ACCELIRATE

Accelerating Automation & AI

2022 Benefits Guide

Plan Year: November 1, 2022 – October 31, 2023

USI

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 27 for more details.

Call the Benefit Resource Center ("BRC"), We're Here To Help!

We speak insurance. Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution
- Medicare basics with your employer plan
- Coordination of benefits
- Finding in-network providers
- Access to care issues
- Obtaining case management services
- Group disability claims
- Filing claims for out-of-network services

USI®

Benefit Resource Center

BRCsouth@usi.com I Toll Free: 855-874-0835

A Message from Accelirate, Inc.

At Accelirate, Inc. we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs, we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all our employees. This benefit guide will help you choose the type of plan and level of coverage that is right for you.

We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family. Please take a moment to read through this brochure to familiarize yourself with the benefits available to you as a Accelirate, Inc. team member.

This guide is intended to be a high-level summary of the benefit plans Accelirate, Inc. will offer effective November 1st, 2022.

Brainshark Open Enrollment Presentation: You are able to view the Open Enrollment presentation at any time using any smart device or computer by clicking on the following link, www.brainshark.com **Or, by scanning the QR code below:**

Sincerely,
Gabriela Enriquez
Global Chief
Human Resources Officer

Key Enrollment Information

Benefits Enrollment

Welcome to your 2022 employee benefits guide. In these pages, you'll learn about the Accelirate, Inc. benefits program, which is designed to help you stay healthy, secure, and maintain a work/life balance. Offering a competitive benefits package is just one way we strive to provide our employees with a rewarding workplace. Please read the information in this guide carefully, and for full details about our plans, refer to each plan's summary plan description.

Who is Eligible?

You are eligible to enroll in the Accelirate, Inc. benefits plan if you are a full-time team member working an average of 30 or more hours per week.

Eligible dependents include legally married spouse, dependent child to age 30 (if they meet certain criteria) for the Medical plan and to age 26 for the Dental and Vision plans.

How Can I Enroll?

The first step is to review the benefit offerings. Next, complete your enrollment in the Paycom portal. Make sure to include all required information, including dependent information.

Changing Coverage During the Year

You can change coverage during the year only when you experience a qualifying life event, such as marriage, divorce, birth, adoption, placement for adoption, or loss of coverage. The change must be reported to the Human Resources Department within 30 days of the event. The change must be consistent with the event.

Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change. Please contact HR to make these changes.

When is Coverage Effective?

For new hires, your benefits will begin the 1st day of the month following your date of hire. Current benefit eligible team members can enroll during the annual Open Enrollment period. Open Enrollment occurs annually in October and benefit changes made during this period are effective on November 1st.

Medical/Rx

Definitions

Copay	Flat dollar amount member is responsible for at the time of service. The plan usually pays 100% of the remaining balance.
Deductible	Amount member is responsible for before the plan pays for certain services.
Coinsurance	Percentage of payment shared between the member and the plan for certain services after the deductible has been met.
Out-of-Pocket Maximum	Member total payments for deductible, coinsurance and copays to stated maximum per plan year. Once reached, the plan will pay 100% for eligible expenses for the rest of the plan year.
Network Provider	Medical and pharmacy providers that have contracted with the plan to provide lower out-of-pocket costs for members.

Click on link to view a short video on key terms related to medical insurance.
https://flimp.me/HubDeliverablesKeyHealthTerms

Medical Insurance

For 2022, your medical plans are with Florida Blue.

This chart is intended only to highlight the benefits available and should not be relied upon to fully determine your coverage. If the below illustration of benefits conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your exact description of services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage

Florida Blue	BlueOptions 05302	BlueOptions 05190/05191	BlueOptions 05770
	In-Network	In-Network	In-Network
Annual Deductible			
Individual/Family	$5,000 / $10,000	$1,500 / $3,000	$1,000 / $3,000
Coinsurance	70%	80%	80%
Maximum Out-of-Pocket			
Individual/Family	$6,350 / $12,700	$4,500 / $6,850 / $9,000	$3,500 / $7,000
Physician Office Visit			
Primary Care	$30 copay	80% After Ded.	$30 copay
Specialty Care	$55 copay	80% After Ded.	$55 copay
Preventive Care			
Wellness / Preventive Care	100%	100%	100%
Diagnostic Services			
X-ray and Lab Tests	100% / 70% After Ded.	80% After Ded.	$50 / 100%
Complex Radiology	70% After Ded.	80% After Ded.	$200 copay
Urgent Care Facility	$60 copay	80% After Ded.	$50 copay
Emergency Room Facility Charges	$300 copay	80% After Ded.	$400 copay
Inpatient Hospital Facility	70% After Ded.	80% After Ded.	80% After Ded.
Outpatient Surgical Facility	70% After Ded.	80% After Ded.	80% After Ded.
Out-of-Network Services			
Deductible Individual/Family	$10,000 / $30,000	$3,000 / $6,000	$3,000 / $6,000
Maximum Out-of-Pocket	$20,000 / $40,000	$9,000 / $18,000	$7,000 / $14,000
Coinsurance	50%	40%	50%
Prescription Drugs			
Tier 1/Tier 2 / Tier 3 (30 day Supp)	$10 / 20% / NC	Ded. then $10 / $50 / $80	$10 / $50 / $80
Mail Order	2 X Retail	2 X Retail	2 X Retail

Semi-Monthly Deductions	05302	05190/05191	05770
Employee	$62.01	$79.30	$96.55
Employee & Spouse	$147.58	$188.74	$229.80
Employee & Child(ren)	$119.06	$152.26	$185.39
Family	$198.43	$253.77	$308.98

Click on the link below to view a short video on the PPO plan.

PPO: https://flimp.me/HubDeliverablesPPO

Health Savings Account (HSA)

Who can enroll in an HSA?

Any adult can contribute to an HSA if you:

- Have coverage under an HSA qualified high deductible health plan (Plan 05190/05191)
- Have no other first dollar medical coverage (other types of insurance, including specific injury or accident, disability, dental care, vision care, or long-term care insurance are permitted)
- Are not enrolled in Medicare or Tricare
- Cannot be claimed as a dependent on someone else's tax return

How much can I contribute?

The IRS sets a limit for HSA contributions each year. For 2022, the limits are:

- Employee Only $3,650
- Family $7,300
- Individuals ages 55 and older can also make additional "catch-up" contributions to a maximum of $1,000

How can I use the money in my HSA?

You may use the money in the HSA to pay for qualified expenses for you, your spouse and dependents. You can use the money for expenses for your spouse and dependents, even if they are not enrolled in the QHDHP.

How can I use HSA funds?

- Dental Care
- Medical Expenses not Covered by your Medical Plan
- Vision Care
- Prescription Drugs
- Orthodontics
- Over-The-Counter Medication
- Physical Therapy

Advantages:

- You can invest the money in your HSA so it can grow even more.
- After age 65, you may use the HSA money for expenses other than qualified medical expenses without a penalty, but you'll have to pay taxes on the withdrawals.
- The money in the account is yours and is still available to you even if you switch plans

URGENT CARE OR EMERGENCY ROOM

URGENT CARE CENTER	EMERGENCY ROOM
Cold, flu, or fever	Chest pain
Strains, sprains, or breaks	Abdominal pain
Infections	Stroke
Mild burns	Severe head injury
Allergies	Major trauma

71% of emergency department visits are unnecessary or could have been avoided.[1]

LOWER copay applies[2]

HIGHER copay applies[2]

You will usually be seen in under **20** minutes

Average length of time spent in the ER nationwide[3] **2** hours **15** minutes

EXTENDED HOURS **OPEN** WEEKENDS

Open 24/7

If you have a life-threatening illness or injury, go to the ER or call 911 right away.

BetterYou STRIDES

Map Your Personal Path to Health

Welcome to Better You Strides powered by CaféWell®, a free online wellness program that uses your needs, goals and interests to build your customized plan to better health.

A Personal Plan for You

Better You Strides creates a Personal Health Itinerary® for you—a custom-made plan with recommended actions to reach your health goals. Activities cover healthy eating, tips to move more and ways to feel happier.

Discover the fun of building healthy habits through activities, videos and quizzes. As you progress, your Personal Health Itinerary evolves, offering challenges and activities to help you stay motivated.

Your Mobile Fitness Partner

Tap into your Personal Health Itinerary from your smartphone, tablet or computer to track your progress or get support any time, anywhere. Many fitness apps like iHealth and MyFitnessPal and devices such as FitBit connect to Better You Strides. That makes tracking your progress even easier.

Rewards for Healthy Habits

Earn rewards as you get healthier. As you complete activities in your Personal Health Itinerary, you score points for chances to win monthly prizes.

Florida Blue

Start Your Journey to Better Health Today!

You can register for Better You Strides online or from the CaféWell mobile app.

If you have Florida Blue coverage:

Registering online

1. Log in to your Florida Blue online account at floridablue.com. Find "Your Guide to Better Health" on the right side of your home page. Click "Get Started."
2. Provide a user name and password in the welcome screen that appears. Click "Create your account."

From the CaféWell mobile app

1. Download the CaféWell mobile app from the Apple App store or Google Play. Click "Register now."
2. Enter the sponsor code: betteryoustrides

If you don't have coverage with Florida Blue:

Registering online

- Visit floridablue.com/betteryoustrides.

From the CaféWell mobile app

- Download the CafeWell mobile app and enter sponsor code "betteryou".

Now you've got everything you need to start taking strides toward better health!

If you have questions or need help registering for Better You Strides, call 855-337-8340 or send an email to betteryoustrides@cafewell.com.

HEALTHY LIVING IS JUST A DEAL AWAY.

Join Blue365® and start saving today!

With Blue365, great deals are yours for every aspect of your life – like 20 percent off at Reebok.com, discounted products through Jenny Craig, or a gym membership for only $29 a month.

BlueCross BlueShield

Blue365®

Because health is a big deal℠

Register now at https://www.blue365deals.com/ to take advantage of Blue365. It's an online destination featuring healthy deals and discounts exclusively for our members.

Just have your Blue Cross and Blue Shield member ID card handy. In a couple of minutes, you will be registered and ready to shop. Every week, we will send a special deal straight to your email inbox.

Check out these top brands with discounts just for you:

Beltone™ · fitness your way by Tivity Health · jenny CRAIG® · GARMIN™ · Bicycling · Runner's World · Men's Health · Women's Health · SKECHERS · TruHearing™ · QualSight LASIK · Reebok

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Florida Blue
In the pursuit of health®

When You Don't Have Time to Wait, You've Got Teladoc!

Provides 24/7 Access to Care

When you or a family member don't feel well and your primary care doctor or your child's pediatrician can't see you right away, you can now get care within minutes without leaving home with Teladoc.

For a cost that's less than an urgent care or ER visit, Teladoc gives you 24/7/365 access to U.S. board-certified doctors by web, phone or mobile app. It's a more convenient and affordable option for quality medical care. And there's no obligation or extra monthly fee.

Getting Started

Set up your account today—so when you need care, a Teladoc doctor is a just a call or click away.

How Does Teladoc Work?

1. **Register**
   3 easy ways: download the mobile app, visit the Teladoc website or call the number below.
2. **Provide Medical History**
   Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.
3. **Request a Visit**
   That's it! The next time you need immediate care for a non-emergency illness, you have another option.

The Teladoc Difference

Teladoc can help with many non-emergency illnesses, including:

- Sinus infection
- Flu
- Cough
- Sore throat
- Rash
- Allergies
- Upset stomach
- Nausea
- Other minor health issues and more

TELADOC®

Talk to a doctor anytime.

Call today 1-800-Teladoc (835-2362) or visit Teladoc.com

Teladoc is an independent company contracted by Florida Blue to provide physician visits via phone or online video to members with non-emergent medical issues. Teladoc is only available in the U.S. Teladoc® is a trademark of Teladoc, Inc.

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. For more information, visit floridablue.com/ndnotice.

BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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Florida Blue

Value Choice Provider

Primary Care

SAVE money on your health care!

As a Florida Blue member, you may save time and money when you see a primary care doctor at any Sanitas Medical Center or Diagnostic Clinic Medical Group location. These Value Choice Providers offer you quality care—under one roof—for many conditions. And with more convenient hours, it's easier to find time to go to the doctor.

Sanitas Medical Center | For members of Florida Blue

Includes unlimited scheduled visits to a primary care doctor, X-rays, allergy testing and most allergy shots provided during that visit.

Florida Blue Members
as low as

$0

copay* per PCP visit

For more information, visit Sanitas Medical Center at mysanitas.com.

If you have any questions about what your plan covers, be sure to ask when you make an appointment.

Prescription Discounts

Accelirate, Inc. is always looking to protect its employees' pockets when it can. Take a look at the various pharmacy discounts available to you simply for being a consumer. You do not need to be a member of the medical plan in order to participate in any of these programs. For more information, please visit the websites below and keep in mind that certain restrictions will apply.

You'll find medications for some of the most common ailments available in 90-day supplies for just $7.50. Check out what's on their list to see how you can save. Want your Medications delivered to your home? You can now get select prescriptions delivered for just $5. To review all the fine print please visit the Publix website directly.

https://www.publix.com/pharmacy

$4 Prescriptions
Save big on 30-day generic medications for only $4 & spend just $10 on 90-day prescriptions. No insurance necessary.

Find your medication list at:
https://www.walmart.com/cp/4-prescriptions/1078664

Mark Cuban's CostPlus aims to offer the public low cost generic drugs at a low price, no middleman (PBMs). Simple look up your medication, have your doctor send in the prescription and CostPlus will mail it to you.

To look up your medication, visit their website at www.costplusdrugs.com

Get a GoodRx Prescription Discount Card for free! Use the card for discounts of up to 80% on most prescription drugs at over 70,000 U.S. pharmacies. Get discounts for every member of your family, including pets! No expiration. No fees or obligations. No credit card required. GoodRx is not insurance. Savings based on pharmacy retail price.

GoodRx is 100% free. No registration required.

Visit their website at www.goodrx.com or download their app.

Dental Insurance

As an active benefit eligible employee of Accelirate, Inc. you have access to two dental insurance policies through United of Omaha Life Insurance Company.

To find participating providers go to www.mutualofomaha.com and click on 'Products', 'Dental Insurance' and then 'Find a Provider '. These plans are PPO plan which allow both In-Network and Out-of-Network services; however, if you use an out-of-network provider, your out-of-pocket costs will be higher, and you will be subject to balance billing.

The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

Benefits Coverage	DPPO Low		DPPO High	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible				
Individual	$50		$50	
Family	$150		$150	
Waived for Preventive	Yes		Yes	
Annual Maximum				
Per Person / Family	$1,000	$1,000	$2,000	$2,000
Preventive	100%	100%	100%	100%
Basic	60%	60%	80%	80%
Major	40%	40%	50%	50%
Orthodontia				
Benefit Percentage	Not covered	Not covered	50%	50%
Adults	Not covered	Not covered	Covered	Covered
Dependent Child(ren)	Not covered	Not covered	Covered	Covered
Lifetime Maximum	N/A	N/A	$1,500	$1,500

Semi-Monthly Deductions	DPPO Low	DPPO High
Employee	$3.00	$5.80
Employee & Spouse	$5.40	$12.20
Employee & Child(ren)	$6.20	$13.80
Family	$8.80	$22.40

Click on link to view a short video on how Dental Insurance works.
https://flimp.me/HubDeliverablesDentalInsurance

Vision
Insurance

Accelirate, Inc. two vision plans through Mutual of Omaha vision Powered by EyeMed.

To find participating providers go to www.mutualofomaha.com/vision and click on 'Find a Provider'.

The PPO plans allow both In-Network and Out of Network services; however, if you use an out-of-network provider, your out-of-pocket costs will be higher, and you will be subject to balance billing.

Benefit Coverages	Vision Base	Vision Buy-Up
	In-Network Benefits	In-Network Benefits
Routine Exams (Annual)	$10 Copay	$10 Copay
Vision Materials		
Materials Copay	$25 Copay	$25 Copay
Lenses •Single Vision Lenses •Lined Bifocal Lenses •Lined Trifocal Lenses	$25 Copay	$25 Copay
Frames	100% to $130; 20% off balance	100% to $130; 20% off balance
Contact Lenses •Elective •Medically necessary	100% to $130; 15% off balance (conventional) Covered at 100%	100% to $130; 15% off balance (conventional) Covered at 100%
Frequency		
•Examination •Lenses or contact lenses •Frames	12 Months 12 Months 24 Months	12 Months 12 Months 12 Months

**Standard progressives covered on Buy-up vision plan

Semi-Monthly Deductions	Vision Base	Vision Buy-Up
Employee	$1.03	$2.38
Employee & Spouse	$2.36	$5.49
Employee & Child(ren)	$2.61	$6.08
Family	$3.99	$9.29

Click on link to view a short video on how Vision Insurance works.
https://flimp.me/HubDeliverablesVision

Life and AD&D

Insurance

As a full-time employee, you have the option to purchase Voluntary Life and AD&D insurance through a group plan through Mutual of Omaha. The chart below provides an overview of the plan. Voluntary life insurance is a financial protection plan that provides a cash benefit to a beneficiary upon the death of the insured.

Voluntary Life / AD&D	
Benefit Reduction	By 65% at age 70 and 50% at age 75
Accelerated Life Benefit	Yes
Convertible / Portable	Yes
Employee	
Benefit Increments	$10,000
Benefit Maximum	$500,000 but no more than 5x annual salary
Guaranteed Issue	$150,000
Spouse	
Benefit Increments	$5,000
Benefit Maximum	100% of employee amount up to $100,000
Guaranteed Issue	$25,000
Child	
Benefit Increments	$1,000
Benefit/Guaranteed Issue	$10,000

Vol Life and AD&D Rates Per $1,000 Covered Benefit	
Under Age 25	$0.080
25-29	$0.080
30-34	$0.080
35-39	$0.100
40-44	$0.140
45-49	$0.220
50-54	$0.360
55-59	$0.550
60-64	$0.860
65-69	$1.470
70-74	$2.740
75-99	$2.740

How to calculate Semi-Monthly cost:

Desired Benefit Amount ($_____ ÷ $1,000) x Age Rate_____ = _____ ÷ 2 = $_____ (Semi-Monthly Cost)

Example Age 45: $100,000 / $1,000 = 100 x $0.220 = 22 / 2 = **$11.00**

Click on the link below to view a short video on Life Insurance works

https://flimp.me/HubDeliverablesLifeADandD

Disability
Insurance

As a full-time employee you have the option to purchase Voluntary Short & Long Term disability coverage. Disability Insurance replaces a portion of your income if you are out of work due to illness or injury. The chart below provides an overview of the plan.

	Short Term Disability	Long Term Disability
Benefit Amount	60% of salary to a maximum of $1,000 / week	60% of salary to a maximum of $6,000 / month
Maximum Payment Period	12 weeks	To age 65, standard ADEA
Benefits due to an accident begin	On Day 8	On Day 91
Benefits due to an illness begin	On Day 8	On Day 91
Guarantee Issue (for New Hires)	$1,000 / week	$6,000 / month
Evidence of Insurability	Will be required for enrollees after initial eligibility	Will be required for enrollees after initial eligibility
Pre-existing conditions	3 month look back; 6 months after 2 week limitation	6 month look back; 12 months after exclusion

Short Term Disability Rates	
Under Age 20	$0.150
25-29	$0.150
30-34	$0.150
35-39	$0.150
40-44	$0.150
45-49	$0.150
50-54	$0.150
55-59	$0.150
60-64	$0.150
65-69	$0.150
70-74	$0.150
75+	$0.150

Long Term Disability Rates Per $100 of Covered Benefit	
Under Age 20	$0.070
20-24	$0.080
25-29	$0.120
30-34	$0.180
35-39	$0.190
40-44	$0.200
45-49	$0.550
50-54	$0.880
55-59	$1.100
60-64	$1.317
65-69	$1.103
70+	$1.103

Click on link below to view a short video on Disability Insurance.
https://flimp.me/HubDeliverablesDisability

Disability

Insurance
Semi-Monthly Cost

Below are the calculations to finding the Semi-Monthly Cost for both Short-Term and Long-Term disability with Age examples.

Short-Term Disability Semi-Monthly Cost

Weekly Earnings x 60% = ____ / $10 = _____ x Age Rate = _____ / 2 = _____

Example Age 30: $1,000 x .60 = $600 / $10 = $60 x $0.150 = $9 / 2 = **$4.50**

Long-Term Disability Semi-Monthly Cost

Monthly Earnings x 60% = ____ / $100 = _____ x Age Rate = _____ / 2 = _____

Example Age 45: $4,000 x .60 = $2,400 / $100 = $24 x $0.550 = $13.20 / 2 = **$6.60**

Worksite Benefits*

Accident Insurance – helps offset your out-of-pocket costs by paying you specified amounts for covered injuries sustained in an off the job accident.

Hospital Indemnity Insurance – helps offset your out-of-pocket costs if you experience a stay in the hospital.

Critical Illness Insurance - helps offset your out-of-pocket costs by providing a lump sum payment to you if you experience a covered critical illness.

Voluntary Worksite plans have important features:

- Benefits are paid directly to you, unless you specify otherwise, to use as you see fit.
- Most coverages are portable, so you can keep your coverage even if you retire or change jobs.
- These plans pay benefits regardless of any other insurance you may have with other insurance companies, no coordination.
- Plans offer options to coverage your spouse and dependent children.
- Premiums are paid through payroll deduction for added convenience

*Coverage has exclusions and limitations that may affect benefits payable

Click here to Access Flimp Videos on Worksite Plans
Hospital Indemnity: https://flimp.me/HubDeliverablesHospitalIndemnity
Critical Illness: https://flimp.me/HubDeliverablesCI
Accident: https://flimp.me/HubDeliverablesAccident

Please note that these products are available to all eligible employees, but Accelirate, Inc. does not endorse these products

› We Make Evidence of Insurability Easy

Evidence of Insurability is simply a statement that proves a person is healthy enough to insure. This application process allows you to provide information about you and/or your dependents' health history in order to be considered for coverage.

EVIDENCE OF INSURABILITY (EOI) IS REQUIRED WHEN:

- You request a coverage amount greater than the guaranteed issue (an amount that is guaranteed to be issued to applicants regardless of their health status)
- Coverage is requested outside of your initial benefit enrollment period

To aid us in making a decision of whether to cover the person and/or their dependents, the EOI review may include:

- Questions or details about health conditions provided on the application
- Statement from your physician
- Medical examination

Our medical exams, which include a blood draw and urine sample, must be conducted by our highly reputable mobile medical contractor, American Para Professional Systems (APPS), and can be done in the comfort of your own home or business and are scheduled at your convenience.

All medical information is private and confidential, and is used for underwriting purposes only.

HOW TO SUBMIT AN ELECTRONIC APPLICATION (eApp)

Simply visit mutualofomaha.com/eoi to fill out an eApp. The eApp is a short questionnaire that collects the applicant's medical history. The following information will be needed:

- Group ID Number
- Hire Date
- Current Salary
- Current Coverage Amounts
- Guaranteed Issue Amounts

Once your application is submitted, you will receive an email regarding next steps.

Insurance products and services are offered by Mutual of Omaha Insurance Company or one of its affiliates. Home office: Mutual of Omaha Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175. Mutual of Omaha Insurance Company is licensed nationwide. United of Omaha Life Insurance Company is licensed nationwide, except in New York. Companion Life Insurance Company, 888 Veterans Memorial Highway, Suite 515, Hauppauge, NY 11788. Companion Life Insurance Company is licensed in New York. Each underwriting company is solely responsible for its own contractual and financial obligations. Some exclusions or limitations may apply.

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Employee Benefits

Accessing Claims Online Using the Employee Portal

Managing claims shouldn't be difficult. Mutual of Omaha always has our customers in mind, which is why we created our Employee Portal so you can easily access your claims.

Our Employee Portal provides real-time information giving you the ability to view current claims, access claim forms, report paid family and medical leave time, and submit a new claim for short-term disability benefits.

Getting Started

1. Go to www.mutualofomaha.com/my-benefits.
2. Register for an account by filling out the necessary information. Click on Sign Up.
3. Users will be notified when they have completed the first step of creating an account.
4. An email will be sent with the final steps to finish setting up an account.

Already have an account? Log in with your credentials.

How to View Current Claims

- To access current claims, log in and click on the "Claims" icon*
- View a specific claim and its status, along with the claim number for accident, critical illness and disability.

***PLEASE NOTE:** The "Claims" icon will only be shown if a claim has been filed. If there are no existing claims, the icon will not appear.

Submitting a Claim Form Online

A short-term disability claim form can be submitted online by clicking on the "Submit claim" icon on the Employee Portal homepage.

- On the forms page, select "I am a Plan Member (Employee)" and choose the relevant state
- Select the necessary form, then select "Complete form online"

Forms can also be submitted via fax or mail by clicking the "Claims forms" icon and downloading the form.

PLEASE NOTE: Microsoft Edge, Google Chrome and/or Firefox are the preferred internet browsers to use when accessing the portal.

We are here for you

If you have questions regarding a claim, please contact our dedicated toll-free number: **(800) 877-5176**

(Monday – Friday, 7:30 a.m. – 5 p.m. CST)

Mutual of Omaha

Insurance products and services are offered by Mutual of Omaha Insurance Company or one of its affiliates. Products are not available in all states. Each company is solely responsible for its own contractual and financial obligations.

466503

The Usieb App is now MyBenefits2GO!

To access the upcoming plan year information, download the new **MyBenefits2GO** app to view plan contact information, key plan documents and more.

Accelirate, Inc.

Enter this code when prompted:

U85357

Switching is easy as 1,2,3!

1. Download MyBenefits2GO from the App Store or Google Play store
2. Enter the new access code listed above
3. Start using the new app!

What's New?

Easier to Access and Share ID Cards

ID cards can be accessed through the main menu and emailed with the click of a button.

Updated Navigation

Finding what you need is easier than ever with improved navigation functionality.

New Look

The design within the app has been updated to be more modern.

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Contact Information

Medical	Florida Blue	Phone: 877-352-2583 Website: www.floridablue.com
Dental	Mutual of Omaha	Phone: 800-927-9197 Website: www.mutualofomaha.com
Vision	Mutual of Omaha	Phone: 800-521-3605 Website: www.mutualofomaha.com
Life /AD&D	Mutual of Omaha	Phone: 800-775-6000 Website: www.mutualofomaha.com
STD/LTD	Mutual of Omaha	Phone: 800-775-6000 Website: www.mutualofomaha.com
Supplemental Coverages	Mutual of Omaha	Phone: 800-775-6000 Website: www.mutualofomaha.com
Health Savings Account	HealthEquity	Phone: 866-382-3510 Website: www.healthequity.com
Benefit Resource Center (BRC)	USI	Phone: 855-874-0835 Email: BRCSouth@usi.com

Required Legal Notices

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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 ded.s and coinsurance applicable to other medical and surgical benefits provided under this plan.

NEWBORNS ACT DISCLOSURE – FEDERAL

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).

NOTICE OF 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 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 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.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.
To request special enrollment or obtain more information, contact the person listed at the end of this summary.

MICHELLE'S LAW DISCLOSURE

Under the ACA, dependent children are covered by the group health plan until age 26. Accelirate, Inc. group health plan extends dependent coverage beyond the ACA requirements, to age 30, so long as the child is covered as a student. If your child has extended coverage as a student but loses their student status because they take a medically necessary leave of absence from school your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This is available if, immediately before the first day of the leave of absence, your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

To obtain more information, contact person listed at the end of this summary.

Required Legal Notices

PATIENT PROTECTION MODEL DISCLOSURE

Accelirate, Inc. generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator.

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

You do not need prior authorization from UnitedHealthcare NHP 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 our 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 the Plan Administrator.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

• Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.

• Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

• Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan If applicable Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Accelirate, Inc. or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $156 per day (up to a $1,566 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Required Legal Notices

Creditable Coverage Notice

Important Notice from Accelirate, Inc. About Your Prescription Drug Coverage and Medicare

BlueOptions 05190/05191 and BlueOptions 05770

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Accelirate, Inc. 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. Accelirate, Inc. has determined that the prescription drug coverage offered by the Florida Blue plan BlueOptions 05190/05191 and BlueOptions 05770 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 Accelirate, Inc. coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Accelirate, Inc. coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Accelirate, 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 Accelirate, 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.

Required Legal Notices

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:	11/1/2022
Name of Entity/Sender:	Accelirate, Inc.
Contact--Position/Office:	Gabriela Enriquez, Global Chief Human Resources Officer
Address:	440 Sawgrass Corporate Parkway, Sunrise, FL 33325
Phone Number:	954-909-0958

Required Legal Notices

Non-Creditable Coverage Notice

Important Notice from Accelirate, Inc. About Your Prescription Drug Coverage and Medicare

BlueOptions 05302

Important Notice From Accelirate, Inc. 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 Accelirate, Inc. 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. Accelirate, Inc. has determined that the prescription drug coverage offered by the Florida BlueOptions 5302 is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Florida BlueOptions 5302. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from Florida BlueOptions 5302. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – It explains your options.

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.

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

Since the coverage under Florida BlueOptions 5302, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 Accelirate, Inc. coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Accelirate, Inc. coverage, be aware that you and your dependents will not be able to get this coverage back.

Required Legal Notices

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 Accelirate, 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).

Date:	11/1/2022
Name of Entity/Sender:	Accelirate, Inc.
Contact--Position/Office:	Gabriela Enriquez, Global Chief Human Resources Officer
Address:	440 Sawgrass Corporate Parkway, Sunrise, FL 33325
Phone Number:	954-909-0958

Required Legal Notices

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

In the state of Florida, there are comprehensive balance billing protections (found at Florida Statute 627.64194) in addition to those provided by the federal No Surprises Act. Florida law states that insurance companies are not allowed to bill you for amounts beyond your plan's in-network cost-sharing amount. That protection applies to HMO and PPO insurance plans for emergency services by out-of-network providers and facilities, as well as non-emergency services provided by out-of-network providers at in-network facilities. For PPOs, the state payment standard applies to emergency services and non-emergency services provided by out-of-network providers at in-network facilities. For HMOs, the state payment standard only applies to emergency services, but the state also has a claim dispute resolution program in place. Under Florida law, these protections do not apply to ground ambulance services for PPO insurance plans, patients enrolled in PPO insurance plans who consent to non-emergency out-of-network services, and patients with self-funded insurance plans. The laws put in place by the state of Florida work together with the requirements of the No Surprises Act to ensure that you are protected from surprise medical bills.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Required Legal Notices

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

In the state of Florida, there are comprehensive balance billing protections (found at Florida Statute 627.64194) in addition to those provided by the federal No Surprises Act. Florida law states that insurance companies are not allowed to bill you for amounts beyond your plan's in-network cost-sharing amount. That protection applies to HMO and PPO insurance plans for emergency services by out-of-network providers and facilities, as well as non-emergency services provided by out-of-network providers at in-network facilities. For PPOs, the state payment standard applies to emergency services and non-emergency services provided by out-of-network providers at in-network facilities. For HMOs, the state payment standard only applies to emergency services but the state also has a claim dispute resolution program in place. Under Florida law, these protections do not apply to ground ambulance services for PPO insurance plans, patients enrolled in PPO insurance plans who consent to non-emergency out-of-network services, and patients with self-funded insurance plans. The laws put in place by the state of Florida work together with the requirements of the No Surprises Act to ensure that you are protected from surprise medical bills.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Florida Blue.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Required 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 January 31, 2022. 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) Programhttp://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 ProgramWebsite: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center:1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
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

Required Legal Notices

GEORGIA-Medicaid	MAINE-Medicaid
A 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.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: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	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
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahippPhone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.govPhone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

Required Legal Notices

NEVADA-Medicaid	SOUTH CAROLINA-Medicaid
Medicaid Website: http://dhcfp.nv.govMedicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.govPhone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-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	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chipPhone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	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)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, 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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care 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.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

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.

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 Accelirate, Inc.	4. Employer Identification Number (EIN) 81-4691273	
5. Employer address 440 Sawgrass Corporate Parkway	6. Employer phone number 954-909-0958	
7. City Sunrise	8. State Florida	9. ZIP code 33325
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	12. Email address gabriela.enriquez@accelirate.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:
  - ■ Some employees. Eligible employees are:

    All full-time employees averaging a minimum of 30 hours per week.
- With respect to dependents:
  - ■ We do offer coverage. Eligible dependents are:

    Legal Spouse and Dependents
  - ☐ 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.

* An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)