# 2024-2025

## Tampa Bay Treatment Associates Benefit Guide

# Table of Contents


| | |
|---|---|
| **Welcome to your 2024-2025 Benefit Guide** | **3** |
| **Benefit Offering Directory** | **4** |
| **Benefit Enrollment Information** | **5** |
| Insurance Glossary | 7 |
| **Health Plans** | **8** |
| Medical Plans | 9 |
| Health Savings Account (HSA) | 12 |
| Additional Ways to Save | 13 |
| Dental Plans | 14 |
| Vision Plan | 16 |
| **Voluntary Benefits** | **17** |
| Life & AD&D | 18 |
| Voluntary Disability | 20 |
| Voluntary Benefits | 22 |
| **Annual Notices** | **30** |


**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 31 for more details.**

# Welcome to your 2024-2025 Benefit Guide

Tampa Bay Treatment Associates is proud to offer a comprehensive benefits package to you and your family through our 2024-2025 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 2024-2025 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:***


***Terha Griffith***
***1-813-756-5742***
***tgriffith@whitesandstreatment.com***

# Benefit Offering Directory

| | | |
|---|---|---|
| **MEDICAL** | **Florida Blue**<br>• BlueCare 134/135<br>• BlueOptions 05908<br>• BlueOptions 05192/05193<br>• BlueOptions 05774<br>• BlueOptions 05772 | 1-800-352-2583<br>www.floridablue.com |
| **DENTAL** | **Lincoln Financial**<br>• DHMO<br>• DPPO | 1-800-423-2765<br>www.lincolnfinancial.com |
| **VISION** | **Lincoln Financial**<br>Spectera Vision Network | 1-800-423-2765<br>www.lincolnfinancial.com |
| **LIFE & DISABILITY** | **Lincoln Financial**<br>• Basic Life & AD&D<br>• Voluntary Life & AD&D<br>• Voluntary Short-Term Disability<br>• Voluntary Long-Term Disability | 1-800-423-2765<br>www.lincolnfinancial.com |
| **VOLUNTARY BENEFITS** | Health Savings Account<br><br>**Lincoln Financial**<br>• Accident Protection<br>• Hospital Indemnity | 1-800-423-2765<br>www.lincolnfinancial.com |
| | **AFLAC**<br>• Critical Illness<br>• Cancer Protection | 1-800-433-3036<br>www.mylogin.aflac.com<br>Email: cscmail@aflac.com |
| | **LegalShield** Legal Plan & ID Protection | 1-800-654-7757<br>www.legalshield.com |
| | **Total Pet Plan** Pet Insurance | 1-800-891-2565<br>www.petbenefits.com/land/whitesandstreatment |

# 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 10, 2024 to September 16, 2024**. 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, 2024, to September 30, 2025.**

| September | October |
|---|---|
| **Open Enrollment:** **September 10 – September 16, 2024** | **Plans Effective:** **October 1, 2024** |

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?

Tampa Bay Treatment Associates will provide appointment times from U.S Enrollment Services in order to elect your benefits for the coming year. It is mandatory this year to schedule an appointment to enroll in or decline your benefits. **Please schedule your 1-on-1 personalized call, in between 9:00am – 7:00pm on weekdays only, from 9/10 to 9/16** to review all benefit offerings with a Benefits Counselor.

- To schedule your appointment, please scan the QR code or go to whitesands.mybenefitsinfo.com
- At the time of your appointment, you will **call 1-813-303-1387** to speak with a Benefits Counselor.

## Who Can Enroll?

There are certain restrictions surrounding eligibility for benefit enrollment. If you are an employee who regularly works 30 hours or more per week, you will be eligible for benefits on the 1st day of the month following 60 days of full-time employment.

If you meet the above requirements, your legal spouse, domestic partner, or dependent child(ren) are also eligible for our benefits plan. As a reminder, a dependent child is:

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

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.

# Benefit Enrollment Information

## 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.

## Making Plan Changes

Existing employees can only make plan changes during the Open Enrollment window and cannot make additional changes to your coverage during the year unless you experience a qualified family status change. Below, we have included 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
    - Acquisition of 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

If you think you have experienced a qualified family status change event, you will need to verify the event with Human Resources within 30 days of its occurrence. (60 days in the case of Medicaid or CHIP eligibility).

## 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.**

## 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.

# Health Plans

# Medical Plans

Tampa Bay Treatment Associates offers **five Florida Blue** 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 **Florida Blue'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 (with the exception of plan 134/135). 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).

**HMO Plan:** This plan only covers services performed by health care providers in the plan's network, with the exception of true emergencies.

This version of an HMO plan is open access. You do not need to select a Primary Care Provider (PCP). You can visit a specialist without referrals.

**NOTE**: You can search for participating health care providers by visiting **www.floridablue.com** and clicking "Find a Doctor", and then select "Find a Doctor or Dentist". Enter your location and Select a plan, "**BlueOptions**" for the PPO Plans or "**BlueCare**" for the HMO Plan to view your options. For your reference, **Quest Diagnostics** is **Florida Blue's** preferred lab facility.

# Medical Plans

| COVERAGE | HDHP HMO BlueCare 134/135 | HDHP PPO BlueOptions 05192/05193 | | PPO BlueOptions 05908 | |
|---|---|---|---|---|---|
| | In-Network | In-Network | Out-of-Network[2] | In-Network | Out-of-Network[2] |
| **Calendar Year Deductible** | | | | | |
| Individual | $3,500 /$7,000 | $2,500 / $5,000 | $5,000 / $10,000 | $5,000 | $10,000 |
| Family | $7,000 | $5,000 | $10,000 | $10,000 | $20,000 |
| **Member Coinsurance** | 20% | 20% | 40% | 20% | 50% |
| **Calendar Year Out-of-Pocket Maximum** | | | | | |
| Individual | $6,850 / $7,000 | $5,800 / $6,850 | $11,600 / $23,200 | $8,200 | $16,400 |
| Family | $14,000 | $11,600 | $23,200 | $16,400 | $32,800 |
| **Physician Visit** | | | | | |
| Preventive Care | Covered in Full | Covered in Full | 40% coinsurance | Covered in Full | 50% coinsurance |
| Primary Care Physician (PCP) | $30 copay after DED | 20% after DED | 40% after DED | $0 copay (visits 1-3) / $30 copay | 50% after DED |
| Specialist | $75 copay after DED | 20% after DED | 40% after DED | $60 copay | 50% after DED |
| **Lab Work & Diagnostic Imaging** | | | | | |
| Independent Lab i.e., blood work / IDTC[1] | 20% after DED | No charge after DED / 20% after DED | 40% after DED | $0 copay / $60 copay (x-rays) | 50% after DED |
| Advanced Services Includes MRI, PET, CT | 20% after DED | 20% after DED | 40% after DED | 20% after DED | 50% after DED |
| **Hospital Services** | | | | | |
| Inpatient Hospital | 20% after DED | 20% after DED | $500 copay + 40% after DED | 20% after DED | 50% after DED |
| Outpatient Surgery | 20% after DED | 20% after DED | 40% after DED | 20% after DED | 50% after DED |
| **Emergency Medical Care** | | | | | |
| Urgent Care | $100 copay + DED | 20% after DED | 20% after DED | $100 copay | $100 copay after DED |
| Emergency Room | $350 copay + DED | 20% after DED | 20% after INN DED | $350 copay | $350 copay |
| **Prescription RX (30-day supply)** | | | | | |
| Preferred Generic | $10 copay after DED | $10 copay after DED | INN DED + 50% coinsurance | $10 copay | 50% coinsurance |
| Preferred Brand Name | $50 copay after DED | $50 copay after DED | INN DED + 50% coinsurance | $60 copay | 50% coinsurance |
| Non-Preferred | $80 copay after DED | $80 copay after DED | INN DED + 50% coinsurance | $100 copay | 50% coinsurance |
| **Mail Order (90-day supply)** | | | | | |
| Preferred Generic | $25 copay after DED | $25 copay after DED | INN DED + 50% coinsurance | $25 copay | 50% coinsurance |
| Preferred Brand Name | $125 copay after DED | $125 copay after DED | INN DED + 50% coinsurance | $150 copay | 50% coinsurance |
| Non-Preferred | $200 copay after DED | $200 copay after DED | INN DED + 50% coinsurance | $250 copay | 50% coinsurance |

| Bi-Weekly Payroll Contributions | HDHP 134/135 | HDHP 05192/05193 | PPO 05908 |
|---|---|---|---|
| Employee Only | $30.98 | $98.52 | $105.11 |
| Employee + Spouse | $427.47 | $581.46 | $596.50 |
| Employee + Child(ren) | $340.73 | $475.83 | $489.01 |
| Family | $712.46 | $928.59 | $949.70 |

(1) Independent Diagnostic Testing Center
(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

# Medical Plans

| COVERAGE | PPO BlueOptions 05772 | | PPO BlueOptions 05774 | |
|---|---|---|---|---|
| | In-Network | Out-of-Network[1] | In-Network | Out-of-Network[1] |
| **Calendar Year Deductible** | | | | |
| Individual | $2,000 | $6,000 | $3,000 | $6,000 |
| Family | $6,000 | $18,000 | $9,000 | $18,000 |
| **Member Coinsurance** | 20% | 50% | 20% | 50% |
| **Calendar Year Out-of-Pocket Maximum** | | | | |
| Individual | $5,500 | $11,000 | $6,350 | $15,000 |
| Family | $11,000 | $22,000 | $12,700 | $30,000 |
| **Physician Visit** | | | | |
| Preventive Care | Covered in Full | 50% coinsurance | Covered in Full | 50% coinsurance |
| Primary Care Physician (PCP) | $35 copay | 50% after DED | $40 copay | 50% after DED |
| Specialist | $65 copay | 50% after DED | $100 copay | 50% after DED |
| **Lab Work & Diagnostic Imaging** | | | | |
| Independent Lab i.e., blood work / X-rays | $0 copay / $50 copay | 50% after DED | $0 copay / $50 copay | 50% after DED |
| Advanced Services Includes MRI, PET, CT | $300 copay | 50% after DED | $400 copay | 50% after DED |
| **Hospital Services** | | | | |
| Inpatient Hospital | $100 PAD + 20% after DED | $500 PAD + 50% after DED | $500 PAD + 20% after DED | $500 PAD + 50% after DED |
| Outpatient Surgery | ASC: $250 copay / 20% after DED | 50% after DED | ASC: $350 copay / 20% after DED | 50% after DED |
| **Emergency Medical Care** | | | | |
| Urgent Care | $70 copay | $70 copay after DED | $100 copay | $100 copay after DED |
| Emergency Room | $300 copay | $300 copay | $400 copay | $400 copay |
| **Prescription RX (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 |
| **Bi-Weekly Payroll Contributions** | PPO 05772 | | PPO 05774 | |
| Employee Only | $195.72 | | $173.03 | |
| Employee + Spouse | $803.09 | | $751.35 | |
| Employee + Child(ren) | $670.23 | | $624.84 | |
| Family | $1,239.64 | | $1,167.03 | |

(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

# Health Savings Account (HSA)

If you participate in our High Deductible Health Plans (HDHP), you may be eligible to open a Health Savings Account (HSA). An HSA allows you to make tax-free contributions and earn tax-free growth of interest or investment earnings. You can use these contributions to pay for eligible expenses, such as medical and pharmacy expenses. Please refer to IRS publication 502 for a full list of eligible expenses. According to treasury regulations, you are allowed to revoke or change your HSA contribution election throughout the year. Any unused funds in your HSA will roll over annually. Additionally, your account is portable, which allows you to take your funds with you from job to job or at retirement.

The IRS allows an annual maximum contribution to your HSA. Below are the annual maximum contributions for 2024 and 2025. **Tampa Bay Treatment Associates makes a $40 monthly contribution to your HSA regardless of coverage level.**

| | 2024 | 2025 |
|---|---|---|
| Single | $4,150 | $4,300 |
| Family | $8,300 | $8,550 |
| Catch Up provision if age 55 or Older | $1,000 | $1,000 |

## Eligibility

To be eligible to contribute into an HSA account, you cannot:

- Be covered by any other non-HSA-compatible health coverage plan including, but not limited to, a Traditional Medical FSA or an 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 6 months retroactively but not earlier than Medicare eligibility.
    - Receiving Social Security benefits causes automatic Medicare Part A enrollment when eligible
- Have prior year FSA dollars carryover / rollover into a current year general purpose FSA
- Have a positive general purpose FSA grace period balance

## Frequently Asked Questions

**How do I contribute to my HSA?** You can make a contribution to your HSA through payroll deduction by requesting that your employer deduct a set amount from your paycheck.

**When can I start to use the funds in my HSA?** Once your account is open and you have available funds from a personal or company contribution, you can start using your HSA for eligible expenses. As soon as funds are deposited, you are 100 percent vested and in control of the funds.

**What happens to my HSA if I leave my employer?** You can keep your current HSA or transfer your funds to another qualifying HSA. If you choose to transfer your funds to a new HSA, you should complete the transfer within 60 days of withdrawing the funds in order to avoid taxes and an additional 20 percent penalty. NOTE: you must be enrolled in an HDHP to continue to contribute to your HSA.
***Please consult your tax professional for any personal tax advice.***

# Additional Ways to Save

Outside of an HSA, there are additional ways for you to save on health care expenses and stay on budget.

| Look into discount drug programs offered by local pharmacies | |
|---|---|
| **Pharmacy** | **Offer** |
| Walmart | 30-day supply starting at $4 \| 90-day supply starting at $10 |

| Research brand name drug rebates online | |
|---|---|
| **Website** | **Offer** |
| 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 |

| Use freestanding Surgical and Diagnostic Centers when possible | |
|---|---|
| **Ambulatory Services** | Save on a covered surgery by having it done at an in-network, non-hospital-affiliated ambulatory surgical center. |
| **Freestanding Diagnostic Centers** | Save on MRIs, CAT scans, X-rays, etc. by having them done at participating freestanding diagnostic centers. |

Lower → Higher

| | Telemedicine | Doctor's Office | Convenience Clinic | Urgent Care | Emergency Room |
|---|---|---|---|---|---|
| **Reason** | Health advice or treatment provided by phone, mobile app or online video. | Routine, or preventive care, non-urgent care and to manage a condition | Use for preventive care services and common colds when your doctor is not available. This is a low-cost option. | Use for immediate attention for non-threatening situations. Getting care will cost less than the ER and is generally quicker. | Use for life-threatening injuries, as ERs are best suited for medical emergencies. ER follow-ups are not covered so it is best to schedule with your PCP for a follow-up visit. |
| **Cost** | Lowest Cost | Lower Cost | Low Cost | Higher Cost | Highest Cost |
| **Wait Times** | Available 24/7 | Appointment typically required | Walk-in or same-day appointment | No appointment, wait times vary | Open 24/7, No appointment but standard long wait times |

# Dental Plans

Tampa Bay Treatment Associates offers two **Lincoln Financial** Dental Plans:

- A Dental Health Maintenance Organization (DHMO) plan and
- A Dental Preferred Provider Organization (DPPO)

We have included an explanation of each plan below. The next page provides plan highlights and your bi-weekly 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.lfg.com](http://www.lfg.com) and clicking "Find a dentist" and entering your search criteria.

# Dental Plans

| Plan Highlights | DHMO |
|---|---|
| **Preventive Services** | |
| Office Visit | $5 copay |
| Cleanings (Code 1110/1120) Every 6 months | No charge |
| Routine X-Rays | No charge |
| Resin Based – Posterior One Surface (Code 2391) | $72 copay |
| Root Canal – Molar (Code 3330) | $350 copay, excludes final restoration |
| **Orthodontics** | |
| Start-Up (Code 8660/8999) | $35 / $250 copay |
| Comprehensive Treatment Child/Adult (Code 8080/8090) | $2,775 / $2,875 copay |
| Retention (Code 8680) | $300 copay |
| **Bi-Weekly Payroll Contributions** | |
| Employee Only | $0.00 |
| Employee + Spouse | $3.96 |
| Employee + Child(ren) | $6.17 |
| Family | $9.25 |

| Plan Highlights | DPPO | |
|---|---|---|
| | In-Network | Out-of-Network |
| **Calendar Year Maximum Benefit** | $5,000 per member | |
| **Calendar Year Deductible (DED)** | | |
| Individual<br>Family | $50<br>$150 | $50<br>$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 | Plan pays 50% after DED | Plan pays 50% after DED |
| **Orthodontics (Child up to age 19)** | | |
| Comprehensive | 50%; $1,000 Lifetime Maximum | |
| **Bi-Weekly Payroll Contributions** | | |
| Employee Only | $5.93 | |
| Employee + Spouse | $17.15 | |
| Employee + Child(ren) | $26.33 | |
| Family | $38.15 | |

# Vision Plan

You can receive the following vision benefits when enrolled in **Lincoln Financial** vision plan:

- Every 12 months, **Lincoln Financial** covers your eye exam, frames and either lenses or contact lenses

NOTE: You can search for providers by visiting **www.lfg.com**, under "Service and support", click "Find a vision care provider" and entering your search criteria in the "Provider Quick Search" section.

Below are plan highlights and your bi-weekly payroll contributions.

| Plan Highlights | Spectera Vision Network | |
|---|---|---|
| | In-Network | Out-of-Network |
| **Exam (One every 12 months)** | $10 Copay | Up to $40 |
| **Lenses (One every 12 months)** | | |
| Single | $10 Copay | Up to $40 |
| Bifocal | $10 Copay | Up to $60 |
| Trifocal | $10 Copay | Up to $80 |
| **Frames (One every 12 months)** | $130 Allowance, then up to 30% off remaining balance | Up to $45 |
| **Contact Lenses (One every 12 months)** | | |
| Elective Selection | Covered in Full (material copay applies) | Up to $125 |
| Elective Non-Selection | $125 Allowance | Up to $125 |
| Medically Necessary | Covered in Full | Up to $210 |
| **Bi-Weekly Payroll Contributions** | | |
| Employee Only | $0.00 | |
| Employee + Spouse | $2.92 | |
| Employee + Child(ren) | $3.98 | |
| Employee + Family | $6.94 | |

# Voluntary & Additional Benefits

# Life & AD&D

At Tampa Bay Treatment Associates, you can elect Life and AD&D insurance through **Lincoln Financial**:

## 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.

**Group Life & AD&D Insurance**: As a full-time, benefits-eligible employee, you are eligible for Group Life & AD&D Insurance that will cover **$20,000** through **Lincoln Financial**. Beginning on and after your 65th birthday, your life insurance benefit decreases 35%, and an additional 15% of the original amount at age 70. Benefits end when you retire.

**Be sure to keep your beneficiary designations up to date!** You can change your beneficiary designation at any time, even outside of the Open Enrollment period. You are also able to designate full payment to a sole beneficiary or payment percentages to multiple beneficiaries.

## Voluntary Life & AD&D Insurance – Employee Paid

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 **Lincoln Financial**. In order to receive coverage for dependents, you must be enrolled in your own Voluntary Life and AD&D coverage. The Voluntary Life & AD&D insurance is convertible or portable for eligible individuals. Beginning on and after your 65th birthday, your life insurance benefit decreases 35% and an additional 15% of the original amount at age 70. Benefits end when you retire.

**Evidence of Insurability (EOI)** must be submitted to and approved by the Company when:

- Personal Life Insurance amounts exceed the guarantee issue amount of $200,000 or 5 times salary, whichever is less, at initial enrollment;
- any benefit option increase or new election requested during the specified open enrollment period which exceeds the amount of Personal Life Insurance by more than 2 increment level(s);
- an increased amount of Personal Life Insurance coverage is requested, and any amount of coverage has been previously withdrawn or declined or is pending underwriting review;
- or initial coverage is elected more than 31 days after first becoming eligible.

If any evidence of insurability is required, it will be provided at your own expense.

**Portability**: An insured must apply for the portability option in order to actually keep the coverage. Written application along with the required premium must be made no later than 31 days after the date the insurance would normally terminate.

Here are some coverage highlights.

| Employee Coverage* | Spouse Coverage** | Child(ren) Coverage** |
|---|---|---|
| $10,000 increments to a maximum not to exceed the lesser of 5 times annual earnings rounded to the next higher $10,000 or $300,000<br>*Guarantee Issue: $200,000* | $5,000 increments to a maximum not to exceed the lesser of 2.5 times annual earnings rounded to the next higher $5,000 or $150,000<br>*Guarantee Issue: $30,000* | **Birth to 6 months**: $1,000<br>**6 months to age 26:** $5,000 increments up to a maximum of $20,000 |

# Voluntary Life & AD&D

| Employee life insurance bi-weekly rate | |
|---|---|
| Age[1] | Premium bi-weekly rate |
| Under 25 | $0.026 |
| 25-29 | $0.305 |
| 30–34 | $0.038 |
| 35–39 | $0.052 |
| 40–44 | $0.076 |
| 45–49 | $0.121 |
| 50–54 | $0.205 |
| 55–59 | $0.307 |
| 60–64 | $0.381 |
| 65–69 | $0.612 |
| 70–74 | $0.989 |
| 75+ | $0.989 |

| Spouse life insurance bi-weekly rate[1] | |
|---|---|
| Age[1] | Premium bi-weekly rate |
| Under 25 | $0.026 |
| 25-29 | $0.305 |
| 30–34 | $0.038 |
| 35–39 | $0.052 |
| 40–44 | $0.076 |
| 45–49 | $0.121 |
| 50–54 | $0.205 |
| 55–59 | $0.307 |
| 60–64 | $0.381 |
| 65–69 | $0.612 |
| 70–74 | $0.989 |
| 75+ | $0.989 |

| Benefit | Employee Rate | Spouse Rate | Child(ren) Rate |
|---|---|---|---|
| Voluntary Accidental Death & Dismemberment | $0.034 | $0.034 | $0.034 |

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

** 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.*

***Your dependent's insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. (Totally disabled means that, as a result of an injury, a sickness or a disorder, your dependent spouse is confined in a hospital or similar institution or is confined at home for sickness or injury; or has a life threatening condition.)*

# Voluntary Disability

Disability insurance provides income protection in the event that you are unable to work due to a qualified disability. Below are the two types of disability insurance that we provide:

## Voluntary Short-Term Disability (STD) – Employee Paid*

Our short-term disability program with **Lincoln Financial** provides financial assistance for up to 24 weeks if you are unable to work. ** Below are the benefit highlights.

| Plan Highlights | Level Of Coverage |
|---|---|
| Percentage of Wage Replacement | 60% of covered weekly earnings |
| Maximum per Week | $1,000 |
| Elimination Period | 14 days |
| Maximum Benefit Period | 24 weeks |

| Voluntary Short-Term Disability Cost of Coverage | |
|---|---|
| Age | Rate per $1,000 |
| Under 25 | $0.847 |
| 25-29 | $0.847 |
| 30–34 | $0.847 |
| 35–39 | $0.847 |
| 40–44 | $0.883 |
| 45–49 | $0.908 |
| 50–54 | $0.924 |
| 55–59 | $0.946 |
| 60–64 | $1.026 |
| 65–69 | $1.062 |
| 70+ | $1.105 |
| Child(ren) | $0.847 |

# Voluntary Disability

## Voluntary Long-Term Disability (LTD) – Employee Paid*

Long-Term Disability Insurance with **Lincoln Financial** provides extended financial coverage if you are unable to work. ** 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 | Later of age 65 or Social Security Normal Retirement Age, as long as you meet the plans disability requirements |

| Voluntary Long-Term Disability Cost of Coverage | |
|---|---|
| Age | Rate per $1,000 |
| Under 25 | $0.187 |
| 25-29 | $0.322 |
| 30–34 | $0.537 |
| 35–39 | $0.820 |
| 40–44 | $1.142 |
| 45–49 | $1.476 |
| 50–54 | $1.882 |
| 55–59 | $1.577 |
| 60–64 | $1.238 |
| 65–69 | $1.074 |
| 70+ | $1.074 |
| Child(ren) | $0.187 |

*This information is not intended to be tax or legal advice. Specific questions about tax-related matters should be referred to your tax accountant, legal counsel and the IRS.*

** 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.*

***Pre-existing conditions may be exempt from coverage*

# Voluntary Benefits

## Accident Protection

You can opt into **Lincoln Financial** Accident Protection policy to cover accidents from motor vehicle collisions, sports injuries to everyday slips, and falls.

**Lincoln Financial** policy may pay cash (based on a schedule) to help families offset the expenses associated with these accidents or injuries. Benefits may be paid for:

- Emergency room and doctor visit
- Follow-up and physical therapy visits
- Hospital admission and confinement
- Ambulance
- Medical Equipment (crutches, leg braces, etc.)

| | |
|---|---|
| Employee | $15.05 |
| Employee & Spouse | $24.05 |
| Employee & Child | $27.78 |
| Family | $37.56 |

## Hospital Indemnity

**Lincoln Financial** 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.

| Hospital Type | Option 1 | Option 2 |
|---|---|---|
| Carrier | **Lincoln Financial Group** | **Lincoln Financial Group** |
| Plan Name | Hospital Indemnity (Low Plan) | Hospital Indemnity (High Plan) |
| Rate Guarantee | 3 years | 3 years |
| Participation Requirements | 25 Enrolled (between both plans) | 25 Enrolled (between both plans) |
| **Benefit** | | |
| Admission / ICU | $1,000 / $1,000 | $2,000 / $2,000 |
| Confinement / ICU | $150 / $150 | $200 / $200 |
| ICU Step-Down | $75 | $100 |
| Portability | Yes | Yes |
| Pre-Existing Condition Limitation | None | None |
| Wellness Benefit | $50 | $50 |
| **Monthly Rates** | | |
| Employee | $22.44 | $35.26 |
| Employee & Spouse | $42.82 | $68.92 |
| Employee & Child | $34.54 | $54.44 |
| Family | $54.92 | $96.84 |

## Critical Illness

You can count on **Aflac** to help ease the financial impact of surviving a critical illness. If you are diagnosed with a covered critical illness, **you will receive a cash benefit** based on a specified percentage payable for the condition.

- Benefits are paid directly to you, unless otherwise assigned
- Coverage is available for you, your spouse, and dependent children
- Coverage may be continued (with certain stipulations). That means you can take it with you if you change jobs or retire

Below, you will find the covered critical illness benefits, as well as the bi-weekly payroll deductions.

**COVERED CRITICAL ILLNESS BENEFITS:**

| Benefit | |
|---|---|
| **CANCER** (Internal or Invasive) | 100% |
| **HEART ATTACK** (Myocardial Infarction) | 100% |
| **STROKE** (Ischemic or Hemorrhagic) | 100% |
| **KIDNEY FAILURE** (End-Stage Renal Failure) | 100% |
| **BONE MARROW TRANSPLANT** (Stem Cell Transplant) | 100% |
| **SUDDEN CARDIAC ARREST** | 100% |
| **MAJOR ORGAN TRANSPLANT** (25% of this benefit is payable for insureds placed on a transplant list for a major organ transplant) | 100% |
| **TYPE I DIABETES** | 100% |
| **CORONARY ARTERY BYPASS SURGERY** | 100% |
| **NON-INVASIVE CANCER** | 25% |
| **METASTATIC CANCER** | 25% |

**INITIAL DIAGNOSIS BENEFIT**
We will pay a lump sum benefit upon initial diagnosis of a covered critical illness when such diagnoses is caused by or solely attributed to an underlying disease. Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

**ADDITIONAL DIAGNOSIS BENEFIT**
We will pay benefits for each different critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months.

**REOCCURRENCE BENEFIT**
We will pay benefits for the same critical illness after the first when the two dates of diagnoses are separated by at least 6 consecutive months.

**SKIN CANCER BENEFIT**
We will pay $1,000 for the diagnosis of skin cancer. We will pay this benefit once per calendar year.

**WAIVER OF PREMIUM**
If you become totally disabled due to a covered critical illness prior to age 65, after 90 continuous days of total disability, we will waive premiums for you and any of your covered dependents. As long as you remain totally disabled, premiums will be waived up to 24 months, subject to the terms of the plan.

**SUCCESSOR INSURED BENEFIT** (In Missouri, Conversion Privilege (Successor Insured))
If spouse coverage is in force at the time of the primary insured's death, the surviving spouse may elect to continue coverage. Coverage would continue at the existing spouse face amount and would also include any dependent child coverage in force at the time. See certificate for details.

**CHILD COVERAGE AT NO ADDITIONAL COST**
Each dependent child is covered at 50 percent of the primary insured's benefit amount at no additional charge. Children-only coverage is not available.

Employee - Uni-Tobacco

| | $5,000 | $10,000 | $20,000 | $30,000 |
|---|---|---|---|---|
| 18-25 | $0.55 | $1.09 | $2.19 | $3.28 |
| 26-30 | $0.85 | $1.70 | $3.40 | $5.10 |
| 31-35 | $1.19 | $2.39 | $4.77 | $7.16 |
| 36-40 | $1.66 | $3.32 | $6.63 | $9.95 |
| 41-45 | $2.27 | $4.53 | $9.07 | $13.60 |
| 46-50 | $3.09 | $6.18 | $12.37 | $18.55 |
| 51-55 | $4.97 | $9.94 | $19.87 | $29.81 |
| 56-60 | $6.08 | $12.15 | $24.30 | $36.46 |
| 61-65 | $10.04 | $20.08 | $40.16 | $60.24 |
| 66+ | $16.20 | $32.39 | $64.79 | $97.18 |

Spouse - Uni-Tobacco

| | $5,000 | $10,000 | $20,000 | $30,000 |
|---|---|---|---|---|
| 18-25 | $0.55 | $1.09 | $2.19 | $3.28 |
| 26-30 | $0.85 | $1.70 | $3.40 | $5.10 |
| 31-35 | $1.19 | $2.39 | $4.77 | $7.16 |
| 36-40 | $1.66 | $3.32 | $6.63 | $9.95 |
| 41-45 | $2.27 | $4.53 | $9.07 | $13.60 |
| 46-50 | $3.09 | $6.18 | $12.37 | $18.55 |
| 51-55 | $4.97 | $9.94 | $19.87 | $29.81 |
| 56-60 | $6.08 | $12.15 | $24.30 | $36.46 |
| 61-65 | $10.04 | $20.08 | $40.16 | $60.24 |
| 66+ | $16.20 | $32.39 | $64.79 | $97.18 |

# Voluntary Benefits

Cancer insurance provides you with funds that can be used flexibly, including to help cover both medical and nonmedical expenses that occur during your journey to recovery. These funds can be used to pay for household expenses that may be more difficult to manage while you're sick.

## Cancer Protection Assurance – Option 1

**Benefits overview** Choose the Policy and Riders that Fit Your Needs

| BENEFIT: | DESCRIPTION: |
|---|---|
| INITIAL DIAGNOSIS | Named Insured or Spouse: $1,250<br>Dependent Child: $2,500<br>Payable once per covered person, per lifetime |
| RADIATION THERAPY, CHEMOTHERAPY, IMMUNOTHERAPY OR EXPERIMENTAL CHEMOTHERAPY | Self-Administered: $150 per calendar month<br>Physician Administered: $800 per calendar month<br>This benefit is limited to one self-administered treatment and one physician-administered treatment per calendar month |
| ANNUAL CARE | $250 on the anniversary date of diagnosis; lifetime maximum of five annual $250 payments per covered person |
| CANCER SCREENING | One $25 benefit per calendar year, per covered person<br>Benefit increases to three screenings per calendar year after the diagnosis for internal cancer or an associated cancerous condition |
| PROPHYLACTIC SURGERY (DUE TO A POSITIVE GENETIC TEST RESULT) | $125 per covered person, per lifetime |
| ADDITIONAL OPINION | $150 per covered person, per lifetime |
| HORMONAL THERAPY | $15 once per calendar month |
| TOPICAL CHEMOTHERAPY | $100 once per calendar month |
| ANTINAUSEA | $50 once per calendar month |
| STEM CELL AND BONE MARROW TRANSPLANTATION | $3,500; lifetime maximum of $3,500 per covered person<br>Donor Benefit:<br>$50 for stem cell donation, or<br>$500 for bone marrow donation<br>Payable one time per covered person |
| BLOOD AND PLASMA | Inpatient: $50 times the number of days paid under the Hospital Confinement Benefit, per covered person<br>Outpatient: $140 per day, per covered person |
| SURGICAL/ANESTHESIA | $50-$1,700<br>Anesthesia: additional 25% of the Surgery Benefit<br>Maximum daily benefit will not exceed $2,125; no lifetime maximum on the number of operations |
| SKIN CANCER SURGERY | Laser or Cryosurgery: $20<br>Excision of lesion of skin without flap or graft: $85<br>Flap or graft without excision: $125<br>Excision of lesion of skin with flap or graft: $200<br>Maximum daily benefit will not exceed $200. No lifetime maximum on the number of operations |
| PROPHYLACTIC SURGERY (WITH CORRELATING INTERNAL CANCER DIAGNOSIS) | $125 per covered person, per lifetime |
| HOSPITALIZATION CONFINEMENT FOR 30 DAYS OR LESS | Named Insured or Spouse: $100<br>Dependent Child: $125 |
| HOSPITALIZATION CONFINEMENT FOR 31 DAYS OR MORE | Named Insured or Spouse: $200<br>Dependent Child: $250 |

| | |
|---|---|
| OUTPATIENT HOSPITAL SURGICAL ROOM CHARGE | $100 per day, per covered person |
| EXTENDED-CARE FACILITY | $75 per day; limited to 30 days in each calendar year, per covered person |
| HOME HEALTH CARE | $50 per day; limited to 10 days per hospitalization, per covered person; and 30 days per calendar year, per covered person |
| HOSPICE CARE | $1,000 for first day; $50 per day thereafter; $12,000 lifetime maximum per covered person |
| NURSING SERVICES | $50 per day; payable for only the number of days the Hospital Confinement Benefit is payable |
| SURGICAL PROSTHESIS | $1,000; lifetime maximum of $2,000 per covered person |
| NONSURGICAL PROSTHESIS | $90 per occurrence, per covered person; lifetime maximum of $180 per covered person |
| BREAST RECONSTRUCTION | Breast Tissue/Muscle Reconstruction Flap Procedures: $1,000<br>Breast Reconstruction (occurring within 5 years of breast cancer diagnosis): $250<br>Breast Symmetry (on the nondiseased breast occurring within 5 years of breast reconstruction): $110<br>Permanent Areola Repigmentation (on the diseased breast): $50<br>Maximum daily benefit will not exceed $1,000 |
| OTHER RECONSTRUCTIVE SURGERY | Facial Reconstruction: $250<br>Anesthesia: additional 25% of the Other Reconstructive Surgery Benefit<br>Maximum daily benefit will not exceed $250 |
| EGG HARVESTING, STORAGE (CRYOPRESERVATION) AND IMPLANTATION | $500 for a covered person to have oocytes extracted and harvested<br>$100 for the storage of a covered person's oocyte(s) or sperm<br>$100 for embryo transfer<br>Lifetime maximum of $700 per covered person |
| AMBULANCE | $250 ground<br>$2,000 air ambulance |
| TRANSPORTATION | $.35 cents per mile for transportation; payable up to a combined maximum of $1,050, per round trip |
| LODGING | $50 per day; limited to 90 days per calendar year |
| WAIVER OF PREMIUM | Yes |
| **OPTIONAL RIDERS:** | **DESCRIPTION:** |
| INITIAL DIAGNOSIS BUILDING BENEFIT RIDER | This benefit will increase the amount of your Initial Diagnosis Benefit, as shown in the policy, by $100 for each unit purchased, up to five units, for each covered person on the anniversary date of coverage, while coverage remains in force. |
| SPECIFIED-DISEASE BENEFIT RIDER | When a covered person is diagnosed with any of the diseases listed in the Specified-Disease Rider:<br>Initial diagnosis: $2,000<br>Hospitalization: 30 days or less; $400 per day / 31 days or more; $800 per day |
| DEPENDENT CHILD RIDER | $10,000 when a covered dependent child is diagnosed as having internal cancer or an associated cancerous condition; payable only once for each covered dependent child |

**CANCER PROTECTION ASSURANCE PLAN LEVEL 1 - Series B70100**

| | | Premium | IDR* (5 units) | SDR* | Total |
|---|---|---|---|---|---|
| 18-75 | INDIVIDUAL | $18.10 | $5.95 | $0.91 | $24.96 |
| 18-75 | INSURED/SPOUSE | $29.03 | $14.05 | $0.91 | $43.99 |
| 18-75 | ONE-PARENT FAMILY | $18.10 | $5.95 | $0.91 | $24.96 |
| 18-75 | TWO-PARENT FAMILY | $29.03 | $14.05 | $0.91 | $43.99 |

*IDR* = Optional Initial Diagnosis Rider (Series B70050) premium 1-5 units*

*SDR* = Optional Specified Disease Rider (Series B70052) premium*

## Cancer Protection Assurance – Option 2

**Benefits overview** Choose the Policy and Riders that Fit Your Needs

| BENEFIT: | DESCRIPTION: |
|---|---|
| INITIAL DIAGNOSIS | Named Insured or Spouse: $5,000<br>Dependent Child: $10,000<br>Payable once per covered person, per lifetime |
| RADIATION THERAPY, CHEMOTHERAPY, IMMUNOTHERAPY OR EXPERIMENTAL CHEMOTHERAPY | Self-Administered: $375 per calendar month<br>Physician Administered: $1,600 per calendar month<br>This benefit is limited to one self-administered treatment and one physician-administered treatment per calendar month |
| ANNUAL CARE | $500 on the anniversary date of diagnosis; lifetime maximum of five annual $500 payments per covered person |
| CANCER SCREENING | One $75 benefit per calendar year, per covered person<br>Benefit increases to three screenings per calendar year after the diagnosis for internal cancer or an associated cancerous condition |
| PROPHYLACTIC SURGERY (DUE TO A POSITIVE GENETIC TEST RESULT) | $250 per covered person, per lifetime |
| ADDITIONAL OPINION | $300 per covered person, per lifetime |
| HORMONAL THERAPY | $25 once per calendar month |
| TOPICAL CHEMOTHERAPY | $150 once per calendar month |
| ANTINAUSEA | $100 once per calendar month |
| STEM CELL AND BONE MARROW TRANSPLANTATION | $7,000; lifetime maximum of $7,000 per covered person<br>Donor Benefit:<br>$100 for stem cell donation, or<br>$750 for bone marrow donation<br>Payable one time per covered person |
| BLOOD AND PLASMA | Inpatient: $50 times the number of days paid under the Hospital Confinement Benefit, per covered person<br>Outpatient: $175 per day, per covered person |
| SURGICAL/ANESTHESIA | $100-$3,400<br>Anesthesia: additional 25% of the Surgery Benefit<br>Maximum daily benefit will not exceed $4,250; no lifetime maximum on the number of operations |
| SKIN CANCER SURGERY | Laser or Cryosurgery: $35<br>Excision of lesion of skin without flap or graft: $170<br>Flap or graft without excision: $250<br>Excision of lesion of skin with flap or graft: $400<br>Maximum daily benefit will not exceed $400. No lifetime maximum on the number of operations |
| PROPHYLACTIC SURGERY (WITH CORRELATING INTERNAL CANCER DIAGNOSIS) | $250 per covered person, per lifetime |
| HOSPITALIZATION CONFINEMENT FOR 30 DAYS OR LESS | Named Insured or Spouse: $200<br>Dependent Child: $250 |
| HOSPITALIZATION CONFINEMENT FOR 31 DAYS OR MORE | Named Insured or Spouse: $400<br>Dependent Child: $500 |

| | |
|---|---|
| **OUTPATIENT HOSPITAL SURGICAL ROOM CHARGE** | $200 per day, per covered person |
| **EXTENDED-CARE FACILITY** | $100 per day; limited to 30 days in each calendar year, per covered person |
| **HOME HEALTH CARE** | $100 per day; limited to 10 days per hospitalization, per covered person; and 30 days per calendar year, per covered person |
| **HOSPICE CARE** | $1,000 for first day; $50 per day thereafter; $12,000 lifetime maximum per covered person |
| **NURSING SERVICES** | $100 per day; payable for only the number of days the Hospital Confinement Benefit is payable |
| **SURGICAL PROSTHESIS** | $2,000; lifetime maximum of $4,000 per covered person |
| **NONSURGICAL PROSTHESIS** | $175 per occurrence, per covered person; lifetime maximum of $350 per covered person |
| **BREAST RECONSTRUCTION** | Breast Tissue/Muscle Reconstruction Flap Procedures: $2,000<br>Breast Reconstruction (occurring within 5 years of breast cancer diagnosis): $500<br>Breast Symmetry (on the nondiseased breast occurring within 5 years of breast reconstruction): $220<br>Permanent Areola Repigmentation (on the diseased breast): $100<br>Maximum daily benefit will not exceed $2,000 |
| **OTHER RECONSTRUCTIVE SURGERY** | Facial Reconstruction: $500<br>Anesthesia: additional 25% of the Other Reconstructive Surgery Benefit<br>Maximum daily benefit will not exceed $500 |
| **EGG HARVESTING, STORAGE (CRYOPRESERVATION) AND IMPLANTATION** | $1,000 for a covered person to have oocytes extracted and harvested<br>$200 for the storage of a covered person's oocyte(s) or sperm<br>$200 for embryo transfer<br>Lifetime maximum of $1,400 per covered person |
| **AMBULANCE** | $250 ground<br>$2,000 air ambulance |
| **TRANSPORTATION** | $.40 cents per mile for transportation; payable up to a combined maximum of $1,200, per round trip |
| **LODGING** | $65 per day; limited to 90 days per calendar year |
| **WAIVER OF PREMIUM** | Yes |
| **OPTIONAL RIDERS:** | **DESCRIPTION:** |
| **INITIAL DIAGNOSIS BUILDING BENEFIT RIDER** | This benefit will increase the amount of your Initial Diagnosis Benefit, as shown in the policy, by $100 for each unit purchased, up to five units, for each covered person on the anniversary date of coverage, while coverage remains in force. |
| **SPECIFIED-DISEASE BENEFIT RIDER** | When a covered person is diagnosed with any of the diseases listed in the Specified-Disease Rider:<br>Initial diagnosis: $2,000<br>Hospitalization: 30 days or less; $400 per day / 31 days or more; $800 per day |
| **DEPENDENT CHILD RIDER** | $10,000 when a covered dependent child is diagnosed as having internal cancer or an associated cancerous condition; payable only once for each covered dependent child |

**CANCER PROTECTION ASSURANCE PLAN LEVEL 2 - Series B70200**

| | | Premium | IDR* (5 units) | SDR* | Total |
|---|---|---|---|---|---|
| 18-75 | INDIVIDUAL | $38.08 | $5.95 | $0.91 | $44.94 |
| 18-75 | INSURED/SPOUSE | $65.87 | $14.05 | $0.91 | $80.83 |
| 18-75 | ONE-PARENT FAMILY | $38.08 | $5.95 | $0.91 | $44.94 |
| 18-75 | TWO-PARENT FAMILY | $65.87 | $14.05 | $0.91 | $80.83 |

*IDR* = Optional Initial Diagnosis Rider (Series B70050) premium 1-5 units*

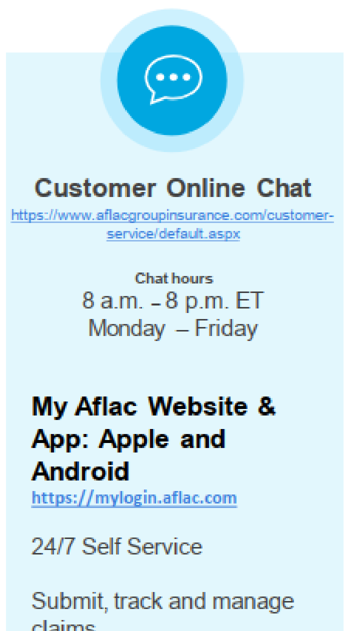
*SDR* = Optional Specified Disease Rider (Series B70052) premium*

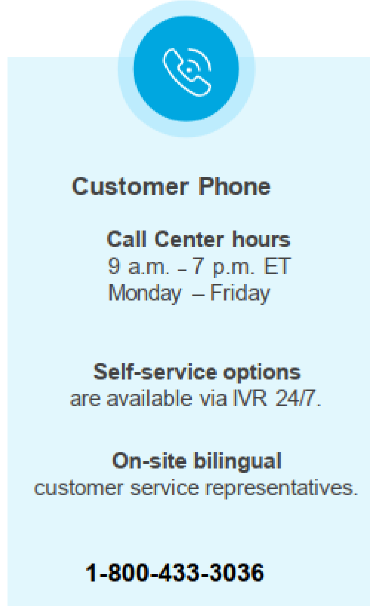
## Aflac Contact Information

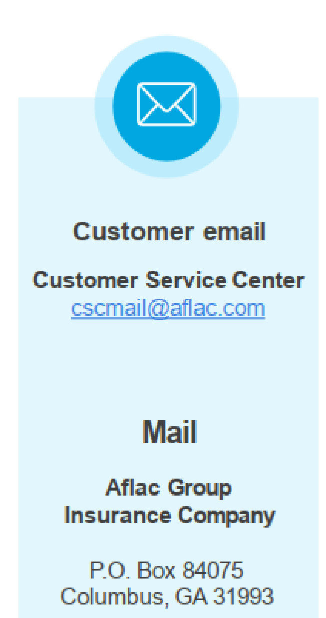
# A full suite of service options

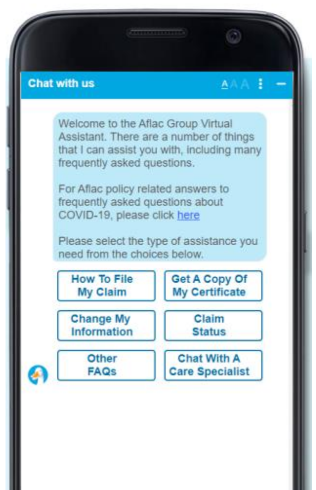
Aflac.

Your employees have access to dedicated customer service solutions and self-service options.



**Have questions?** Connect whenever you need us 24/7 by scanning the QR code on the left, logging in to your account or chatting with us at aflacgroupinsurance.com.

# Voluntary Benefits

## Legal Services

The **LegalShield** is a licensed legal expense organization that provides its members with full service and representation on all types of legal services. This plan covers services including, but not limited to, divorce, traffic tickets, buying or selling a home, foreclosures, will preparation, bankruptcy, garnishments criminal defense, lawsuits, child support, custody and visitation, and much more.

## Identity Protection

Identity Protection, coverage, assistance is offered through **IDShield.**

### How does IDShield help?

- **Auto-on Alerts** - As soon as coverage starts, we proactively monitor for misuse not only of credit but also of compromised Personal Identifiable Information (PII).
- **Financial Threshold Monitoring -** To actively track finances and spending, participants can set dollar amount limits and alerts will trigger from sources such as bank account, thresholds, credit and debit cards, 401(k)s, and other investment accounts.
- **High Risk Applications and Transaction Monitoring -** Application and transaction monitoring can prevent identity theft faster than traditional credit monitoring.

| LegalShield Only | Plan Pricing |
|---|---|
| Employee, Spouse, & Dependent Children up to age 26 | $16.30 |
| **IDShield Only** | |
| Employee | $5.80 |
| Employee & Family | $10.70 |
| **LegalShield & IDShield** | |
| Employee | $21.10 |
| Employee & Family | $25.00 |

## Pet Insurance

**Total Pet Plan** provides everything for your pet's care. All pets are eligible if there are no pre-existing conditions.

| Total Pet Plan Rates | |
|---|---|
| **One Pet** | **Family Plan (2+ Pets)** |
| $11.75/month | $18.50/month |

**Plan Benefits**

- Get up to 40% off on brand name prescriptions, products, foods, treats, toys, and more
- Free shipping on all orders from petcarerx.com
- Unlimited assistance via a 24/7 pet telehealth service
- 25% off discount on medical services at participating veterinarians
- Receive benefits from PetPlus, Pet Assure, AskVet and ThePetTag

# Annual Notices

## 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 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 may 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, 2024 |
| 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 |

## HIPAA Special Enrollment Rights Notice

If you are declining enrollment in TAMPA BAY TREATMENT ASSOCIATES's 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
1-813-756-5742
tgriffith@whitesandstreatment.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 (WHCRA), 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?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator.

## 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 12-31-2026)

**Part A: General Information**
Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

**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 in your geographic area.

**Can I Save Money on my Health Insurance Premiums in the Marketplace?**
You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

**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 is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[12]

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

1 Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
2 An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

**When Can I Enroll in Health Insurance Coverage through the Marketplace?**
You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15. Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

**What about Alternatives to Marketplace Health Insurance Coverage?**
If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/gettingmedicaid-chip/ for more details.

**How Can I Get More Information?**
For more information about your coverage offered through your employment, please check your health plan's summary plan description. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

**PART B: Information About Health Coverage Offered by Your Employer**
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

| 3. Employer Name | 4. Employer Identification Number (EIN) | |
|---|---|---|
| Tampa Bay Treatment Associates | 833713245 | |
| **5. Employer address**<br>600 W Hillsboro Blvd | **6. Employer phone number**<br>813 - 756-5742 | |
| **7. City**<br>Deerfield Beach | **8. State**<br>FL | **9. Zip code**<br>33441 |
| **10. Who can we contact about employee health coverage at this job?**<br>Terha Griffith | | |
| **11. Phone number (if different from above)** | **12. Email address**<br>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 up to age 26 or 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** will guide you through the process.

Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

## 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, 2024. Contact your State for more information on eligibility –**

| ALABAMA – Medicaid | ALASKA – Medicaid |
| --- | --- |
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility:<br>https://health.alaska.gov/dpa/Pages/default.aspx |
| **ARKANSAS – Medicaid** | **CALIFORNIA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Health Insurance Premium Payment (HIPP) Program Website:<br>http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Fax: 916-440-5676<br>Email: hipp@dhcs.ca.gov |
| **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** | **FLORIDA – Medicaid** |
| Health First Colorado Website:<br>https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center:<br>1-800-221-3943/State Relay 711<br>CHP+: https://hcpf.colorado.gov/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/State Relay 711<br>Health Insurance Buy-In Program (HIBI):<br>https://www.mycohibi.com/<br>HIBI Customer Service: 1-855-692-6442 | Website:<br>https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>Phone: 1-877-357-3268 |
| **GEORGIA – Medicaid** | **INDIANA – Medicaid** |
| GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website:<br>https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: 678-564-1162, Press 2 | Health Insurance Premium Payment Program<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>http://www.in.gov/fssa/dfr/<br>Family and Social Services Administration<br>Phone: 1-800-403-0864<br>Member Services Phone: 1-800-457-4584 |
| **IOWA – Medicaid and CHIP (Hawki)** | **KANSAS – Medicaid** |
| Medicaid Website:<br>Iowa Medicaid \| Health & Human Services<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website:<br>Hawki - Healthy and Well Kids in Iowa \| Health & Human Services<br>Hawki Phone: 1-800-257-8563<br>HIPP Website: Health Insurance Premium Payment (HIPP) \| Health & Human Services (iowa.gov)<br>HIPP Phone: 1-888-346-9562 | Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884<br>HIPP Phone: 1-800-967-4660 |

# Annual Notices

| KENTUCKY – Medicaid | LOUISIANA – Medicaid |
|---|---|
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br>https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br>KCHIP Website: https://kynect.ky.gov<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms | Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP) |
| **MAINE – Medicaid** | **MASSACHUSETTS – Medicaid and CHIP** |
| Enrollment Website:<br>https://www.mymaineconnection.gov/benefits/s/?language=en_US<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-977-6740<br>TTY: Maine relay 711 | Website: https://www.mass.gov/masshealth/pa<br>Phone: 1-800-862-4840<br>TTY: 711<br>Email: masspremassistance@accenture.com |
| **MINNESOTA – Medicaid** | **MISSOURI – Medicaid** |
| Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672 | Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 |
| **MONTANA – Medicaid** | **NEBRASKA – Medicaid** |
| Website:<br>http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084 | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **NEVADA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 | Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 15218<br>Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov |
| **NEW JERSEY – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Phone: 1-800-356-1561<br>CHIP Premium Assistance Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 (TTY: 711) | Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |

# Annual Notices

| NORTH CAROLINA – Medicaid | NORTH DAKOTA – Medicaid |
|---|---|
| Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 | Website: https://www.hhs.nd.gov/healthcare<br>Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **OREGON – Medicaid and CHIP** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website: http://healthcare.oregon.gov/Pages/index.aspx<br>Phone: 1-800-699-9075 |
| **PENNSYLVANIA – Medicaid and CHIP** | **RHODE ISLAND – Medicaid and CHIP** |
| Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **SOUTH DAKOTA - Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |
| **TEXAS – Medicaid** | **UTAH – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Texas Health and Human Services<br>Phone: 1-800-440-0493 | Utah's Premium Partnership for Health Insurance (UPP)<br>Website: https://medicaid.utah.gov/upp/<br>Email: upp@utah.gov<br>Phone: 1-888-222-2542<br>Adult Expansion Website: https://medicaid.utah.gov/expansion/<br>Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/<br>CHIP Website: https://chip.utah.gov/ |
| **VERMONT– Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 | Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid/CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/<br>http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700<br>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/<br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2024, 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)

## Model 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
- The child stops being eligible for coverage under the Plan as a "dependent child."

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- 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 longer period permitted under the terms of the Plan, after the qualifying event occurs. You must provide this notice to the Plan Administrator.***

***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 period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease (ESRD).

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***

| | |
|---|---|
| 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 |

## EEOC Wellness Program Notice

**Notice Regarding Wellness Program**

TAMPA BAY TREATMENT ASSOCIATES's 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. 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. 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 the Plan Administrator.

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 TAMPA BAY TREATMENT ASSOCIATES may use aggregate information it collects to design a program based on identified health risks in the workplace, TAMPA BAY TREATMENT ASSOCIATES 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 the Plan Administrator.