
# A Guide to Your Benefits

## Plan Year: March 1, 2021 - February 28, 2022

Kenyon Companies, Inc.

## Enrolling in Your Benefits

All employees MUST complete the Section 125 pre-tax election form and the Tobacco free affdavit.

You must complete a medical and dental enrollment form if you are electing or making changes to your benefits.

If you are waiving coverage, you MUST complete the Waiver of Group Health Insurance form. Your pay check will be held until we receive your waiver form.

All forms are due to Denise Varrone no later than February 12, 2021.

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# Your Kenyon Companies benefits

At Kenyon Companies, we understand the importance of responding to your needs and providing you with the resources and opportunities you need to be a successful member of our organization. One of the most important and valuable resources is your benefits package.

Use this guide as a tool to understand familiarize yourself with our benefits package. Open enrollment is your annual opportunity to make changes to your current benefit elections. The benefits you elect during open enrollment will be available from March 1, 2021 to February 28, 2022. We are excited to share the following updates for the 2021 - 2022 plan year:

- We will remain with United Healthcare and Delta Dental
- There will be no plan changes
- Due to the rising costs of healthcare and inflation, there will be an increase to your medical premiums.

This guide only contains a brief description of your benefit plans. We have attempted to describe important details and changes to the plans in a clear, simple and concise manner. If there is a conflict between this newsletter and the wording of plan documents, the plan documents will govern. We retain the right to change, modify, suspend, interpret, or cancel some or all of the plans at any time.

# Benefit basics

Kenyon Companies pays for some of your benefits and you share the cost for others, as shown here.

| Benefit | Tax Treatment | Who Pays |
|---|---|---|
| **Medical and Pharmacy** | Pretax | Kenyon & You |
| **Dental** | Pretax | Kenyon & You |
| **Vision** | N/A | Kenyon |
| **Health Savings Account** | Pretax | Kenyon & You |

## Section 125 Plan

We will continue to offer our Section 125 premium conversion plan. The Section 125 plan allows the cost of your medical and dental coverage to be deducted from your paycheck before payroll taxes. This is a significant tax saving!

The attached Election Form MUST be completed to take advantage of this benefit. At the top of the form please print your name. At the bottom of the form please date, sign, and enter your social security number.

Your pre-tax election will remain in effect until March 1, 2022. Your election may be changed only if you have a family status event (i.e. marriage, divorce, birth of a child/adoption, death of a dependent). These guidelines are established by the IRS.

If you have a family status event you must contact Denise Varrone within 30 days of the event or you will not be able to make a change until the following annual enrollment.

For more information regarding the plan contact Denise Varrone.

# Eligibility

You are eligible to enroll in the Plan if you are a regular full-time employee who is scheduled to work at least 35 hours per week. Employees meeting the Afforadable Care Act (ACA) eligibility requirements may also enroll in the plan. You will be notified by HR if you meet the ACA eligibility requirements.

Benefits are effective the first of the month following 60 days of employment. The following dependents are also eligible:

- Your legal spouse
- Your children up to age 26
- Your unmarried child age 26 or older who is disabled and dependent upon you.

## Changes to your benefits

Generally, you may only make or change your existing benefit elections as a new hire or during the annual open enrollment period. However, you may change your benefit elections during the year if you experience an event such as:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Loss or gain of other coverage by the employee or dependent
- Eligibility for Medicare or Medicaid

**You have 31 days from the qualified life event to make changes to your coverage.** Depending on the type of event, you may need to provide proof of the event, such as a marriage license. If you do not make the changes within 31 days of the qualified event, you will have to wait until the next open enrollment period to make changes (unless you experience another qualified life event).

### Important notice if you use nicotine/tobacco

Going nicotine- and tobacco-free is one of the most important steps you can take to maintain good health. If you enroll in our medical plan and you use tobacco/nicotine, you will be required to pay a tobacco surcharge of $40 per month in addition to your regular medical premiums. If you complete a tobacco cessation program, notify HR and complete a new Tobacco Affidavit to receive a reduction in premium.

### E-Cigarettes are considered nicotine products

E-cigarettes are battery-operated products which deliver nicotine, flavor, and other chemicals. Electronic cigarettes are a subset of a category known as Electronic Nicotine Delivery Systems (ENDS); this fast-growing category includes a number of delivery methods including vape pens and hookahs. E-cigarettes are not a tobacco cessation tool. The safety of these products has not been demonstrated.

# Medical and pharmacy plan overview

Kenyon offers a choice of four medical plans through United Healthcare (UHC). All of the medical options include coverage for prescription drugs. To select the plan that best suits your family, you should consider the key differences between the plans, the cost of coverage (including payroll deductions), and how the plan covers services throughout the year.

## Understanding how your plan works

### 1. Your deductible

You pay out-of-pocket for most medical and pharmacy expenses until you reach the deductible. Some of our plans of copays for office visits, urgent care, emergency room visits, and prescription drug fills. The deductible will not apply to these services unless otherwise noted.

### 2. Your coverage

Once your deductible is met, you and the plan share the cost of covered medical and pharmacy expenses with coinsurance. The plan will pay a percentage of each eligible expense, and you will pay the rest.

### 3. Your out-of-pocket maximum

When you reach your out-of-pocket maximum, the plan pays 100% of covered medical and pharmacy expenses for the rest of the plan year. Your deductible and coinsurance apply toward the out-of-pocket maximum eligible health care expenses.

**All of our plans have an embedded deductible and out-of-pocket maximum**

- **Under an embedded approach,** each person only needs to meet the individual deductible and out-of-pocket maximum before the plan begins paying its share for that individual. (And, once two or more family members meet the family limits, the plan begins paying its share for all covered family members.)

## Making the most of your plan

Getting the most out of your plan also depends on how well you understand it. Keep these important tips in mind when you use your plan.

- **In-network providers and pharmacies:** You will always pay less if you see a provider within the medical and pharmacy network.
- **Preventive care:** In-network preventive care is covered at 100% (no cost to you). Preventive care is often received during an annual physical exam and includes immunizations, lab tests, screenings and other services intended to prevent illness or detect problems before you notice any symptoms.
- **Preventive drugs:** Many preventive drugs and those used to treat chronic conditions like diabetes, high blood pressure, high cholesterol and asthma are designated on the Chronic/Preventive Condition Drug List as preventive. These prescriptions are covered at 100% (no cost to you) when you use an in-network pharmacy.
- **Pharmacy coverage:** Medications are placed in categories based on drug cost, safety and effectiveness.
- **Mail order pharmacy:** If you take a maintenance medication on an ongoing basis for a condition like high cholesterol or high blood pressure, you can use the mail order pharmacy to save on a 90-day supply of your medication.

# Wellness Program

For the 2021-2022 plan year, we will be continuing our Wellness Program in partnership with United Healthcare. Our Wellness Program is designed to help you understand your current health status and make positive lifestyle and behavioral changes that may reduce your health risks and save you money.

Kenyon's Wellness Program encourages you to complete an annual health assessment and physician wellness exam to find your potential health risk factors. If needed, you can work with your physician to develop a treatment plan to help improve your health.

## What is the objective of this program?

Kenyon's Wellness Program rewards you for completing specific health and wellness actions. By working with your doctor to manage your lifestyle and health behaviors, this program can help you save money by giving you:

- An opportunity to learn about your potential health risks
- The ability to work with your doctor to establish a personalized treatment plan
- Ways to manage your current health based on health screenings and physician recommendations
- A chance to reduce your health risks so you can live a healthier life

## What is the program incentive?

Participating in Kenyon's Wellness Program is simple.

- All health employees and their spouse if applicable will need to have a wellness exam and discuss your results with your doctor. If you complete your exam and the required documentation is submitted by April 30, 2021, you and your covered family members will continue to have a reduced premium. Please note exams performed between January 1, 2021 - April 30, 2021 will be accepted.
- If you do not meet the program requirements, you and your covered family members will not be eligible for the reduced premium resulting in higher out of pocket costs.

## What are the health and wellness action steps?

1. Complete a Health Assessment on www.myuhc.com.
2. Meet with your doctor for an annual wellness visit and receive basic testing and health screenings with the following targets:
   - No tobacco use
   - BMI between 18.5 and 25
   - Blood Pressure less than 140/90
   - LDL Cholesterol less than 130
   - Fasting Blood Sugar less than 100 or A1c less than 5.7
3. Complete the Health Action form, which you will receive in this enrollment packet and have it signed by your physician. After all of your results are filled in, send the completed Health Action form to the address or fax number on the bottom of the form.

# Health Savings Account

A Health Savings Account (HSA) is a savings account that belongs to you and that is paired with the Choice Plus – HSA Plan. It allows you to make tax-free contributions to a savings account to pay for current and future medical expenses for you and your dependents.

### START IT

- Contributions to the HSA are tax-free for you whether they come from you or the company. Kenyon contributes $200 to your HSA account.
- Plans with an HSA typically cost less than other plans so the money you save on premiums can be put into your HSA. You save money on taxes and have more flexibility and control over your health care dollars.

### BUILD IT

- All of the money in your HSA is yours (including any contributions deposited by the company) even if you leave your job, change plans or retire.
- In 2021, the total of your contributions and the company's can be up to $3,600 for individual coverage and $7,200 for family coverage.

### USE IT

- You can withdraw your money tax-free at any time, as long as you use it for qualified expenses (a list can be found on www.irs.gov).
- You can also save this money and hold onto it for future eligible health care expenses.

### GROW IT

- Unused money in your HSA will roll over, earn interest and grow tax-free over time.
- You decide how to use the HSA money, including whether to save it or spend it for eligible expenses. When your balance is large enough, you can invest it — tax-free.

## Eligibility Details

- If you are age 55 or older, you can contribute an additional $1,000 per year.
- You are not allowed to be enrolled in any other health coverage, and cannot have an HSA if you are enrolled in any other health coverage or Medicare, or claimed as a dependent on someone else's tax return.
- You cannot participate in the Health Care Flexible Spending Account (FSA) if you have an HSA. Your spouse also cannot have a Health Care FSA.

# Dental plan

It's important to have regular dental exams and cleanings so problems are detected before they become painful — and expensive. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and is an important part of maintaining your overall health. We offer a dental plan options through Delta Dental.

| Plan Provisions | Delta Dental |
|---|---|
| **Contract Year Deductible** (Individual/Family) | None |
| **Contract Year Maximum** | $2,000 |
| **Orthodontia Lifetime Maximum** | Combined with Contract Year Annual Maximum |
| **Diagnostic and Preventive Services** (e.g., X-rays, cleanings, exams) | Covered at 100% |
| **Basic and Restorative Services** (e.g., fillings) | 50% |
| **Major Services** (e.g., dentures, crowns, bridges) | 50% |
| **Orthodontia** | 50% for children and adults |

## Using in-network dental providers

While you have the option of choosing any provider, you will save money when you use in-network dentists. When using an out-of-network dental provider, you will pay more because the provider has not agreed to charge you a negotiated rate.

# Vision reimbursement plan

Kenyon will continue to offer our vision reimbursement plan this year. Through this plan, we will reimburse eligible employees and dependents up to $200 per person once every 12 months for vision expenses, including exams and prescription eyewear. As in the past, you and/or your dependents must be enrolled in the medical plan to be eligible for the vision reimbursement plan, however, you are not required to make payroll deductions. This is a company paid benefit! For more information, please contact Denise Varrone in HR.

# Contact information

If you have any questions regarding your benefits, please refer to the Customer Service number below or on the back of your ID card, If you need further assistance, please contact Denise Varrone in Human Resources.

| Coverage | Carrier | Phone | Website |
|---|---|---|---|
| **Medical and Pharmacy** | United Healthcare (UHC) | PPO Plan: 866-844-4864<br>HSA Plan: 866-314-0335 | www.myuhc.com |
| **Wellness** | United Healthcare (UHC) | n/a | www.myuhc.com |
| **Dental** | Delta Dental of Arizona | 800-352-6132 | www.deltadentalaz.com |
| **Vision Reimbursement Plan** | Kenyon | Denise Varrone / HR<br>602-233-1191 | dvarrone@kenyonweb.com |
| **Health Savings Account** | Optum Bank | 866-314-0335 | www.optumbank.com |
| **Enrollment and Human Resources** | Kenyon | Denise Varrone<br>602-233-1191 | dvarrone@kenyonweb.com<br>HR@kenyonweb.com |

# Glossary

- **Brand preferred drugs** – A drug with a patent and trademark name that is considered "preferred" because it is appropriate to use for medical purposes and is usually less expensive than other brand-name options.
- **Brand non-preferred drugs** – A drug with a patent and trademark name. This type of drug is "not preferred" and is usually more expensive than alternative generic and brand preferred drugs.
- **Calendar Year Maximum** – The maximum benefit amount paid each year for each family member enrolled in the dental plan.
- **Coinsurance** – The sharing of cost between you and the plan. For example, 80 percent coinsurance means the plan covers 80 percent of the cost of service after a deductible is met. You will be responsible for the remaining 20 percent of the cost.
- **Copay** – A fixed amount (for example $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.
- **Deductible** – The amount you have to pay for covered services before your health plan begins to pay.
- **Elimination Period** – The time period between the beginning of an injury or illness and receiving benefit payments from the insurer.
- **Generic drugs** – A drug that offers equivalent uses, doses, strength, quality and performance as a brand-name drug, but is not trademarked.
- **Health Savings Account (HSA)** – An HSA is a personal health care account for those enrolled in a High Deductible Health Plan (HDHP). You may use your HSA to pay for qualified medical expenses such as doctor's office visits, hospital care, prescription drugs, dental care, and vision care. You can use the money in your HSA to pay for qualified medical expenses now, or in the future, for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP.
- **In-network** – A designated list of health care providers (doctors, dentists, etc.) with whom the health insurance provider has negotiated special rates. Using in-network providers lowers the cost of services for you and the company.
- **Inpatient** – Services provided to an individual during an overnight hospital stay.
- **Mail Order Pharmacy** – Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.
- **Out-of-network** – Health care providers that are not in the plan's network and who have not negotiated discounted rates. The cost of services provided by out-of-network providers is much higher for you and the company. Additional deductibles and higher coinsurance will apply.
- **Out-of-pocket maximum** – The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year. Your annual deductible is included in your out-of-pocket maximum.
- **Outpatient** – Services provided to an individual at a hospital facility without an overnight hospital stay.
- **Primary Care Provider (PCP)** – A doctor (generally a family practitioner, internist or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions.
- **Reasonable & Customary Charges (R&C)** – Prevailing market rates for services provided by health care professionals within a certain area for certain procedures. Reasonable and Customary rates may apply to out-of-network charges.
- **Specialist** – A provider who has specialized training in a particular branch of medicine (e.g., a surgeon, cardiologist or neurologist).
- **Specialty drugs** – A drug that requires special handling, administration or monitoring. Most can only be filled by a specialty pharmacy and have additional required approvals.

# Important Legal Rights Information

**MANDATED HEALTH PLAN INFORMATION REQUIRED FOR FEDERAL COMPLIANCE**

According to Federal regulations all employers MUST provide information annually pertaining to certain rights covered under health plans.

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 **Kenyon Companies, Inc.** Human Resources Department.

If you have any questions regarding the below information, please contact **Denise Varrone at (602) 233-1191** or **dvarrone@kenyonweb.com**.

**Patient Protection Disclosure**

The medical plan options offered under **Kenyon Companies, Inc.** Insurance Plan generally allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact United Healthcare at the number on your ID card.

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

**HIPAA Special Enrollment Rights**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards 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 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.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within "60 days" after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within "60 days" after the determination of eligibility for such assistance.

**Note:** The "60-day" or any longer period that applies under the plan period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a "30-day" period applies to most special enrollments.

As stated earlier in this notice, a special enrollment opportunity may be available in the future if you or your dependents lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage may eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you may not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraphs above, however, regarding enrollment in the event of marriage, birth, adoption, placement for adoption, loss of eligibility for Medicaid or a state CHIP, and gaining eligibility for a state premium assistance subsidy through Medicaid or a state CHIP.)

To request special enrollment or obtain more information, please contact **Denise Varrone at (602) 233-1191** or **dvarrone@kenyonweb.com**.

### 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 within the plan.

### Notice of Privacy Practices

**Kenyon Companies Benefit Plan (the "Plan")** provides health benefits to eligible employees of **Kenyon Companies, Inc. (the "Company")** and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information. To receive a copy of the Plan's Notice of Privacy Practices you should contact **Denise Varrone** in Human Resources at **(602) 233-1191** or **dvarrone@kenyonweb.com** who has been designated as the Plan's contact person for all issues regarding the Plan's privacy practices and covered individuals' privacy rights.

### GINA Warning against Providing Genetic Information

The Genetic Information Nondiscrimination Act (GINA) prohibits collection of genetic information by both employers and health plans, and defines genetic information very broadly. Asking an individual to provide family medical history is considered collection of genetic information, even if there is no reward for responding (or penalty for failure to respond). In addition, a question about an individual's current health status is considered to be a request for genetic information if it is made in a way likely to result in obtaining genetic information (e.g., family medical history). Wellness programs that require completion of health risk assessments or other forms that request health information may violate the collection prohibition unless they fit within an exception to the prohibition for inadvertent acquisition of such information. This exception applies if the request does not violate any laws, does not ask for genetic information and includes a warning against providing genetic information in any responses. An employer administering a wellness program might include on the relevant forms a warning such as the one set out below.

### Newborn's and Mother's Health Protection Act

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

### COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued coverage for a certain period of time at applicable monthly COBRA rates if you, your spouse, or your dependents lose group medical, dental, or vision coverage because you terminate employment (for reason other than gross misconduct); your work hours are reduced below the eligible status for these benefits; you die, divorce, or are legally separated; or a child ceases to be an eligible dependent.

### Request for Social Security Number

A Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers, third-party administrators (TPAs), and plan administrators or fiduciaries of self-insured/self-administered group health plans (GHPs) to report, as directed by the Secretary of the Department of Health and Human Services, information that the Secretary requires

for purposes of coordination of benefits. The law also imposes this same requirement on liability insurers (including self-insurers), no-fault insurers, and workers' compensation laws or plans. Two key elements that are required to be reported are HICNs (or SSNs) and EINs. In order for Medicare to properly coordinate Medicare payments with other insurance and/or workers' compensation benefits, Medicare relies on the collection of both the HICN (or SSN) and the EIN, as applicable.

As a subscriber (or spouse or family member of a subscriber) to a GHP arrangement, **Kenyon Companies, Inc.** will ask for proof of your Medicare program coverage by asking for your Medicare HICN (or your SSN) to meet the requirements of P.L. 110-173 if this information is not already on file with your insurer. Similarly, individuals who receive ongoing reimbursement for medical care through no-fault insurance or workers' compensation or who receive a settlement, judgment, or award from liability insurance (including self-insurance), no-fault insurance, or workers' compensation will be asked to furnish information concerning whether or not they (or the injured party if the settlement, judgment or award is based on an injury to someone else) are Medicare beneficiaries and, if so, to provide their HICNs or SSNs. Employers, insurers, TPAs, etc., will be asked for EINs. To confirm that this ALERT is an official government document and for further information on the mandatory reporting requirements under this law, please visit **http://www.cms.gov** on the CMS website.

**Notice Regarding Wellness Program**

The Kenyon Companies Wellness Program is a voluntary wellness program available to all employees and eligible spouses. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you and/or your spouse will be asked to complete a health assessment that contains a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening with your physician, which will include testing for tobacco use, BMI, blood pressure, LDL cholesterol, and fasting blood sugar. You are not required to complete the health assessment or complete the biometric screening with your physcian

However, employees and spouses who choose to participate in the wellness program will receive an $40 per month discount off of their medical premium. Although you are not required to complete the health assessment or participate in the biometric screening, only employees and spouses who do so will receive the incentive.

The information from your health assessment and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program.

**You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.**

**If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Denise Varrone at 602-233-1191 or dvarrone@kenyonweb.com**

**Reasonable Alternatives:**

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Denise Varrone at 602-233-1191 or **dvarrone@kenyonweb.com** and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

**Protections from Disclosure of Medical Information**

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

## NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

**PART A: General Information**

When key parts of the health care law took effect in 2014, there was 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 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 November each year for coverage starting as early as the immediately following January 1.

**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 **Kenyon Companies Human Resources Department at 602-233-1191.**

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.

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

| ALABAMA – Medicaid | COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) |
|---|---|
| Website: **http://myalhipp.com/**<br>Phone: 1-855-692-5447 | Health First Colorado Website:<br>**https://www.healthfirstcolorado.com/**<br>Health First Colorado Member Contact Center:<br>1-800-221-3943/State Relay 711<br>CHP+: **https://www.colorado.gov/pacific/hcpf/child-health-plan-plus**<br>CHP+ Customer Service: 1-800-359-1991/ State Relay 711<br>Health Insurance Buy-In Program (HIBI):<br>**https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program**<br>HIBI Customer Service: 1-855-692-6442 |
| **ALASKA – Medicaid** | **FLORIDA – Medicaid** |
| The AK Health Insurance Premium Payment Program<br>Website: **http://myakhipp.com/**<br>Phone: 1-866-251-4861<br>Email: **CustomerService@MyAKHIPP.com**<br>Medicaid Eligibility: **http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx** | Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**<br>Phone: 1-877-357-3268 |
| **ARKANSAS – Medicaid** | **GEORGIA – Medicaid** |
| Website: **http://myarhipp.com/**<br>Phone: 1-855-MyARHIPP (855-692-7447) | Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**<br>Phone: 678-564-1162 ext 2131 |
| **CALIFORNIA – Medicaid** | **INDIANA – Medicaid** |
| Website: **https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx**<br>Phone: 916-440-5676 | Healthy Indiana Plan for low-income adults 19-64<br>Website: **http://www.in.gov/fssa/hip/**<br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: **https://www.in.gov/medicaid/**<br>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

## KANSAS – Medicaid

Website: **http://www.kdheks.gov/hcf/default.htm**
Phone: 1-800-792-4884

## KENTUCKY – Medicaid

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

## LOUISIANA – Medicaid

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

## MAINE – Medicaid

Enrollment Website: **https://www.maine.gov/dhhs/ofi/applications-forms**
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: **https://www.maine.gov/dhhs/ofi/applications-forms**
Phone: 1-800-977-6740
TTY: Maine relay 711

## MASSACHUSETTS – Medicaid and CHIP

Website: **http://www.mass.gov/eohhs/gov/departments/masshealth/**
Phone: 1-800-862-4840

## MINNESOTA – Medicaid

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

## MISSOURI – Medicaid

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

## MONTANA – Medicaid

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

## NEBRASKA – Medicaid

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

## NEVADA – Medicaid

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

## NEW HAMPSHIRE – Medicaid

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

## NEW JERSEY – Medicaid and CHIP

Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/**
Medicaid Phone: 609-631-2392
CHIP Website: **http://www.njfamilycare.org/index.html**
CHIP Phone: 1-800-701-0710

## NEW YORK – Medicaid

Website: **https://www.health.ny.gov/health_care/medicaid/**
Phone: 1-800-541-2831

## NORTH CAROLINA – Medicaid

Website: **https://medicaid.ncdhhs.gov/**
Phone: 919-855-4100

## NORTH DAKOTA – Medicaid

Website: **http://www.nd.gov/dhs/services/medicalserv/medicaid/**
Phone: 1-844-854-4825

| OKLAHOMA – Medicaid and CHIP | UTAH – Medicaid and CHIP |
|---|---|
| Website: **http://www.insureoklahoma.org**<br>Phone: 1-888-365-3742 | Medicaid Website: **https://medicaid.utah.gov/**<br>CHIP Website: **http://health.utah.gov/chip**<br>Phone: 1-877-543-7669 |
| **OREGON – Medicaid** | **VERMONT– Medicaid** |
| Website: **http://healthcare.oregon.gov/Pages/index.aspx**<br>**http://www.oregonhealthcare.gov/index-es.html**<br>Phone: 1-800-699-9075 | Website: **http://www.greenmountaincare.org/**<br>Phone: 1-800-250-8427 |
| **PENNSYLVANIA – Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: **https://www.dhs.pa.gov/providers/Providers/Pagers/Medical/HIPP-Program.aspx**<br>Phone: 1-800-692-7462 | Website: **https://www.coverva.org/hipp/**<br>Medicaid Phone: 1-800-432-5924<br>CHIP Phone: 1-855-242-8282 |
| **RHODE ISLAND – Medicaid** | **WASHINGTON – Medicaid** |
| Website: **http://www.eohhs.ri.gov/**<br>Phone: 1-855-697-4347, or 401-462-0311<br>(Direct RIte Share Line) | Website: **https://www.hca.wa.gov/**<br>Phone: 1-800-562-3022 |
| **SOUTH CAROLINA – Medicaid** | **WEST VIRGINIA – Medicaid** |
| Website: **https://www.scdhhs.gov**<br>Phone: 1-888-549-0820 | Website: **http://mywvhipp.com/**<br>Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **SOUTH DAKOTA - Medicaid** | **WISCONSIN – Medicaid and CHIP** |
| Website: **http://dss.sd.gov**<br>Phone: 1-888-828-0059 | Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**<br>Phone: 1-800-362-3002 |
| **TEXAS – Medicaid** | **WYOMING – Medicaid** |
| Website: **http://gethipptexas.com/**<br>Phone: 1-800-440-0493 | Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/**<br>Phone: 1-800-251-1269 |

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

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

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

**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.

**IMPORTANT NOTICE FROM KENYON COMPANIES, INC. INSURANCE PLAN 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 Kenyon Companies, Inc. Insurance Plan 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. Kenyon Companies, Inc. has determined that the prescription drug coverage offered by the Kenyon Companies, Inc. Insurance 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 Kenyon Companies, Inc. Insurance Plan coverage will not be affected.

You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Kenyon Companies, Inc. Insurance coverage, be aware that you and your dependents may or may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Kenyon Companies, Inc. 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 **Kenyon Companies, Inc.** 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:** | January 15, 2021 |
| **Name of Entity/ Sender:** | Kenyon Companies, Inc |
| **Contact – Position/Office:** | Human Resources |
| **Address:** | 4001 W. Indian School Rd, Phoenix, AZ 85019 |
| **Phone Number:** | 602-233-1191 |

# Notes

# Notes

Kenyon Companies, Inc.

**About this Guide**

This benefit summary provides selected highlights of the Kenyon Companies, Inc. benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. Kenyon Companies, Inc. reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.