WhiteSands TREATMENT

A Guide to Your

2026 Employee Benefits for Full-Time Employees

BIRCH

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Important Plan Notices

Contacts and Resources

Program	Vendor	Contact Information
Enrollment Assistance	US Enrollments	(813)303- 1387
Medical	Cigna	(888)726-3171 Mycigna.com
Pharmacy	Cigna	(866)494-2111 (800)835-3784 express scripts home delivery Mycigna.com
Telemedicine	MDLIVE	(866)494-2111 Mycigna.com
HSA	Health Equity	Health Equity App
Dental	MetLife	www.metlife.com/mybenefits
Vision	MetLife	www.metlife.com/mybenefits
Life & Disability	Mutual of Omaha	(800)655-5142
Group Accident, Critical Illness & Hospital Indemnity	Mutual of Omaha	(800)655-5142
ID Theft	MetLife Aura	(844) 931-2872 Aura App
Legal	MetLife	(800)821-6400 Members.legalplans.com
EAP	Mutual of Omaha	(800)316-2796 Mutualofomaha.com/eap
Pet Insurance	Pet Benefits Solutions	(800)891-2565 www.petbenefits.com/land/whitesandstreatment
Customer Service Support	Birch Benefits	(888)921-1865 prompt 1 serviceteam@birchbenefits.com

Welcome!

Tampa Bay Treatment Associates is proud to offer a comprehensive benefits package to you and your family through our 2026-2027 Health and Welfare Benefits Plan. We understand that our employees have diverse needs, and so we have developed a well-rounded plan capable of helping to protect you and your family members in the case of illness or injury.

This Benefit Guide provides necessary plan and program information to help you understand your many benefit options and ultimately enroll in the benefits that work best for you and your family for the 2025-2026 Plan Year. We hope that our guide can be an effective and comprehensive resource while you consider your benefit elections.

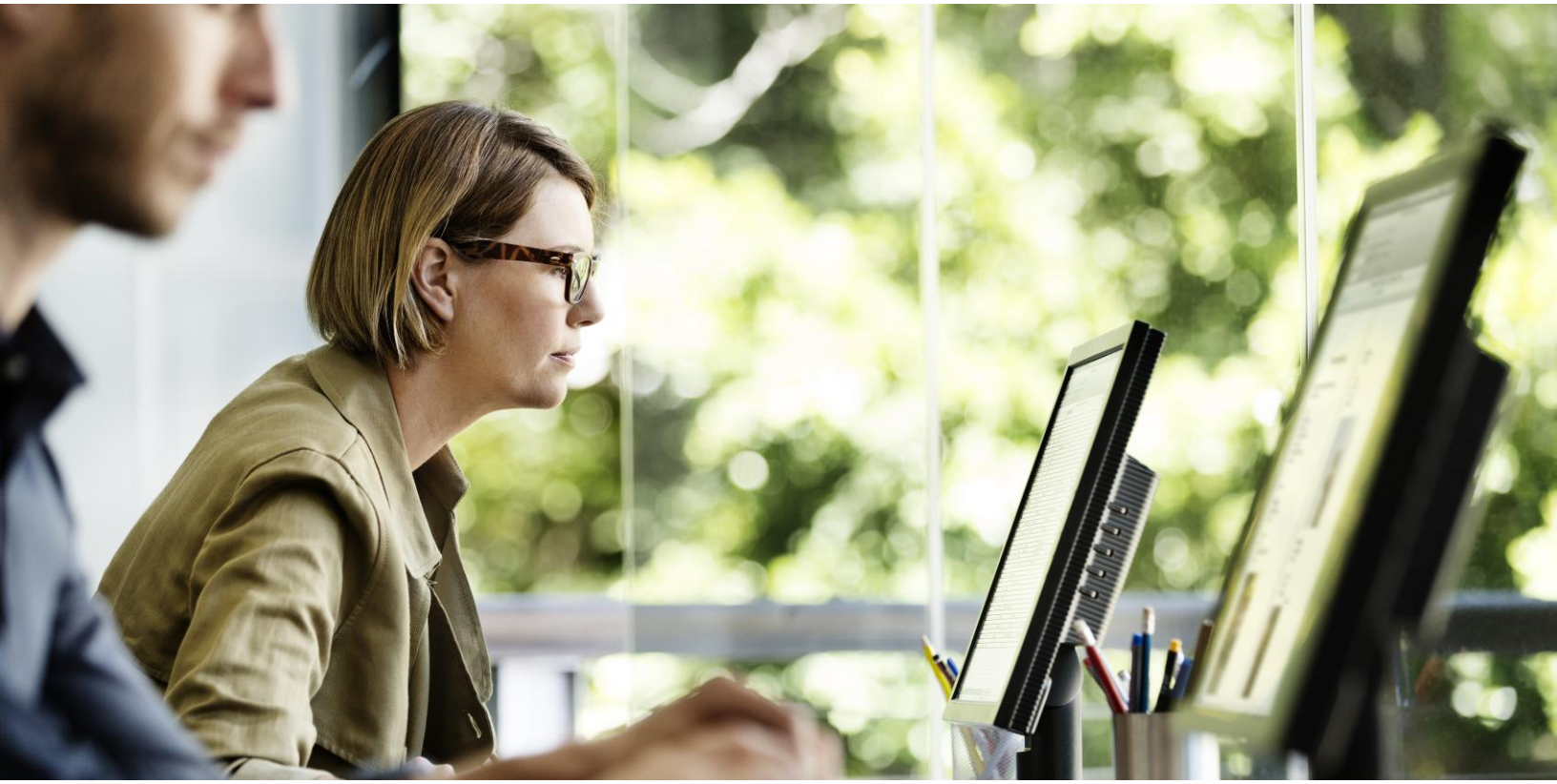
This document contains a summary in English of information about your upcoming benefits enrollment. If you have difficulty understanding any part of this document, contact your HR Department:

Cindy Grubbs

1-813-756-5741

cgrubbs@whitesandstreatment.com

Enrollment and Eligibility



Employees who work a minimum of 30 hours per week are eligible for benefits. Newly hired employee coverage begins on the 1st of the month following/coinciding with 60 days of full-time employment.

Who Can You Add To Your Plan?

Eligible:

- Legally married spouse
- Domestic partners
- Natural or adopted children up to age 26, regardless of student or marital status (Please note that your dependent children are generally eligible only up until age 26, but can be eligible up until age 30 if they meet specific requirements.)
- Children under your guardianship
- Stepchildren
- Children under a qualified medical child support order
- a child who is totally and permanently disabled, incapable of self-support because of a mental or physically handicap, and is financially supported by you
- Children placed in your physical custody for adoption

Ineligible:

- Divorced or legally separated spouse
- Sisters, brothers, parents, in-laws, grandchildren etc.

Change in Status

You may enroll in the plan when you are first eligible. You can also make changes/enroll during the plan year if you experience a Qualified Life Event. You must submit your paperwork within 30 days of the change.

You can make changes to your elections during Open Enrollment and for Qualified Life Events in the Paycom portal.

Examples of changes in status:

- You get married, divorced, or legally separated
- You have a baby or adopt a child
- You or your spouse has a change in employment
- Your spouse dies
- You become eligible for or lose Medicaid coverage

Benefit Enrollment Information

When do I Enroll?

Current colleagues will make all of your benefit elections for the upcoming plan year during Open Enrollment from **September 15, 2026 to September 21, 2026**. During this time, you will be able to enroll in new benefits or change your current elections as well as add or remove dependents. Any of these changes or additions will be effective from **October 1, 2026, to September 30, 2027.**

New Hires must sign up for benefits by the 1st day of the month following 60 days of full-time employment.

How do I enroll?

It is mandatory this year to enroll in or decline your benefits.
U.S Enrollment Services is here to assist with your enrollment questions and help you enroll!
Please reach out to **1-813-303- 1387** to speak with a Benefit Counselor

Benefit Termination Rules

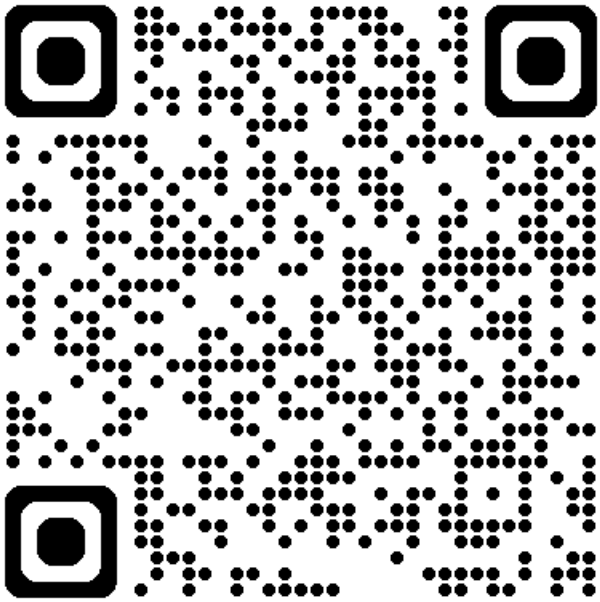
Should your employment terminate, or your work status change, making you ineligible for benefits, your benefits will terminate at the end of the month. Life and disability coverage will terminate on the date of employment termination Your dependent children are generally eligible only up until age 26, but can be eligible up until the end of the year that they turn age 30 on your medical plan, if they meet specific requirements.

Enrollment Assistance

You can use the below QR code to take you directly to the Tampa Bay Treatment Associates Benefits Microsite. This provides all your benefit offerings in one convenient location!

Call Toll Free 813-303-1387 between 9:00am and 8:00pm EST
Monday - Friday

You can also log on directly via
https://whitesands.mybenefitsinfo.com



Online Enrollment Portal

WhiteSands TREATMENT

How to Enroll in the Plans

Read your materials and make sure you understand all the options available. Complete enrollment electronically via Employee Navigator.

- Fill out any necessary personal information.
- Make your benefit selections.
- If you have questions or concerns, contact your HR department.

Step 1: Log-in

You can quickly & easily access your Employee Navigator account by going to www.employeenavigator.com.

Login

- Returning users: Log in with the username and password you selected.
- First time users: Click on your Registration Link in the email sent to you by admin or Register as a new user. Create an account and create your own username and password.
- Company Identifier: **TBTWS**

Step 2: Welcome!

After you login click Let's Begin to complete your required tasks.

Step 3: Onboarding (For first time users, if applicable)

Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks click Start Enrollment to begin.

Online Enrollment Portal, Continued

Step 4: Enrollments

After clicking Start Enrollment, you'll need to complete some personal and dependent information before moving to your benefit elections.

Step 5: Benefit Elections

- To enroll dependents in a benefit, click the checkbox next to the dependent's name under Who am I enrolling? Below your dependents you can view your available plans and the cost per pay.
- To elect a benefit, click Select Plan underneath the plan cost. Click Save & Continue at the bottom of each screen to save your elections.
- If you do not want a benefit, click Don't want this benefit? At the bottom of the screen and select a reason from the drop-down menu.

Step 6: Forms

If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of Evidence of Insurability form, you will be prompted to add in those details.

Step 7: Review & Confirm Elections

Review the benefits you selected on the enrollment summary page to make sure they are correct then click Sign & Agree to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.

Insurance Glossary

Here is a list of relevant insurance-related terms to help you navigate the information provided in this guide.

Healthcare Provider: A healthcare provider is a person or company that provides a healthcare service to you, such as a dentist, primary care physician, chiropractor, clinical social worker, etc.

In-Network: Doctors, clinics, hospitals, and other providers are considered in network when they have made an agreement to care for the health plan's members. Health plans cover a greater share of the cost for using in-network healthcare 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 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.

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 healthcare services are received.

Coinsurance: The portion of an eligible medical bill a plan 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 healthcare 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 healthcare plans and based on a plan 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.

MEDICAL BENEFITS & SPENDING ACCOUNTS

Medical Plans

Tampa Bay Treatment Associates offers **five Cigna** medical plans:

- Three Preferred Provider Organization (PPO) plans, and
- Two High Deductible Health Plans (HDHP) with Health Savings Account (HSA)

Here is a closer look at how **Cigna's** medical plan options work. All plans are open access. You do not need to select a Primary Care Provider (PCP), and you can visit a specialist without referrals. You will find more plan highlights as well as your bi-weekly payroll contributions on the following page.

PPO Plan: This plan covers services performed by in-network and out-of-network health care 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, meaning the agreed-upon amount that the insurance company and health care provider have agreed to pay/be paid for the medical service. The plan begins to pay only after the deductible has been satisfied.

High Deductible Health Plan (HDHP) with Health Savings Account (HSA): This plan covers services performed by in-network and out-of-network health care 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. Those who participate in this plan may be eligible to open a Health Savings Account (HSA).

NOTE: You can search for participating health care providers by visiting www.cigna.com and clicking "Find a Doctor".

Medical and Prescription Benefits

Plan	OAPIN HSA	OAP HSA
In-Network		
Deductible (Single/Family)	$3,500 / $7,000 (Collective)	$5,000 / $5,000 (Non-Collective)
Out-of-Pocket (Single/Family)	$7,000 / $14,000 (Non-Collective)	$6,850 / $11,600 (Non-Collective)
Coinsurance	80%	80%
Physician Services - PCP	$30 copay after deductible	80% after deductible
Physician Services - SPC	$75 copay after deductible	80% after deductible
Inpatient Services	80% after deductible	80% after deductible
Outpatient Services	80% after deductible	80% after deductible
Emergency Room	$350 copay after deductible	80% after deductible
Urgent Care	$100 copay after deductible	80% after deductible
MDLive Virtual - UC	100% after deductible	100% after deductible
Lab Services - OV	80% coinsurance	80% coinsurance
Lab Services - Ind. Lab	80% after deductible	80% after deductible
Adv. Radiology - Outpatient	80% after deductible	80% after deductible
Outpatient PT	$75 copay after deductible	80% after deductible
Outpatient Speech & OT	$75 copay after deductible	80% after deductible
Chiropratic Care	80% coinsurance	80% coinsurance
Pharmacy		
Pharmacy Network	Cigna 90 Now Walgreens	Cigna 90 Now Walgreens
Formulary/PDL	Advantage	Advantage
Retail	$10*/$50*/$80* *after deductible	$10*/$50*/$80* *after deductible
Home Delivery Drug	$25*/$125*/$200* *after deductible	$25*/$125*/$200* *after deductible
Out-of-Network		
Deductible	NA	$10,000/$10,000
Out-of-Pocket	NA	$23,200/$23,200
Coinsurance	NA	60%

Cost Per P:ay Period	OAPIN HSA	OAP HSA
Employee Only	$36.01	$116.82
Employee/Spouse	$498.92	$675.80
Employee/Children	$400.18	$555.35
Family	$823.34	$1,071.60

Medical and Prescription Benefits

Plan	OAP Low	OAP Mid	OAP Buy Up
Network	Open Access Plus - National OAP	Open Access Plus - National OAP	Open Access Plus - National OAP
In-Network			
Deductible (Single/Family)	$5,000 / $10,000 (Non-Collective)	$3,000 / $9,000 (Non-Collective)	$2,000 / $6,000 (Non-Collective)
Out-of-Pocket (Single/Family)	$8,200 / $16,400 (Non-Collective)	$6,350 / $12,700 (Non-Collective)	$5,500 / $11,000 (Non-Collective)
Coinsurance	80%	80%	80%
Physician Services - PCP	$30 copay	$40 copay	$35 copay
Physician Services - SPC	$60 copay	$100 copay	$65 copay
Inpatient Services	80% after deductible	$100/Admit copay	$100/Admit copay
Outpatient Services	80% after deductible	$350 copay	$250 copay
Emergency Room	$350 copay	$400 copay	$300 copay
Urgent Care	$100 copay	$100 copay	$70 copay
MDLive Virtual - UC	100%	100%	100%
Lab Services - OV	80% coinsurance	80% coinsurance	80% coinsurance
Lab Services - Ind. Lab	100%	100%	100%
Adv. Radiology - Outpatient	80% after deductible	$400 copay	$300 copay
Outpatient PT	$60 copay	$100 copay	$65 copay
Outpatient Speech & OT	$60 copay	$100 copay	$65 copay
Chiropratic Care	$60 copay	80% coinsurance	$65 copay
Pharmacy			
Pharmacy Network	Cigna 90 Now Walgreens	Cigna 90 Now Walgreens	Cigna 90 Now Walgreens
Formulary/PDL	Advantage	Advantage	Advantage
Retail	$10/$60/$100	$10/$50/$80	$10/$50/$80
Home Delivery Drug	$25/$150/$250	$25/$125/$200	$25/$125/$200
Out-of-Network			
Deductible	$10,000/$20,000	$6,000/$18,000	$6,000/$18,000
Out-of-Pocket	$16,400/$32,800	$15,000/$30,000	$11,000/$22,000
Coinsurance	50%	50%	50%

Cost Per Pay Period	OAP Low	OAP Mid	OAP Buy Up
Employee Only	$124.31	$202.60	$228.57
Employee/Spouse	$692.87	$871.36	$930.58
Employee/Children	$570.30	$726.88	$778.82
Family	$1,095.54	$1,346.05	$1,429.18

Have your ID card handy?

With myCigna, the answer is always "yes."

Big news: You never have to worry about misplacing your ID card. It's always right there on myCigna®, whenever and wherever you need it.*

Accessing your digital ID cards is easy.

- Log in to **myCigna.com** or the **myCigna® App**
- Click or tap "ID Cards"
- View your card(s), as well as any dependents' card(s)**
- Email cards directly to doctors
- Save your digital ID cards in your Apple Wallet

Not registered on myCigna yet?
It's quick and easy.

Visit **myCigna.com®** or scan the QR code to download the **myCigna® App** and register now.

cigna healthcare

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FINDING A DOCTOR IN OUR DIRECTORY IS EASY

Is your doctor or hospital in your plan's Cigna network? Cigna's online directory makes it easy to find who (or what) you're looking for.

SEARCH YOUR PLAN'S NETWORK IN FOUR SIMPLE STEPS

Step 1

Go to **Cigna.com**, and click on "Find a Doctor" at the top of the screen. Then, under "How are you Covered?" select "Employer or School."

(If you're already a Cigna customer, log in to **myCigna.com** or the myCigna® app to search your current plan's network. To search other networks, use the **Cigna.com** directory.)

Step 2

Change the geographic location to the city/state or zip code you want to search. Select the search type and enter a name, specialty or other search term. Click on one of our suggestions or the magnifying glass icon to see your results.

Step 3

Answer any clarifying questions, and then verify where you live (as that will determine the networks available).

Step 4

Optional: Select one of the plans offered by your employer during open enrollment.

That's it! You can also refine your search results by distance, years in practice, specialty, languages spoken and more.

Search first. Then choose Cigna.

There are so many things to love about Cigna. Our directory search is just the beginning.

After you enroll, you'll have access to **myCigna.com** – your one-stop source for managing your health plan, anytime, just about anyplace. On **myCigna.com**, you can estimate your health care costs, manage and track claims, learn how to live a healthier life and more.

Questions? Call **1.866.494.2111**

Together, all the way.®

Cigna.

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Providers and facilities that participate in the Cigna network are independent practitioners solely responsible for the treatment provided to their patients. They are not agents of Cigna. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, see your plan documents.

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YOUR NEW CIGNA PHARMACY BENEFITS

Five steps to take before your new plan starts

Welcome! We're excited to be managing your pharmacy benefits, and look forward to helping you with your health and prescription medication needs. We want to help make the move to Cigna as smooth as possible. Here are five important steps you can take now so you're ready when your new plan starts – and avoid surprises at the pharmacy.

1 Refill your prescription(s) before your current plan ends

This will help make sure you have enough medication at home while you're moving to your new Cigna pharmacy plan.

2 See how your medication will be covered under your Cigna pharmacy plan

To view your new drug list before your Cigna plan starts, go to Cigna.com/druglist. There, you can see if your medication is covered, what tier it's covered on, and if there are any extra requirements before your plan will cover it.

For example, if your medication has a **PA** (prior authorization) or **ST** (Step Therapy) next to it, your medication will need approval from Cigna before it can be covered. If it has a **QL** (quantity limit) or **AGE** (age requirement) next to it, your medication *may* need approval.

If your medication needs approval, here's what you need to do:

- **Make sure you have your new Cigna ID card.** Your doctor's office will need the information listed on the card.
- **Call your doctor's office.** Have your Cigna ID card handy when you call.
  - Let your doctor's office know **you've switched to Cigna**, and give them your new insurance information.
  - Then, let them know that **your current medication needs approval** from Cigna before it can be covered.
  - Ask them to **contact Cigna as soon as possible** so we can start the coverage review process. They know how the review process works and will take care of everything for you. In case your doctor's office asks, they can download a request form from Cigna's provider portal at cignaforhcp.com.

  Cigna will review information your doctor provides to make sure your medication meets coverage guidelines. We'll send you and your doctor a letter with next steps. It can take between **1–5 business days to hear from us**. You can always check with your doctor's office to find out if a decision's been made.

Cigna.

Offered by Cigna Health and Life Insurance Company

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3 See if your retail pharmacy is in your plan's new network

- Before your new plan starts: Go to Cigna.com and click on "Find a Doctor" to see if your current pharmacy is in Cigna's network.
- Once your Cigna plan starts: Log in to the **myCigna®** App[1] or myCigna.com®. Click on the Prescriptions tab, and then choose Price a Medication from the dropdown menu to see which pharmacies are in your plan's new network – and which ones offer the best price.[2] You can also use our home delivery pharmacy to fill your prescriptions.

4 Create a myCigna account – It's 24/7 access to your plan's coverage info

As soon as your new plan starts, you can go to myCigna.com and/or download the myCigna mobile App to create an account.

- See which medications your plan covers.
- Use the Price a Medication tool to find out how much your medication costs, and view lower-cost alternatives (if available).[2]
- Find an in-network pharmacy.
- Ask a pharmacist a question.
- See your pharmacy claims and coverage details.
- Manage, track, order, and pay for your home delivery prescription orders online.

5 Consider using Express Scripts® Pharmacy, our home delivery pharmacy

Home delivery is a convenient option when you're taking a medication on a regular basis to treat an ongoing health condition. It's simple and safe – and saves you trips to the pharmacy. To learn more, go to Cigna.com/homedelivery.

- Easily order, manage and track your medications **on your phone or online**.
- Standard shipping at **no extra cost**.[3]
- Fill up to a **90-day supply** at one time.
- **Helpful pharmacists** available 24/7.
- **Automatic refills**[4] or refill reminders so you don't miss a dose.
- **Flexible payment options** if you need help paying for your medications.

Questions?

Call the number on your Cigna ID card – 24/7/365

myCigna.com – Click to Chat
Monday–Friday,
9:00 am–8:00 pm EST

1. The downloading and use of the myCigna App is subject to the terms and conditions of the App and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply. Actual App features available may vary depending on your plan and individual security profile. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
2. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
3. Standard shipping costs are included as part of your prescription plan.
4. Express Scripts® Pharmacy can automatically refill certain medications. Log in to the myCigna App or website, or call 800.835.3784, to sign up.

Para obtener ayuda en español llame al número en su tarjeta de Cigna.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna representative.

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Health Savings Accounts (HSA)

HealthEquity

A Health Savings Account is a special tax-advantaged savings account designated for medical expenses. It allows individuals to pay for current out-of-pocket health care expense and save for future qualified medical and retiree health care expenses on a tax-favored basis. Your account is administered with Health Equity.

Tampa Bay Treatment Associates offers an HSA contribution of $480 annually for all employees enrolled in the HSA, regardless of your coverage level.

To be eligible, you:

➢ Must be enrolled in an IRS-qualified high-deductible medical plan

➢ Cannot have any other health coverage which is not also a qualified high-deductible plan

➢ Cannot be claimed as a dependent on another person's tax return

➢ Must not be enrolled in Medicare (A, B or D), TRICARE, or a Full Purpose FSA (including a spouse's Full Purpose FSA

Employees who elect to contribute to an HSA account will receive a debit card. Money deposited into the HSA account can be used on IRS qualified expenses, such as copays, deductibles, dental, vision, and certain over-the-counter health items!

The IRS has set the following thresholds for HSA contributions in 2025 calendar year.

Under Age 55 - 2026

- **Up to $4,700 individual coverage**
- **Up to $8,750 family coverage**

Under Age 55 - 2027

- **Up to $4,500 individual coverage**
- **Up to $9,000 family coverage**

Age 55 or older

- **Maximum contribution increases by $1,000 (considered a "catch-up" contribution)**
- **Catch-up contribution permissible anytime in the calendar year in which you turn Age 55**

HealthEquity

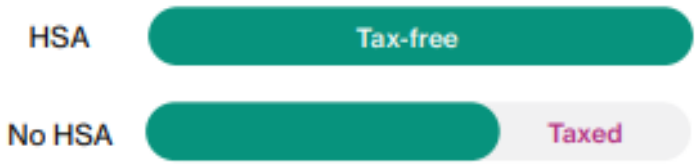
Health Savings Account

An HSA lets you save money for future healthcare costs while also saving on taxes. How? HSAs are the only benefit with a triple-tax advantage:[1] Tax-free contributions. Tax-free account growth. And tax-free spending on HSA-qualified expenses. It's your healthcare emergency safety net.

- Rolls over every year – funds never expire
- Available tax-free investing, just like a 401(k)[2]
- Requires an eligible high-deductible health plan (HDHP)

Less tax. More paycheck.

Get $20 tax savings for every $100 you contribute.[3]



2026 HSA Contribution Limits

$4,400 Individual plan

$8,750 Family plan

Members 55+ can contribute an extra $1,000.

See how much you can save.

HealthEquity.com/Learn/HSA

Scan to download the HealthEquity mobile app.

You can set up your account directly in the app – no need to register online.

Spend tax-free on HSA-qualified expenses.

- Medical
- Vision
- Dental
- Rx and OTC

Discover more: HealthEquity.com/QME

[1]HSAs are federally tax-deductible for qualified medical expenses and usually state-deductible; consult a tax advisor for details. | [2]Investments are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. Investing through the HealthEquity investment platform is subject to the terms and conditions of the Health Savings Account Custodial Agreement and any applicable investment supplement. | [3]Example for illustration only; savings based on a 20% federal and state tax bracket. | HealthEquity does not provide legal, tax or financial advice.

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DENTAL & VISION BENEFITS

Dental Benefits

Tampa Bay Treatment Associates offers two **MetLife** Dental Plans:

We have included an explanation of each plan below. the next page provides plan highlights and your biweekly payroll contributions.

- **DHMO Plan**: If you decide to enroll in the DHMO plan, please keep in mind that you and your enrolled dependents will need to select a primary care dentist who participates in the plan's network. To receive benefits in the DHMO plan, your primary care dentist must provide your dental care or refer you to a specialist for services. If you receive services outside of these requirements, you would be responsible for paying the entire dental bill yourself. Please refer to your primary care dentist's Patient Charge Schedule for procedures and applicable copays. A DHMO plan provides you with an unlimited benefit maximum.

- **DPPO Plan**: The DPPO plan gives you the freedom to receive dental care from any licensed dentist of your choice. You will 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.

- **NOTE**: You can search for providers by visiting **www.metlife.com** and clicking "Find a dentist" and entering your search criteria.

Dental Benefits – Dental HMO (DHMO)

Voluntary Dental Plan – DHMO (managed plan)	Must Use In-Network Dentist for Benefits to apply
Preventative	$0
Diagnostic Treatment	$5 office visit
Crowns	$245
Oral Surgery – Depending on severity	$30-$80
Orthodontia Limited	$1,000
Orthodontia Comprehensive	$1,850

Dental DHMO	Monthly Rate
Employee Only	$0.00
Employee + Spouse	$4.66
Employee + Child(ren)	$6.84
Employee + Family	$12.11

***This is not a complete listing of the plan benefits, please refer to the summary.**
****Any discrepancies in the above, please note that the insurance plan document will govern.**

Dental Benefits – PPO Plan

Voluntary Dental Plan – PPO Plan	In-Network	Out-of-Network
Preventative	100%	80%
Basic	80%	50%
Major	50%	50%
Calendar Year Deductible – Individual	$50	$50
Calendar Year Deductible – Family (Aggregate)	$150	$150
Calendar Year Maximum	$5,000	$5,000
Orthodontia	50%	50%
Orthodontia Lifetime Maximum	$1,000	$1,000

Dental PPO	Monthly Rate
Employee Only	$6.00
Employee + Spouse	$18.21
Employee + Child(ren)	$28.20
Employee + Family	$41.07

***This is not a complete listing of the plan benefits, please refer to the summary.**
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Vision Benefits

Voluntary Vision Plan – Superior Vision National Network	In-Network	Out-of-Network
Eye Examination		
Comprehensive Exam	$10 copay	$45 allowance after $0 copay
Retinal Imaging	Up to $39 copay	Applied to the exam allowance
Materials – Corrective Lenses (Glasses)		
Single Vision	$10 copay	$30 allowance
Lined Bifocal	$10 copay	$50 allowance
Lined Trifocal	$10 copay	$65 allowance
Lenticular	$10 copay	$100 allowance
Materials – Contact Lens		
Necessary	Covered in full	$210 allowance
Elective	$125 allowance	$105 allowance

Vision	Monthly Rate
Employee Only (Single)	$0.00
Employee + Spouse	$2.31
Employee + Child(ren)	$3.16
Employee + Family	$5.51

***This is not a complete listing of the plan benefits, please refer to the summary.**
****Any discrepancies in the above, please note that the insurance plan document will govern.**

LIFE, DISABILITY & VOLUNTARY BENEFIT OPTIONS

Life Insurance

Basic Life & AD&D insurance coverage provides important supplemental financial protection for your family in the event of your death. Tampa Bay Treatment Associates provides eligible employees with Basic Life & AD&D insurance at no cost to you.

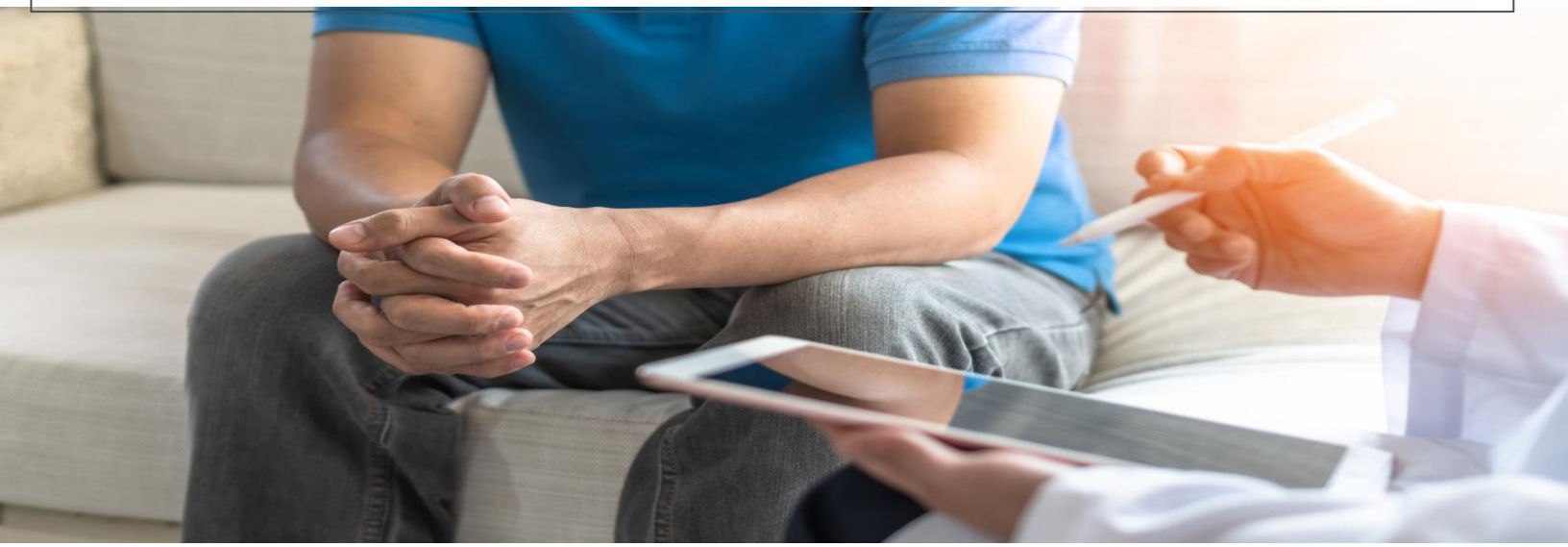
- ✓ 100% Employer-paid
- ✓ No Medical questions

Life/AD&D	Coverage
All Full-Time Eligible Employees	$20,000
Reduction Schedule	By 35% @ 65, by 50% @ 70

Voluntary Term Life coverage is available without answering medical questions or physical exam up to the Guaranteed Issue Amount when first eligible.

Coverage Guidelines	Employee	Spouse	Child(ren)
Minimum	$10,000	$5,000	$5,000
Maximum	Up to **$300,000**	100% of Employee's Benefit, up to $150,000	$20,000
Guaranteed Issue Amount	$200,000	100% of Employee's Benefit, up to $30,000	$20,000

Evidence of Insurability (EOI) medical questionnaire is required for amounts above the Guaranteed Issue Amount



Voluntary Short Term Disability Plan

Short-Term Disability (STD) coverage provides income replacement if you become disabled and are unable to work due to a qualifying disability.

Short-Term Disability	Coverage
Core Benefit	60%
Core **Weekly** Maximum	$1,000
Waiting Period (Injury/Sickness)	14 days
Benefit Duration	24 weeks
Pre-existing Condition Clause	3 / 6

Age Band	Monthly Rate (Per $10 of Weekly Benefit)
<20	$0.635
20-24	$0.635
25-29	$0.635
30-34	$0.635
35-39	$0.635
40-44	$0.662
45-49	$0.681
50-54	$0.693
55-59	$0.710
60-64	$0.770
65-69	$0.797
70-99	$0.829

Voluntary Long Term Disability Plan

Your Ability to Earn an Income May Be Your Most Important Asset

Most people don't think twice about insuring their home, automobile or health. However, many people don't recognize just how important it is to insure their income.

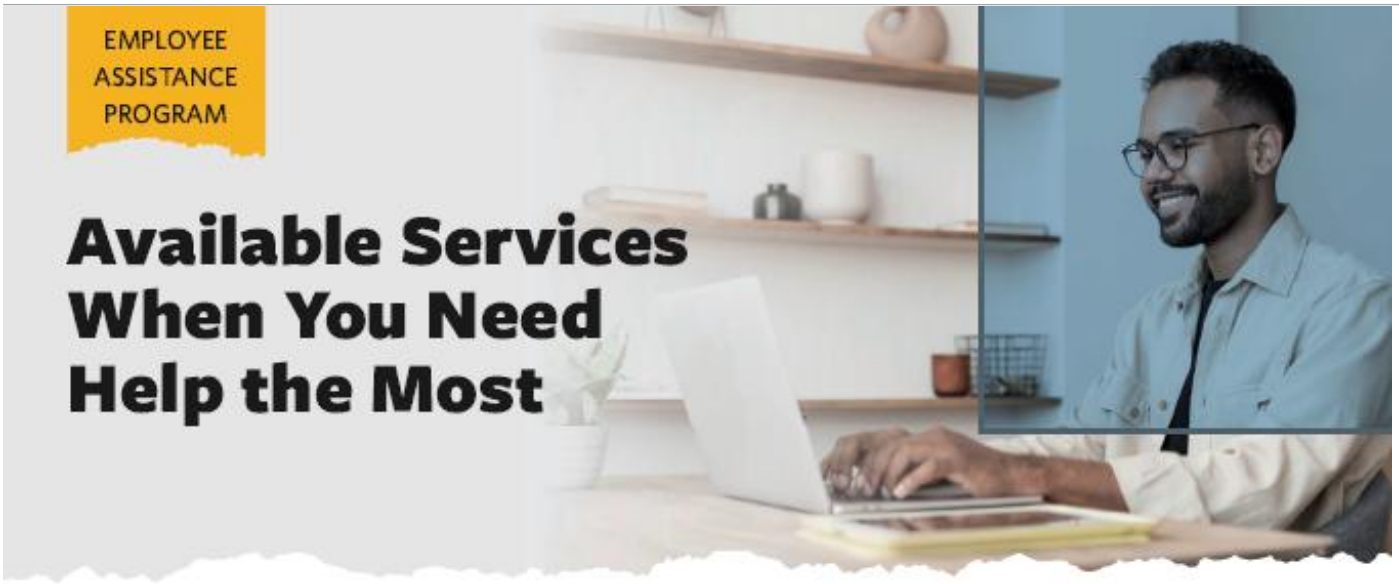
Long-Term Disability (LTD) provides income replacement if you are disabled longer than the STD benefit period and are unable to work. LTD provides a crucial financial safety net, by replacing a portion of your lost income.

Long-Term Disability	Coverage
Core Benefit	60%
Core **Monthly** Maximum	$5,000
Elimination Period	180 days
Benefit Duration	SSNRA – Social Security Normal Retirement Age
Pre-existing Condition Clause	12/ 12

Age Band	Monthly Rate (Per $100 of Weekly Benefit)
20-24	$0.238
25-29	$0.424
30-34	$0.607
35-39	$0.845
40-44	$1.092
45-49	$1.393
50-54	$1.167
55-59	$0.916
60-64	$0.795
65-69	$0.795
70-99	$0.795

***This is not a complete listing of the plan benefits, please refer to the summary.**
****Any discrepancies in the above, please note that the insurance plan document will govern.**

Employee Assistance Program (EAP)



Life isn't always easy. Sometimes a personal or professional issue can affect your work, health and general well-being. During these tough times, it's important to have someone to talk with to let you know you're not alone.

With Mutual of Omaha's Employee Assistance Program, you can get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker your employer counts on to get the job done.

Learn more about the Employee Assistance Program services available to you.

We are here for you

Visit the Employee Assistance Program website to view timely articles and resources on a variety of financial, well-being, behavioral and mental health topics.

mutualofomaha.com/eap
or call us: 1-800-316-2796

Enhanced EAP Services

Features	Value to Company and Employees
Employee Family Clinical Services	• An in-house team of Master's level EAP professionals who are available 24/7/365 to provide individual assessments • Outstanding customer service from a team dedicated to ongoing training and education in employee assistance matters • Access to subject matter experts in the field of EAP service delivery
Counseling Options	• Three sessions per year (per household) conducted by face-to-face* counseling or telehealth (text, chat, phone or video) via a secure, HIPAA compliant portal

Voluntary Benefits

Mutual of Omaha

For more information regarding plan benefits, please visit the Document Library located in Employee Navigator or ask your Benefit Counselor at US Enrollments

Accident

Who is it for?

Nobody can predict when an accident might happen. That's why accident insurance is a great add-on policy for people who want to supplement the health and disability insurance coverage they already have individually or through an employer.

What does it cover?

Accident insurance pays you lump sum benefits after you suffer an accident. This could be a severe burn, broken bone or emergency room visit. Our accident insurance policies also offer a special benefit that pays extra for children injured while playing an organized sport like soccer, baseball, lacrosse, or football.

Coverage Tier	Premium Amount
Employee	$3.30
Employee + Spouse	$5.51
Employee + Child(ren)	$6.98
Employee + Family	$9.77

Critical Illness

Who is it for?

Critical illness insurance is a supplemental policy for people who already have health insurance. It provides you with an additional payment to cover expenses like deductibles, treatments, and living costs.

What does it cover?

Critical illnesses include strokes, heart attacks, Parkinson's disease and cancer. Our policies can cover over 30 major illnesses, helping you stay financially stable by paying you a lump sum if you're diagnosed with one of them.

Rates vary based on Employee age and dependents covered and can be found in your Benefits Portal

Hospital Indemnity

Who is it for?

Hospital indemnity insurance is for people who need help covering the costs associated with a hospital stay if they suddenly become sick or injured.

What does it cover?

If you are admitted to a hospital for a covered sickness or injury, you'll receive payments that can be used to cover all sorts of costs, including:

- Deductibles and co-pays.
- Travel to and from the hospital for treatment.
- Childcare service assistance while recovering.

Low Plan	
Coverage Tier	Premium Amount
Employee	$9.63
Employee + Spouse	$18.38
Employee + Child(ren)	$14.82
Employee + Family	$23.58

High Plan	
Coverage Tier	Premium Amount
Employee	$15.13
Employee + Spouse	$29.58
Employee + Child(ren)	$23.37
Employee + Family	$41.57

MetLife · ĀURA
Identity & Fraud Protection

Group Benefits
100-999 Employees

Your employees do everything online, we help them do it more safely.

MetLife and Aura Identity & Fraud Protection is an award-winning, AI-powered solution that helps keep employees and their families safe from online threats and scams – all in one, easy-to-use app.

Identity Theft Protection - Monitors personal info, accounts, and online reputation and sends alerts if we detect threats. Automatically requests removal of information found online to help keep it out of the hands of thieves and spammers.

Financial Fraud Protection - Helps keep money and assets safe by monitoring credit, financial accounts, and property titles and sends alerts if suspicious changes are detected.

Privacy & Device Protection - Shop, bank, and connect online more securely and privately with intelligent safety tools that help protect passwords, devices, and WiFi connections from hackers.

Family Safety - Gives you the tools to protect loved ones — no matter who they are, how old they are, or where they live — from online predators and thieves.

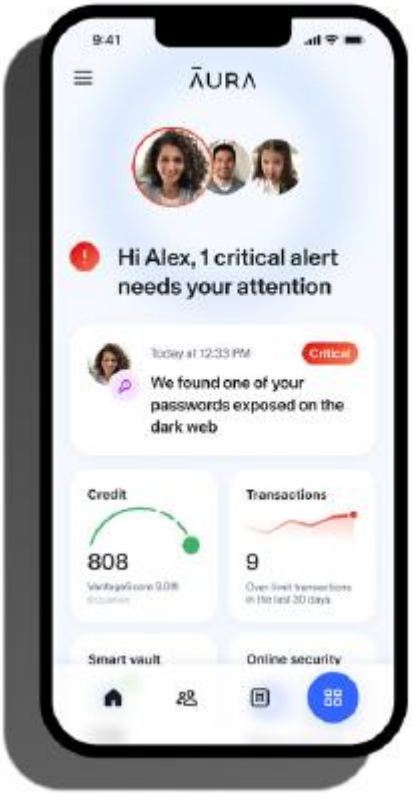
Service and Support - 24/7/365 100% US-based customer care, White Glove Resolution Services, one MetLife account team, and much more.

Voluntary Pricing*

Protection Individual	Protection Family	Protection Plus Individual	Protection Plus Family
$6.95	$11.95	$10.95	$16.95

1 in 4 Odds of falling victim of online crime[1]

90% of employees are concerned with online safety but less than 10% have a solution[2]



MetLife | Legal Plans

Empowering employees through easy access to legal help

Legal issues occur throughout life, when employees are getting married, buying a home, becoming a caregiver or handling financial matters like debt or tax audits. Dealing with these matters can be costly and time consuming, taking employees away from work and impacting their overall well-being.

We provide your employees with the cost-effective, multi-channel access to legal help they need to easily handle costly legal matters in their life—helping them to feel more financially and emotionally secure.

Flexibility to handle matters how employees want

We want your employees to get the help they need how they want it. That's why we allow them to choose their attorney from our network, or outside of it, or use our digital tools to handle matters.[1] With a large network of attorneys and the ability to complete estate planning or download self-help documents on our website, employees have the flexibility to choose how they want to handle their legal matter.

Wide range of coverage for a diverse workforce

LGBTQ+	• Adoption • Creating estate planning documents to recognize same-sex partners • Name and gender marker change
Caregivers	• Personalized caregiving solutions through Family First[2] • Reviewing Medicare/Medicaid documents • Reviewing parents' estate planning documents
Veterans/ Military	• Assistance with real estate or rental issues • Guardianship • Updating or creating estate planning documents
International employees	• Access to attorneys out of the country[3] • Assistance with immigration issues • Translation services for Call Center and Attorneys
Those just starting out	• Assistance with rental issues and landlords • Reviewing leases • Student loan debt assistance

Cost per employee per month (covers spouse and dependents):

Employee Paid: $18.75

The MetLife Legal Plans Difference

Telephone and office consultations, demand letters and document review on **unlimited number** of personal legal matters

Over 18,000 attorneys in all 50 states and many U.S. territories who have an average of 25 years of experience and are subject to a comprehensive set of criteria

Best-in-class digital experience to find attorneys and complete estate planning

We're focused on providing **exceptional customer service** and are appropriately staffed for peak call volume

Pet Benefits

TOTAL PET PLAN COVERAGE DETAILS

DISCOUNTS ON PRODUCTS AND RX

PETplus

- Receive member-only pricing (up to 40% off) on prescription medications, preventatives, food, toys, treats & more
- Shipping is always free and same-day pickup is available for human-grade medications
- Covers dogs & cats
- Covers pre-existing conditions

DISCOUNTS ON VETERINARY CARE

Pet Assure

- Save 25% on all in-house medical services at any network vet
- Instant savings; no claim forms or waiting for reimbursements
- Covers all pets
- Covers pre-existing conditions
- Visit www.petbenefits.com/search to locate a network vet

24/7 PET TELEHEALTH

AskVet

- Access real-time vet support, even when your vet's office is closed
- Chat a US-based veterinarian 24/7
- Unlimited support on your pet's health, wellness, behavior and more
- Covers dogs & cats

LOST PET RECOVERY SERVICE

PetTag

- Durable tag can be scanned from any smart phone to access your contact information
- Instantly update contact information online, even after your pet goes missing
- Covers any pet wearing a collar!

Single Pet Plan	Family Plan
$11.75/month	$18.50/month

Please Reach out to US Enrollments or Your HR Representative to take advantage of this benefit!

Pet Insurance – New Option This Year

Please Reach out to US Enrollments or Your HR Representative to take advantage of this benefit!

WISHBONE
PET HEALTH INSURANCE

- Comprehensive accident and illness plan with optional wellness riders
- Can be used at any veterinary facility, including specialty and emergency clinics
- Covers dogs and cats from 7 weeks of age, with no upper age restriction
- Rate is based on age, breed and zip code
  - Includes 5% group discount
  - Additional 5% discount available when you enroll 2+ pets

White Sands Treatment - Wishbone Sample Quotes

Monthly rates for a $250 Deductible, 70% Reimbursement & $10,000 Annual Limit:

	33441
1 year old Mixed- Small (<20lbs full grown) Dog	$26.50
3 years old Jack Russell Terrier Dog	$41.43
4 years old Australian Shepherd Dog	$33.55
5 years old Domestic Shorthair Cat	$22.48

ANNUAL NOTICES

Required Compliance Notices

(CHIP) Special Enrollment Period

Gain or loss of eligibility for Medicaid or CHIP coverage is treated as a Special Enrollment Right. The Plan will permit an employee or a dependent of an employee who is eligible, but not enrolled,
to enroll under the PLAN if either of the following two conditions are met:

1. The employee or dependent is covered under a Medicaid plan or under a state child health plan and the coverage is terminated due to loss of eligibility AND the employee requests coverage under the group health plan no later than 60 days after the loss of eligibility.

2. The employee or dependent becomes eligible for assistance coverage under the group health plan, Medicaid plan or state child health plan AND the employee requests coverage under the group health plan no later than 60 days after the employee or dependent is determined to be eligible for assistance.

Health Information Privacy/Availability of "Notice of Privacy Practices"

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal regulations issued by the Department of Health and Human Services. The Plan's
privacy polices are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

Group health plans and health 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96
hours if applicable).

Women's Preventative Health Benefits

As you may know, the Affordable Care Act (ACA, or Health Reform Law) includes changes that are being phased in over several years. The latest set of changes includes additional benefits for certain Women's Preventative Health Services. When plans renew or after effective on or after August 1, 2012, all the following women's health services will be considered preventive (some were already covered). These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Generic formulary contraceptives are covered without
  member cost-share (For example, no copayment).

Women's Health and Cancer Rights Act of 1998

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extend that the benefits otherwise meet with the requirements for coverage under the plan:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a
  symmetrical appearance; and
- Coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits.

Required Compliance Notices

Genetic Nondiscrimination

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

There is a new way to buy health insurance called the Health Insurance Marketplace, which is part of the healthcare reform law (effective 2014).

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.

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.

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 Marketplace in your area.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternative recipients'" right to receive benefits for which a participant or beneficiary is eligible under group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Notice Regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA): Special Enrollment Rights

The Health Insurance Portability and Accountability Act of 1996 ("HIPPA") is the federal law which requires, for example, that a group health plan provide immediate coverage in the event of your marriage or birth or adoption of a child, or upon exhaustion of your COBRA continuation coverage from a previous employer. This immediate coverage is referred to as HIPAA "special enrollment rights". HIPAA special enrollment rights are also extended when you lose eligibility under Medicaid or a State Children's Health Insurance Program ("CHIP") and when you become eligible for a Medicaid or CHIP premium assistance subsidy with respect to this Plan.

If during the year you are entitled to HIPAA special enrollment rights with respect to coverage under the Company's group health plans, the Plan will permit you to change your pre-tax payment election with respect to your health insurance premiums and make a new pre-tax election that corresponds with your HIPAA special enrollment rights.

The Plan also allows you to suspend your pre-tax payment election, or make an entirely new pre-tax election, for the coverage if it corresponds with your HIPAA special enrollment rights. HIPAA special enrollment changes must be requested within 31 days of the special enrollment event; or, in the case of changes due to loss of Medicaid or CHIP coverage or eligibility for a premium assistance subsidy, within 60 days of the date Medicaid or CHIP coverage ends or eligibility for the subsidy is determined. Please refer to the Summary Plan Description for the Company's group health plans for more details concerning HIPAA special enrollment rights.

Required Compliance Notices

Also, during a FMLA leave, you are entitled to suspend your coverage under the Company's group health plans or participation in the Plan. Your suspension would become effective prospectively. Upon return, you have the right to reinstate any suspended coverage or participation, provided you do so within 31 days of your return from FMLA leave. The reinstatement will be effective retroactive to the date of your return from FMLA leave.

If you continue your election for coverage or participation in the Plan while on FMLA Leave (whether paid or unpaid), you will continue to be responsible for the medical insurance premiums and contribution amounts. Failure to pay for coverage would result in a COBRA Qualifying event. Please contact the Company for procedures regarding the timing and manner of payment of your premiums with respect to your FMLA leave.

The Plan also permits you to revoke or change or make a new election under other circumstances, such as entitlement to Medicare, a court order or medical child support order or uniformed services under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Mental Health Parity & Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

Employee Retirement Income Security Act (ERISA)

Group plan participants may be entitled to these rights and protections under ERISA:

- Examine documents or request copies of the plans, contracts, annual report (Form 5500), and Summary Annual Report.
- Fiduciaries to operate the plans prudently and in the interests of participants and beneficiaries; no one may fire or discriminate against you interior prevent you from obtaining a benefit or exercising rights under ERISA.
- If a claim is denied or ignored, you have a right to know why, obtain copies of documents relating to the decision without charge, and to appeal denials.

Questions about ERISA rights or obtaining documents, contact the nearest EBSA Office OR write to: EBSA, Dept. of Labor, 200 Constitution Ave., N.W., Washington, DC 20210 OR call the publications hotline of the EBSA.

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-KIDSNOW 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, 2023. Contact your State for more information on eligibility.

ALABAMA - Medicaid	ALASKA - Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS - Medicaid	**CALIFORNIA - Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA - Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA - Medicaid	INDIANA - Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- l iability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	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)	**KANSAS - 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://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY - Medicaid	**LOUISIANA - Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.as px 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: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (La HIPP)
MAINE - Medicaid	**MASSACHUSETTS - Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA - Medicaid	**MISSOURI - Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-fami lies/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA - Medicaid	**NEBRASKA - Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA - Medicaid	NEW HAMPSHIRE - Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY - Medicaid and CHIP	**NEW YORK - 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: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA - Medicaid	**NORTH DAKOTA - Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA - Medicaid and CHIP	**OREGON - Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA - Medicaid and CHIP	**RHODE ISLAND - Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA - Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS - Medicaid	**UTAH - Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT- Medicaid	**VIRGINIA - Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva .org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON - Medicaid	**WEST VIRGINIA - Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN - Medicaid and CHIP	**WYOMING - Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance, and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, 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 plan's deductible or 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're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). 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.

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 can 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 types of 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.

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

Your Rights and Protections Against Surprise Medical Bills

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed: *The federal phone number for information and complaints is: 1-800-985-3059*.

Visit https://www.cms.gov/newsroom/fact-sheets/no-surprises-understand-your-rights-against-surprise- medical-bills for more information about your rights under federal law.

Required Compliance Notices – Medicare Part D

Important Notice 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 and about your options under Medicare's prescription drug coverage. This information can help you decide whether 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. The prescription drug coverage offered on average for all plan participants, is expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current plan will not be affected. If you do decide to join a Medicare drug plan and drop your current 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 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 Birch Benefits' Help Line at (1-888-921-1865) or your HR Department. 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 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
Birch Benefits also has a Medicare team that can meet with you and
answer any Medicare related questions as well as help you enroll.

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).

FMLA: Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

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

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, **to request FMLA leave you must**:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

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

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing**:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process**.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

Patient Protection Model Disclosure

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to participants of these rights when applicable. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. The following model language can be used to satisfy the notice requirement:

> HealthNow generally, requires 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, please call the number on the back of your ID card.
>
> For children, you may designate a pediatrician as the primary care provider.
>
> You do not need prior authorization from HealthNow 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 number on the back of your ID card.

BIRCH