American Medical
Home Health & Hospice Care

2025 - 2026 Employee Benefit Guide

AN OVERVIEW OF THE WIDE ARRAY OF BENEFITS PROVIDED BY AMERICAN MEDICAL HOME HEALTH SERVICES, TO HELP YOU ENJOY INCREASED WELL-BEING AND FINANCIAL SECURITY

PREPARED BY HARMONY INSURANCE GROUP FOR AMERICAN MEDICAL HOME HEALTH SERVICES

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This booklet provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions set forth in each insurance carrier or provider's contract.

Benefits for 2025 - 2026

Introduction

As an employee of American Medical Home Health Services enjoying your work and making valuable contributions to business are equally vital. The health, satisfaction and security of you and your family are important, not only to your well-being, but ultimately, in terms of achieving the goals of our organization.

For the 2025 - 2026 plan year, American Medical Home Health Services has worked hard to offer a competitive total rewards package that includes valuable and competitive benefits plans. These programs reflect our commitment to keeping our staff healthy and secure. We understand that your situation is unique, and American Medical Home Health Services is offering an overall benefits package that can be shaped and molded by you to fit your needs.

This benefits booklet is a summary description of your American Medical Home Health Services benefit plans. If there is a discrepancy between these summaries and the written legal plan documents, the plan documents shall prevail. This booklet and plan summaries do not constitute a contract of employment.

We hope this benefits booklet, along with our additional communication and decision-making tools, will help you make the best health care choices for you and your family.

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Benefits for 2025 - 2026

Overview of Benefits

American Medical Home Health Services provides an array of benefits that can help you enjoy increased well-being, deal with an unexpected illness or accident, build and protect your financial security, balance your personal and professional life and meet everyday needs. These benefits are affordable, comprehensive and competitive. The table below summarizes the benefits available to eligible staff and their dependents. These benefits are described in greater detail in this booklet.

Benefits At-A-Glance

Coverage	Carrier
Medical	Aetna
Dental	Mutual of Omaha
Vision	Mutual of Omaha
Life	Mutual of Omaha
Short-Term Disability	Mutual of Omaha

Eligibility

All regular full-time employees of American Medical Home Health Services who are actively at work and regularly scheduled to work at least **30 hours per week or more** are eligible to participate in the Plan.

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Benefits for 2025 - 2026

Overview of Benefits

Changes and Qualifying Events

When Coverage Begins and Ends

1st of the month after 60 days from the day of hire.

Your coverage under the benefits plans will end if you no longer meet the eligibility requirements, your contributions are discontinued or the Group Insurance Policy is terminated.

Qualifying Events

Eligible employees may enroll or make changes to their benefits elections during the annual open enrollment period. As with most benefits, once you elect an option you are bound to that choice for the entire plan year unless you experience a "Qualifying Event". These may include, but are not limited to:

- Changes in employment status
- Changes in legal marital status
- Changes in number of dependents
- Taking an unpaid leave of absence
- Dependent satisfies or ceases to satisfy eligibility requirement
- Family Medical Leave Act (FMLA) leave.
- A COBRA-qualifying event
- Entitlement to Medicare or Medicaid
- A change in the place of residence of the employee, resulting in the current carrier not being available

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Benefits for 2025 - 2026

Medical

Summary of Coverage

The health plan is Fully Insured, meaning the premiums paid go to the insurance carrier to cover claims and administrative costs. For the 2025–2026 plan year, American Medical Home Health Services is offering a fully insured plan through Aetna.

Plan Features	AFA OAAS 3500 HSA 80%E CY V25	AFA OAAS 5000 100%$0LXR CY V25	AFA OAAS 1500 80%$0LXR CY V25
IN NETWORK			
Calendar Year Deductibles (Indiv / Family)	$3,500 / $7,000	$5,000 / $10,000	$1,500 / $3,000
Preventive Care	No charge	No charge	No charge
Primary Care Visit	$35 /visit	$35 /visit	$25 /visit
Specialist Visit	$75 /visit	$75 /visit	$75 /visit
Diagnostic Exam	20% A.D.	0% A.D.	No charge
X-Rays	20% A.D.	0% A.D.	No charge
Complex Images	20% A.D.	0% A.D.	20% A.D.
Outpatient Procedure	20% A.D.	0% A.D.	20% A.D.
Inpatient Visit	20% A.D.	0% A.D.	20% A.D.
Emergency Room	20% A.D.	$300 /visit	$300 /visit +20% A.D.
Urgent Care	20% A.D.	$75 /visit	$75 /visit
Pharmacy / RX (30 Day Supply)	$10 / $50 / $100 / 20% A.D. / NC / NC	$10 / $50 / $80 / 20% A.D. / NC / NC	$10 / $45 / $75 / 20% A.D. / NC / NC
Pharmacy / RX (90 Day Supply)	$20 / $100 / $200 / NC / NC / NC	$20 / $100 / $160 / NC / NC / NC	$20 / $90 / $150 / NC / NC / NC
Calendar Year Out-of-Pocket Max (Indiv / Family)	$6,000 / $12,000	$7,500 / $15,000	$5,500 / $11,000
OUT OF NETWORK			
Calendar Year Deductibles (Indiv / Family)	Not Covered / Not Covered	Not Covered / Not Covered	$5,000 / $15,000
Preventive Care	Not Covered	Not Covered	50% A.D.
Primary Care Visit	Not Covered	Not Covered	50% A.D.
Specialist Visit	Not Covered	Not Covered	50% A.D.
Diagnostic Exam	Not Covered	Not Covered	50% A.D.
X-Rays	Not Covered	Not Covered	50% A.D.
Complex Images	Not Covered	Not Covered	50% A.D.
Outpatient Procedure	Not Covered	Not Covered	50% A.D.
Inpatient Visit	Not Covered	Not Covered	50% A.D.
Emergency Room	Not Covered	Not Covered	$300 /visit
Urgent Care	Not Covered	Not Covered	50% A.D.
Pharmacy / RX (30 Day Supply)	Not Covered / Not Covered / Not Covered / Not Covered	Not Covered / Not Covered / Not Covered / Not Covered	50% / 50% / 50% / NC
Pharmacy / RX (90 Day Supply)	Not Covered / Not Covered / Not Covered / Not Covered	Not Covered / Not Covered / Not Covered / Not Covered	Not Covered / Not Covered / Not Covered / Not Covered
Calendar Year Out-of-Pocket Max (Indiv / Family)	Not Covered / Not Covered	Not Covered / Not Covered	$15,000 / $45,000
Summary of Benefits of Coverage	AFA OAAS 3500 HSA 80% E CY V25	AFA OAAS 5000 100%$0LXR CY V25	AFA OAAS 1500 80%$0LXR CY V25
BI-WEEKLY PRICING			
Employee	$110.92	$127.77	$169.60
Employee + Spouse	$575.79	$626.14	$757.28
Employee + Child(ren)	$419.40	$458.48	$559.58
Employee + Family	$864.68	$935.87	$1,122.52

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Key Terms to Remember

Plan Types

EPO/PPO – A network of doctors, hospitals and other health care providers

POS – Combines aspects of a PPO and HMO to manage cost

HMO – A network that requires you to select a Primary Care Physician (PCP) who coordinates your health care

HDHP – A plan that has higher cost sharing (e.g. deductible), but typically also lower monthly premiums.

Out-of-Pocket Maximum

This is the total amount you can pay out of pocket each calendar year before the plan pays 100 percent of covered expenses for the rest of the calendar year. Most expenses that meet provider network requirements count toward the annual out-of-pocket maximum, including expenses paid to the annual deductible*, copays and coinsurance.

*Except for Grandfathered medical plans

Annual Deductible

The amount you have to pay each year before the plan starts paying a portion of medical expenses. All family members' expenses that count toward a health plan deductible accumulate together in the aggregate; however, each person also has a limit on their own individual accumulated expenses (the amount varies by plan).

Copays and Coinsurance

These expenses are your share of cost paid for covered health care services. **Copays** are a fixed dollar amount, and are usually due at the time you receive care. **Coinsurance** is your share of the allowed amount charged for a service, and is generally billed to you after the health insurance company reconciles the bill with the provider.

The Value of Preventive Care

Wellness and Health Management

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and incorporating healthy habits into your lifestyle. Some examples include getting regular physical examinations, mammograms and immunizations.

Through the plans offered by American Medical Home Health Services , all covered individuals and family members are eligible to receive routine wellness services like these, at no cost; all copays, coinsurance, and deductibles are waived.

Which Preventive Care Services Are Covered?

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act (i.e. Health Care Reform) compliant insurance plans should cover at 100% for in-network providers. Below is a list of common services that are included in the plans offered this year:

- Routine Physical Exam
- Well Baby and Child Care
- Well Woman Visits
- Immunizations
- Routine Bone Density Test
- Routine Breast Exam
- Routine Gynecological Exam
- Screening for Gestational Diabetes
- Obesity Screening and Counseling
- Routine Digital Rectal Exam
- Routine Colonoscopy
- Routine Colorectal Cancer Screening
- Routine Prostate Test
- Routine Lab Procedures
- Routine Mammograms
- Routine Pap Smear
- Smoking Cessation Programs
- Health Education/Counseling Services
- Health Counseling for STDs and HIV
- Testing for HPV and HIV
- Screening and Counseling for Domestic Violence

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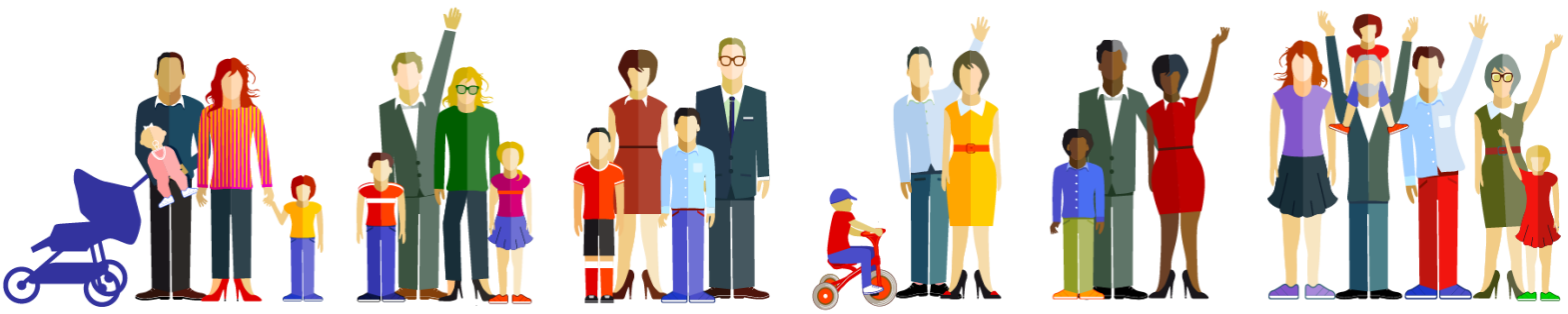
Benefits for 2025 - 2026

Dental Coverage

Summary of Coverage

	Voluntary Dental
IN NETWORK	
Annual Deductible (Individual / Family)	$50 / $150
Preventive Care	100%
Basic Procedures (Extractions, fillings, etc.)	80%
Major Procedures (Crowns, dentures, etc.)	50%
Child Orthodontia	Not covered
Calendar Year Maximum Benefit	$1,500
OUT OF NETWORK	
Annual Deductible (Individual / Family)	$50 / $150
Preventive Care	100%
Basic Procedures (Extractions, fillings, etc.)	80%
Major Procedures (Crowns, dentures, etc.)	50%
Child Orthodontia	Not covered
Calendar Year Maximum Benefit	$1,500
Summary of Benefits	Dental

BI-WEEKLY PRICING	
Employee	$15.39
Employee + Spouse	$29.30
Employee + Child(ren)	$30.74
Employee + Family	$47.18



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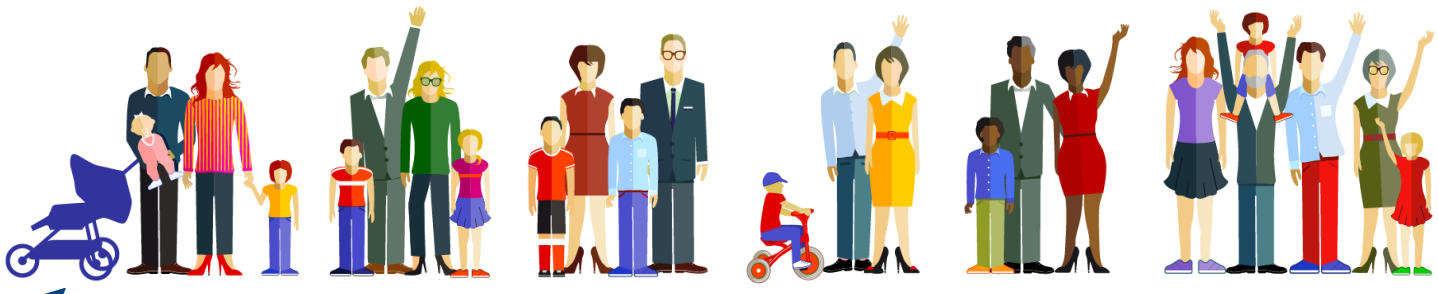
Benefits for 2025 - 2026

Vision Coverage

Summary of Coverage

Plan Features	Voluntary Vision
IN NETWORK	
Vision Exam	$10 copay
Lenses	
Single	$25 copay
Bifocal	$25 copay
Trifocal	$25 copay
Progressive	$90 copay
Frames	$150 allowance; 20% off
Elective Contact Lenses	$150 allowance; 15% off
Medically Necessary Contact Lenses	$0 copay
Frequency (Months)	
Exam	Every 12 Months
Lenses	Every 12 Months
Frames	Every 24 Months
Contacts	Every 12 Months
OUT OF NETWORK	
Vision Exam	Up to $37
Lenses	
Single	Up to $20
Bifocal	Up to $36
Trifocal	Up to $64
Progressive	Up to $72
Frames	Up to $66
Elective Contact Lenses	Up to $102
Medically Necessary Contact Lenses	Up to $210
Summary of Benefits	Vision

BI-WEEKLY PRICING	
Employee	$3.51
Employee + Spouse	$7.04
Employee + Child(ren)	$5.81
Employee + Family	$9.60



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Benefits for 2025 - 2026

Disability Insurance Short Term

Summary of Coverage

Plan Features	
Employee Benefit Amount	60%
Maximum Benefit Amount	$1,000
Elimination Period (Accident)	8 days
Elimination Period (Sickness)	8 days
Benefit Duration	12 weeks

Please view the full details at the link below:

View Plan

This is a voluntary, employee-paid benefit program. The employer does not contribute to the cost of coverage and does not endorse, recommend, or administer the program beyond permitting the insurer to make the coverage available. Because the employer's involvement is limited and the coverage is fully paid by employees, the plan is not subject to the Employee Retirement Income Security Act of 1974 (ERISA). All terms, conditions, exclusions, and limitations of coverage are set forth in the policy or certificate issued by the insurer.

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Benefits for 2025 - 2026

Accident – Mutual of Omaha

BENEFIT AMOUNTS

Benefits are paid once per accident unless otherwise noted here or in the brochure

PLAN INFORMATION

Initial Care & Emergency	Option 1	Option 2
Emergency Room	$200	$400
Urgent Care Center	$175	$325
Initial Physician Office Visit	$100	$175
Ambulance	Up to $1,000	Up to $2,000
Specified Injuries		
Fractures (Surgical/ Non-surgical)	Up to $9,000/ Up to $4,500	Up to $12,000/ Up to $6,000
Dislocations (Surgical / Non surgical)	Up to $10,000/ Up to $5,000	Up to $12,000/ Up to $6,000
Lacerations	Up to $900	Up to $1,500
Burns	Up to $20,000	Up to $25,000
Dental	Up to $300	Up to $400

BI-WEEKLY PRICING	Option 1	Option 2
Employee	$4.67	$3.65
Employee + Spouse	$7.74	$6.07
Employee + Child(ren)	$10.59	$8.03
Employee + Family	$14.29	$11.21

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Benefits for 2025 - 2026

Critical Illness – Mutual of Omaha

BENEFIT AMOUNTS

Covered dependents receive 50% of your benefit amount

PLAN INFORMATION

BENEFIT CATEGORY	CONDITION	% OF CI PRINCIPAL SUM
Heart/Circulatory/Motor Function	Heart Attack, Heart Transplant, Stroke, ALS (Lou Gehrig's), Advanced Alzheimer's, Advanced Parkinson's	100%
	Heart Valve Surgery, Coronary Artery Bypass, Aortic Surgery	25%
Organ	Major Organ Transplant/Placement on UNOS List, End-Stage Renal Failure	100%
	Acute Respiratory Distress Syndrome (ARDS)	25%
Childhood/Developmental *benefits only available to children	Cerebral Palsy, Structural Congenital Defects, Genetic Disorders, Congenital Metabolic Disorders, Type 1 Diabetes	100%
Cancer	Cancer (Invasive)	100%
	Bone Marrow Transplant	50%
	Carcinoma in Situ, Benign Brain Tumor	25%

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Benefits for 2025 - 2026

Hospital Indemnity – Mutual of Omaha

BENEFIT AMOUNTS

Plan Information	

Benefits Hospital Admission & Confinement	Amounts
Hospital Admission	$1,000 per admission
Daily Hospital Confinement	$100 per day
ICU Admission	$2,000 per admission
Daily ICU Confinement	$200 per day
Daily Newborn Nursery Care Confinement (Up to 2 days per policy year)	$75 per day
Initial Care	
Emergency Room (1 visit per policy year)	$200
Urgent Care (1 visit per policy year)	$100
Physician Office Visit (Up to 3 visits per policy year)	$50
Minor Diagnostic Procedure (X-Rays and Lab Work) (1 procedure per policy year)	$100
Major Diagnostic Procedure (MRI/CT/EKG/EEG/PET/SPECT) (1 procedure per policy year)	$450

BI-WEEKLY PRICING	
Employee	$17.88
Employee + Spouse	$32.79
Employee + Child(ren)	$25.93
Employee + Family	$43.22

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Benefits for 2025 - 2026

Voluntary Term Life Insurance

Summary of Coverage

Supplemental / Voluntary Term Life Insurance	
Plan Features	**Voluntary Term Life and AD&D**
Employee Benefit Amount	Employees can choose different amounts of coverage between the minimum and maximum benefit amount. See plan documentation for more details.
Minimum Benefit Amount	$10,000
Maximum Benefit Amount	Lesser Of: $500,000
Spouse Benefit	100% of employee's benefit, up to $100,000
Dependent Benefit	100% of employee's benefit, up to $10,000
The following shows how much benefits are reduced at certain ages:	
Age Band	**Benefit Reduction**
65	35%
70	50%

Please view the full details at the link below:

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Benefits for 2025 - 2026

Value of Pre-Tax Benefits

Section 125 Plan

American Medical Home Health Services operates a Premium Only Section 125 Plan, which allows you to reduce your total taxable income by your portion of group insurance premiums. In effect, this is just like getting a raise - your withholding taxes are reduced, and your take-home pay increases!

Example: Employee earning $30,000 annually, paying $200/month for benefits

	Without Pre-Tax Benefits	With Pre-Tax Benefits
Gross Pay	$30,000	$30,000
Insurance Deductions/Payments	$0	$2,400
Taxable Income	**$30,000**	**$27,600**
Taxes at 25%	$7,500	$6,900
After-Tax Income	**$22,500**	**$20,700**
After-Tax Payment for Benefits	$2,400	$0
Take-home Pay	**$20,100**	**$20,700**
INCREASE IN TAKE-HOME PAY		**+$600**

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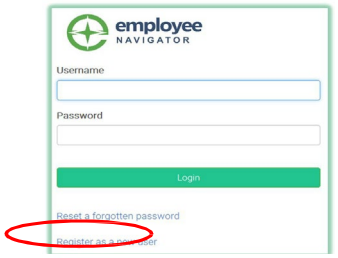
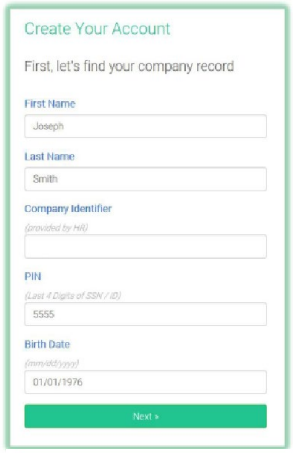
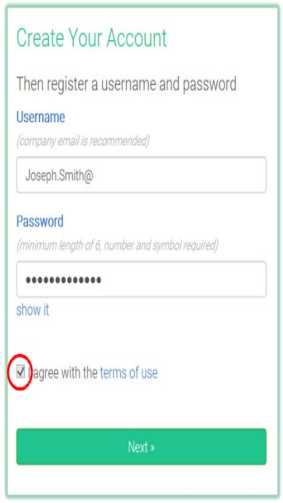
Benefits for 2025 - 2026

How to Access Your Benefits in Employee Navigator







Step 1 – Go to Employee Navigator
- Visit: www.employeenavigator.com
- Click **Login** (top right)

Step 2 – First Time Users
- Click **Register as a New User**
- **Company Identifier: AMHHS**
- **PIN:** Last 4 digits of your SSN
- **Date of Birth:** mm/dd/yyyy

Step 3 – Create Your Account
- **Password Requirements:**
  - 6–20 characters, no spaces
  - At least one number
  - At least one symbol
- Check **Terms of Use** box, then **Next**

Step 4 – Returning Users
- Enter your username and password

If you forgot your password, click **Reset a forgotten password**

Step 5 – Enroll or Make Changes
- Click **Let's Begin** or **Start Enrollment**
- Follow prompts to review benefits, add dependents, and make elections
- Click **Sign & Agree** to confirm

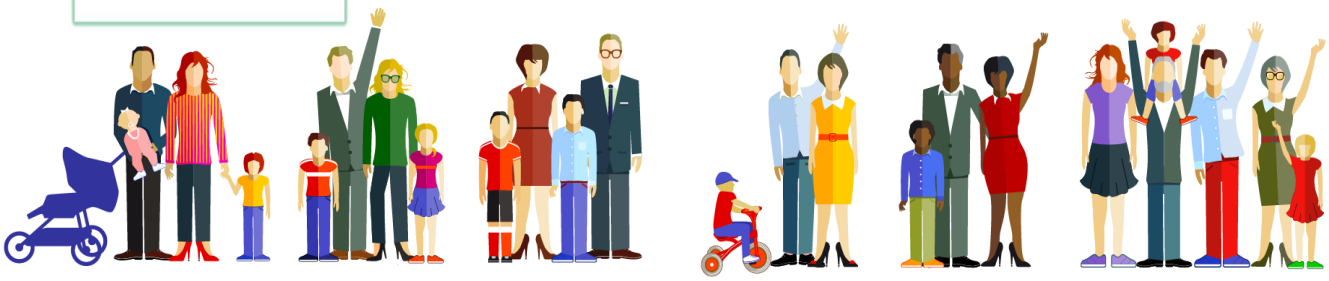
Why Register?

📄 **Access Your Benefits Anytime** — View plan details, coverage levels, and carrier contacts

📥 **Download Important Documents** — Including your **Summary of Benefits (SBCs)** and **Wrap Summary Plan Description (SPD)**

🖊️ **Enroll or Make Changes** — During open enrollment or after a qualifying life event

📝 **Keep Your Information Updated** — Ensure your dependents and contact info are correct



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Legal Notices

Important: Your Summary Plan Description (SPD) is a legally required document under the Employee Retirement Income Security Act (ERISA).

This Benefit Guide is a summary of the benefits offered by American Medical Home Health Services. This guide is not the Summary Plan Description (SPD) or the official Plan Document. The official SPD for the American Medical Home Health Services Benefit Plan, which contains comprehensive information about your rights, benefits, and the full details of the plan, is available in the American Medical Home Health Services Employee Navigator portal.

It is essential that you review the full SPD, as it provides a detailed explanation of:

- How to make a claim for benefits.
- Your rights under ERISA.
- The circumstances under which you might lose or be disqualified from receiving benefits.
- The procedures for appealing a denied claim.

The Plan Document and SPD are the controlling documents. In the event of a conflict between this Benefit Guide and the official Plan Document or SPD, the terms of the Plan Document and SPD will govern.

If you need a paper copy of the Plan Document and SPD, you can request one by contacting the Plan Administrator Checcid Vasquez at (210) 964-0204.

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Legal Notices

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that addresses the privacy and security of certain individually identifiable health information, called protected health information (or PHI). You have certain rights with respect to your PHI, including a right to see or get a copy of your health and claims records and other health information maintained by a health plan or carrier. For a copy of the Notice of Privacy Practices, describing how your PHI may be used and disclosed and how you get access to the information, contact Human Resources.

Women's Health and Cancer Rights Act Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Woman'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:

1. All stages of reconstruction of the breast on which mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses.
3. 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: $5,000 ded/ 100% coinsurance/ $3,500 ded/ 80% coinsurance/ $1,500 ded/ 80% coinsurance. If you would like more information on WHCRA benefits, call your plan administrator at (210) 964-0204.

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Patient Protection Notice

Your carrier generally may require the designation of a primary care provider. You have the right to designate any primary care provider who participates in your network and who is available to accept you or your family members. Until you make this designation, your carrier may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Aetna at 1-800-872-3862.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from your carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Aetna at 1-800-872-3862.

Legal Notices

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

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. To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact the plan administrator at (210) 964-0204.

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Legal 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 July 31, 2025. Contact your State for more information on eligibility —

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-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
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

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Legal Notices

GEORGIA-Medicaid	MAINE-Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	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: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-Medicaid**
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid Medicaid Phone: 1-800-338-8366 Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: dhh.louisiana.gov/index.cfm/subhome/1/n/331 or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

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Legal Notices

NEVADA-Medicaid	PENNSYLVANIA-Medicaid and CHIP
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
NEW HAMPSHIRE-Medicaid	**RHODE ISLAND-Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
NEW JERSEY-Medicaid and CHIP	**SOUTH CAROLINA-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW YORK-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://dss.sd.gov Phone: 1-888-828-0059
NORTH CAROLINA-Medicaid	**TEXAS-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
NORTH DAKOTA-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
OKLAHOMA-Medicaid and CHIP	**VERMONT-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
OREGON-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

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Legal Notices

WASHINGTON-Medicaid	WISCONSIN-Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WEST VIRGINIA-Medicaid and CHIP	**WYOMING-Medicaid**
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)	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, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Legal Notices

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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Legal Notices

USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right to Be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
  - Initial employment;
  - Reemployment;
  - Retention in employment;
  - Promotion; or
  - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

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Legal Notices

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets.* An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm*.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *http://www.dol.gov/vets/programs/userra/poster.htm*. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

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Legal Notices

Model General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 and other members of your family when group health coverage would otherwise end. For more 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. 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 it would otherwise end because of a life event. This is also called 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're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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Legal Notices

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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 of the following qualifying events:

- 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 continuation 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. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all 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 after the qualifying event occurs. You must provide this notice to: Checcid Vasquez.

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Legal Notices

How is COBRA continuation 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.

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. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

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

If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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**.

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Legal Notices

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[1] 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 the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 **www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about 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

American Medical Home Health Services 5805 Callaghan Rd Suite 300 San Antonio, TX 78228, 210-964-0204, Checcid Vasquez - Checcidvasquez@amhhs.com
Aetna - 1-888-792-3862

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[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

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Legal Notices

Family Medical Leave Act (FMLA)

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

Benefits & Protections

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

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Legal Notices

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

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Legal Notices

Important Notice from American Medical Home Health Services About Your Prescription Drug Coverage and Medicare

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

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **American Medical Home Health Services has determined that the prescription drug coverage offered by the American Medical Home Health Services – Group Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current American Medical Home Health Services coverage will not be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current American Medical Home Health Services coverage, be aware that you and your dependents will not be able to get this coverage back.

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Legal Notices

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with American Medical Home Health Services and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through American Medical Home Health Services 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).

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

Date:	10/01/2025
Name of Entity/Sender:	American Medical Home Health Services
Contact Position/Office:	Checcid Vasquez/ Human Resources
Address:	5805 Callaghan Rd, Suite 300, San Antonio, TX 78228
Phone Number:	210-964-0204

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Legal Notices

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 8-31-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Checcid Vasquez Checcidvasquez@amhhs.com or 210-964-0204

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

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Legal Notices

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name American Medical Home Health Services		4. Employer Identification Number (EIN) 74-2694882
5. Employer address 5805 Callaghan Rd, Suite 300		6. Employer phone number 210-964-0204
7.City San Antonio	8. State Texas	9. ZIP code 78228
10. Who can we contact about employee health coverage at this job? Checcid Vasquez		
11. Phone number (if different from above)	12. Email address Checcidvasquez@amhhs.com	

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

- As your employer, we offer a health plan to:
  - ✓ All employees. Eligible employees are: Employees which work 30 or more hours per week
  - □ Some employees. Eligible employees are:
- With respect to dependents:
  - ✓ We do offer coverage. Eligible dependents are: Spouses and children under the age of 26
  - □ We do not offer coverage.
  - ✓ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

Legal Notices

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

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

- ✓ **Yes** (Continue)
  - 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____(mm/dd/yyyy) (Continue)
- ☐ **No** (STOP and return this form to employee)

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

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
    a. How much would the employee have to pay in premiums for this plan? $ 110.92
    b. How often? ☑ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

16. What change will the employer make for the new plan year?_____
    - ☐ Employer won't offer health coverage
    - ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

    a. How much would the employee have to pay in premiums for this plan? $_____
    b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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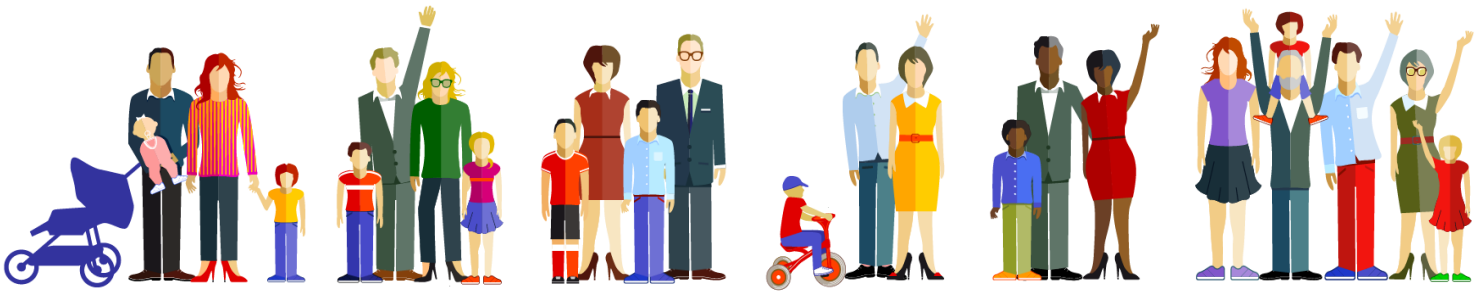
Benefits for 2025 - 2026

Contact Information

Carrier Name	Website	Email	Phone Number
Aetna	www.aetna.com	help@aetna.com	(800) 872-3862
Mutual of Omaha	mutualofomaha.com	stl.service@mutualofomaha.com	(800) 369-3809



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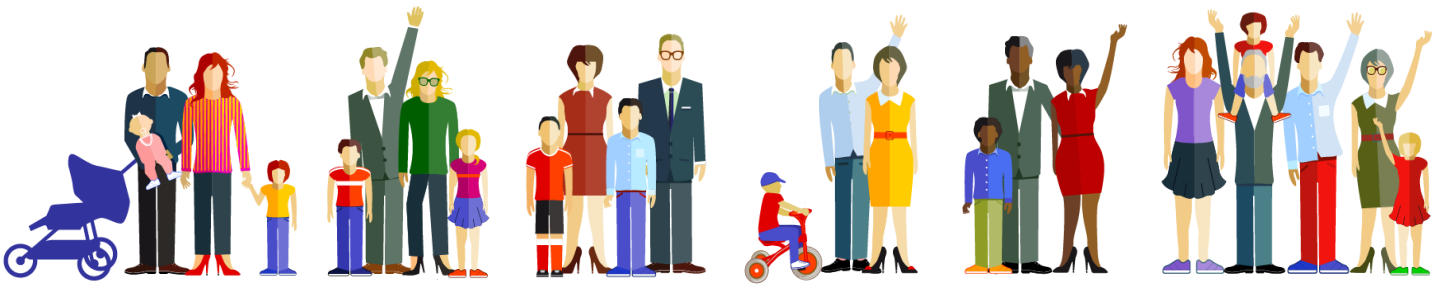
Benefits for 2025 - 2026

Notes



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American Medical
Home Health & Hospice Care

American Medical Home Health Services