

EMPLOYEE BENEFITS GUIDE

Fulltime Employees

2021



Family
HOME HEALTH SERVICES

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This booklet serves as a summary of the benefits available to you. It is not a detailed description, nor is it a guarantee of benefits. If there is a difference between this overview and the SPD or official plan documents governing the plan, the plan documents will govern. Family Home Health Services reserves the right to amend or terminate the programs in whole or in part at any time.

Your Benefits Package

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Family Home Health Services takes pride in providing our employees with one of the most competitive, affordable benefit packages in the industry. Employees enjoy favorable purchasing power due to negotiated discounts as well as a company contribution towards healthcare coverage. In addition, our Cafeteria Plan allows our employees to pay for certain benefit plans with pre-tax dollars.

All of our benefit programs are designed to work cohesively to protect you and your family from catastrophic losses. Keeping our annual healthcare increases year-over-year to a minimum takes a joint effort. We depend on our employees to become educated healthcare consumers and to spend healthcare dollars wisely. Visit your primary care physician annually and take advantage of the “no cost to you” preventive screenings included in all of our medical plan options. When medical tests or surgical procedures are recommended, use the on-line quality and cost comparison tools. This will reduce your out-of-pocket expenses and help manage the cost to the plan.

Full-time benefit eligible employees have an annual opportunity to review your benefit option selections and make any changes in your plan selections. During this annual open enrollment period you can **contact an Enrollment Counselor by calling BenefitHelp at 888-663-1285** to discuss your personal benefit needs for the upcoming new plan year (6/1/2021—5/31/2022). If you are confused about putting together a benefit package, this discussion can be a valuable resource for you.

Your Benefit Options:

- ◆ **Medical Plan**—choose from three different plans
- ◆ **Critical Illness Plan**—what living with a critical illness can mean to you
- ◆ **Accident Plan**—protect you and family members from life accidents
- ◆ **Dental Plan**—covers routine annual cleanings and x-rays at no cost to you; additional benefits
- ◆ **Vision Plan**—save money on eye glasses and contact lenses
- ◆ **Flexible Spending Accounts**—both Healthcare and Dependent Care
- ◆ **Health Savings Account**—use with the High Deductible Health Plan; company contribution
- ◆ **Term Life Insurance**—for you and your dependents. Take care of those you love.
- ◆ **Short Term Disability Coverage**—protect your paycheck
- ◆ **Long Term Disability Coverage**—when savings aren’t always enough
- ◆ **Legal Plan**—access to attorneys at a price that won’t break your budget
- ◆ **Identify Theft Protection Plan**—ID Monitoring and Restoration

To Learn More, visit MyFHHSBenefits.com

2021 Benefits



Changes Effective 6/1/2021

Florida Blue Medical —choose from three different plans:

- Plan design changes to HDHP, PPO, and HMO plan offerings
- No change to Employee Only HDHP and PPO plan premiums!
- Increase to all other medical premiums

When am I eligible for benefits?

Full-Time Employees For medical benefits purposes, a full-time employee is defined as an employee who is regularly scheduled to work at least 30 hours per week. Upon completion of required enrollment, benefits will be effective the first of the month following 30 days of employment.

Example: An employee is hired on 6/23/2021, he/she has 30 days to elect benefits. Benefits would then be effective on 8/1/2021.

Affordable Care Act

As a result of some key parts of the healthcare law that took effect in 2014, there are now other ways to buy health insurance: the Health Insurance Marketplace.

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 at www.healthcare.gov offers “one-stop-shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I save money on my health insurance premiums in the Marketplace?

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

Does employer health coverage affect eligibility for premium savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.83 percent of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State Income Tax Purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. ¹<https://www.healthcare.gov/fees-exemptions/fee-for-not-being-covered/>

FHHS’s responsibility under healthcare reform

Under the Employer Shared Responsibility provisions of Healthcare Reform, employers with 50 or more full-time employees must offer affordable health coverage that provides a minimum level of coverage to their full-time employees² (and their dependents), or pay a penalty. All of the Family Home Health Service’s medical plans do provided minimum essential coverage and are deemed to be affordable using the IRS federal poverty line safe harbor definition.

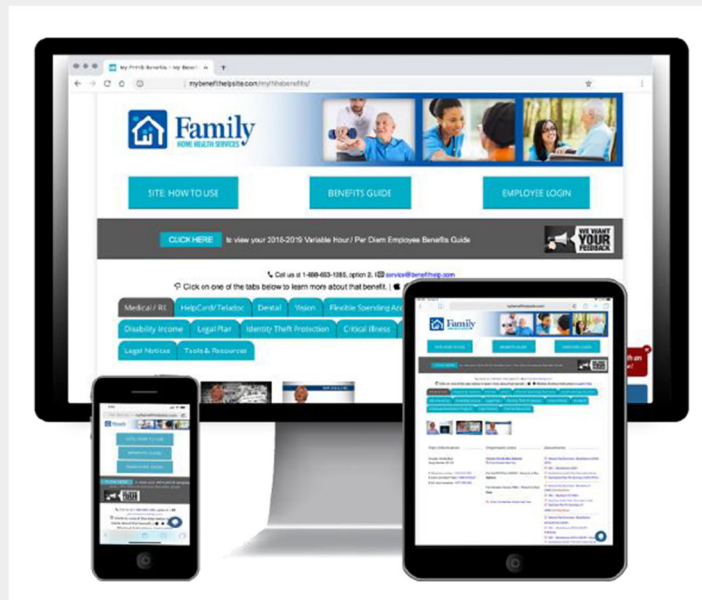
²For purposes of the Employer Shared Responsibility provisions, an employee is a full-time employee for a calendar month if he or she averages at least 30 hours of service per week.

<http://www.irs.gov/Affordable-Care-Act/Employers?Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act>

To Learn More, visit MyFHHSBenefits.com

WWW.MYFHHSBENEFITS.COM

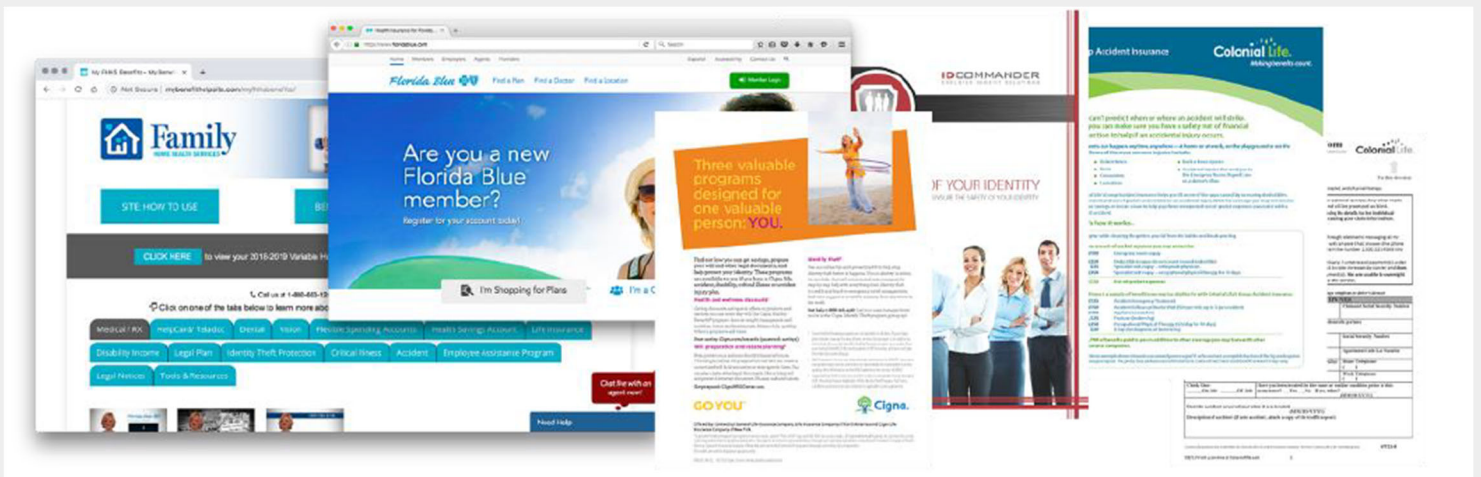
Where online can I get more information about my benefits?



Have you ever had trouble locating information about your benefits? What about trying to remember how to find a participating doctor or dentist?

Not to worry, with MyFHHSBenefits.com you are just an internet connection away from 24/7 access to:

- Important phone numbers
- Carrier information
- Provider and facility searches
- Employee benefit news
- Important documents
- Videos about specific benefits



Open Enrollment Instructions

What does Passive Enrollment mean?

If you do not make any changes to your current benefits, you are not required to do anything. Your benefits elections will automatically rollover and you will begin paying any new rates effective 6/1/2021. If you are considering a change during this open enrollment, please log into the enrollment system and review each option. You may want to review current dependent information to ensure that you are covering those you intend to cover and verify dates of birth and social security numbers.

System Login Reminders

- Go to your HelpSITE - www.MyFHHSBenefits.com and click on the "Employee Login" button
- Your username has not changed from previous years. Your username remains the first six letters of your last name, your first initial, and the last four digits of your social security number.
- Passwords have all been reset to your social security number. You will be prompted to setup security questions and change your password once you log on.
- Dates of birth and social security numbers are required for each family member that you intend to enroll in coverage. You will not be able to proceed with enrollment if this information is not entered into the enrollment system.
- Once you have reviewed your current elections and selected coverage for the plan year beginning 6/1/2021 be sure to click on the "FINISHED" button near the top of the confirmation page.
- The benefit plans and benefit selections go into effect on 6/1/2021

Please make your selections carefully as you are not able to make changes during the year unless you experience a qualifying life event. Examples of a qualifying event include, but are not limited to: marriage, divorce, birth, adoption, death, loss of coverage.

Adding Dependents

If you are adding dependents to the medical, dental or vision plans for the first time during this open enrollment, you must present the following verification documentation to your Human Resources Department immediately following your enrollment. If proper documentation is not provided, these newly added dependents will not be enrolled for coverage.

Dependent	Required Documentation
Spouse	Marriage License and first page of your most recent joint tax return (financials should be blackened out)
Natural Children	Birth Certificate
Step-Children	Birth Certificate and Marriage License showing both parent's names
Dependent Child(ren); Legal guardian, adoption or foster	Birth Certificate, Final court order of legal guardianship with judge's signature and/or final adoption decree with judge's signature

If you have any questions regarding the benefits program and coverages, please email LCPbenefithelp@rcpholdings.com. If you experience technical difficulties on the HelpSITE, please contact BenefitHelp at 1-888-663-1285 (Option 2).

To Learn More, visit MyFHHSBenefits.com

Reminders

How can you get the most out of your health coverage?

It is all about educating yourself on the options available. Balancing cost and coverage is the key. Find out the plan coverage levels, applicable deductibles, and copays. Know what your money is buying.

Every year the cost of healthcare increases faster than just about every other product or service you buy. For most of us, the ways to go about saving money on healthcare expenses aren't always obvious. It actually is a lot like the ways you save money on other things—by learning everything you can about the product and taking advantage of discounts wherever you can find them.

Do you check to see if your doctor is part of the network?

To get the highest level of benefits, you need to use doctors and facilities that are participating in the Florida Blue network. If enrolled in the HMO plan, your doctor must be part of the network. On the PPO or High Deductible Health Plan, just because a doctor is out of network does not mean you cannot use him or her, it just means you pay more. Check the provider directory online at www.MyFHHSBenefits.com www.bcbsfl.com to see if your physician is in the network in order to receive the highest level of benefits.

Personal Health and Wellness

This should be a high priority for all of us. We all know that making smarter, healthier decisions will have a direct impact on the quality of our lives. As a Florida Blue member you have access to the Florida Blue Stores. You may stop into one of their locations for a free health screening. To locate a Florida Blue Store near you, check on the medical tab on www.MyFHHSBenefits.com. Once complete, the health coach will provide you with tools and resources to help improve your overall health. Online resources are also available that offer members support to maintain or improve their overall health. Through the program, members can access information related to:

- Weight management
- Stress management
- Nutrition
- Smoking Cessation
- Exercise



Health Coverage

To fit your specific needs, your benefits package provides you with three options in medical plans.

HDHP Plan—has the lowest payroll deduction

PPO Plan—has the highest payroll deduction

HMO Plan—the cost is between the PPO and HDHP

All plans cover the same services, just with different copayments and deductibles. It is up to you to take advantage of everything your health plan offers. To choose the plan that is right for you, ask yourself the questions that will help you assess your needs. Think about the ways you use healthcare, the medical needs you can foresee, and how you can balance cost and coverage.

To locate a provider or to
review the plan
details, please visit:
www.MYFHHSBenefits.com

Terms and Definitions

Deductible

This is the amount of money you pay for health services before your medical insurance begins paying. For some services you have to pay the deductible before the plan pays. Your deductible starts over each January 1.

Copay

This is the amount of money that you pay each time a particular service is utilized.

Coinsurance

This is the rate you will essentially be splitting the cost of your healthcare with your insurance provider. For instance, if your health plan has an 80/20 coinsurance rate, your insurance plan pays for 80 percent of your eligible medical expenses and you are responsible for the remaining 20 percent.

Out-of-Pocket Coinsurance Maximum

This is the most you will have to pay under your medical plan each year. This includes copays and deductible and coinsurance. This protects you from the financial drain of high medical expenses. Copays do count towards your out-of-pocket maximum and still apply after you meet your maximum.

In-Network / Out-of-Network

If your medical plan has "in and out" coverage, this means you can see any provider you wish. However, if you choose to see a provider that is not on the approved in-network list, you will pay a greater share of the cost. Determining whether or not a provider is in-network is your responsibility. Please check with the provider to see if he or she is in the network, before services are rendered, preferably when making the appointment.

To Learn More, visit MyFHHSBenefits.com

Florida Blue Medical Plans

Pick the medical plan that best fits your needs...

FHHS Medical Plans	Option 1		Option 2	Option 3
In Network Benefits	BlueOptions HDHP (Single Coverage)	BlueOptions HDHP (Family Coverage)	BlueOptions PPO	BlueCare HMO
Calendar Year Deductible				
Individual	\$3,000	\$6,000	\$3,000	\$2,500
Family		<i>Deductible is shared for all individuals on the family plan</i>	\$9,000	\$6,500
Coinsurance	You pay 30% after deductible	You pay 30% after deductible	You pay 20% after deductible	N/A
Out-of-Pocket Maximum				
Individual	\$6,550	\$6,850 embedded	\$6,350	\$5,500
Family		\$13,100 family <i>Out of pocket maximum is embedded. A covered family member's out of pocket costs are capped at the individual out of pocket maximum on the family plan.</i>	\$12,700	\$11,000
Preventive Care*	You pay 0%	You pay 0%	You pay 0%	You pay 0%
Office Visits				
Primary Care Physician	You pay 30% after deductible	You pay 30% after deductible	\$40 Copay	\$35 Copay
Specialist	You pay 30% after deductible	You pay 30% after deductible	\$100 Copay	\$65 Copay
Virtual Visit	You pay 30% after deductible	You pay 30% after deductible	\$0 Copay for PCP and \$100 Copay for Specialist	\$0 Copay for PCP and \$65 Copay for Specialist
Emergency Care				
Urgent Care	You pay 30% after deductible	You pay 30% after deductible	\$100 Copay	\$70 Copay
Emergency Room			\$400 Copay	\$300 Copay

Prescription Drug Coverage

Drugs on the Drug List/Formulary are grouped by "tiers." A number of factors are considered when classifying drugs into tiers, including, but not limited to: the absolute cost of the drug; the cost of the drug relative to other drugs in the same therapeutic class; the availability of over-the-counter alternatives; and other clinical and cost-effective factors.

Retail Pharmacy	Option 1		Option 2	Option 3
31 Day Supply	BlueOptions HDHP (Single Coverage)	BlueOptions HDHP (Family Coverage)	BlueOptions PPO	BlueCare HMO
Tier 1	Deductible, then \$10 Copay	Deductible, then \$10 Copay	\$10 Copay	\$10 Copay
Tier 2	Deductible, then \$50 Copay	Deductible, then \$50 Copay	\$60 Copay	\$60 Copay
Tier 3	Deductible, then \$80 Copay	Deductible, then \$80 Copay	\$100 Copay	\$100 Copay

Mail Order Pharmacy	Option 1		Option 2	Option 3
90 Day Supply	BlueOptions HDHP (Single Coverage)	BlueOptions HDHP (Family Coverage)	BlueOptions PPO	BlueCare HMO
Tier 1	Deductible, then \$25 Copay	Deductible, then \$25 Copay	\$25 Copay	\$25 Copay
Tier 2	Deductible, then \$125 Copay	Deductible, then \$125 Copay	\$150 Copay	\$150 Copay
Tier 3	Deductible, then \$200 Copay	Deductible, then \$200 Copay	\$250 Copay	\$250 Copay



To Learn More, visit MyFHHSBenefits.com

Teladoc

When you don't have time to wait, you've got Teladoc!

Provides 24/7 Access to Care

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

For a cost that's less than an urgent care or ER visit, Teladoc gives you 24/7/365 access to U.S. board-certified doctors by web, phone, or mobile app. It's a more convenient and affordable option for quality medical care.

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

- Sinus infection
- Flu
- Cough
- Sore Throat
- Rash
- Allergies
- Upset Stomach
- Nausea
- Other minor health issues

How does Teladoc work?



Register

Three easy ways: download the mobile app, visit the Teladoc website or call



Provide Medical History

Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.



Request a Visit

That's it! The next time you need immediate care for a non-emergency illness, you have another option.



Talk to a doctor anytime.

Call today 1-800-Teladoc (835-2362) or visit [Teladoc.com](https://www.teladoc.com)

Get started with Teladoc

It's quick and easy to set up your account online. Simply visit the Teladoc® website, click "Set up account" and then follow the instructions below.

The screenshot shows the Teladoc registration process. At the top, there's a 'CANCEL REGISTRATION X' button and a progress bar with three steps: '1. Check Eligibility', '2. Enter Account Information', and '3. Next Steps'. The main heading is 'Let's begin with a few basics'. The form includes input fields for 'FIRST NAME', 'LAST NAME', 'EMAIL ADDRESS', 'DATE OF BIRTH', 'PHONE NUMBER', 'GENDER', and 'PREFERRED LANGUAGE'. There are three callout boxes: 1. 'Where can I find my username?' with instructions to check health care benefits cards or Teladoc ID cards. 2. 'I cannot find my employer or insurance provider.' with instructions to call 1-800-Teladoc. 3. 'Do you have a username?' with radio button options for 'Yes, I know my username' and 'No, I don't know my username'. At the bottom, there are 'CANCEL' and 'CONTINUE >' buttons.

STEP 1:

The basics

Provide a little information about yourself to confirm your eligibility.

STEP 2:

Do you have a username?

Select "yes" or "no". Not everyone has a username to activate their Teladoc account, so don't worry about selecting "No."

STEP 3:

How do you have Teladoc?

Teladoc is an exclusive service that is not available to everyone. Teladoc is offered by your employer. Enter your employer name or health plan name and the number on your health plan ID card. If you're not sure you have Teladoc, call the number below for assistance over the phone.

Talk to a doctor anytime!

 [Teladoc.com](https://www.teladoc.com)

 [Facebook.com/Teladoc](https://www.facebook.com/Teladoc)

 1-800-TELADOC (835-2362)

 [Teladoc.com/mobile](https://www.teladoc.com/mobile)

To Learn More, visit [MyFHHSBenefits.com](https://www.MyFHHSBenefits.com)

Critical Illness

What can living with a critical illness mean to you?

Critical Illness Insurance helps fill the gaps in your health insurance.

With Critical Illness Insurance, you are paid a benefit directly to you that can help cover:

- Deductibles, copays, and coinsurance of your health insurance
- Home healthcare needs and household modifications
- Travel expenses to and from treatment centers
- Lost income
- Rehabilitation
- Child care expenses
- Everyday living expenses

Meeting Your Needs

Our critical illness coverage helps offer financial peace of mind should a covered cancer or critical illness be diagnosed.

- Choose benefit amounts of \$5,000, \$10,000, \$15,000 or \$20,000
- You are able to purchase up to \$20,000 in coverage during your new hire enrollment without medical questions
- Coverage is portable, which means you can take it with you if you change jobs or retire
- Includes Subsequent Diagnosis Benefit and \$50 Wellness Screening
- Coverage is available for you and your spouse

Benefits—Critical Illness with Subsequent Diagnosis

100 percent of face amount per covered person

- Heart attack
- Stroke
- Major organ failure
- End Stage Renal (Kidney) Failure
- Cancer (if selected)
- Permanent paralysis due to a covered accident
- Coma
- Blindness
- Coronary artery bypass graft surgery
- Carcinoma in situ (if selected)

Every 40 seconds, on average, someone in the United States has a stroke.

-American Heart Association

47 percent¹

Of Americans have at least one of the three risk factors for heart disease: high blood pressure, high cholesterol and/or smoking.

108.9² billion

The cost of heart disease in the United States.

83.6³ million

The number of Americans with cardiovascular disease.

**Rates
Page 26**

Colonial Life

Accident Coverage

Accidents can happen anytime, anywhere.

If you're like most people, you don't budget for life's unexpected moments.

But at some point, you may make an unexpected trip to your local emergency room and that could add a set of unexpected bills to the mix. According to the National Safety Council, one in every 14 people in the United States experience an unintentional injury at home serious enough to consult with a medical professional.

That's the benefit of Accident Coverage.

In the event of a covered accident, the plan pays cash benefits directly to you fast to help with the costs associated with out-of-pocket expenses and bills—expenses major medical may not take care of, including but not limited to:

- Accident and Treatment: up to \$125
- Fractures: up to \$5,500
- Burns: up to \$12,000
- Accidental Dismemberment: up to \$15,000
- Air Ambulance: up to \$2,000
- Hospital Admission: up to \$1,000 per accident
- AD&D Life Insurance: up to \$25,000

Features

- Coverage is guaranteed issue (which means you may qualify for coverage without having to answer health questions)
- Benefits are paid directly to you unless you choose otherwise
- Coverage is available for you, your spouse, and dependent children
- Coverage is portable. That means you can take it with you if you change jobs or retire.

*Colonial Life products are underwritten by Colonial Life & Accident Insurance Company, for which Colonial Life is the marketing brand. This information is only intended for informational purposes only. Refer to your policy for more detailed information and benefits.

Every eight seconds someone is injured as a result of a slip or fall; more than 21,000 people die each year.

-Injury Facts, National Survey

300,000¹

The number of disabling injuries from a slip or fall.

40.1² million

The number of ER visits due to injuries.

38³ million

The number of people who sought medical attention for an injury.

1. Summary Health Statistics for the U.S. population, National Health Institute, 2013

2. Injury Facts, 014 Edition, National Safety Council



To Learn More, visit MyFHHSBenefits.com

Dental Plan

Family Home Health Services offers dental protection through Humana Dental.

With Humana, you can receive care from any dentist, however, Humana has contracts with a large network of dentists who have agreed not to charge more than a specified amount for particular services. If you use one of these network dentists, you won't have to worry about being charged for additional amounts above the allowable amount covered by the plan.

Plan Deductible and Maximums	
Deductible	\$50 Individual \$150 Family
Benefit Maximum	\$1,000
Preventive Services	
<i>Oral exams, X-Ray, Cleanings, Brush Biopsy, Topical Fluoride, Space Maintainers, Sealants</i>	100% Coverage
Basic Services	
<i>Restorative services using amalgam, Synthetic porcelain and plastic filling material, Periodontics, Endodontics, Oral Surgery</i>	80% Coverage
Major Services	
<i>Prosthetics: Bridges and Dentures, Crowns, Inlays and Onlays, Implants</i>	50% Coverage



Vision Plan

Under the Humana Vision Plan you may receive care from the vision care provider of your choice. Humana Vision has an extensive nationwide network of doctors who provide eye care and eye wear. When you receive care through these vision care providers, you simply pay the appropriate copayment. If you visit an out-of-network provider, be aware that your out-of-network benefits do not guarantee full payment.

Covered Benefits	In-Network	Out-of-Network
Routine Eye Exam Once every 12 months	\$10 Copay	\$30 Allowance
Eyeglass Frame One pair every 24 months	\$160 Allowance plus 20% off balance	\$80 Allowance
Eyeglass Lenses One pair Every 12 months in a standard plastic with choice of the following options -Single Lenses -Bifocal Lenses -Trifocal Lenses	\$10 Copay \$10 Copay \$10 Copay	\$25 Allowance \$40 Allowance \$60 Allowance
Contact Lenses Once every 12 months instead of eyeglass lenses -Elective Conventional Lenses -Non-Elective Contact Lenses	\$160 Allowance Covered in Full	\$128 Allowance \$210 Allowance



To Learn More, visit [MyFHHSBenefits.com](https://www.MyFHHSBenefits.com)

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) enable you to put aside money for important expenses and help you reduce your income taxes at the same time. Family Home Health Services offers two types of Flexible Spending Accounts: a Healthcare FSA and a Dependent Care FSA. These accounts allow you to set aside pre-tax dollars to pay for certain out-of-pocket healthcare or dependent care expenses.

The plan year for the Flexible Spending Account runs from 1/1/2021 through 12/31/2021. Open enrollment for the Flexible Spending Accounts is offered during the months of November and December. Remember to calculate your expenses conservatively when making your FSA elections. IRS regulations require that you forfeit any money left in your account at the end of the plan year.

How Flexible Spending Accounts Work

1. Each year during the Flexible Spending Open Enrollment, you decide on how much to set aside for healthcare and/or dependent care expenses.
2. Your contributions are deducted from your paycheck on a pre-tax basis in equal installments throughout the calendar year.
3. When you incur eligible healthcare or dependent care expenses, funds may be deducted from your account through a debit card or you may submit a claim form for reimbursement. Amounts paid using your debit card may require verification, so you may be asked to provide a receipt to substantiate the charge.

Please note that these accounts are separate and you may choose to participate in one, both or neither. You cannot use money from the Healthcare FSA to cover expenses eligible under the Dependent Care FSA or vice versa.

Plan	Annual Maximum Contribution	Examples of Covered Expenses
Healthcare Flexible Spending Account	\$2,750	Copays, deductibles, prescriptions, orthodontia, eye-glasses, etc.
Dependent Care Flexible Spending Account	\$5,000 (\$2,500 if married and filing separate tax returns)	Day care, nursery school, elder care expenses, etc.

FSA Example			
WITHOUT a Flexible Spending Account		WITH a Flexible Spending Account	
Gross Annual Pay	\$30,000	Gross Annual Pay	\$30,000
Estimated Tax	\$7,500	FSA Pretax Contribution for Unreimbursed Expenses	\$1,000
Take Home Pay	\$22,500	Lower Taxable Income	\$29,000
Unreimbursed Expenses	\$1,000	Estimated Tax	\$7,250
Total Take Home Pay	\$21,500	Greater Total of Take Home Pay	\$21,750

Health Savings Accounts

A Health Savings Account or HSA is designed to help you pay your out-of-pocket medical expenses using pre-tax dollars.

An HSA is a personal savings account that can help you build a nest egg for future healthcare expenses. When you need healthcare in the future you can use the account to pay for qualified healthcare expenses, even once you have retired. You do not pay taxes on your contributions, earnings or withdrawals, as long as you use the account for qualified medical expenses. Any unused money in your account at the end of the year remains yours to use on eligible medical expenses in the future.

Family Home Health contributions to HSA are made in four installments, 25 percent after three months, 25 percent after six months, 25 percent after nine months, and 25 percent after 12 months.

Who is eligible to participate?

Employees who enroll in the High Deductible Health Plan (HDHP) are eligible to participate in the Health Savings Account. However, if you have coverage through Medicare, Medicaid, TriCare or any other insurance plan that is not considered a High Deductible Health Plan, you are not eligible for participation in the HSA.

How much can I contribute?

IRS rules define how much you can contribute to a Health Savings Account (HSA). For 2021, you may contribute the following amounts:

Individuals — \$3,600

Families — \$7,200

If you are over the age of 55, the IRS allows for a “catch-up” contribution amount of an additional \$1,000 per year to your Health Savings Account.

Family Home Health Services will contribute \$500 to a Health Savings Account on your behalf.

Anyone hired after 1/1/2021 will receive a prorated contribution.

Examples of Eligible Medical Expenses may include:

Deductibles	Acupuncture	Chiropractor
Contact Lenses	Prescription Drugs	Eye Examinations
Eyeglasses	Hearing Aids	Smoking Cessation Programs
Dental Treatment	Orthodontics	Homecare Services
Hospital Services	Therapy	



A full list of eligible expenses can be found on the IRS Web site, www.IRS.gov in IRS Publication 502.

To Learn More, visit MyFHHSBenefits.com

Term Life and AD&D

Family Home Health Services provides an employee benefits program that is intended to protect you and your family from catastrophic financial loss.

As an employee, you and your dependents will receive company paid life insurance and AD&D as noted:

Class	Covered Person	Amount
Non-Management	Employee	\$25,000
	Spouse / Child(ren)	\$10,000 / \$5,000
Designated Management	Employee	\$50,000
	Spouse / Child(ren)	\$25,000 / \$10,000

Who depends on you? Term life insurance can help you take care of those you love. How much life insurance do you need?

1. If you or your spouse die, how much money will your family need to:

- Live on each year (75 percent of current net income) \$_____ annually x ___ years = \$_____
- Pay for child care \$_____ annually x ___ years = \$_____
- Provide for your children's education \$_____ annually x ___ years = \$_____
- Pay for major purchases (cars, home repair, etc.) \$_____ annually x ___ years = \$_____
- Pay off estate and funeral expenses \$_____
- Pay off your mortgage loan or pay your rent \$_____
- Pay off debts, such as credit cards, auto loans, student loans, etc. \$_____
- Have funds available for an emergency or provide for a family member with special needs \$_____

Add up the above to estimate the total amount your family will need: \$_____

2. Consider how much money would be available in the event of your or your spouse's death:

- Life insurance you now have (including employer paid) \$_____
- Cash and savings \$_____
- Retirement Savings (IRA, 401(k), etc.) \$_____
- Stocks and bonds (at current market value) \$_____
- Income from your spouse (multiply by 60 percent) \$_____ annually x ___ years = \$_____
- Other assets (e.g. pension plans) = +\$_____

Add up this total = +\$_____

Then, from the total in question 1, subtract the total in question 2. = \$_____

Optional Term Life and AD&D

You have the opportunity to purchase additional life coverage for yourself and your dependents at your expense.

How much coverage can you buy?

All Employees: You may purchase additional term life insurance in \$10,000 increments not to exceed 5x your salary or \$100,000.

Spouse: You may purchase term life insurance for your spouse in \$5,000 increments not to exceed 50 percent of employee coverage or \$50,000. You must have coverage for yourself under the optional term life plan to have coverage on your spouse.

Child/Children: Life insurance in the amount of \$10,000 is available for your children provided that you have optional life insurance for yourself.

Guaranteed Issue: means you are guaranteed coverage without having to answer any health questions or provide evidence of good health.

All NEWLY ELIGIBLE Employees:

Guaranteed issue up to \$100,000

Guaranteed issue for your spouse is \$25,000 and \$10,000 for your children.

Reductions in Insurance:

By the time you or your spouse reach age 65, changes are that your children will be grown and your mortgage paid.

At age 65, providing you are still employed, your coverage will decrease to 65 percent of the benefit amount. It will decrease to 50 percent at age 70.



Rates

Page 27

USAble Life™

To Learn More, visit MyFHHSBenefits.com

Short and Long Term Disability

When savings aren't always enough.

You and your family rely on your income. But what would happen if you became ill or suffered a serious accident and were **unable to work**? Who would pay the bills? You may never even think that you could be laid up for an extended period of time. But what if you had a stroke or some other injury that kept you from working? How many months could you continue your standard of living from your savings? The changes of becoming disabled prior to age 65 are one in three, yet the changes of your house burning down are one in 1,000.

In helping you prepare to meet financial obligations should you face a period of disability, Family Home Health Services offers both Short Term Disability (STD) insurance and Long Term Disability (LTD) insurance at competitive rates.

Who is at risk?

- More than 26 million Americans suffer disabling injuries each year
- More than two-thirds of disabling injuries suffered by American workers occur off the job and are not covered by workers' compensation.

Short Term Disability Insurance (STD) - USABLE Life

Your Short Term Disability plan is administered through USABLE Life. The plan requires that you be out of work, and certified disabled by your doctor, due to illness or injury for a minimum of 14 days before your weekly benefit is paid. Your weekly benefit will continue for 24 weeks provided you remain disabled.

You may purchase Short Term Disability coverage in \$50 increments, not to exceed 60 percent of your weekly earnings or \$1,000.

Long Term Disability Insurance (LTD) - USABLE Life

Your Long Term Disability plan is provided at no cost to you and is administered through USABLE Life. The plan includes a 180-day elimination period, that is the amount of time you are deemed disabled by your doctor and unable to work. Once you complete your elimination period, the plan will begin paying a monthly benefit until you are able to return to work or you reach the age of 65, whichever occurs first.

The Long Term Disability benefit is equal to 60 percent of your monthly income to a maximum monthly benefit of \$5,000.

Rates
Page 28

2021 Open Enrollment Note:

If you are an existing employee applying for Short Term Disability coverage for the first time during this open enrollment or you are increasing coverage, you are required to complete Evidence of Insurability.

401(k)

401(k) plan administered through The Standard

Who is eligible to participate?

You are eligible to participate in the 401(k) on the first day of the month once you have completed 90 days of employment.



Why should you participate in a 401(k) plan?

Here are some of the top reasons:

- It's painless. You are auto-enrolled at 4 percent of your salary. You may opt-out or choose to elect a different deferral amount.
- Your money grows and compounds tax-deferred. This simply means your contributions are deducted before federal income taxes are withheld and you do not pay any taxes on the gains until you take the money out at retirement.
- You can take your account with you if you change jobs.

Additional information is available from your Human Resources Department.

Remember...it's never too late to save for retirement!



To Learn More, visit MyFHHSBenefits.com

Legal Plan

Smart. Simple. Affordable.



Legal Plan from \$0.62 a day.

Finding an affordably priced lawyer to represent you when you have trouble with creditors, buy or sell your home, or even prepare your will can be a challenge. Now there is a smart, simple, affordable solution—U.S. Legal Services. U.S. Legal is a legal services plan that provides legal representation for you, your spouse, and dependents at a price that won't break your budget. With U.S. Legal you have access to over 10,000 participating attorneys, as well as coverage for non-participating attorneys. Representation is provided for these services:

- **Estate Planning Document**—simple and complex wills; trusts; power of attorneys; living wills; codicils
- **Document Review and Preparation**—any personal legal document; affidavits; deeds; demand letter; mortgages; promissory notes
- **Family Law**—prenuptial agreement; protection from domestic violence; adoption; guardianship; name change
- **Immigration Assistance**—advice and consultation; review of immigration documents; preparation of affidavits and powers of attorney
- **Real Estate Matters**—sale, purchase, or refinancing of your primary, secondary or vacation home; eviction and tenant problems (primary residence); home equity loans; boundary or title disputes; property tax assessment; security deposit assistance (for tenant); zoning applications
- **Traffic Offenses**—defense of traffic tickets (excludes DUI); driving privileges restoration (includes license suspension due to DUI)
- **Financial Matters**—negotiations with creditors; debt collection defense; personal bankruptcy; tax audit representation; foreclosure defense; tax collection defense
- **Defense of Civil Lawsuits**—administrative hearings; civil litigation defense; incompetency defense; school hearings; pet liabilities
- **And much more...**

When you use a Plan Attorney for covered services, there are no deductibles, no copayments and no claim forms.

Identify Theft Protection

We think your identify is worth protecting.

Information is moving faster than ever, and life has never flowed more quickly or been shared so broadly. We all conduct more and more of our personal business, like banking and shopping, on our computers and mobile devices. While the convenience is great, it also creates a greater risk for our personal information to be compromised.

We have partnered with LifeLock so you can start safeguarding your finances, credit and good name, LifeLock Identify Theft Protection helps safeguard against identify fraud by monitoring millions of transactions a second, and providing services that remediation-only or free credit monitoring services don't offer.

Identify theft can impact:

- Your finances
- Your employment records
- An unwarranted criminal history
- Homeowners and auto insurance rates
- Your ability to qualify for a loan



LifeLock Membership Includes:

Identity Alert System†- notifying you of potential threats to your personal identity, including suspicious uses of name, address, phone number, birth date, and Social Security Number to obtain loans, credit and services, or to commit crimes.

Financial Activity Alerts† - helping protect your finances with alerts that notify you of withdrawals, balance transfers and large purchases on 401(k), investments, checking, savings, and credit card accounts.

Stolen Funds Reimbursement‡ - protecting your hard earned money with dollar for dollar reimbursement for stolen funds up to \$1 Million.

\$1 Million Service Guarantee‡ & Identify Restoration—helping restore your identify if you should become a victim of identify theft. If you become a victim of identify theft while a LifeLock member, LifeLock will spend up to \$1 million to hire the necessary lawyers, accountants, and investigators to help your recovery.

Black Market Website Surveillance & LifeLock Privacy Monitor—patrolling over 10,000 criminal websites and notifying you when your data is found. LifeLock also scans common public people search websites to find your personal information and helps you opt-out.

No one can prevent all identify theft.

†LifeLock does not monitor all transactions at all businesses.

††Fastest alerts require member's current email address.

††Phone alerts made during normal local business hours.

‡Stolen Funds Reimbursement and Service Guarantee benefits for State of New York members are provided under a Master Insurance Policy issued by State National Insurance Company. Benefits for all other members are provided under a Master Insurance Policy underwritten by United Speciality Insurance Company. Under the Service Guarantee LifeLock will spend up to \$1 Million to hire experts to help your recovery. Under the Stolen Funds Reimbursement, LifeLock will reimburse stolen funds up to \$1 million. Please see the policy for terms, conditions and exclusions at LifeLock.com/legal.

To Learn More, visit MyFHHSBenefits.com

Other Benefits

Employee Assistance Program

Just when you think you have it figured out, along comes a challenge. But whether those challenges are big or small, your Employee Assistance Program is available to help you and your family find a solution and restore your peace of mind.

Through USAble Life's Employee Assistance Program (EAP) you have unlimited access to consultants by telephone, resources and tools online, and up to three face-to-face visits with a counselor for help with a short-term problem.

Help for personal challenges, big and small

Personal problems can occur unexpectedly, and unnecessary worrying can affect your health and your professional life. Ease the stress of any uncomfortable situation by calling and speaking with an advocate who is ready to help assess your needs and develop a solution to help resolve your concerns. He or she can also direct you to an array of resources in your community and advice on topics such as:

- Improve your overall health
- Get help with legal needs
- Manage your money matters
- Be your best at work
- Care for your loved ones

You also have unlimited website access where you can find:

- Assessment and referral consultations
- Legal and financial services
- Relationship support
- Health Resource Library
- Weekly tips
- Access network of attorneys and financial counselors for legal expertise and advice

Whatever life throws at you, throw it our way.

Visit MyFHHSBenefits.com to locate phone numbers and online resources.



Other Benefits

Managed Behavior Health One-on-One Visits

The New Directions Employee Assistance program provides you and your family three free one-on-one visits in person/per topic for you and your dependents to assist you with your difficult challenges.

Managed Behavior Health Services:

- Mental illness
- Trauma
- Includes integrated care coordination to specialty clinical programs
- Substance abuse
- Autism resource program

Visit www.ndbh.com

- Click login
- Choose Employee Assistance Program from the drop down menu
- Enter your EAP company code **USAL903**



To Learn More, visit MyFHHSBenefits.com

Rate Worksheet

Review your worksheet prior to your enrollment session.

Medical Plan - Bi-Weekly Payroll Deduction			
Who to Cover	BlueOptions HDHP	BlueOptions PPO	BlueCare HMO
Employee Only	\$28.39	\$108.45	\$85.86
Employee + Spouse	\$397.47	\$575.34	\$519.34
Employee + Child(ren)	\$274.44	\$419.70	\$374.85
Family	\$616.78	\$852.75	\$776.91

Medical—p.10-11

Critical Illness Plan <i>SAMPLE</i> Rates - Bi-Weekly Payroll Deduction				
<i>Sample rates are based on a \$10,000 policy with Subsequent Diagnosis and Health Screening Benefit</i>				
Employee Age (Rate locks in at issue age)	Employee	Employee & Spouse	Employee & Children	Family
16-29	\$3.28	\$4.94	\$3.51	\$5.17
30-39	\$5.08	\$7.66	\$5.31	\$7.89
40-49	\$9.09	\$13.71	\$9.37	\$13.98
50-59	\$15.55	\$23.82	\$15.88	\$24.09
60-74	\$24.42	\$37.25	\$24.69	\$35.57

Critical Illness—p. 12

Accident Plan <i>SAMPLE</i> Rates - Bi-Weekly Payroll Deduction	
Who to Cover?	Accident Plan with Health Screening Benefit
Employee	\$7.38
Employee + Spouse	\$11.91
Employee + Child(ren)	\$12.95
Family	\$17.47

Accident - p.13

Dental Plan - Bi-Weekly Payroll Deduction	
Who to Cover?	
Employee	\$2.00
Employee + Spouse	\$19.71
Employee + Child(ren)	\$16.85
Family	\$34.56

Dental - p.14

Vision Plan - Bi-Weekly Payroll Deduction	
Who to Cover?	
Employee	\$0.68
Employee + Spouse	\$3.40
Employee + Child(ren)	\$3.13
Family	\$6.08

Vision - p.15

Rate Worksheet

Review your worksheet prior to your enrollment session.

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Optional Employee Life with AD&D Monthly Rates				
Employee Age (as of 6/1/2021)	Rate (per \$1,000)		Employee Age (as of 6/1/2021)	Rate (per \$1,000)
<20-29	\$0.070		50-54	\$0.430
30-34	\$0.110		55-59	\$0.690
35-39	\$0.140		60-64	\$1.05
40-44	\$0.170		65-69	\$1.46
45-49	\$0.240		70+	\$2.61

Optional Life Employee—p.19

Calculator for Bi-weekly Cost

$$\begin{array}{ccccccc}
 \boxed{\$ } & \times & \boxed{} & / \$1,000 = & \boxed{} & \times 12/26 = & \boxed{} \\
 \text{Coverage Amount} & & \text{Rate} & & \text{Monthly Cost} & & \text{Per Pay Cost}
 \end{array}$$

Optional Employee Life with AD&D Monthly Rates				
Employee Age (as of 6/1/2021)	Rate (per \$1,000)		Employee Age (as of 6/1/2021)	Rate (per \$1,000)
<20-29	\$0.070		50-54	\$0.430
30-34	\$0.110		55-59	\$0.690
35-39	\$0.140		60-64	\$1.05
40-44	\$0.170		65-69	\$1.46
45-49	\$0.240		70+	\$2.61

Optional Life Spouse—p.19

Calculator for Bi-weekly Cost

$$\begin{array}{ccccccc}
 \boxed{\$ } & \times & \boxed{} & / \$1,000 = & \boxed{} & \times 12/26 = & \boxed{} \\
 \text{Coverage Amount} & & \text{Rate} & & \text{Monthly Cost} & & \text{Per Pay Cost}
 \end{array}$$

Optional Dependent Life		
Child or Children	\$10,000 (Child Age Birth to 6 Months \$500; Child 6 Months to 25 Years \$10,000)	\$2.00 per month

Dependent Life

To Learn More, visit MyFHHSBenefits.com

Rate Worksheet

Review your worksheet prior to your enrollment session.

Optional Short Term Disability Monthly Rates				
Age (as of 6/1/2021)	Rate (per \$1,000)		Employee Age (as of 6/1/2021)	Rate (per \$1,000)
Through 29	\$0.593		50-54	\$0.612
30-34	\$0.593		55-59	\$0.702
35-39	\$0.593		60-64	\$0.772
40-44	\$0.593		65-69	\$0.772
45-49	\$0.593		70+	\$0.772

STD—p.20

Calculator for Bi-weekly Cost

$$\begin{array}{ccccccc}
 \boxed{\$ \quad \quad \quad} & \times & \boxed{\quad \quad \quad} & / \$10 = & \boxed{\quad \quad \quad} & \times 12/26 = & \boxed{\quad \quad \quad} \\
 \text{Coverage Amount} & & \text{Rate} & & \text{Monthly Cost} & & \text{Per Pay Cost}
 \end{array}$$

Legal	Bi-Weekly Payroll Deduction
Employee Plan	\$8.65
Family Plan	\$9.92

Legal -p.22

Identity Theft	Bi-Weekly Payroll Deduction	
	Benefit Elite	Ultimate Plus
Who to cover?		
Employee Only	\$3.91	\$11.76
Employee + Spouse	\$7.84	\$23.53
Employee + Child(ren)	\$6.86	\$16.67
Family	\$10.78	\$28.44

ID Theft -p.23

Tips to Maximize Your Benefits

Utilize IN-NETWORK

Providers to limit your out-of-pocket expenses

- ◆ Primary Care Physicians
- ◆ Specialist (i.e. Anesthesiologist)
- ◆ Independent Laboratories

Finding in-network providers is easy:

Employees can find a list of in-network doctors and hospitals:

- ◆ Download the Florida Blue app from iTunes or Google Play
- ◆ Click on "Find a Doctor" at floridablue.com
- ◆ Call the phone number on the back of their Florida Blue ID card

FREE Annual Preventative visits for early detection

Florida Blue's Online portal anytime to speak with a doctor for non-emergency medical conditions through your mobile device, tablet or computer (must have video capability). It's available 24/7 and you only pay \$25 per visit.

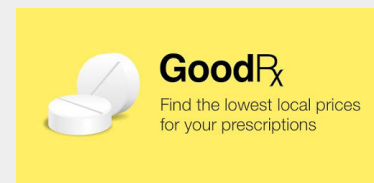
Mail Order Pharmacy utilization will allow for lower costs.

Trying a new maintenance drug for the first time? Request lower quantity at first to make sure you do not have an unwanted reaction and taking the risk of paying for a full prescription you will not use.

GoodRx

Website and free mobile app that tracks prescription drug prices and offers drug coupons.

- ◆ www.goodrx.com
- ◆ Mobile App: GoodRx



Emergency Room Visits

You may be responsible for ER costs when it's **not a true emergency!** Try:

1. Call your doctor
2. Visit a retail or convenience care clinic
3. Head to Urgent Care
4. Access Teladoc

We know there are situations when the ER is the only options, so exceptions are included:

- ◆ Members under the age of 14
- ◆ ER visits directed by your doctor
- ◆ ER visits between 8pm Saturday and 8am Monday
- ◆ When the closest Urgent Care is more than 15 miles from your home

Important Contact Information

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0
2
1

Plan Type and Carrier	Phone and Website	Group Number (if applicable)
Medical Florida Blue <i>Care Consultant Team</i> <i>24 Hour Nurse Line</i>	Provider Phone: 800-352-2583 Provider Web Address; www.floridablue.com 888-476-2227 877-789-2583 800-835-2362	B7116
FSA & HSA Health Equity	Provider Phone: 866-346-5800 Provider Web Address: www.my.healthequity.com/login	
Critical Illness & Accident Colonial Life	Provider Phone: 800-325-4368 Provider Web Address: www.coloniallife.com	E5011648
Dental Humana	Provider Phone: 800-448-6262 Provider Web Address: www.humana.com	784988
Vision Humana	Provider Phone: 800-448-6262 Provider Web Address: www.myhumanavcp.com	784988
Life & Disability USABLE Life	Provider Phone: 800-370-5856 Provider Web Address: www.usable.com	50040864
401K Retirement The Standard	Provider Web Address: www.thestandard.com	
Legal Plan U.S. Legal Services	Provider Phone: 800-356-LAWS Provider Web Address: www.uslegalservices.net	
Identity Theft LifeLock	Provider Contact: 866-917-2555 Provider Web Address: www.lifelock.com	
Employee Assistance Program USABLE Life	Provider Phone: 800-370-5856 Provider Web Address: www.bdbh.com	50040864
Enrollment on HelpSITE BenefitHelp	Provider Phone: 888-663-1285 Option 2 Provider Email: service@benefithelp.com	
Questions on Benefits Risk Consulting Partners	Provider Email: LCPbenefithelp@rcpholdings.com	

To Learn More, visit MyFHHSBenefits.com



2021 ANNUAL LEGAL NOTICES



IMPORTANT NOTICE: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.

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

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- ◆ All stages of reconstruction of the breast on which the mastectomy was performed;
- ◆ Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- ◆ Prostheses; and
- ◆ Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

- ◆ Deductible (In-Network/Out-of-Network): HDHP: \$3,000/\$5,000; PPO: \$3,000/\$6,000 HMO: \$2,500/n/a
- ◆ Coinsurance (Florida Blue pays In-Network/Out-of-Network): HDHP: 70%/60%; PPO: 80%/50%; HMO: /n/a

If you would like more information on WHCRA benefits, contact HR.

Annual Notice

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

NEWBORN AND MOTHER'S HEALTH PROTECTION ACT (NMHPA)

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

HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

If you are declining 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 after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

To Learn More, visit MyFHHSBenefits.com

Marriage, Birth, or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact:

Human Resources

6320 Venture Drive, Suite 205 Bradenton, FL 34202

Telephone: 941-907-1595

To request special enrollment, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272)

IMPORTANT NOTICE FROM LIFE CARE PARTNERS OF FL, LLC ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

OMB 0938-0990

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Life Care Partners of FL, LLC. 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:

- ◆ 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.
- ◆ Life Care Partners, LLC has determined that the prescription drug coverage offered by Florida Blue 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 10/15 to 12/7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Florida Blue coverage will not be affected.

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

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Life Care Partners LLC 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 percent 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 percent 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 Life Care Partners of FL, LLC 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:	06/01/2021
Name of Entity/Sender:	Life Care Partners, LLC
Contact--Position/Officer:	Judy Robbins / HR
Address:	6320 Venture Drive, Suite 250 Bradenton, FL 34202
Phone Number:	941-907-1595

To Learn More, visit MyFHHSBenefits.com

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average eight hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As a participant in the company Florida Blue plan (the "Plan"), you are eligible for certain health care benefits. In the course of providing these benefits to you, the Plan may receive and maintain some of your medical information. Federal law requires that the Plan protect the privacy of, generally, medical information that identifies you and relates to your past, present or future health or condition, the provision of health care to you, or the payment for health care received by you ("protected health information" or "PHI"). The Plan may hire other companies ("Business Associates") to help provide health care benefits to you. These Business Associates may also receive and maintain your medical information.

The Plan is required to abide by the terms of the Notice currently in effect.

The Plan may change its privacy practices and the terms of this Notice at any time. Changes will be effective for all of your medical information received or created by the Plan. If the Plan changes its policies regarding the protection of your medical information, the Plan will mail you a new notice of privacy practices that incorporates any changes within 60 days. The Plan will also will post a new notice on its internet website.

How the Plan May Use and Disclose Your Medical Information

The Plan may use and disclose your medical information without your written permission for the following purposes:

For treatment. While the Plan does not directly participate in decisions regarding your health treatment, the Plan may disclose medical information it has created or received for treatment purposes. For example, the Plan may disclose your medical information to your doctor, at the doctor's request, for his or her treatment of you.

For payment. The Plan or one of its Business Associates may use or disclose your medical information to pay claims for medical services provided to you or to provide eligibility information to your doctor when you receive medical treatment.

For health care operations. The Plan may provide your medical information to our accountants, attorneys, consultants, and others in order to make sure we are complying with federal law. Also, your medical information may be used or disclosed to assess the quality of health care that you receive or to assist the Plan in the management of its performance of administrative activities.

To you, your personal representative, or others involved in your healthcare. The Plan may provide your medical information to you and your legal representative. The Plan may also provide medical information to a person, including family members, other relatives, friends or others identified by you and acting on your behalf, so long as you do not object and the information is directly relevant to such person's involvement in your health care. For this purpose, a person acts on your behalf by being involved in the provision and/or payment of your health care.

As required by law. For example, the Plan may disclose your medical information to comply with workers' compensation laws or other similar laws.

To Business Associates. The Plan may disclose your medical information to its Business Associates so that they may perform the services that the Plan has asked them to perform. The Plan requires that these entities appropriately safeguard your medical information

For health-related benefits. The Plan or one of its Business Associates may contact you about treatment alternatives or other health benefits or services that may be of interest to you.

NOTICE OF PRIVACY PRACTICES

For Other Uses and Disclosures Permitted by Law Such As:

The Plan may use and disclose your medical information without your written permission for the following:

- ◆ To public health authorities for public health purposes (e.g. the reporting of communicable diseases);
- ◆ To state agencies handling cases of abuse, neglect, or domestic violence;
- ◆ To a government agency authorized to oversee the health care system or government programs (e.g. determining eligibility for public benefits);
- ◆ To law enforcement officials for limited law enforcement purposes (e.g. to locate a missing person or suspect);
- ◆ To a coroner, medical examiner, or funeral director about a deceased person (e.g. to identify a person);
- ◆ To an organ procurement organization under limited circumstances;
- ◆ For research purposes in limited circumstances (e.g. if identifying information is removed or a research board has approved the use of the information);
- ◆ To avert a serious threat to your health or safety or the health or safety of others;
- ◆ To military authorities if you are a member of the armed forces or a veteran of the armed forces;
- ◆ To federal officials for lawful intelligence, counterintelligence, and other national security purposes;
- ◆ To an executor or administrator of your estate; and
- ◆ To any other persons and/or entities authorized under law to receive medical information.

For any other use or disclosure of your medical information, the Plan must have your written authorization. You may cancel your written authorization for the use and disclosure of any or all of your medical information, unless the Plan has taken action in reliance on your permission.

Some Uses and Disclosures That Require Your Authorization are Those with Respect to:

- ◆ Psychotherapy notes, except: to carry out the following treatment, payment, or health care operations:
 - ◇ use by the originator of the psychotherapy notes for treatment;
 - ◇ use or disclosure by the provider for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or
 - ◇ use or disclosure by the Plan to defend itself in a legal action or other proceeding brought by the individual; or with respect to a use or disclosure that is:
 - ◇ required by the Secretary to investigate or determine the Plan's compliance;
 - ◇ permitted to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law and in accordance with HIPAA;
 - ◇ to a health oversight agency for oversight activities authorized by law with respect to the oversight of the originator of the psychotherapy notes;
 - ◇ to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law; or
 - ◇ as necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- ◆ Marketing except if the communication is in the form of:
 - ◇ a face-to-face communication made by a Plan to an individual; or
 - ◇ a promotional gift of nominal value provided by the Plan.
- ◆ If the marketing involves financial remuneration, to the Plan from a third party, the authorization must state that such remuneration is involved.
- ◆ Sale of PHI.
- ◆ The Plan is prohibited from using or disclosing PHI that is genetic information of an individual for underwriting purposes.

To Learn More, visit MyFHHSBenefits.com

The Plan is required by law to maintain the privacy of PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured PHI.

Your Rights

You may make a written request to the Plan to do one or more of the following concerning your medical information received or created by the Plan and/or the Plan's Business Associates:

- ◆ The right to request restrictions on certain uses and disclosures of medical information; however, the Plan is not required to agree to such request unless:
 - ◇ the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and
 - ◇ the PHI pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the Plan in full.
- ◆ The right to receive confidential communications of medical information by alternative means or at alternative locations.
- ◆ The right to inspect and copy medical information.
- ◆ The right to amend medical information.
- ◆ The right to receive an accounting of disclosures of medical information.
- ◆ The right, even if you have agreed to receive this notice electronically, to obtain a paper copy of this from the Plan upon request.

Although the Plan will utilize its best efforts to comply with your request, the Plan may legally deny your request under certain circumstances. The Plan will notify you of the reason for the denial and you will get a chance to respond. The Plan may not deny a request to communicate with you in confidence by a different means or location if the current means or location used by the Plan endangers you. The Plan may, however, request payment for any additional expenses it incurs to comply with your request. Your request to communicate by a different means or location must be in writing, include a statement that disclosure of all or part of the medical information by the current means could endanger you, specifically state the different means or location by which you would like the Plan to communicate with you, and continue to allow the Plan to pay claims.

Complaints

If you feel as if your privacy rights have been violated, you may file a written complaint with your administrator.

You may also send a written or electronic complaint to the Secretary of the Department of Health and Human Services. The complaint must state the name of the entity that is the subject of the complaint and describe the act or omissions believed to be in violation of law. A complaint must be filed within 180 days of when you knew or should have known that the act or omission complained of occurred. The Plan may not retaliate against you if you file a complaint.

More Information

If you would like more information about this Notice, please contact HR.

This document is intended to convey general information and may not take into account all the circumstances relevant to a particular person's situation.

STATEMENT OF ERISA RIGHTS

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

Receive Information about Your Plan and Benefits

- ◆ Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- ◆ Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- ◆ Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

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

If you have creditable coverage from another plan, you may be entitled to a reduction or elimination of exclusionary periods (if applicable) of coverage for preexisting conditions under your group health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to COBRA continuation of coverage, when COBRA continuation of coverage ceases, if you request before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of prior creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

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

Enforce your Rights

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

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

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

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court.

STATEMENT PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid	INDIANA – Medicaid
<p>Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx</p> <p>Phone: 1-800-541-5555</p>	<p>Healthy Indiana Plan for low-income adults 19-64</p> <p>Website: http://www.in.gov/fssa/hip/</p> <p>Phone: 1-877-438-4479</p> <p>All other Medicaid</p> <p>Website: http://www.indianamedicaid.com</p> <p>Phone 1-800-403-0864</p>
IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
<p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366</p> <p>Hawki Website: http://dhs.iowa.gov/Hawki</p> <p>Hawki Phone: 1-800-257-8563</p>	<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</p> <p>Phone: 1-800-694-3084</p>
KANSAS – Medicaid	NEBRASKA – Medicaid
<p>Website: http://www.kdheks.gov/hcf/default.htm</p> <p>Phone: 1-800-792-4884</p>	<p>Website: http://www.ACCESSNebraska.ne.gov</p> <p>Phone: 1-855-632-7633</p> <p>Lincoln: 402-473-7000</p> <p>Omaha: 402-595-1178</p>
KENTUCKY – Medicaid	NEVADA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</p> <p>Phone: 1-855-459-6328</p> <p>Email: KIHIPP.PROGRAM@ky.gov</p> <p>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx</p> <p>Phone: 1-877-524-4718</p> <p>Kentucky Medicaid Website: https://chfs.ky.gov</p>	<p>Medicaid Website: http://dhcfp.nv.gov</p> <p>Medicaid Phone: 1-800-992-0900</p>
LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp</p> <p>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p>Website: https://www.dhhs.nh.gov/oii/hipp.htm</p> <p>Phone: 603-271-5218</p> <p>Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>

To Learn More, visit MyFHHSBenefits.com

MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
<p>Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html</p> <p>Phone: 1-800-442-6003</p> <p>TTY: Maine relay 711</p>	<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</p> <p>Medicaid Phone: 609-631-2392</p> <p>CHIP Website: http://www.njfamilycare.org/index.html</p> <p>CHIP Phone: 1-800-701-0710</p>
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
<p>Website: http://www.mass.gov/eohhs/gov/departments/masshealth/</p> <p>Phone: 1-800-862-4840</p>	<p>Website: https://www.health.ny.gov/health_care/medicaid/</p> <p>Phone: 1-800-541-2831</p>
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
<p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see “what if I have other health insurance?”]</p> <p>Phone: 1-800-657-3739</p>	<p>Website: https://medicaid.ncdhhs.gov/</p> <p>Phone: 919-855-4100</p>
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</p> <p>Phone: 573-751-2005</p>	<p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/</p> <p>Phone: 1-844-854-4825</p>
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
<p>Website: http://www.insureoklahoma.org</p> <p>Phone: 1-888-365-3742</p>	<p>Medicaid Website: https://medicaid.utah.gov/</p> <p>CHIP Website: http://health.utah.gov/chip</p> <p>Phone: 1-877-543-7669</p>
OREGON – Medicaid	VERMONT – Medicaid
<p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html</p> <p>Phone: 1-800-699-9075</p>	<p>Website: http://www.greenmountaincare.org/</p> <p>Phone: 1-800-250-8427</p>
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
<p>Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx</p> <p>Phone: 1-800-692-7462</p>	<p>Website: https://www.coverva.org/hipp/</p> <p>Medicaid Phone: 1-800-432-5924</p> <p>CHIP Phone: 1-855-242-8282</p>

RHODE ISLAND – Medicaid and CHIP	WASHINGTON – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlts Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 1, 2021, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Beginning in 2014, there is another way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

The 2021 open enrollment period for health insurance coverage through the Marketplace ran from Nov. 1, 2020, through Dec. 15, 2020. Individuals must have enrolled or changed plans prior to Dec. 15, 2020, for coverage starting as early as Jan. 1, 2021. After Jan. 31, 2021, you can get coverage through the Marketplace for 2021 only if you qualify for a special enrollment period or are applying for Medicaid or the Children’s Health Insurance Program (CHIP). Open enrollment for the 2021 plan year runs from Nov. 1, 2021 through Dec. 15, 2021.

To Learn More, visit MyFHHSBenefits.com

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.69 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources, 941-907-1595.

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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

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;
- 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 after the qualifying event occurs. You must provide this notice to: Human Resources, Life Care Partners, LLC. 6320 Venture Drive, Suite 250, Bradenton, FL 34202. You will be required to present certified documentation to make this change.

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. *[Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]*

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, Medicaid, 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.

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/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

Contact--Position/Officer:	Life Care Partners, LLC. Human Resources
Address:	6320 Venture Drive, Suite 250, Bradenton, FL 34202
Phone Number:	941-907-1595

PREPARED BY:



RISK CONSULTING PARTNERS