

TAMPA BAY TREATMENT ASSOCIATES

2021 - 2022

BENEFITS INFORMATION GUIDE



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This document contains a summary in English of information about the [client name] upcoming open enrollment benefits. If you have difficulty understanding any part of this document, contact your Plan Administrator at 513-756-5742] during regular business hours or by email at tgriffith@wstampa.com

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 [16] for more details.

BENEFIT OFFERINGS

BENEFITS



Medical



Dental



Vision



Life & Disability



Additional Benefits

PLAN OPTIONS

- Florida Blue BlueCare 128/129
- Florida Blue BlueOptions 05182/05183
- Florida Blue BlueOptions 05302
- Florida Blue BlueOptions 05772
- Florida Blue BlueOptions 03769

- Humana DHMO
- Humana PPO

- Humana Vision

- The Hartford Basic Life & AD&D
- The Hartford Voluntary Life & AD&D
- The Hartford Long-Term Disability

- Health Savings Account (HSA)
- Critical Illness
- Long-Term Care (LTC)
- Accident Protection
- Short Term Disability

Important

This information is not accounting, tax, or legal advice—please contact your accounting, tax, or legal professional for such guidance. This information should not be relied upon as advice regarding any individual situation.

It is a general outline of covered benefits and does not include all the benefits, limitations, and exclusions of the policy. If there are any discrepancies between the illustrations contained herein and the insurance carrier proposal or contract, the insurance carrier materials prevail. See insurance company contract for full list of exclusions.

BENEFITS ENROLLMENT & INFORMATION

Welcome to your 2021 Benefits Information Guide.

At TAMPA BAY TREATMENT ASSOCIATES, we understand the importance of a well-rounded benefits program and are dedicated to providing you with unique benefits that meet the needs of you and your family. We are proud to offer a range of plans that help protect you in the case of illness or injury. This Benefits Information Guide is a comprehensive tool to help you become familiar with the plans and programs that you and your family can enroll in for the plan year.

Open Enrollment

We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family. Open Enrollment is a period of time dedicated to selecting your benefits for the upcoming year. You can enroll or change your current elections and also add or remove dependents. The plans selected will be effective from October 1, 2021 through September 30, 2022.

Eligibility

All employees who regularly work 30 hours or more per week are eligible for benefits on the 1st day of the month following 60 days of full time employment.

An eligible dependent is your legal spouse, domestic partner, or dependent child(ren) up to age 26, or 30 if they meet specific requirements.

A dependent child is your natural born child, legally adopted child, stepchild, child you have been appointed legal guardian for foster parent, child you are required to cover under a Qualified Medical Child Support Order, or a child that is totally and permanently disabled, incapable of self-support because of a mental or physical handicap, and financially supported by you.

Plan Changes

After this Open Enrollment period, you may not make changes to your coverage during the year unless you experience a qualified family status change. These are a few examples of qualified family status change events:

1. Special Enrollment Events (Add coverage for yourself and/or dependents).
 - Involuntary loss of other group coverage
 - Acquire a new dependent through marriage, birth or adoption
 - Change in Medicaid or CHIP eligibility
2. IRC Section 125 Status Change Events (Add, cancel or change coverage for yourself and/or dependents).
 - Involuntary loss or gain of other group coverage
 - Divorce
 - Death of covered spouse or child
 - Change in employment status
 - Medicare entitlement

You should verify the allowed events with Human Resources. You must notify Human Resources within 30 days of an event (60 days in the case of Medicaid or CHIP eligibility).
app.

MEDICAL PLANS

TAMPA BAY TREATMENT ASSOCIATES offers five **Florida Blue** medical plans: a Health Maintenance Organization (HMO) plan, a Preferred Provider Organization (PPO) plan, and two High Deductible Health Plans (HDHP) with Health Savings Account (HSA). **Florida Blue's** preferred lab facility is Quest Diagnostics. The next page illustrates highlights of the plans and your bi-weekly payroll contributions.

You can search for participating providers by visiting www.floridablue.com and clicking "Find a Doctor". Enter your search criteria and select "BlueOptions" as your plan.

HMO Plan: This plan only provides coverage for services performed by providers in the plan's network, with the exception of true emergencies.

PPO Plan: This plan provides coverage for services performed by In-Network and Out-of-Network providers. In-Network services yield the highest level of benefits with the lowest out of pocket expenses because services are paid based on contracted rates.

High Deductible Health Plan (HDHP) with Health Savings Account (HSA): This plan provides coverage for services performed by In-Network and Out-of-Network providers. In-Network services yield the highest level of benefits with the lowest out of pocket expenses because services are paid based on contracted rates. The plan begins to pay only after the deductible has been satisfied. Those who participate in this plan may be eligible to open a Health Savings Account (HSA). Refer to page 8 for more information.

Insurance Glossary

- **Copay:** A copay is a fixed-dollar amount that a plan member pays to a participating network doctor, caregiver, or other medical provider or pharmacy each time health care services are received.
- **Coinsurance:** The portion of an eligible medical bill a member must pay. Coinsurance amounts are usually a percentage of the total eligible medical bill, such as 20%. Coinsurance applies after the member meets a required deductible or copay amount. Coinsurance is part of certain health care plans.
- **Deductible:** A fixed-dollar amount that a plan member must pay for eligible services before the insurer begins applying insurance benefits. Deductibles are part of certain health care plans and based on a member's specific benefit period.
- **Out-of-Pocket Maximum:** The highest dollar amount you will need to pay during your benefit period for covered medical services from network providers. See your plan benefit for a list of services included.
- **In-Network:** Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.
- **Out-of-Network:** A health plan will cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers. Employees are also responsible for any difference between what the provider charges and the insurance company pays.
- **Preventive Care Services:** Covered services that are intended to prevent disease or to identify disease while it is more easily treatable. Examples of preventive care services include screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. Your policy specifies what qualifies as preventive coverage at a 100% level.

PLAN HIGHLIGHTS

BlueCare HMO HDHP128/129

BlueOptions HDHP 05182/05183

BlueOptions PPO 05302

	In-Network	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Calendar Year Deductible (DED)					
Individual	\$2,500	\$2,500	\$5,000	\$5,000	\$10,000
Family	\$5,000	\$5,000	\$10,000	\$10,000	\$30,000
Member Coinsurance	20%	10%	40%	30%	50%
Calendar Year Out-of-Pocket Maximum					
Individual	\$5,000	\$5,000	\$10,000	\$6,350	\$20,000
Family	\$6,850 per person/\$10,000	\$6,850 per person/\$10,000	\$20,000	\$12,700	\$40,000
Physician Visit					
Preventive Care	Covered in Full	Covered in Full	40% coinsurance	Covered in Full	50% coinsurance
Primary Care Physician (PCP)	20% after DED	10% after DED	40% after DED	\$30 copay	50% after DED
Specialist	20% after DED	10% after DED	40% after DED	\$55 copay	50% after DED
Lab Work and Diagnostic Imaging					
Independent Lab i.e., blood work	20% after DED	10% after DED	40% after DED	Covered in Full	50% after DED
Advanced Services Includes MRI, PET, CT	20% after DED	10% after DED	40% after DED	30% after DED	50% after DED
Hospital Services					
Inpatient Hospital	20% after DED	10% after DED	40% after DED	30% after DED	50% after DED
Outpatient Surgery	20% after DED	10% after DED	40% after DED	30% after DED	50% after DED
Emergency Medical Care					
Urgent Care	20% after DED	10% after DED	10% after DED	\$60 copay	50% after DED
Emergency Room	20% after DED	10% after DED	10% after DED	\$300 copay	\$300 copay
Prescription Drugs (30-day supply)					
Preferred Generic	DED + \$10 copay	DED + \$10 copay	INN DED + 50% coinsurance	\$10 copay	50% coinsurance
Preferred Brand Name	DED + \$50 copay	DED + \$50 copay	INN DED + 50% coinsurance	\$60 copay	50% coinsurance
Non-Preferred	DED + \$80 copay	DED + \$80 copay	INN DED + 50% coinsurance	\$100 copay	50% coinsurance
Mail Order (90-day supply)					
Preferred Generic	DED + \$25 copay	DED + \$25 copay	INN DED + 50% coinsurance	\$25 copay	50% coinsurance
Preferred Brand Name	DED + \$125 copay	DED + \$125 copay	INN DED + 50% coinsurance	\$150 copay	50% coinsurance
Non-Preferred	DED + \$200 copay	DED + \$200 copay	INN DED + 50% coinsurance	\$250 copay	50% coinsurance
Payroll Contributions Bi-Weekly					
Employee Only	\$21.75		\$67.90		\$70.08
Employee + Spouse	\$317.60		\$426.37		\$436.94
Employee + Child(ren)	\$218.37		\$306.13		\$314.65
Family	\$494.46		\$640.71		\$654.92

(1) Out of network services are always subject to balance billing. Member will be responsible for payment of the difference between Florida Blue's allowable charges and the provider's actual fee.

Use in-network providers.

Participating providers (doctors, hospitals, and others in your plan's network) generally charge discounted rates for plan members. When you go to a non-participating provider, you will likely pay a higher coinsurance percentage. In addition, you will likely have to pay the difference in price between the participating provider's discounted fee and the non-participating provider's "regular" fee.

TIP

PLAN HIGHLIGHTS

BlueOptions PPO 05772

BlueOptions PPO 03769

	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Calendar Year Deductible (DED)				
Individual	\$2,000	\$6,000	\$500	\$1,500
Family	\$6,000	\$18,000	\$1,500	\$4,500
Member Coinsurance	20%	50%	0%	50%
Calendar Year Out-of-Pocket Maximum				
Individual	\$5,500	\$11,000	\$3,000	\$6,000
Family	\$11,000	\$22,000	\$6,000	\$12,000
Physician Visit				
Preventive Care	Covered in Full	50% coinsurance	Covered in Full	50% coinsurance
Primary Care Physician (PCP)	\$35 copay	50% after DED	\$25 copay	50% after DED
Specialist	\$65 copay	50% after DED	\$60 copay	50% after DED
Lab Work and Diagnostic Imaging				
Independent Lab i.e., blood work	Covered in Full	50% after DED	Covered in Full	50% after DED
Advanced Services Includes MRI, PET, CT	\$300 copay	50% after DED	20% after DED	50% after DED
Hospital Services				
Inpatient Hospital	\$100 PAD + 20% after DED	\$500 PAD +50% after DED	20% after DED	50% after DED
Outpatient Surgery	20% after DED	\$300 copay	20% after DED	50% after DED
Emergency Medical Care				
Urgent Care	\$70 copay	DED + \$70	\$65 copay	DED + \$65 copay
Emergency Room	\$300 copay	\$200 copay	\$300 copay	\$300 copay
Prescription Drugs (30-day supply)				
Preferred Generic	\$10 copay	50% coinsurance	\$10 copay	50% coinsurance
Preferred Brand Name	\$50 copay	50% coinsurance	\$50 copay	50% coinsurance
Non-Preferred	\$80 copay	50% coinsurance	\$80 copay	50% coinsurance
Mail Order (90-day supply)				
Preferred Generic	\$25 copay	50% coinsurance	\$25 copay	50% coinsurance
Preferred Brand Name	\$125 copay	50% coinsurance	\$125 copay	50% coinsurance
Non-Preferred	\$200 copay	50% coinsurance	\$200 copay	50% coinsurance
Payroll Contributions Bi-Weekly				
Employee Only		\$121.18		\$146.62
Employee + Spouse		\$558.55		\$619.10
Employee + Child(ren)		\$412.76		\$461.61
Family		\$818.43		\$899.85

(2) Out of network services are always subject to balance billing. Member will be responsible for payment of the difference between Florida Blue's allowable charges and the provider's actual fee.



Use in-network providers. Participating providers (doctors, hospitals, and others in your plan's network) generally charge discounted rates for plan members. When you go to a non-participating provider, you will likely pay a higher coinsurance percentage. In addition, you will likely have to pay the difference in price between the participating provider's discounted fee and the non-participating provider's "regular" fee.

HEALTH SAVINGS ACCOUNT (HSA)

Those who participate in our BlueCare 128/129 and BlueOptions 05182/05183 High Deductible Health plans may be eligible to open a Health Savings Account (HSA) where they can save money on a tax-free basis to pay for eligible expenses. This money can be rolled over annually.

An HSA is a tax-favored savings account that can be used to pay for qualified medical and pharmacy expenses (refer to IRS publication 502 for a list of eligible expenses). It allows tax-free contributions by the employee and tax-free growth of interest or investment earnings.

Treasury regulations allow you to revoke or change your HSA contribution election throughout the year. Any unused funds in your HSA will roll over to subsequent years. Your account is portable therefore you can take it with you from job to job or at retirement.

TAMPA BAY TREATMENT ASSOCIATES makes a \$40 monthly contribution to your HSA regardless of coverage level.

The IRS allows an annual maximum contribution to your HSA. These maximums include funds from all sources – both your contributions and the company's contributions. Below are the annual maximum contributions for 2021-2022.

	2021	2022
Single	\$3,600	\$3,650
Family	\$7,200	\$7,300
Catch Up Provision if Age 55 or Older	\$1,000	\$1,000

Important!

To be eligible to contribute, or receive employer contributions, into an HSA account, you **cannot**:

- Be covered by any other non HSA-compatible health coverage plan including but not limited to Traditional Medical FSA or HRA held by a spouse or partner.
- Be claimed as a dependent on another person's tax return (excluding spouses).
- Be "entitled" (enrolled in) to Medicare (A, B, C, or D).
 - Be aware – if you delay Medicare Part A enrollment after turning age 65, your Medicare Part A coverage will begin up to six months retroactively but not earlier than Medicare eligibility.
 - Receiving Social Security benefits causes automatic Medicare Part A enrollment when eligible

FAQs

When can I start to use the funds in my HSA? Once your account is open, a deposit has been made to your account and funds are available, you can start using your HSA. You are 100 percent vested as soon as the funds are deposited and you have total control over the funds.

How do I make contributions to my HSA? You can make a contribution to your HSA through payroll deduction— you can request that your employer deduct a set amount from your paycheck.

What happens to my HSA if I leave my employer? You can keep your current HSA or transfer your funds to another qualifying HSA within 60 days of withdrawing the funds to avoid taxes and an additional 20 percent penalty. Note you must be enrolled in a HDHP to continue to contribute to your HSA.

Please consult your tax professional for any personal tax advice.

WAYS TO SAVE

Health care and pharmacy costs continue to increase. Here are tips for staying on budget.

1. Look into discount generic drug programs offered by local pharmacies.*



PHARMACY	CURRENT OFFER
Publix	FREE Antibiotics (Amoxicillin, Ampicillin, SMZ-TMP or Penicillin VK) (up to 14-day supply) FREE Amlodipine, Lisinopril, or Metformin (up to 90-day supply) 90-day supply of common medications for \$7.50
Winn-Dixie	FREE select Antibiotics and Maintenance Medications 30-day supply starting at \$4 90-day supply starting at \$10
Walmart	30-day supply starting at \$4 90-day supply starting at \$10

2. Research brand name drug rebates online.



WEBSITE	DESCRIPTION
www.needymeds.org	Find help with the cost of medicine
www.gskforyou.com	Help with GSK medications and vaccines for qualified patients
www.rxpharmacycoupons.com	Search for drug coupons to use at your local pharmacy
www.goodrx.com	Compare Rx prices, print free coupons and save on your meds
www.internetdrugcoupons.com	Hundreds of free manufacturer drug coupons

3. Use Freestanding Surgical & Diagnostic Centers when possible.



AMBULATORY SURGICAL CENTER	FREESTANDING DIAGNOSTIC CENTERS
Save on a covered surgery by having it done at an in-network, non-hospital-affiliated ambulatory surgical center.	Save on MRIs, CAT scans, X-rays, etc. by having them done at participating freestanding diagnostic centers.

4. Save time and money when you choose the right level of care.



CONVENIENCE CLINIC	URGENT CARE	EMERGENCY ROOM
Cost: \$	Cost: \$\$	Cost: \$\$\$
Use for preventive care services and common colds when your doctor is not available for a low cost	Use for immediate attention for non-threatening situations. Getting care will cost less than the ER and almost certainly be faster	Use for life-threatening injuries, as ERs are best suited for medical emergencies. Do not return to the ER for follow-up visits as they will not be covered; visit your PCP instead

*Membership fees may apply. Offers are subject to change.

DENTAL PLANS

TAMPA BAY TREATMENT ASSOCIATES offers two **Humana** Dental Plans: Dental Health Maintenance Organization (DHMO) plan and a Dental Preferred Provider Organization (DPPO). The next page illustrates highlights of the plans and your bi-weekly payroll contributions.

You can search for providers by visiting www.humana.com, selecting “Find a Doctor”, and entering your search criteria.

DHMO Plan: If you decide to enroll in the DHMO plan, please keep in mind that you and your dependents will need to select a primary care dentist who participates in the plans network. To receive benefits in the DHMO plan, your dental care must either be provided by your primary care dentist or referred to a specialist by your primary care dentist. If you receive services from any other dentist, you would be responsible for paying the entire dental bill yourself. Please refer to your Patient Charge Schedule for procedures and applicable copays. The plan provides you with an unlimited benefit maximum.

DPPO Plan: The DPPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you’ll receive the highest level of benefit from the plan if you select an in-network contracted PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rates. A calendar year maximum benefit will apply to in and out-of-network services.



PLAN HIGHLIGHTS

DHMO

Routine Cleanings 1110/1120 2 per Calendar Year	No charge
Routine X-Rays	No charge
Resin Based – Posterior One Surface 2391	\$30 copay
Root Canal – Molar 3330	\$210 copay, excludes final restoration
Orthodontics	
Start-Up 8660/8999	\$35 / \$250 copay
Comprehensive Treatment: Child/Adult 8080/8090	\$1,850 / \$1,850 copay
Retention 8680	\$300 copay
Payroll Contributions Bi-Weekly	
Employee Only	\$0.00
Employee + Spouse	\$6.32
Employee + Child(ren)	\$7.90
Family	\$16.55

PLAN HIGHLIGHTS

DPP0

	In-Network	Out-of-Network
Calendar Year Maximum Benefit	Unlimited	
Calendar Year Deductible (DED)		
Individual	\$50	\$50
Family	\$150	\$150
Preventive Services		
Exams	Plan pays 100%, DED waived	Plan pays 80%, DED waived
Cleanings (2 per calendar year)	Plan pays 100%, DED waived	Plan pays 80%, DED waived
X-Rays	Plan pays 100%, DED waived	Plan pays 80%, DED waived
Basic Services		
Fillings (anterior/posterior)	Plan pays 80% after DED	Plan pays 50% after DED
Surgical Extractions	Plan pays 80% after DED	Plan pays 50% after DED
Root Canal	Plan pays 80% after DED	Plan pays 50% after DED
Major Services		
Crowns, Dentures, Implant Prosthetics	Plan pays 50% after DED	Plan pays 50% after DED
Implants	N/A	N/A
Orthodontics Child through age 18)		
Comprehensive	50%; \$1,000 Lifetime Maximum	
Payroll Contributions Bi-Weekly		
Employee Only	\$5.39	
Employee + Spouse	\$17.09	
Employee + Child(ren)	\$26.67	
Family	\$39.00	

VISION PLAN

We offer a vision plan through **Humana**. Benefits are available every 12 months for exams and lenses or contact lenses and every 24 months for frames. Below are highlights of the plan and your bi-weekly payroll contributions.

You can search for providers by visiting www.humana.com, clicking “Find a Doctor”, and entering your search criteria.

PLAN HIGHLIGHTS

VISION

	In-Network	Out-of-Network
Exam 1 every 12 months	\$10 Copay	Up to \$30
Lenses 1 every 12 months		
Single	\$10 Copay	Up to \$25
Bifocal	\$10 Copay	Up to \$40
Trifocal	\$10 Copay	Up to \$60
	\$10 Copay	Up to \$100
Frames 1 every 12 months	\$160 Allowance, then 20% off remaining balance	Up to \$80
Contact Lenses ¹ 1 every 12 months		
Standard Contact Lens Fit & Follow-Up	Covered in full	Up to \$30
Premium Contact Lens Fit & Follow-Up	10% off retail, less \$55 allowance	Up to \$30
Conventional	\$160 allowance, then 15% off balance over \$160	\$128 allowance
Disposable	\$160 allowance	\$128 allowance
Medically Necessary	Covered in Full	\$210 allowance
Payroll Contributions Bi-Weekly		
Employee Only		\$0.00
Employee + Spouse		\$4.25
Employee + Child(ren)		\$3.82
Employee + Family		\$8.44

(1) In lieu of eyeglass benefits



LIFE AND AD&D

Basic Life & AD&D Insurance – Employer Paid

In the event of a death, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

All full-time benefits-eligible employees are eligible for Group Life & AD&D Insurance of \$20,000 through **The Hartford**.

Be sure to keep your beneficiary designations up to date! You can change your beneficiary designation at any time. You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.

Voluntary Life & AD&D Insurance

In addition to the company paid Life & AD&D Insurance, you can purchase additional coverage by enrolling in Voluntary Life & AD&D for yourself and your eligible dependents through **The Hartford**. Dependent coverage is contingent on you having Voluntary Life & AD&D coverage. The Voluntary Life & AD&D insurance is convertible or portable for eligible individuals.

EMPLOYEE COVERAGE*

\$10,000 increments to a maximum of the lesser of \$480,000 or 3x annual earnings

Guarantee Issue: \$100,000

SPOUSE COVERAGE**

\$5,000 increments to a maximum of \$100,000; cannot exceed 100% of combined basic and voluntary employee coverage

Guarantee Issue: \$30,000

CHILD(REN) COVERAGE**

15 days to age 19: \$10,000

Guarantee Issue: \$10,000

COST OF COVERAGE

Age ¹	Bi-Weekly Rate per \$1,000
18-24	\$0.11
25-29	\$0.09
30-34	\$0.09
35-39	\$0.14
40-44	\$0.21
45-49	\$0.34
50-54	\$0.55
55-59	\$0.80
60-64	\$1.03
65-69	\$1.49
70-74	\$2.57
75+	\$7.24
AD&D	\$0.026
Child(ren) Life/AD&D	\$0.09/\$0.026

To calculate your bi-weekly premium, find your age group to locate the correct rate. The rates shown are for each \$1,000 of coverage, so you will need to take the total coverage amount elected and divide by \$1,000. Once you have that number you will multiply that by the rate.

Example:

Age 31

Rate is \$ 0.09

Elects \$50,000 life insurance coverage

$\$50,000 / \$1,000 = 50$

$0.09 \times 50 = \$4.50$ bi-weekly cost

(1) Employee's rate is determined by the Employee's age. Spouse's rate is determined by the Employee's age.

DISABILITY INSURANCE

Long Term Disability (LTD) – Employer Paid*

Long-Term Disability Insurance is designed to protect your earnings for an extended disability. During a covered disability, this valuable benefit helps you meet your financial commitments in a time of need. The LTD insurance is insured by **The Hartford**. Below are the benefit highlights.

PLAN HIGHLIGHTS	LEVEL OF COVERAGE
Percentage of Wage Replacement	60% of covered monthly earnings
Maximum per Month	\$5,000
Elimination Period	180 days
Maximum Benefit Period	Social Security Normal Retirement Age, as long as you meet the plans disability requirements

* Your benefit will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

ADDITIONAL COVERAGES

Critical Illness

The Critical Illness coverage is insured through **Allstate**. If you are diagnosed with a covered critical illness, you will receive a cash benefit based on the percentage payable for the condition. If you have covered family members on the policy, the critical illness coverage will also provide cash benefits for those members. Benefits are paid directly to you at the time of the diagnosis and you determine how to use the cash benefit.

Accident Protection

Accidents happen when you least expect them and can include motor vehicle accidents, sports injuries, slips, falls or just every day mishaps! **Allstate and Colonial Life's** policy may pay cash (based on a schedule) to help families offset the expenses associated with accidents or injuries.

Hospital Insurance

Allstate and Colonial Life offer the highest benefits and the lowest premium. It covers you for inpatient and outpatient surgery. The plan is portable and benefits increase for the 1st 6 years.

Whole Life and Long-Term Care Insurance

Allstate Guarantees issue the 1st year regardless of health (as the employee). Cash value in the plan, between \$10k and \$50k available. Long Term Care Benefits are included as well as accelerated death benefits.

Short Term Disability Insurance

Colonial Life offers protection for you and your family from loss of income. Benefits are paid Day 1 for an accident or injury and Day 8 for sickness. You do not need to be hospitalized to receive the benefit. Your coverage can vary from 3 months or 6 months.

MEDICARE PART D CREDITABLE COVERAGE NOTICE

Important Notice from TAMPA BAY TREATMENT ASSOCIATES 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 TAMPA BAY TREATMENT ASSOCIATES 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. TAMPA BAY TREATMENT ASSOCIATES has determined that the prescription drug coverage offered by the Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan while enrolled in TAMPA BAY TREATMENT ASSOCIATES coverage as an active employee, please note that your TAMPA BAY TREATMENT ASSOCIATES coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in TAMPA BAY TREATMENT ASSOCIATES coverage as a former employee.

You may also choose to drop your TAMPA BAY TREATMENT ASSOCIATES coverage. If you do decide to join a Medicare drug plan and drop your current TAMPA BAY TREATMENT ASSOCIATES coverage, be aware that you and your dependents 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 TAMPA BAY TREATMENT ASSOCIATES 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 TAMPA BAY TREATMENT ASSOCIATES 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: September 9, 2021
Name of Entity/Sender: TAMPA BAY TREATMENT ASSOCIATES
Contact-Position/Office: Terha Griffith, HR Director
Address: 600 W Hillsboro Blvd., Deerfield Beach, FL 33441
Phone Number: 813-756-5742

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

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact:

Terha Griffith
813-756-5742
tgriffith@wstampa.com

WOMEN'S HEALTH CANCER RIGHTS ACT (WHCRA) NOTICE

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA) NOTICE

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 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).



NEW HEALTH INSURANCE MARKETPLACE OPTIONS AND YOUR HEALTH COVERAGE

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

Part A: General Information

Now that key parts of the health care law have taken effect, there is 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 the fall of 2021 for coverage starting January 1, 2022.

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 9.83% (for 2021) 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 your Human Resource department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its costs. Please visit [Healthcare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹An 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.

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 Tampa Bay Treatment Associates	4. Employer Identification Number (EIN) 833713245	
5. Employer address 600 W Hillsboro Blvd	6. Employer phone number 813 - 756-5742	
7. City Deerfield Beach	8. State FL	9. Zip code 33441
10. Who can we contact about employee health coverage at this job? Terha Griffith		
11. Phone number (if different from above)	12. Email address tgriffith@wstampa.com	

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

- As your employer, we offer a health plan to:
 - ☐ All employees.
 - ☒ Some employees. Eligible employees are:
 - Employees working 30 or more hours per week.
- With respect to dependents:
 - ☒ We do offer coverage. Eligible dependents are:
 - Spouse or domestic partner and children to age 30, if they qualify
 - ☐ 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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

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, 2021. 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/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplecovery.com/flmedicaidtplecovery.com/hip/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: http://dhcs.ca.gov/hipp Health Insurance Premium Payment (HIPP) Program Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	MONTANA – 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: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	NEBRASKA – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	NEVADA – 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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	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
MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
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	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
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – 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	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	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 Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	VERMONT – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	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
RHODE ISLAND – Medicaid and CHIP	WASHINGTON – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

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

Introduction

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

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

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

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

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

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days, or a longer period permitted under the terms of the Plan after the qualifying event occurs.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period."

Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period² to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Date: September 9, 2021
Name of Entity/Sender: TAMPA BAY TREATMENT ASSOCIATES
Contact-Position/Office: Terha Griffith, HR Director
Address: 600 W Hillsboro Blvd., Deerfield Beach, FL 33441
Phone Number: 813-756-5742

² <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

ADA WELLNESS PROGRAM NOTICE

NOTICE REGARDING WELLNESS PROGRAM

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

However, employees who choose to participate in the wellness program will receive an incentive for participating in the program. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources.

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

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

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

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources.

GRANDFATHERED PLAN STATUS NOTICE

The TAMPA BAY TREATMENT ASSOCIATES health plan is a “grandfathered health plan” under the Affordable Care Act (ACA). Being a grandfathered health plan means that the plan is not required to include certain consumer protections under the ACA that apply to other plans, such as providing coverage for ACA-mandated preventive services without cost sharing when received in-network. However, grandfathered health plans must comply with certain other consumer protections under the ACA, such as the elimination of lifetime limits on essential health benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed HR.

[For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.]

HIPAA WELLNESS PROGRAM REASONABLE ALTERNATIVE STANDARDS NOTICE

Your group health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible 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 HR 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.

HIPAA NOTICE OF AVAILABILITY OF NOTICE OF PRIVACY PRACTICES

The TAMPA BAY TREATMENT ASSOCIATES maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact HR.

DIRECTORY & RESOURCES

Need additional information? Have a question about one of your benefits? Keep this brochure handy for a quick reference for all your benefit needs. Below is contact information for each of our providers.

CONTACT INFORMATION

Human Resources		
Terha Griffith	1-813-756-5742	tgriffith@swstampa.com
Medical Coverage		
Florida Blue	1-800-352-2583	www.floridablue.com
Health Savings Account		
FL Blue – Health Equity	1-866-382-3510	www.healthequity.com
Dental Coverage		
Humana	1-800-233-4013	www.humana.com
Vision Coverage		
Humana	1-800-233-4013	www.humana.com
Life and AD&D		
Hartford Life	1-888-277-4767	www.thehartford.com
Disability		
Hartford Life	1-888-277-4767	www.thehartford.com
Work Site Products		
TSIPG – Allstate and Colonial	1-866-TSI-4YOU	www.tsigp.com

