a $75 benefit per covered person per calendar year if you or your covered dependents complete a covered health screening test such as a physical exam or receive an FDA-approved COVID-19 immunization.

How Critical Illness Insurance Works

When Marco had a heart attack, he was grateful his doctors were able to stabilize his condition. He learned there was some permanent damage to his heart. He began to see his costs adding up quickly. The good news is Marco received a lump sum payment of $10,000 to help cover these expenses from the Critical Illness coverage he elected during Benefits Annual Open Enrollment.

** The policies/certificates of coverage have exclusions and limitations which may affect any benefits payable. The policies/certificates of coverage or their provisions, as well as covered illnesses, may vary or be unavailable in some states for supplemental medical benefits.*

***The coverage pays 25% of the face amount of the policy once per lifetime for coronary bypass surgery.*

Accident Insurance

Major injuries are painful. But the financial impact of the medical treatment doesn't have to be.

Accident Insurance pays benefits directly to you if you suffer a covered injury such as a fracture, burn, ligament damage or concussion. Benefits are paid even if you have other coverage.

The benefit amount is calculated based on the type of injury, its severity, and the medical services required in treatment and recovery. The plan covers a wide variety of injuries and accident-related expenses, including:

- Injury Treatment (fractures, dislocations, concussions, burns, lacerations, etc.)
- Hospitalization
- Physical Therapy
- Emergency Room Treatment
- Transportation

Plan Features

- **Guaranteed Acceptance:** There are no health questions or physical exams required.
- **Family Coverage:** You can elect to cover your spouse and children.
- **24/7 Coverage:** Benefits are paid for accidents that happen on and off the job.
- **Portable Coverage:** You can take your policy with you if you change jobs or retire.

Health Screening Benefit

The plan provides a $75 benefit per covered person per calendar year if you or your covered dependents complete a covered health screening test such as a physical exam or receive an FDA-approved COVID-19 immunization.

How Accident Insurance Works

Sam trips playing basketball. He breaks his arm and chips a tooth which require a trip to the emergency room, physician follow-up visits, and physical therapy.

Fortunately, Sam has Accident Insurance which helps cover his out-of-pocket medical costs, including his deductible and coinsurance.

How Sam's Accident Benefit Was Calculated:

Medical Service	Sample Benefit
Emergency Room	$ 300
Fracture Benefit	$ 500
Broken Tooth Benefit	$ 400
Physician Follow-Up Visits (2)	$ 200 ($100 per visit)
Physical Therapy Visits (6)	$ 540 ($90 per visit)
TOTAL SAMPLE BENEFIT	**$1,940**

This scenario does not reflect the benefits of a specific Accident Insurance plan schedule. The benefits are generic for the purposes of this example to show how the benefit total of an Accident Insurance plan is calculated. The plan offered to you may provide different benefit amounts and may not cover all services. See the plan details for the benefit schedule for the plan offered to you.

Hospital Indemnity Insurance

Receive payments to help cover the cost of a hospital stay.

If you are admitted into a hospital, it doesn't take long for the out-of-pocket costs to add up. Hospital Indemnity Insurance pays benefits directly to you if you are admitted into a hospital for care or childbirth. Benefits are paid even if you have other coverage.

You receive a benefit as soon as you are admitted and then an additional benefit based on the number of days you are confined to the hospital. The benefit increases if you are admitted and confined to an intensive care unit or Inpatient Rehabilitation.

Plan Features

- **Guaranteed Acceptance:** There are no health questions or physical exams required.
- **Family Coverage:** You can elect to cover your spouse and children.
- **Portable Coverage:** You can take your policy with you if you change jobs or retire.

Benefits Available

Hospital Admission: $1,000 per day, limited to one day

Hospital Stay: $200 a day, up to 30 days per confinement, once per 90 days

Initial Confinement: Additional payment of 5x the daily benefit amount after confinement in a hospital, critical care unit, and/or rehabilitation facility. This benefit is limited to a maximum of four Initial Confinement Benefits per calendar year for all covered persons, but no more than one for each covered person.

ICU Confinement: $400 per day, up to 30 days per confinement, once per 90 days

Health Screening Benefit

The plan provides a $50 benefit per covered person per calendar year if you or your covered dependents complete a covered health screening test such as a physical exam or receive an FDA-approved COVID-19 immunization.

How Hospital Indemnity Insurance Works

Carl is injured in a car accident and is in the hospital for four days. He is then moved to a rehabilitation unit for three additional days. Carl has Hospital Indemnity Insurance. He receives a benefit for being admitted into the hospital and a benefit for each day of his in-patient and rehab stays.

How Carl's Hospital Indemnity Benefit Was Calculated:

Medical Service	Sample Benefit	Total
Hospital Admission	$1,000 per admission	$1,000
Hospital Confinement	$200 per day (4 days)	$800
Inpatient Rehabilitation Unit	$200 per day (3 days)	$600
TOTAL SAMPLE BENEFIT		**$2,400**

This scenario does not reflect the benefits of a specific Hospital Indemnity Insurance plan schedule. The benefits are generic benefits for the purposes of this example to show how the benefit total of a Hospital Indemnity plan is calculated. The plan offered to you may provide different benefit amounts and may not cover all services. See the plan details for the benefit schedule for the plan offered to you.

Health Savings Account (HSA)

Save for future medical costs and reduce your tax bill with this special savings account available to Bronze or Bronze Plus plan participants.

An HSA is a special tax deferred savings account in which both the employer and employee can deposit money, up to annual IRS limits. You can use your HSA funds to pay for qualified health care related expenses on a tax-free basis.

Here's How it Works

- When you enroll in the Bronze or Bronze Plus Plan, you are eligible to open an HSA.
- Choose the amount to contribute on a tax deferred bi-weekly basis, not to exceed the annual maximum.
- The deposited money is available to you and your dependents to help pay for qualified health care expenses, such as medical plan deductibles or coinsurance, prescription costs, dental bills, or other eligible out-of-pocket medical costs.
- If the money is not used by the end of the year, it will roll over and can be used at any time.

Keys to Growing Your HSA:

- Try not to use your HSA for routine expenses. If you can pay out-of-pocket, leave your HSA funds alone so that they can grow for when you need them in the future.
- Consider electing supplemental medical benefits to cover big ticket expenses from unexpected serious illnesses or injuries, and ensure they don't wipe away the money in your HSA.
- Monitor your fund's growth. Like a 401(k), your HSA funds earn interest through investments. Make sure your money is growing at an acceptable and safe pace.

HOW MUCH CAN YOU CONTRIBUTE?	Annual IRS Contribution Limit
Individual Coverage	$4,150*
Family Coverage	$8,300*

**Individuals age 55 or older can make an additional $1,000 in "catch up" contributions.*

Visit the **Make It Yours** microsite to see the HSA User's Guide, which includes details about how to grow your HSA, pay with an HSA, access your funds online and more.

Use your debit card from Alight Smart-Choice Accounts for your HSA or FSA

- Alight Smart-Choice Accounts makes it easy to access your HSA or FSA funds with:
- The Alight Smart-Choice Accounts debit card, which can be used to pay for eligible expenses.
- The Alight Smart-Choice Accounts mobile app, which provides a fast and secure way to check your balance and track expenses.

HSAs Deliver Triple Tax Savings

1. You don't pay federal income tax on the money you contribute.
2. You don't pay taxes on the interest you earn in your account.
3. You don't pay taxes when you use the money to pay for qualified medical services.

Flexible Spending Accounts (FSAs)

Reduce your income taxes while putting aside money for health and dependent care needs.

Flexible Spending Accounts allow you to put aside money for important expenses and help you reduce your income taxes at the same time. ChenMed offers three types of accounts — a Health Care FSA, a Limited Purpose FSA and a Dependent Care FSA.

HEALTH CARE FSA

Deductibles, copays, prescription drugs, medical equipment, etc.*

LIMITED PURPOSE FSA

Works with HSA eligible medical plans to cover dental and vision expenses.

DEPENDENT CARE FSA

Babysitters, daycare, day camp, home nursing care, etc.

How Flexible Spending Accounts Work

1. During your New Hire Enrollment, you decide how much to set aside for FSA expenses. You can update your amount once a year during Benefits Annual Open Enrollment for the following plan year. Your full contribution amount will be available for use on your benefit effective date.

2. Your contributions are then deducted from your paycheck on a pre-tax basis in equal installments throughout the calendar year for use on qualified expenses.

3. You can use your FSA debit card to pay for eligible expenses at the point of sale, or you can pay out-of-pocket and submit a claim form for reimbursement.

Use It or Lose It!

Be sure to calculate your FSA contributions carefully. The funds won't roll over from year-to-year, and you will have to actively re-enroll on a yearly basis. You are not automatically re-enrolled.

ANNUAL MAXIMUM CONTRIBUTION

Health Care or Limited Purpose Flexible Spending Accounts	2024 Limit not yet announced Current limit: $3,050
Dependent Care Flexible Spending Account	$5,000 ($2,500 if married and filing separate tax returns)

Please note that these accounts are separate. You cannot use money from the Health Care FSA to cover expenses eligible under the Dependent Care FSA or vice versa.

**If you are enrolled in a medical plan that offers an HSA, you are not eligible for the Health Care FSA.*

Items You Might Not Realize are Health Care FSA Eligible:

- Sunscreen
- Heating and cooling pads
- First aid kits
- Shoe inserts
- Travel pillows
- Motion sickness bands

To view a list of eligible expenses for the Health Care FSA, log into Alight and select "Reimbursement Accounts" from the top menu. On the "Reimbursement Accounts Overview" page, choose "Eligible Expenses" from the "More Options" drop-down menu.

Dental Plan Options

Keep your smile healthy! Just like your medical coverage, you get to choose the dental coverage level, cost and insurance carrier that are right for you. You can choose from four options (**Bronze**, **Silver**, **Gold** or **Platinum**) with different coverage levels. The coverage level determines how much you pay out of your paycheck (premiums) and how much you pay out-of-pocket when you receive care (deductibles, coinsurance, copays, etc.). Be sure to consider all of your associated costs when choosing a coverage level. You can enroll any combination of you, your eligible spouse, and your children in the option you choose, even if they are not enrolled in the medical plan. Each dental carrier (**Aetna**, **Cigna**, **Delta Dental**, **MetLife** and **UnitedHealthcare**) has its own insurance provider networks that can vary by plan. Learn more about each carrier on the **Make It Yours** microsite.

	BRONZE	SILVER	GOLD	PLATINUM[2]
Annual Deductible and Plan Limits				
Annual Deductible (Individual/Family)	$100 / $300	$100 / $300	$50 / $150	None
Annual Maximum (Individual/Family)	$1,000 per person	$1,500 per person	$2,500 per person	None
Orthodontia Lifetime Maximum[1]	Not covered	$1,500 per child	$2,000 per person	Varies by Insurance Carrier
In-Network Benefit				
Preventive Care	100% covered, no deductible	100% covered, no deductible	100% covered, no deductible	Varies by insurance carrier; generally covered 100%
Minor Restorative Care (e.g., root canal treatment, gum disease treatment, and oral surgery)	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible	Varies by insurance carrier
Major Restorative Care (e.g., implants, dentures)	Not covered	You pay 40% after deductible	You pay 20% after deductible	Varies by insurance carrier
Orthodontia	Not covered	You pay 50%, no deductible; children up to age 19 only	You pay 50%, no deductible; for children and adults	Varies by insurance carrier

[1]If you switch insurance carriers, any orthodontic expenses you've already incurred under your current carrier will count toward your new carrier's orthodontia lifetime maximum.
[2]Not available in some limited areas. Only the coverage levels for which you are eligible will show as options when you enroll.
*This chart is a high-level listing of commonly covered benefits across carriers and coverage levels for the Aon Active Health Exchange. For a more detailed look at these and additional coverages, go to the **ChenMed Benefits Portal**.*

Considering the Platinum Plan? Platinum dental benefits may cost less than some other options, but you must designate a primary care dentist who participates in the insurance carrier's Platinum network (where available by carrier) and get care from your primary care dentist. The network could be considerably smaller than in other plans, so be sure to check the availability of providers before you enroll. If you don't designate a primary care dentist when you enroll, one may be assigned to you. To change your primary care dentist, you will need to contact the insurance carrier directly. If you enroll in a Platinum option and don't use a network dentist, you'll pay the full cost of services.

Considering a Delta Dental Plan? There are two Delta Dental networks under their Bronze, Silver or Gold options. You can choose providers from their PPO and Premier networks. Although the benefits are the same for both, you may have to pay more if your dentist is only a part of the Premier network. Delta Dental dentists who participate in both the PPO and Premier networks will cost you less.

If you choose Delta Dental and the Platinum option, the Delta Dental network applicable is called "DeltaCare." Make sure your dentist is in the DeltaCare network — not just the Delta Dental network — in order to maximize your plan benefits.

Vision Plan

You have several vision plan options that offer a range of coverage — from exams only to coverage for lenses, frames, and contacts. You can choose from three coverage levels (**Bronze**, **Silver** and **Gold**), offered by national and regional insurance carriers. The coverage levels are designed to give you choices. It's up to you to pick the one that makes sense based on your family's needs. Each vision insurance carrier (**EyeMed**, **MetLife**, **UnitedHealthcare** and **VSP Vision Care**) has its own provider network. If it's important that you continue to use the same eye doctor or retail store, make sure to check whether your doctor or store is in-network before you select a carrier. Visit the **Make It Yours** microsite to learn more about each of the carriers.

	BRONZE	SILVER	GOLD
In-Network Benefits			
Routine Vision Exam (One per Plan Year)	Covered 100%	You pay $20	You pay $10
Frames (One per Plan Year)	Discount may apply	$130 allowance[1]	$200 allowance[1]
Lenses (Once per Plan Year; Premium Lenses May Cost More)			
Single Vision	Discount may apply	You pay $20	You pay $10
Bifocal	Discount may apply	You pay $20	You pay $10
Trifocal	Discount may apply	You pay $20	You pay $10
Standard Progressive[2]	Discount may apply	You pay $20	You pay $10
Lenticular	Discount may apply	You pay $20	You pay $10
Lens Enhancements			
UV Treatment	Discount may apply	You pay $15	You pay $15
Tint (Solid and Gradient)	Discount may apply	You pay $15	You pay $15
Standard Plastic Scratch-Resistant Coating	Discount may apply	You pay $15	You pay $15
Standard Anti-Reflective Coating	Discount may apply	You pay $45	You pay $45
Standard Polycarbonate (Adults)	Discount may apply	You pay $40	You pay $15
Standard Polycarbonate (Children)	Discount may apply	You pay nothing	You pay nothing
Other Add-Ons	Discount may apply	Discount only	Discount only
Contact Lenses			
Medically Necessary	Not covered	You pay $20	You pay $10
Elective	Not covered	$130 allowance[1]	$200 allowance[1]
Fit and Evaluation	Discount may apply	You pay $20	You pay $10
Laser Surgery			
Elective	15% off regular price or 5% off promotional price	15% off regular price or 5% off promotional price	15% off regular price or 5% off promotional price

[1]Allowance can be used for frames or elective contact lenses, but not both.

[2]Vision benefits are for standard progressives. Enhanced progressives may cost more and will vary by insurance carrier.

*This chart is a high-level listing of commonly covered benefits across carriers and coverage levels for the Aon Active Health Exchange. For a more detailed look at these and additional coverages, go to the **ChenMed Benefits Portal**.*

Life and Accidental Death & Dismemberment Insurance

Always be there financially for your loved ones.

ChenMed provides Basic Term Life and Accidental Death and Dismemberment (AD&D) Insurance and offers additional coverage options to protect team members and their families from unexpected life events.

Basic Term Life and Accidental Death and Dismemberment (AD&D) Insurance*

ChenMed provides Basic Term Life and AD&D coverage at no cost to you and enrollment is automatic.

BASIC TERM LIFE & ACCIDENTAL DEATH AND DISMEMBERMENT	**All Other Team Members, including Center Directors, Senior Managers, Analysts, and Care Promoters:** 1x salary, up to $1,000,000 **Directors and Above Includes PCPs, Nurse Practitioners, Market / COE / Corporate Directors and Above:** 3x salary, up to $1,000,000
AGE REDUCTION	On January 1 coinciding with or next following the team member's attained age 67% at age 65; 45% at age 70; 30% at age 75; 20% at age 80; 15% at age 85; 10% at age 90

Supplemental Life and AD&D Insurance*

You may also choose to purchase Supplemental Life and AD&D Insurance for yourself, spouse and child(ren) in addition to the company-paid benefit. You pay the total cost of this benefit through convenient payroll deductions. The cost of coverage depends on your age and the amount of coverage elected. Age reductions also apply to these coverages.

TEAM MEMBER	Amounts in $10,000 benefit increments, up to the lesser of 8x Annual Salary or $1,000,000 Guaranteed Issue Amount – $500,000
SPOUSE	Amounts in $10,000 benefit increments, up to 100% of the team member's coverage or $500,000 Guaranteed Issue Amount – $30,000
CHILD(REN)	Amounts in $2,000 benefit increments, not to exceed $10,000
COVERAGE HIGHLIGHTS	• Accelerated Benefit – 50% of your Life Insurance amount, up to $250,000. Any payout would reduce the death benefit. • AD&D Coverage amount does not have to match Supplemental Life amount. You do not have to complete Evidence of Insurability (EOI) for AD&D Insurance.

**You may be required to pay income taxes on the value of Term Life Coverage over $50,000 and Supplemental Spouse or Child Life Insurance coverage over $2,000. This amount, called "imputed income," will appear on your paycheck stubs and on the W-2 form you receive at the end of each year. This value is determined based on rates established by the IRS and not the actual insurance premium. Refer to IRS section 79.*

Guaranteed Issue during New Hire Enrollment

For New Hires eligible to participate in Supplemental Life and AD&D Insurance and are enrolling in this benefit, EOI is required for any amount over the Employee Guarantee Issue Amount.

EOI must be completed within 31 days from enrollment. If you and your dependents are enrolled and want to increase your coverage, EOI is not required for amounts up to Guarantee Issue Amounts.

Note: Dual coverage for married couples is not allowed. If you and your spouse both work for ChenMed, you cannot cover your spouse under the spouse life and AD&D insurance. In addition, you both cannot cover any dependent children under child life and AD&D insurance.

You're covered for a specific period of time, or "term." If you pass away during the term, the beneficiary you designate will receive a payment. Provide protection to those who matter most. Be sure to select or update your beneficiary designations.

Short-Term Disability (STD) Benefits

Your ability to bring home a paycheck is your most valuable asset. We help you protect it.

If an injury or illness kept you out of work and prevented you from earning a paycheck, how would you cover your bills and other household expenses? Disability Insurance provides income protection, paying a portion of your salary that you can use to offset out-of-pocket expenses and make up for lost wages.

A disability occurs if you are unable to perform the material duties of your regular job and you are unable to earn 80% or more of your covered earnings from working in your regular job.

Short-Term Disability Insurance

Short-Term Disability Insurance replaces a portion of your income if an injury or illness forces you out of work for an extended period of time.

BASE STD PLAN

Cost	ChenMed pays 100%
Benefit Amount	50% of your weekly eligible Earnings to a maximum of $1,000 per week
Benefit Begin	8th day after injury or sickness
Benefit Duration	13 weeks

Voluntary Short-Term Disability Insurance

Depending on your household budget, you may need additional disability coverage. To help you increase your disability protection, ChenMed offers a Buy-Up STD Plan.

BUY-UP STD PLAN

Cost	100% employee paid; rates based on age and annual salary
Benefit Amount	Up to 60% of your weekly eligible Earnings to a maximum of $2,500 combined eligible Earnings per week
Benefit Begin	8th day after injury or sickness
Benefit Duration	13 weeks

Did You Know?

It's estimated that **1 in 4** 20-year-olds will experience a disability for 90 days or more before they reach age 67.

Social Security Administration, Disability Insurance, Facts 2021

Definition of Earnings: Team member's annual base wage or salary, excluding bonuses, commissions, overtime pay and extra compensation.

Note: If you are currently enrolled in any benefits through ChenMed, while you are on a leave of absence, you will remain responsible for paying the cost of your benefits.

Long-Term Disability (LTD) Benefits

Long-Term Disability Insurance helps protect your finances when your disability continues beyond the period covered by the Short-Term Disability plan.

Voluntary Long-Term Disability Insurance

Full-Time Team Members can now enroll in a Voluntary Long-Term Disability Plan. This plan is paid through employee payroll deductions.

VOLUNTARY LTD PLAN

Cost	100% employee paid
Benefit Waiting Period	90 days
Benefit Amount	60% to $15,000, 24 months own occupation Minimum benefit: greater of $100 or 10% benefit
Benefit Duration	To age 65

Employer Paid Long-Term Disability Insurance

ChenMed provides a LTD benefit for Full-Time Owners, Execs, Physicians, PAs, Officers, MDs, NPs and Non-Managing Members.

EMPLOYER PAID LTD PLAN

Cost	ChenMed pays 100%
Benefit Waiting Period	90 days
Benefit Amount	60% to $20,000, own occupation to age 65 Minimum benefit: greater of $100 or 10% benefit
Benefit Duration	To age 65

Definition of Earnings: Team member's annual base wage or salary, excluding bonuses, commissions, overtime pay and extra compensation.

ChenMed 401(k) Plan

Building a healthy financial future is just as important as taking care of your health needs today. Putting money aside for your future is easy with the ChenMed 401(k) plan through Principal Financial Group. And with contributions deducted before federal taxes are calculated, there is less of an impact to your take home pay than you might think.

You decide how much to contribute to the Plan through convenient payroll deductions, and ChenMed will match a portion of what you save.

Eligibility

You are eligible to participate in the plan if you:

- Are at least age 18
- Have completed 60 days of service with the company

Plan Features

- **Start Contributing.** You enter the Plan on the first day of the month on or after you meet the eligibility requirements. You begin making contributions as soon as administratively feasible.
- **Automatic Enrollment.** If you are a new participant, you will be automatically enrolled in the retirement plan at 6% pre-tax rate. You may elect to waive automatic enrollment or defer to another percentage.
- **Salary Deferral Contributions.** Federal law limits the amount of pre-tax contributions and/or after-tax Roth 401(k) contributions you may make to the Plan each year. For 2024, you may defer up to $23,000 annually, and when over the age of 50 an additional $7,500. The annual limit may be adjusted by the IRS in future years. This Plan allows you to defer 92% of your eligible pay.
- **Safe Harbor Matching Contributions.** If you are a new hire and you make salary deferrals to the plan, you will be eligible to receive a matching contribution equal to 100% of the salary deferral contributions up to 4% of pay, plus 50% of salary deferral contributions (in excess of 4%) up to 6% of pay for the plan year. Your pay may be restricted to the annual compensation limit announced by the IRS.
- **Hourly Employee Contributions.** If you are an **hourly team member**, ChenMed will contribute 3% of your earnings to your 401(k) account after the end of each year, even if you don't contribute your own deferral. The contribution will be subject to a 3-year cliff vesting.
- **Vesting.** You are always 100% vested in contributions you make to your account. You may be 100% vested in the account from the Employer QACA Match Safe Harbor after two years of service.

Important 401(k) Elections

It's important that ChenMed has the most up-to-date information on file for your 401(k) investment elections, as well as your beneficiary designations. If you enroll in the plan or are already a plan participant, we encourage you to do the following:

- Log onto the Principal website at **www.principal.com**,
- Add your contact information, and
- Make your investment and beneficiary designations.

Please note, the beneficiary designations you make online through the Principal website will be effective for 401(k) plan purposes, even if you have designated a beneficiary for other benefit plans.

ChenMed Perks at Work

ChenMed has partnered with Perks at Work to give you access to team member discounts, so **you don't have to pay full price on the things you buy**.

From 30% off movie tickets to hundreds of dollars off a new personal laptop or hotel stay, start your shopping at Perks at Work to take advantage of private, best-in-market pricing.

Perks at Work Features

- Attend free live or on-demand virtual classes for both adults and kids in wellness and self-development.
- Support what matters to you, and browse collections of local, sustainable and minority-owned small businesses. Refer a favorite business or entrepreneur you know. Over 2,000 new brands join the program each year.
- Earn cash-back rewards that can be redeemed on thousands of brands, and never expire.
- Invite family members and friends to enjoy your perks, too.

What are WOWPoints?

WOWPoints are loyalty points you can earn and redeem when you shop through ChenMed Perks at Work. Redeem the WOWPoints you earn from shopping at a wide variety of shops on the platform for whatever it is you love: Travel, Electronics, Apparel, Movies, Gifts and more! Earning 10x WOWPoints is like getting 10% back on your purchase. Plus, if you're a 5 STAR user, you earn WOWPoints when you redeem!

To Sign Up:

1. Go to **www.perksatwork.com** and click "Sign Up for Free"
2. Follow the instructions to activate your account

TicketsatWork

More perks. More savings. More of what makes you happy.

We're here to support your personal and financial well-being though exclusive deals and limited-time offers on the products, services and experiences you need and love.

Start saving on:

- Electronics
- Flowers
- Hotels
- Special Events
- Appliances
- Fitness Memberships
- Movie Tickets
- Theme Parks
- Cars
- Gift Cards
- Rental Cars
- ***and more!***

New to TicketsatWork? Getting Started is Easy.

1. Visit **TicketsatWork.com**
2. Click *Become a Member*
3. Enter your company code (**ChenMed**) or work email to create an account

Legal Assistance

Legal Assistance provides access to a network of participating attorneys for help with a range of legal matters.

$14/month!

(Includes dependents as defined in the description)

Free and Discounted Legal Advice:

Free Legal Services: Examples of services available at no charge from your plan attorney:

- Initial consultation for each new legal matter
- Simple Will for you and your family with annual updates
- State specific, web based, Living Will form (can be notarized by a Notary Public)
- Phone calls and letters written on your behalf (one each per legal matter) when considered appropriate by plan attorney;

Discounted Legal Services: Examples of discounted services for which attorneys will charge a one-time, deeply discounted fee:

- Traffic Ticket Defense $89
- Simple Will $250
- Simple Divorce $275
- Personal Real Estate Closing $250
- Reduced Hourly Rate Plan attorneys have contracted to charge 40% off their normal hourly rate, with a minimum of $125 per hour, for legal care beyond the free and discounted services. Retainers in certain situations, attorney liability may require plan attorneys.

Free Tax Preparation and Advice:

Members and their families receive free tax preparation and unlimited advice on federal taxation, IRS notice and audit assistance, tax planning services and small business tax support from tax attorneys, CPAs, financial analysts and/or Enrolled Agents certified by the IRS.

Identity Theft Solutions:

Identity theft is the fastest growing financial crime in America, striking thousands of victims each year. In a matter of seconds, personal information such as a social security number, a credit card number or an address can be stolen and used to obtain a new mortgage, line of credit or additional credit cards. Members will have 24/7 access to Identity Theft Restoration paralegals who will provide them with comprehensive, personalized recovery services. If a member becomes a victim of identity theft, the plan administrator assigns a Privacy Advocate to manage the case. The Advocate mobilizes a Recovery Team to assist with the recovery process from beginning to end. The team includes fraud investigators, legal counsel, paralegals and other identity theft experts.

Financial Education and Credit Counseling:

Offering free consultations, financial assessments, assistance with first-time home ownership, credit and debt analysis, and pre-bankruptcy counseling.

Eligibility:

Membership includes the member's spouse, dependent children and any dependent individuals living in the plan member's home such as a parent or grandparent.

Back-Up Child Care

Back-Up Child, Adult and Elder Care: Don't stress about school breaks, bad weather or caregiver cancellations. Reserve high-quality child care in a center, or in-home care for your child, adult or elder relatives.

Access up to 10 annual days of back-up care for children and adults when your regular care arrangements are unavailable. Center-based care is $15 per child/day or $25 per family/day (two or more children). In-home care for children and adults is $6 per hour (4-hour minimum required; for up to 3 dependents). There is no cost to register.

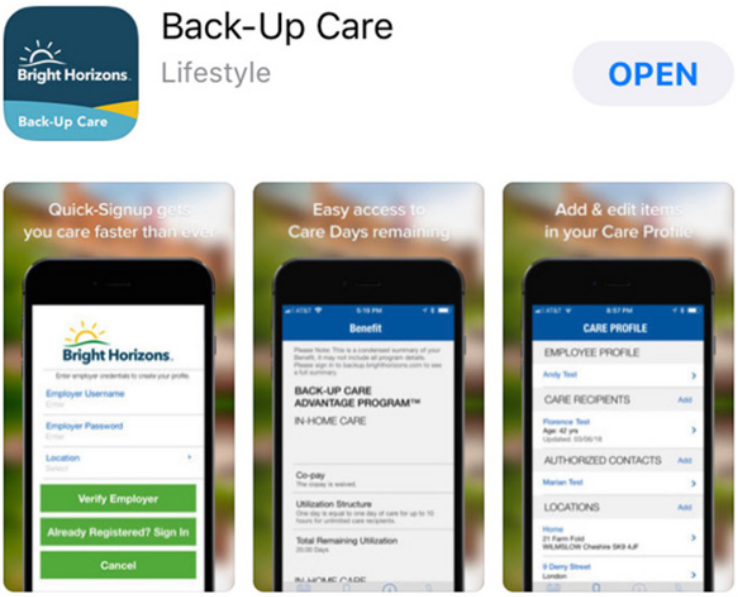
Care for the Whole Family: Easily find sitters, elder care and pet care (your membership fee to the database is waived!); jump ahead on the waitlist or enjoy discounts at participating child care centers.

Step 1: Register

- Visit **https://backup.brighthorizons.com**
- Click "Sign Up," then enter the following information to create your account.

  UN: ChenMed

  PW: Benefits4You
- You can also download the mobile app (search "back-up care" in the App Store or Google Play).



Step 2: Complete Your Care Profile

Provide contact information, care recipients, authorized contacts, and care locations.

Step 3: Reserve Back-Up Care

Reserve care online, by phone, or via mobile app

Questions? Call **877-BHCares (877-242-2737)**

ChenMed Cares

What is ChenMed Cares?

Striving to improve the lives of team members, the ChenMed Cares program is an emergency assistance fund created to support individuals at ChenMed who find themselves experiencing a sudden emergent crisis.

ChenMed team members can request assistance to offset financial burdens related to sudden emergent crises, such as homelessness, domestic violence, transportation accidents, natural disasters, death and life-threatening medical emergencies.

How is ChenMed Cares funded?

ChenMed Cares is funded by compassionate team members, deemed as "ChenMed Cares Champions," who donate through payroll deduction, as well as the Chen Family Foundation. Gifts can range from $5 a month to $100 or more. Donations are made as bi-weekly contributions that are tax-deductible in accordance with applicable federal and state tax laws.

To learn more about the Emergency Assistance Fund, visit **chenmedcares.com**.

Additional Benefits

Financial Wellness Program

SmartDollar is a FREE employee financial wellness program that can help you relieve that money stress! Following the program, you'll learn:

- How to budget
- How to get out of debt
- How to save for the future

Plus, you can access it anytime, anywhere and from any device.

SmartDollar has the tools to help you win with money! Track your progress and get personalized content with the free Baby Steps app. Stay on track with a detailed budget when you sync your bank account to the free and secure budgeting app, EveryDollar.

You have the chance to take control of your money and change your family tree with SmartDollar. Sign up today by visiting **smartdollar.com/enroll/chenmed** or text chenmed to 33789.

Cigna Employee Assistance Program (EAP)

The Cigna Employee Assistance Program (EAP) provides support for everyday issues and life challenges. Take advantage of a wide range of services available to you and your household family members, at no cost!

- Contact Cigna EAP any day, anytime – **877-622-4327** or log into **myCigna.com** (Employer ID for initial registration: chenmed)
- Get up to five face-to-face counseling sessions per issue, per year, with a counselor in your area, as well as video-based sessions
- Referrals for child care, senior care and pet care
- Financial, identity theft and legal consultations

TravelConnect®

ChenMed team members enrolled in life and/or AD&D insurance have access to travel assistance if you face an emergency when you're 100 or more miles from home. TravelConnect helps with:

- Emergency medical transportation for you, managing travel for a companion and/or your dependent children, planning and paying for a safe evacuation due to a natural disaster and more
- Service is available 24 hours a day, 7 days a week

Visit **mysearchlightportal.com** and enter Group ID #: LFGTravel123 for access to plan documents, international calling instructions and destination information.

IMPORTANT NOTICES

ABOUT THIS GUIDE

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan descriptions (SPDs), plan document, or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail. ChenMed reserves the right to make changes at any time to the benefits, costs, and other provisions relative to benefits.

REMINDER OF AVAILABILITY OF PRIVACY NOTICE

This is to remind plan participants and beneficiaries of the ChenMed Health and Welfare Plan (the "Plan") that the Plan has issued a Health Plan Privacy Notice that describes how the Plan uses and disclosed protected health information (PHI). You can obtain a copy of the ChenMed Health and Welfare Plan Privacy Notice upon your written request to the Human Resources Department, at the following address:

ChenMed, Human Resources

1505 NW 167th Street

Miami Gardens, FL 33169

If you have any questions, please contact the ChenMed Human Resources Office at 833-692-7547.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: HSA Choice: Ded $2,800/$5,200, Coins 25%; HSA Premium: $2,200/$4,400 Coins 10%; Traditional: $1,500/$3,000 Coins 10%. If you would like information on WHCRA benefits, call your plan administrator at 833-692-7547.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT DISCLOSURE

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).

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted and you will continue to pay the same amount as if you were not absent. If the absence is for more than 31 days and not more than 24 months, you may continue to maintain your coverage under the Plan by paying up to 102% of the full amount of premiums. You and your dependents may also have the opportunity to elect COBRA coverage. Contact ChenMed HR for more information.

Also, if you elect not to continue your health plan coverage during your military service, you have the right to be reinstated in the Plan upon your return to work, generally without any waiting periods or pre-existing condition exclusions, except for service connected illnesses or injuries, as applicable.

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Your Options

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with ChenMed and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. ChenMed has determined that the prescription drug coverage offered by the ChenMed Medical Plan through Express Scripts 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 ChenMed coverage will be affected. If you or a covered dependent decide to enroll in a Medicare drug plan, Medicare will be the secondary payer for prescription drug costs. In other words, eligible prescription claims will be paid by the ChenMed plan first. If there are prescription drug claims that are not covered or partially covered by the ChenMed plan, Medicare may pay for eligible expenses that are not paid by the ChenMed plan.

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 ChenMed 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 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage:

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through ChenMed 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 for personalized help. See the inside back cover of your copy of the "Medicare & You" handbook for their telephone number.

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: 1-800-772-1213 (TTY: 1-800-325-0778)

Date: 9/29/2022
Name of Entity/Sender: ChenMed
Contact: ChenMed HR
ChenMed
Address: 1505 NW 167th Street,
Miami Gardens, FL 33169
Phone Number: 833-692-7547

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

YOUR ERISA RIGHTS

As a participant in the ChenMed benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan participants shall be entitled to receive information about their plan and benefits, continue group health plan coverage, and enforce their rights. ERISA also requires that plan fiduciaries act in a prudent manner.

Receive Information About Your Plan and Benefits

You are entitled to:

- Examine, without charge, at the plan administrator's office, all plan documents—including pertinent insurance contracts, trust agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the plan's administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary report of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continued Group Health Plan Coverage

You are entitled to:

- Continued health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have credible coverage from another plan. You should be provided a certificate of credible coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the plan;
  - You become entitled to elect COBRA continuation coverage;
  - You request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plans. The people who operate your plans are called "fiduciaries," and they have a duty to act prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to:

- Know why this was done;
- Obtain copies of documents relating to the decision without charge; and
- Appeal any denial.

All of these actions must occur within certain time schedules. Under ERISA, there are steps you can take to enforce your rights. For instance, you may file suit in a federal court if:

- You request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator;
- You have followed all the procedures for filing and appealing a claim (as outlined earlier in this summary) and your claim for benefits is denied or ignored, in whole or in part. You may also file suit in a state court.
- You disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order; or
- The plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. This should occur if the court finds your claim frivolous.

Assistance with Your Questions

If you have questions about how your plan works, contact the Human Resources Department. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office listed on EBSA's website:

https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/regional-offices

Or you may write to the:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee and Employer Hotline of the Employee Benefits Security Administration at: 1-866-444-3272. You may also visit the EBSA's web site on the Internet at: https://www.dol.gov/agencies/ebsa.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage.

It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (www.healthcare.gov). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan

Administrator within 60 days after the qualifying event occurs. You must provide this notice to: ChenMed Human Resources or COBRA Administrator.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Any qualified beneficiary who does not elect COBRA within the 60-day election period specified in the election notice will lose his or her right to elect COBRA.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of the date of the Social Security Administration's disability determination; the date of the covered employee's termination of employment or reduction in hours; and the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction in hours. You must also provide this notice within 18 months after the covered employee's termination or reduction in hours in order to be entitled to this extension. You must provide the notice by contacting WEX and completing the extension request.
Email: cobraforms@wexhealth.com
Mail: WEX, PO Box 869, Fargo, ND 58107-0869.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Other Coverage Options

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at https://www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

For further information regarding the plan and COBRA continuation, please contact:

ChenMed Benefits Supervisor
1505 NW 167th Street
Miami Gardens, FL 33169
833-692-7547

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. 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: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

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-healthplan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

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

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/healthinsurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-partyliability/childrens-health-insurance-program-reauthorizationact-2009-chipra
Phone: (678) 564-1162, Press 2

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

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

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-766-9012

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website:https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

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

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
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

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

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

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

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programsservices/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: https://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://www.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/Services/Assistance/Pages/HIPPProgram.aspx
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: https://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: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid/CHIP Phone: 1-800-432-5924

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

WEST VIRGINIA-Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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

Contact Information

PLAN	CARRIER	GROUP NUMBER	PHONE NUMBER	WEBSITE
Medical, Prescription, Dental, and Vision Insurance	Carrier availability is based on the region in which you live, as determined by your ZIP code. Learn about all the different carriers available to you on the **Make It Yours** website. The **Make It Yours** website also provides insurance carrier preview sites so you can learn about all available options.			
Health Savings Account (HSA)	Alight	Smart-Choice	855-536-8228	digital.alight.com/chenmed
Dependent Care/ Healthcare Limited purpose/ Flexible Spending Accounts (FSA)	Alight	Smart-Choice	855-536-8228	digital.alight.com/chenmed
Basic & Optional AD&D Basic & Optional Life Base Short-Term Disability Insurance Long-Term Disability Insurance	Lincoln Financial	09-LF0903	855-745-8604	www.MyLincolnPortal.com
FMLA				
Critical Illness Plan, Hospital Indemnity Accident Plan	Cigna	CI0961503, HC0960830, AI0961582	800-997-1654	http://www.cigna.com/ or my.cignasupplementalhealth.com/chen-medical-associates
Legal Protection Plan	Legal Club	N/A	800-305-6816	http://www.legalclub.com/
Employee Assistance Plan (EAP)	Cigna		877-622-4327	myCigna.com (Employer ID for registration: chenmed)
TravelConnect (Emergency Travel Assistance)	Lincoln Financial Group	LFGTravel123	U.S. or Canada: 866-525-1955 Call collect from anywhere: +1-603-328-1955	mysearchlightportal.com (enter Group ID: LFGTravel123) Email: mail@oncallinternational.com
401(k) Retirement Plan	Principal Financial Group	714734	800-547-7754	www.principal.com
Compliance, Assistance & Reporting Line (CARL)	ChenMed	N/A	866-571-5105	CARL@chenmed.com
ChenMed Benefits Portal	ChenMed	N/A	855-536-8228	digital.alight.com/chenmed
Back-up Child Care	Bright Horizons	N/A	877-242-2737	www.backup.brighthorizons.com

ChenMed

NOTE: This guide is not intended to be a complete description of ChenMed's benefits. For complete details, refer to the Summary Plan Descriptions ("SPD") and the plan documents. If there is any conflict between the information presented here and the official plan documents, the plan documents will govern. ChenMed reserves the right to modify or terminate any of the benefits described in this guide at any time.