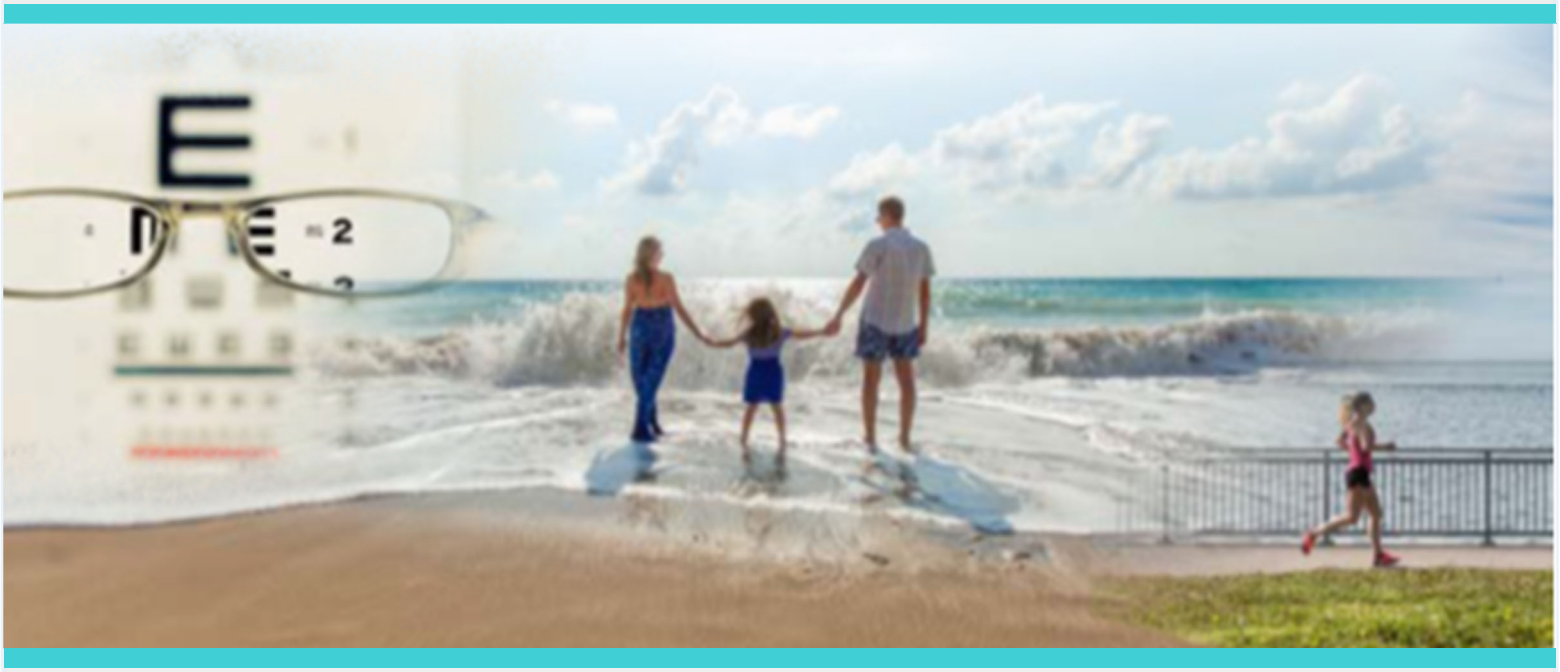
# EMPLOYEE BENEFITS GUIDE 2021

## Per Diem Employees



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

2021

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.

## When am I eligible for benefits?

Under Healthcare Reform, eligibility for health benefits is determined through the use of an initial or standard measurement period. Initial measurement periods will be used for the first 12 months of employment for all new Variable Hour / Per Diem employee. The standard measurement period will be used for all employees after you have had 12 months of service.

**Variable Hour / Per Diem Employees—** if you are not hired as a full-time employee and it cannot be determined at the time of hire that you will average at least 30 yours per week, then you will be considered a variable hour / per diem employee. Using a 12 month initial measurement period from your date of hire, we will count the number of hours you worked in those 12 months and divide by the number of weeks in those months. If you averaged 30 or more hours of service per week for the initial 12 months measurement period, you will be eligible for benefits the first of the month following 30 days after your initial measurement period for the medical and prescription drug plans.

Once it has been determined that you qualify for variable hour / per diem benefits, you may elect to enroll in the company's HDHP and prescription drug plan and the Health Savings Account. As long as you make timely premium contributions, you may continue with your elected coverage through the company's stability period. Please note that this coverage is offered to you and your eligible dependents. Spousal coverage is not an option.

***Your Benefit Options...***

- Medical Plan
- Health Savings Account

**To Learn More, visit MyFHHSBenefits.com**

# *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 employees[2] (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.

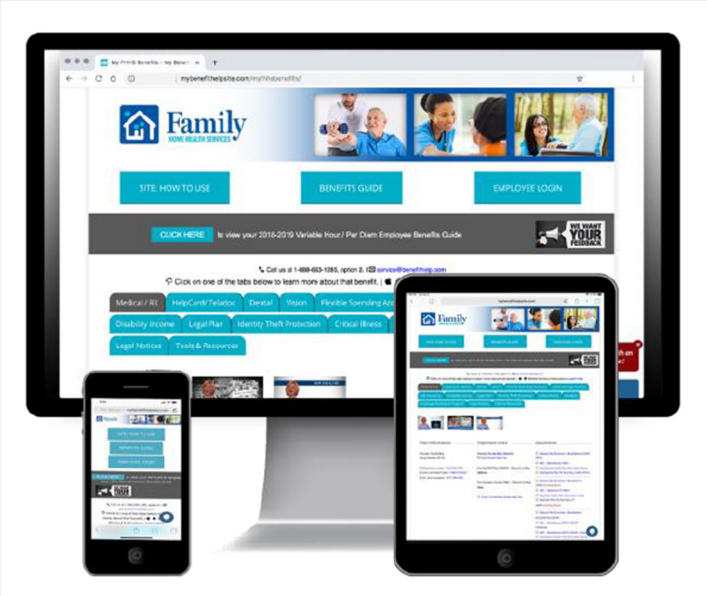
[2]For purposes of the Employer Shared Responsibility provisions, an employee is a full-time employee for a calendar month if he or she averages at least 30 hours of service per week.

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

# WWW.MYFHHSBENEFITS.COM

2021

**Where online can I get more information about my benefits?**

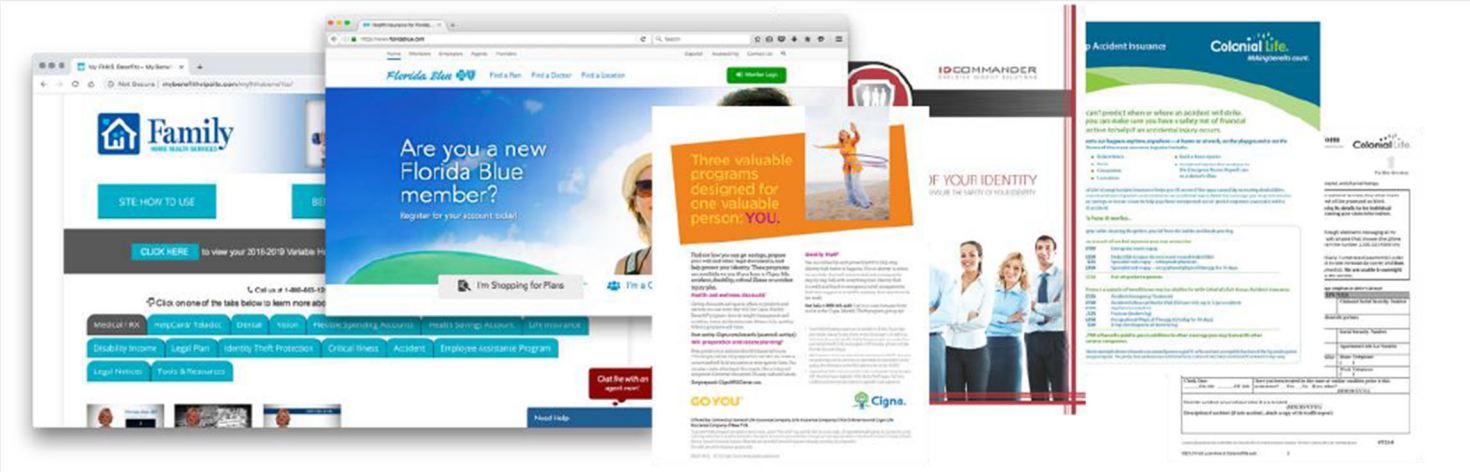



Have you ever had trouble locating information about your benefits?

What about trying to remember how to find a participating doctor?

**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**




**To Learn More, visit MyFHHSBenefits.com**

# 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).

# Reminders

2021

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

It is all about educating yourself on the options available. Balancing cost and coverages 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. On the 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 or 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


**To Learn More, visit MyFHHSBenefits.com**

# Health Coverage

## 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% of your eligible medical expenses and you are responsible for the remaining 20%.

**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 locate a provider or to review the plan details, please visit:**

**Www.MyFHHSBenefits.com**

Florida Blue

In the pursuit of health®

# Florida Blue Medical Plan

2021

| FHHS Medical Plans | In-Network Benefits | |
|---|---|---|
| **In Network Benefits** | **BlueOptions HDHP *(Single Coverage)*** | **BlueOptions HDHP *(Family Coverage)*** |
| **Calendar Year Deductible**<br>Individual<br>Family | $3,000 | $6,000<br>*Deductible is shared for all individuals on the family plan* |
| **Coinsurance** | You pay 30% after deductible | You pay 30% after deductible |
| **Out-of-Pocket Maximum**<br>Individual<br>Family | $6,550 | $6,850<br>$13,100<br>*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.* |
| **Preventive Care*** | You pay 0% | You pay 0% |
| **Office Visits**<br>Primary Care Physician<br>Specialist<br>Virtual Visit | You pay 30% after deductible | You pay 30% after deductible |
| **Emergency Care**<br>Urgent Care<br>Emergency Room | You pay 30% after deductible | You pay 30% after deductible |

Florida Blue

In the pursuit of health®

Rates
Page 26

To Learn More, visit MyFHHSBenefits.com

# 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 | | |
|---|---|---|
| **31 Day Supply** | **BlueOptions HDHP *(Single Coverage)*** | **BlueOptions HDHP *(Family Coverage)*** |
| **Tier 1** | Deductible, then $10 Copay | Deductible, then $10 Copay |
| **Tier 2** | Deductible, then $50 Copay | Deductible, then $50 Copay |
| **Tier 3** | Deductible, then $80 Copay | Deductible, then $80 Copay |

| Mail Order Pharmacy | | |
|---|---|---|
| **90 Day Supply** | **BlueOptions HDHP *(Single Coverage)*** | **BlueOptions HDHP *(Family Coverage)*** |
| **Tier 1** | Deductible, then $25 Copay | Deductible, then $25 Copay |
| **Tier 2** | Deductible, then $125 Copay | Deductible, then $125 Copay |
| **Tier 3** | Deductible, then $200 Copay | Deductible, then $200 Copay |

# Health Savings Accounts

2021

**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 | Weight-Loss Programs |

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

HealthEquity
Building Health Savings

**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.

TELADOC®

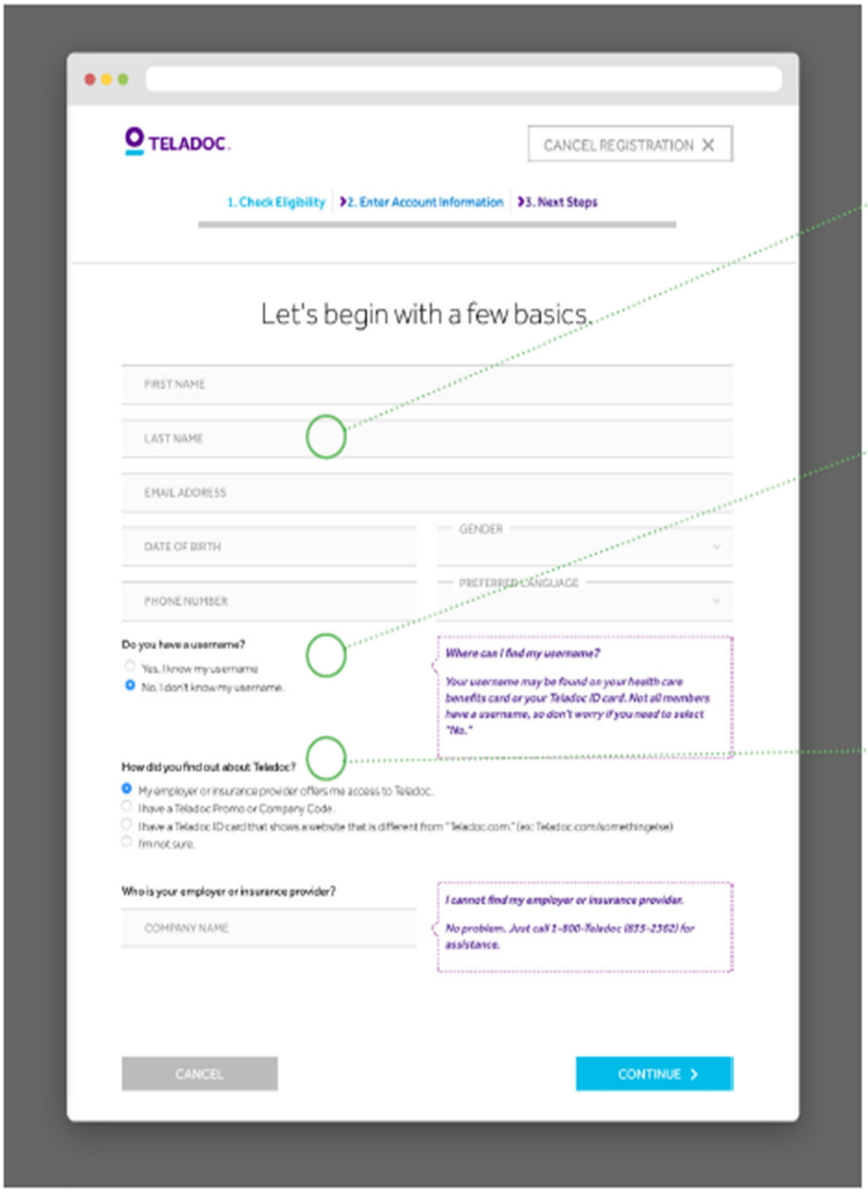
Talk to a doctor anytime.

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

# Get started with Teladoc

2021

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.




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

1-800-TELADOC (835-2362)

Facebook.com/Teladoc

Teladoc.com/mobile

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 |
| Employee Only | $28.39 |
| Employee + Spouse | $397.47 |
| Employee + Child(ren) | $274.44 |
| Family | $616.78 |

Medical—p.9-10

# Tips to Maximize Your Benefits

2021

### 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

# *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!*

# *Important Contact Information*

| Plan Type and Carrier | Phone and Website | Group Number *(if applicable)* |
|---|---|---|
| **Medical**<br>Florida Blue<br>*Care Consultant Team*<br>*24 Hour Nurse Line*<br>*Teladoc* | Provider Phone: 800-352-2583<br>Provider Web Address; www.floridablue.com<br>888-476-2227<br>877-789-2583<br>800-835-2362 | B7116 |
| **HSA**<br>Health Equity | Provider Phone: 866-346-5800<br>Provider Web Address: www.my.healthequity.com/login | |
| **401K Retirement**<br>The Standard | Provider Web Address: www.thestandardcom | |
| **Enrollment on HelpSITE**<br>BenefitHelp | Provider Phone: 888-663-1285 Option 2<br>Provider Email: service@benefithelp.com | |
| **Questions on Benefits**<br>Risk Consulting Partners | Provider Email: LCPbenefithelp@rcpholdings.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
- Coinsurance (Florida Blue pays In-Network/Out-of-Network): HDHP: 70%/60%

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.

### 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 of FL, 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 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 |

# 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.

**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.

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.*

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income

## STATEMENT OF ERISA RIGHTS

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

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

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

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

### 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

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| 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**