2022-2023 Georgia Employee Benefits Guide

Plan Year: December 1, 2022 - November 30, 2023

Information Provided by:

This Benefits Guide is designed to provide select information about the benefit plans and programs offered by Aspire Health Partners from December 1, 2022 - November 30, 2023. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs described herein**. This booklet does not constitute a Summary Plan Description (SPD) or Plan Document as defined by the Employee Retirement Income Security Act (ERISA). If there is a conflict between this document and the SPD, the SPD shall prevail. The SPD is available from your Human Resource representative.**

If you are electing dental, vision, short term disability, long term disability, basic life and/or voluntary life coverage for the first time, you are required to be 'Actively at Work' on a full-time basis on the day that the coverage begins. 'Actively at Work' is defined as, you are working for your employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation.

Aspire Health Partners strives to provide you with a comprehensive employee benefits program as part of your overall compensation package.

We put this guide together to help you understand your benefits and to help you get the most out of them. We encourage you to review it thoroughly so you can identify which offerings are best for you and your family.

If you have questions about your benefits, reach out to Human Resources or use the contact information included in this guide to get the answers you need.

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CONTACT INFORMATION

Contact **Human Resources** if you have questions about the plans prior to enrolling or if you have issues with claims once enrolled.

Carrier / Vendor	Phone / Email	Website
Aspire Health Partners Human Resources	Jannette Mulero 407-875-3700 x6025	Jannette.Mulero@aspirehp.org
	Reina Gordon 407-875-3700 x3267	Reina.Gordon@aspirehp.org
	Brianna Fagan 407-875-3700 x2657	Brianna.Fagan@aspirehp.org
	Wanda Torres 407-875-3700 x1352	Wanda.Torres@aspirehp.org
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	Leticia Garcia 407-875-3700 x6680	Leticia.Garcia@aspirehp.org
	Ashley Zeisloft 407-875-3700 x6182	Ashley.Zeisloft@aspirehp.org
LassiterWare Employee Customer Service	800-845-8437 Ext 118 Customer Service Specialist EAHelp@lassiterware.com	www.lassiterware.com
BlueCross BlueShield	Medical: 800-830-1501	www.myhealthtoolkitfl.com
Drexi / AROrx	AROrx: 833-306-4092	www.drexi.com
Teladoc	Virtual Visit: 866-789-8155	www.teladoc.com

CONTACT INFORMATION

Carrier / Vendor	Phone / Email	Website
MetLIfe	Dental & Vision: 800-438-6388	Dental: www.metlife.com Vision: www.mymetlifevision.com
VOYA	STD: 866-228-8742 Life & LTD: 800-955-7736 Supplemental: 800-955-7736 (Accident; Critical Illness and Hospital)	www.voya.com View the benefits video: EBRC - Aspire Health Partners (voya.com)
VOYA **Employee Assistance Program**	EAP: 877-533-2363	www.GuidanceResources.com Web ID: MY5848i
Optum Bank **Health Savings Account**	H.S.A.: 866-234-8913 Account Group #755931	www.optumbank.com
Medcom **Flexible Spending Accounts**	Customer Service 800-523-7542 Email claims to: Medcomreceipts@emedcom.net	Check your debit card: www.mywealthcareonline.com/medcom Employer ID: MCOASPIRE
Empower **Retirement Solutions**	866-467-7756	www.empowermyretirement.com

MAKING YOUR SELECTIONS

There are limited opportunities to enroll and/or make changes to your benefit elections. Make your selections carefully! The choices you make now will be effective through the end of the plan year, as long as you remain eligible.

When you're first hired

The benefits you elect begin on the first day of the month following 60 days of employment.

You will be required to make your elections using the Datis e3 **portal** http://e3.aspirehp.org/ online enrollment system by the due date specified by Human Resources.

At Open Enrollment

Open Enrollment is your annual opportunity to make changes to your elections. Benefits selected during Open Enrollment are effective December 1, 2022, unless Evidence of Insurability (EOI) is required.

You will be required to make your Open Enrollment elections using the Datis e3 online enrollment system by the due date specified by Human Resources.

Please note the Flexible Spending Accounts Enrollment effective date is January 1 effective date

If you have a life event

Some life events allow you to change your coverage during the year. If you experience a life event, you have 30 days from the date of the event to request changes and provide any required documentation. Some common life events are:

- Birth or adoption
- Marriage or Divorce
- Change in employment status or change in coverage under another employer-sponsored plan
- Loss or gain of eligibility under Medicare or Medicaid

ELIGIBILITY

- **Employees**
  - You are eligible to participate in the employee benefits program on the first of the month following 60 days of full-time employment; if you normally work a minimum of 30 hours each week or more.
- **Spouse**
  - If you enroll, you may also enroll your current legal spouse or qualified domestic partner in the same plans you select for yourself.
- **Children**
  - If you enroll, you may also enroll your qualified dependent children in the same plans you select for yourself. There are additional qualifications that vary by plan as follows:
    - Medical plan: Coverage may continue until the end of the month in which the child reaches age 26.
    - Dental and Vision plans: Coverage may continue until the end of the month in which the child reaches age 26.
    - Voluntary Life plan: Coverage for unmarried dependent children may continue under the voluntary life plan until the child's 26th birthday.
    - Supplemental Insurance plans: Coverage may be elected for your dependent children under the supplemental plans until their 26th birthday.
    - A dependent child may remain covered beyond the limiting ages listed above if the child is incapable of self-sustaining employment by reason of mental or physical handicap. Special approval must be obtained from the insurance carriers.

Tobacco Free Discount

TOBACCO USE DISCOUNT

- If you used tobacco products in the preceding 6 months (smoke, chew or any other manner) and are enrolled in *Aspire Health Partners'* medical plan, you will be assessed a tobacco-use surcharge.

- Not only are we trying to reduce our escalating insurance costs, but we are also striving for a healthier work force. There is a proven link between smoking and the rising cost of healthcare because smokers / tobacco-users have a higher risk of cancer, stroke, heart disease and chronic obstructive pulmonary disease (COPD) than non-tobacco users. You will be required to complete a Tobacco-Use certification as part of your benefits enrollment.

- *Aspire Health Partners* offers a reasonable opportunity for employees to avoid the smoking premium surcharge upon completion of an approved tobacco cessation program. This applies to covered employees, for whom it is unreasonably difficult because of a medical condition, or for whom it is medically inadvisable to be tobacco-free under our standard. *Aspire Health Partners* has chosen the standards that the tobacco cessation program must meet such as the timeframe, and the manner in which employees must certify their completion of the program. An approved tobacco cessation program may be a certified online program, classroom-based course, or telephonic counseling/support program.

Smoking Premium Surcharge Reasonable Alternative Information

- The following information describes *Aspire Health Partners* "reasonable opportunity" for you to avoid the smoking premium surcharge. It is each employee's responsibility to pay for the cost of tobacco cessation.

- **Step 1:** Choose an approved online, classroom-based or telephonic tobacco cessation program. Some resources available to help you locate approved tobacco cessation programs include:
  - **Telephonic Courses:** More than 30 states now run tobacco guidelines that are confidential, staffed by trained specialists and free to residents. Some of these helplines provide over-the-counter support products, such as gum or patches, at reduced prices or as part of the program. Courses must consist of at least four telephonic counseling / support sessions to be acceptable. You will have to obtain verification that you completed at least four sessions.
  - **Online Course:** Take the online American Lung Association's *Freedom From Smoking* Program (make sure to elect the Premium membership for a nominal fee so you can present a completion certificate.) Go to: www.ffsonline.org A completion certificate will be required as proof of your online course.
  - **Classroom-Based Courses:** Approved classroom-based courses are those offered through a hospital, community organizations (such as the American Cancer Society) or your state's Department of Health courses. Courses must consist of at least four classroom-based meetings to be acceptable. You will have to obtain verification that you completed at least four sessions.
  - **The Tobacco Free Florida Website is a great place to start** www.tobaccofreeflorida.com; If you do not have access to a computer, you may call 877-822-6669 for your options.

- **Step 2:** Enroll in and complete one of the approved tobacco cessation programs listed above

- **Step 3:** Obtain a completion certificate from your program and submit to your Human Resources Department

MEDICAL INSURANCE

You may choose from two medical plans through BlueCross BlueShield. When selecting your medical plan, consider:

- The premium you'll pay (your payroll deduction)
- What you'll pay when accessing care (copays, deductible, coinsurance)
- How your prescriptions will be covered

<u>SOME INSURANCE TERMS</u>

Copay – a fixed amount you pay when seeking care for certain services.

Deductible – the amount you pay for certain health care services in a calendar year before the plan begins paying any portion of those services.

Coinsurance – the percentage you pay for certain services after meeting your deductible and before you meet your Out-of-Pocket Maximum.

Out of Pocket Maximum – the most you will pay in a calendar year for covered services. This includes medical copays, deductibles, and coinsurance. Once the Out-of-Pocket Maximum has been met, the plan will pay 100% of covered services for the remainder of that calendar year.

Balance Billing – the amount you are billed by out-of-network providers to make up the difference between the amount they charge and what the insurance reimburses. This amount is in addition to and does not count toward your Out-of-Pocket Maximum.

	Bronze Plan with the H.S.A.	**Silver Plan**
What Provider Network do I use?	EQN	EQN
Do I need to choose a Primary Care Physician (PCP)?	No	No
Do I need a referral to see a Specialist?	No	No
Can I go Out-of-Network?	Yes. However, you will pay a higher cost share when using a provider that is not in the network.	No out-of-Network benefits

MEDICAL INSURANCE

	Bronze Plan with the H.S.A.	Silver Plan
In-Network Coverage		
Deductible (calendar year)	$2,100 Individual | $4,200 Family Limit	$1,500 Individual | $4,000 Family Limit
Coinsurance	20% after Deductible	20% after Deductible
Out of Pocket Maximum	$3,500 Individual | $7,000 Family	$3,500 Individual | $7,000 Family
Office Visit	Convenience Clinic: Deductible + 20% Primary Physician: Deductible + 20% Specialist: Deductible + 20% Teladoc: $49 Copay	Convenience Clinic: $25 Copay Primary Physician: $25 Copay Specialist: $50 Copay Teladoc: $0 Copay
Diagnostic Testing at an Independent Facility	Bloodwork: Deductible + 20% X-ray: Deductible + 20% MRI / CT / PET: Deductible + 20%	Bloodwork: No Charge X-ray: No Charge MRI / CT / PET: Deductible + 20%
Urgent Care Center	Deductible + 20%	$30 Copay
Emergency Room	Facility: Deductible + 20% Physician Services: Deductible + 20%	Facility: $300 Copay Physician Services: Deductible + 20%
Inpatient Hospitalization	Deductible + 20%	Deductible + 20%
Outpatient Hospital Services	Facility: Deductible + 20% Physician Services: Deductible + 20%	Facility: Deductible + 20% Physician Services: Deductible + 20%
Pharmacy Coverage **Retail: 30-day supply** **Mail Order: 90-day supply** **Tier 1 / Tier 2 / Tier 3**	**Deductible of $500 Individual / $1,000 Family then:** Tier 1 Retail: $10 Copay Tier 2 Retail: $30 Copay Tier 3 Retail: $50 Copay Mail Order: $20 / $60/ $100 **Separate Out of Pocket Max $1,000 Ind/$2,000 Fam**	**Separate Out of Pocket Max $2,850 ind/$6,200 Fam** Tier 1 Retail: $30 Copay Tier 2 Retail: $50 Copay Tier 3 Retail: $100 Copay Mail Order: $60 / $100/ $200
Out-of-Network Coverage	**Note: You also pay the balance over the allowed amount when using an Out-of-Network Provider**	
Deductible	$4,000 Individual | $8,000 Family Limit	**NO COVERAGE,** Except Emergency Services
Out of Pocket Maximum	$9,000 Individual | $18,000 Family	
Payroll Deductions	Employee Only ....$ 24.56 Employee & 1 ....$135.84 Employee & 2+ $179.52	Employee Only ....$ 66.16 Employee & 1 ....$211.76 Employee & 2+ $250.24
Tobacco Free Payroll Deductions Discount	Employee Only ....$ 14.56 Employee & 1 ....$125.84 Employee & 2+ $169.52	Employee Only ....$ 56.16 Employee & 1 ....$201.76 Employee & 2+ $240.24

PHARMACY INSURANCE

Manage your pharmacy benefits through our secure online member portal, www.drexi.com

Your pharmacy benefit manager is called Drexi. You will need to present your new ID card to your pharmacist for any prescription. You can set up a new mail order medication by registering at my.pillpack.com/signup or call 866-332-1668.

Locate pharmacies:	**All major pharmacies in your area are participating.**
Register at www.drexi.com	**Review your medication history and search your plan for lower cost pharmacies, generic medications substitutes, or over-the-counter (OTC) alternatives.**
Update your profile:	**Add or change payment information, set your communication preference (email or phone), change contact information, and more.**
Specialty Pharmacy	**If your doctor prescribes a high-cost specialty medication for you or a covered family member you must call ARORx at 1-833-306-4092 to go through an approval process before you will be able to receive your medication. ARORx is available Monday through Friday from 9AM and 5PM EST.**

If you will be using our Paypack Prescription Delivery Service, provide a payment method (credit, debit, FSA or HSA card) to speed up the ordering process.

After you sign up for the Paypack Delivery service they will contact you doctor for the prescriptions you wish to have delivered to your home. There may be limitations on some medications, such as controlled medications, due to state and federal laws.

MEDICAL INSURANCE

A Note about Provider Networks

Verify that your provider is In-Network BEFORE your visit by searching **myhealthtoolkitfl.com**; find a provider using the EQN network.

Enroll in Member Messaging

All members age 16+ can sign up for member messaging.

1. Call 844-206-0624.
2. Enter the numbers in your Member ID.
   Do not include the letters at the beginning of your Member ID.
3. Enter your date of birth to complete enrollment.

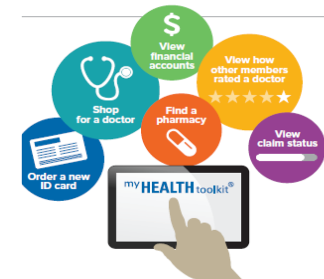
Sign up for My Health Toolkit

All members age 16+ can sign up for personal accounts.

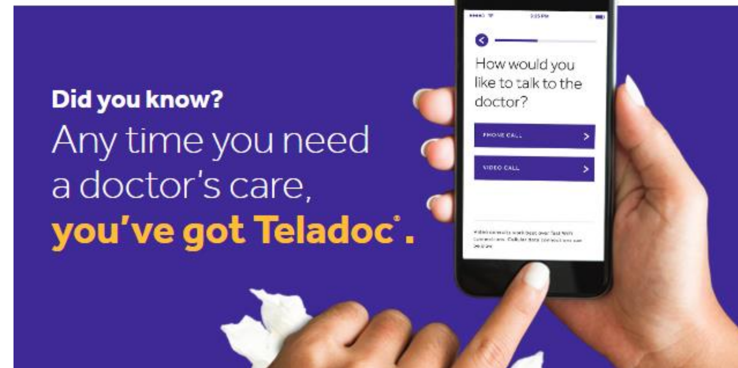
1. Go to www.MyHealthToolkitFL.com.
2. Select "Register Now."
3. Follow the instructions to complete registration.

Shop for Member Discounts

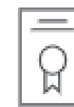
1. Go to MyHealthToolkitFL.com.
2. Select the Member Discounts tab.
3. Use your Blue membership to access special rates on fitness and wellness programs, hearing and vision services and much more.



TELADOC: VIRTUAL VISITS



24/7/365 care for:
Cold & flu, allergies, rash and much more!



Licensed doctors
U.S. board-certified doctors average 20 years of experience

In minutes
Connect with a doctor by phone or video

Get a diagnosis
Our doctors recommend treatment and prescribe medication (when medically necessary)

Register for Teladoc now!

Visit My Health Toolkit® to complete your Teladoc registration.

1. Visit www.MyHealthToolkitFL.com and log in.
2. Under the Resources tab, select Teladoc. This will take you to the Teladoc site.
3. Your insurance information will appear so you can easily complete your registration.
4. Don't forget to complete your medical history. This will need to be completed before you speak with a Teladoc doctor.

***You may be charged a $50 fee* for no-shows and cancellations within 24 hours of a scheduled visit**

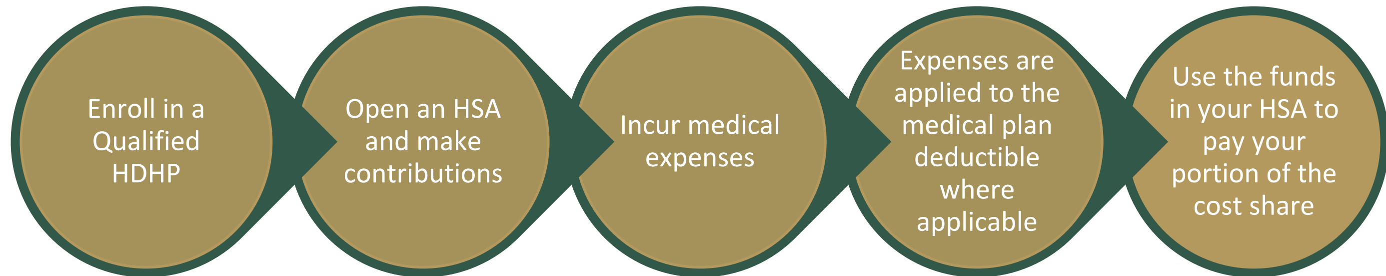
HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account, commonly referred to as an HSA, is a bank account that may be funded with tax-exempt dollars. The money in an HSA may be used to pay for unreimbursed medical expenses on a tax-free basis. You must meet the qualifications defined by the IRS in order to open or make contributions to an HSA.

HSA Eligibility	In order to open or make contributions to an HSA, you must meet ALL of the following criteria: • Be enrolled in a Qualified High Deductible Health Plan (HDHP), and • Not be covered under another medical plan that is not a Qualified HDHP, and • Not be enrolled in Medicare or Medicaid, and • Not be eligible to be claimed on another person's tax return, and • Not be covered under an Unlimited Medical FSA or HRA (including through a spouse's employer). Enrollment in Dental, Vision, and most Supplemental Plans (accident, cancer, etc.) will not disqualify you from HSA eligibility.
Qualified High Deductible Health Plan (HDHP)	In order for a plan to be an HSA Qualified HDHP it must meet minimum deductible and maximum out-of-pocket limits established by the IRS. These limits are updated annually for inflation. In addition, a Qualified HDHP may not pay for any services, except preventive care, before the plan's deductible has been met. Plans that have copayments for office visits, prescriptions, or other services PRIOR to meeting the deductible are NOT Qualified HDHPs.
HSA Contributions	The IRS establishes the maximum amount that may be contributed to an HSA each calendar year based on your enrollment in a Qualified HDHP. This is the most that may be deposited into an HSA each year from all sources. • 2023 Contribution Limits: $3,850 if you are enrolled with Individual coverage or $7,750 if you are enrolled with family coverage. • Catch Up Contributions: If you are at least age 55 and not enrolled in any part of Medicare you may contribute an additional $1,000 to your HSA per calendar year as a catch-up contribution. As the HSA owner, you are responsible for tracking deposits from all sources to ensure your contributions stay within the IRS limits.
HSA Distributions	The money in your HSA may be used tax-free to pay for qualified medical expenses incurred after the date the HSA was opened by you, your spouse, and your tax-dependent children. Eligible expenses include charges applied to a medical plan deductible, coinsurance, and copayments as well as prescriptions, dental expenses, and vision expenses. A list of qualified expenses can be found in IRS Publication 502.
Tax Reporting	You will need to report that you have an HSA when you file your annual income tax return. You should keep receipts for all expenses paid from your HSA. Refer to IRS Publication 969 or talk to your tax advisor for more information. LassiterWare does not provide tax advice.

HEALTH SAVINGS ACCOUNT (HSA)

How does an HSA work?



How do I open an HSA?	While a number of financial institutions offer HSA accounts and employees may always use the bank of their choice, in order to benefit from the convenience of payroll deductions, employees must open an HSA with Optum Bank. If you do not already have an HSA and wish to establish one, please see Human Resources for information.
How do I get money out of my HSA?	Most banks issue you a debit card and/or a check book. You access funds like you would from any other checking account.
What happens to the money if I don't spend it?	It sits in your account until you decide to spend it at any time in the future, even if you are no longer HSA Eligible.
What happens if I change to a plan that is not HSA Qualified?	You can not put any more money in your HSA if you are no longer HSA Eligible but the money in the account will stay there until you decide to spend it. You can continue to spend it on qualified expenses tax-free even if you are no longer HSA Eligible.
What happens if my employment ends?	Your HSA goes with you. You can only continue to put money in it if you remain HSA eligible. If you are no longer HSA eligible you can't put more money in the HSA but you can continue to spend what is already there on qualified medical expenses tax-free.
Can I use my HSA to pay for my family's expenses if they are not on my health plan?	Yes, as long as the expense is not reimbursed by another health plan, you may use your HSA to pay for qualified expenses incurred by you, your spouse, and your tax-dependent children, even if they are not covered on the qualified HDHP.
How much will I have to pay when I go to the doctor?	This will be determined at the time of service. After the claim has been processed, you will receive a statement from Florida Blue showing what portion of the claim you are responsible to pay. Most providers are able to quote you this amount at the time of service. Always compare your medical statement to your provider's charge to verify you paid the correct amount.
What if I don't have enough money in my HSA?	You will need to pay the provider from another source. You can later reimburse yourself from the HSA when the funds are available, if you choose to do so. Remember to keep all receipts to show that the funds were withdrawn for qualified expenses.

DENTAL INSURANCE - METLIFE

The **Dental PPO** plan allows you to see any dentist. However, you will take advantage of discounted pricing and enjoy lower out-of-pocket expenses by visiting a dentist that participates in the network.

	MetLife PPO Plan	
	In-Network	**Out-of-Network**
Deductible	$50 Individual | $150 Family Applies to Basic and Major Services	
Preventive Services Routine Oral Exams, Routine Cleanings, Bitewing X-Rays, Child Fluoride, Child Sealants	No Charge	No Charge
Basic Services Fillings, Simple Extractions, Oral Surgery, Root Canals, Periodontics	Deductible + 20%	Deductible + 20% + of eligible expenses
Major Services Inlays, Onlays, Crowns, Bridges, Dentures,	Deductible + 50%	Deductible + 50% + of eligible expenses
Orthodontia Braces and related services	50% Child to Age 19 Only $1,000 Lifetime Maximum	50%
Maximum Annual Benefit	$3,000 per person per calendar year Includes a Maximum Accumulation Account, see details on next page. Applies to Preventive, Basic and Major Services	
Payroll Deductions	Employee Only……………………………………………$15.30 Employee & 1 Dependent…………………………$29.93 Employee & 2 or more Dependents……………$50.58	

Frequency and Age Limits apply to certain services under both plans.

DENTAL INSURANCE - METLIFE

PPO Contracted Fee – this refers to the discounted charge for each service agreed upon by Metlife and In-Network providers. When accessing care Out-of-Network under the PPO Plan**,** this is the amount on which the claim will be paid. You are responsible to pay the difference in the provider's actual charge and what the insurance reimburses.

Predetermination of Benefits – This optional service provides you with an estimate on the amount to be covered prior to having a dental procedure under the PPO plan. When your treatment plan is expected to exceed $300, ask your dentist to request the Predetermination Review. Your dentist will submit your treatment plan and Metlife returns an estimate of what they expect to pay and what you can expect to pay.

Maximum Annual Benefit – This is the most that Metlife will pay for covered services in a calendar year. You are responsible for any additional charges during that calendar year once the benefit has been exhausted.

How to find an In-Network PPO Dentist or Register as a Member

- Go to www.metlife.com
- Click on Find a Dentist
- Select The 'PDP Plus Dental Network' then follow the prompts
- **To register as a Member**: click 'Register now'
- Start creating your account by following the prompts

SPECIAL LIMITATION

Teeth lost or missing before a covered person becomes insured by this plan. The plan won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan or previous plan.

VISION INSURANCE - METLIFE

Our Vision plan through MetLife offers affordable coverage for your routine eye care needs.

To find an In-Network Vision Provider or Register as a Member

- Go to www.metlifevision.com
- Click on “Find a Vision Provider”
- Complete either your zip code or address to find a provider in your area
- **To register as a Member:** click ‘Register’
- Start creating your account by following the prompts

	Frequency Limits	In-Network Coverage	Out-of-Network Coverage
Eye Exam	Covered once every 12 months	$10 Copay	No Coverage
Eyeglass Lenses	Covered once every 12 months	$25 Copay	Reimbursed up to: $30 Single Vision $50 Bifocal $65 Trifocal
Eyeglass Frames	Covered once every 24 months	$25 Copay with a $130 Retail Frame	Reimbursed up to $61
Contact Lenses	Covered once every 12 months instead of lenses and frames	Elective: $130 Contact Lens Allowance Medically Necessary: $25 Copay	Elective: Reimbursed up to $125 Medically Necessary: Reimbursed up to $210
Payroll Deductions	Employee Only……………………………………..….$2.46 Employee & 1 Dependent………………………….$4.49 Employee & 2 or more Dependents…………….$7.77		

BASIC LIFE AND AD&D INSURANCE

As a benefit to all eligible employees, Aspire Health Partners provides you with Basic Life and Accidental Death & Dismemberment (AD&D) Insurance through Voya Financial at no cost to you.

Basic Life and AD&D	
Basic Life Benefit	Equal to one times your annual salary up to $300,000
Benefit Reduction	The benefit amounts shown above will reduce by 40% of original amount at age 70 and by 50% of original amount at age 75.
Conversion	Upon termination allows a covered person who has life insurance coverage to obtain an individual policy at his/her expense, without providing evidence of insurability. A covered person may convert all or part of the coverage. The premiums will be based on the amount of coverage and the covered person's age and class of risk at the time of conversion (Subject to state requirements).

Primary Beneficiary - The person or people that will receive the benefit upon your death. You name the beneficiary at the time of enrollment. You may also change your beneficiary at any time.

Secondary Beneficiary or Contingent Beneficiary - The person or people that will receive the benefit upon your death ONLY if there is no living Primary Beneficiary at the time of your death.

IMPORTANT: Please be sure to name a Beneficiary when making your elections. You may name more than one if desired. Caution: Listing someone under age 18 as a beneficiary is not recommended. Payment of a claim may be delayed and may be paid to someone other than the minor that was named as beneficiary.

VOLUNTARY LIFE INSURANCE

You also have the option to purchase Voluntary Life Insurance through VOYA at affordable group rates. If you purchase Voluntary Life coverage for yourself, you may also purchase coverage for your spouse and/or dependent children.

	Employee Coverage	Spouse Coverage	Dependent Child Coverage
Available Increments	$10,000	$5,000	$10,000
Coverage Maximum	Up to 5 times your annual salary (rounded to the nearest $1,000) or $500,000, whichever is less	100% of the employee coverage amount or $100,000, whichever is less	$10,000 Ages 6 months to the child's 19th birthday or 25th birthday for a Full Time Student
Guarantee Issue Amount	Newly eligible employees under age 70 may elect up to $250,000 without Evidence of Insurability	Elect up to $30,000 on your newly eligible Spouse under age 70 without Evidence of Insurability	Elect up to $10,000 on your newly eligible dependent children without Evidence of Insurability
Additional Features	Conversion: provides an option to convert this coverage to an individual policy after you terminate employment. Portability: provides an option to continue this coverage for a specified period after you terminate employment. You must apply and pay the required premium to Voya within 30 days of your termination to exercise the conversion or portability options.		

Note: If you and your spouse both work for Aspire Health Partners you cannot cover each other on spouse life insurance. Additionally, only one of you may elect dependent child life coverage.

Primary Beneficiary - The person or people that will receive the benefit upon your death. You name the beneficiary at the time of enrollment. You may also change your beneficiary at any time.

Secondary Beneficiary or Contingent Beneficiary - The person or people that will receive the benefit upon your death ONLY if there is no living Primary Beneficiary at the time of your death.

VOLUNTARY LIFE INSURANCE

You also have the option to purchase Voluntary Life Insurance through VOYA at affordable group rates. If you purchase Voluntary Life coverage for yourself, you may also purchase coverage for your spouse and/or dependent children.

To Calculate Payroll Deduction:

Step 1: Determine if you want to elect 1, 2, 3, 4 or 5 x your salary
Step 2: Round up to the next $1,000
Step 3: Divide the amount you elect by 1,000
Step 4: Multiply the amount in # 2 times the corresponding rate in the table

Age Spouse Rate is determined by using Employee's Age	Payroll Deduction Rates Per $1,000 of Coverage
30-34	0.028
35-39	0.042
40-44	0.069
45-49	0.106
50-54	0.203
55-59	0.318
60-64	0.346
65-69	0.637
70-74	1.306
75-79	3.748
80+	$8.270
All Children (over 6 months of age to age 19 or 25 if full time student)	0.92/ $10,000

Example: John is 42, his salary is $40,000. He elects the amount of $80,000:

1) $80,000
2) $80,000 / 1,000 = 80
3) 80 x 0.069 = $5.52 = *payroll deduction*

Evidence of Insurability (EOI) - A Medical questionnaire referred to as an Evidence of Insurability (EOI) Form is required if you (1) are a newly eligible employee or spouse electing an amount over the Guarantee Issue Limits, (2) you are adding or increasing your coverage during the annual enrollment. When an EOI is required the insurance company will decide if your request will be approved. Amounts subject to EOI will not begin unless/until approved by the insurance company.

Benefit Reduction - Employee coverage reduces by 40% at age 70, an additional 10% at age 75. Benefits will terminate upon retirement. The reduction is a percentage of the original amount.

SHORT TERM DISABILITY INSURANCE

Short Term Disability Insurance is intended to provide you with temporary income replacement if you are unable to work due to an off-the-job accident or illness and are under the care of a doctor.

Benefits Begin	On the 8th day you are disabled
Benefit Amount	The plan pays you 66.67% of your weekly income, to a maximum of $1,000 per week
Payment Lasts	The plan will continue to pay you for up to 13 weeks if you remain disabled
Pre-Existing Condition	If you have been treated for a condition in the 3 months prior to the effective date, that condition will not be covered for the first 12 months of coverage.

Estimated Payroll Deductions		
Weekly Earnings	**Weekly Benefit**	**Payroll Deduction**
$350	$233	$8.94
$400	$267	$10.22
$450	$300	$11.49
$500	$333	$12.77
$550	$367	$14.05
$600	$400	$15.32
$650	$433	$16.60
$700	$467	$17.88
$750	$500	$19.15
$800	$533	$20.43
$850	$567	$21.71

LONG TERM DISABILITY INSURANCE

Long Term Disability Insurance is intended to provide you with income replacement if you are unable to work due to an accident or illness and are under the care of a doctor.

Benefits Begin	On the 91st day you are disabled
Benefit Amount	The plan pays you 60% of your monthly income, to a maximum of $6,000 per month
Payment Lasts	The plan will continue to pay you for up to Social Security Normal Retirement Age if you remain disabled
Pre-Existing Conditions	If you have been treated for a condition in the 3 months prior to the effective date, that condition will not be covered for the first 12 months of coverage.
Coverage Note	Your benefits may be limited to a shorter time period, such as 24 months during your lifetime, if: · The disability is due to a mental illness, alcoholism or drug abuse. · The disability is due to a special condition as defined in the certificate, such as fibromyalgia or chronic fatigue syndrome.

HOW TO CALCULATE LTD PAYROLL DEDUCTIONS
(determine the approximate payroll deductions)

Annual Income	Monthly Income	Per $100 Increment	Multiply by Rate 0.93	Convert monthly deduction to 26 Pay Periods
$24,000	(÷) Divide by 12 $2,000	(÷) Divide by $100 $20.00	(x) Multiply by 0.93 $18.60	(x) Multiply by 12 months and (÷) divide by the 26 pay periods $8.58

FLEXIBLE SPENDING ACCOUNT:

HEALTH CARE ACCOUNT (HCA)

A Health Care Flexible Spending Account (FSA) may be used to set aside money on a pre-tax basis to pay for eligible health care expenses (including dental and vision expenses) not paid by an insurance plan. This allows you to save money on taxes!

HOW THE FLEX ACCOUNT WORKS WITH THE HSA ACCOUNT (Limited Flex Account)
You may continue to use your debit MasterCard to pay for unreimbursed expenses on anything other than medical expense. Out of pocket expenses for things like dental work and eyeglasses would still be covered under the debt MasterCard.

FSA Plan Year	The FSA Plan Year runs on a Calendar Year basis, from January 1st – December 31st. **It is important to note if you elect to contribute to an HSA, your FSA will be limited and CANNOT be used to pay for ANY medical expenses.**
Contribution Limits	• You may contribute up to **$3,050** for the 2023 calendar year. • The amount you elect is divided equally by the number of paychecks you will receive during the plan year and deducted from each paycheck before taxes are calculated.
Claim Payment or Reimbursement	• Claims must be incurred during the FSA plan year to be paid from the FSA. • You will receive a pre-paid credit card which may be used to pay your provider for eligible expenses at the time of service. • You may also submit a paper claim to MedCom for reimbursement if the card is not used. • You have 30 days following the end of the plan year to submit a reimbursement request for claims incurred during the plan year.
Carry Over	• Up to $610 of any unused balance at the end of the plan year will be carried over for use in the following year. • Any unclaimed balance over $610 left after the end of the plan year is forfeited.
Claim Substantiation	Federal guidelines require MedCom to substantiate most claims. This means that after you use your FSA credit card to pay an expense you will often receive a request from MedCom for a copy of your receipt. The receipt must be submitted as soon as possible to avoid interruption in the use of your FSA funds.

FLEXIBLE SPENDING ACCOUNT:
HEALTH CARE ACCOUNT (HCA)

ELIGIBLE EXPENSES

The general rule is that any medical expense that is deductible on your federal income tax return may be reimbursed through the FSA if it is not paid for by an insurance plan.

EXAMPLES OF ELIGIBLE EXPENSES:

- Artificial limbs
- Chiropractor fees
- Contact Lenses
- Crutches
- Dental fees
- Doctor fees
- Eyeglasses
- Hearing Aids
- Hospital Services
- In vitro fertilization
- Lab fees
- Optometrist fees
- Oxygen
- Orthodontics
- Psychoanalysis
- Surgery
- Telephones for the hearing impaired
- Therapy (medical)
- Transplants of organs
- Wheelchairs
- X-rays

When deciding how much to contribute to the FSA, consider how much you know you will spend in medical care over the course of the year. Remember that any unclaimed balance over $610 left after the end of the plan year is forfeited.

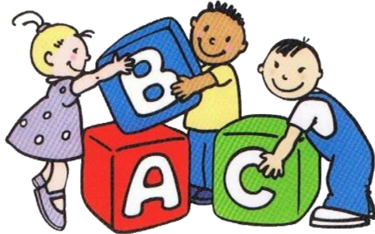
Your FSA may be used to pay for eligible expenses incurred by you, your legal spouse, and your tax-dependent children during the FSA plan year, even if they are not enrolled in your medical, dental, and/or vision plan.

EXAMPLES OF EXPENSES THAT ARE NOT ELIGIBLE:

- Health clubs or spas
- Non prescribed weight loss program
- Expenses paid by in insurance plan
- Smoking cessation education materials and programs
- Hair transplants
- Electrolysis
- Teeth whitening
- Cosmetic surgery
- Insurance premiums
- Medications from other countries

FLEXIBLE SPENDING ACCOUNT:

DEPENDENT CARE ACCOUNT (DCA)



A Dependent Care Flexible Spending Account (DCA) may be used to set aside money on a pre-tax basis to pay for daycare expenses for your children under age 13 and other qualified dependents.

USE IT OR LOSE IT WITH THE DEPENDENT CARE ACCOUNT

DCA Eligible Expenses	Childcare by a licensed facility for children under age 13 who qualify as dependents on your Federal income tax return. Adult care for an adult of any age who is physically or mentally unable to care for themselves and who qualifies as a dependent.
DCA INELIGIBLE Expenses - not limited to	Child Support Payment; Educational supplies & activity fees; Overnight camp Food, clothing, entertainment; Cleaning & cooking services
Contribution Limits	• You may contribute up to **$5,000** for the per year • The amount you elect is divided equally by 26 (the number of deductions taken) the plan year and this amount is deducted from your paycheck before taxes are calculated. DCA funds are not available until they are deposited through payroll.
Claim Payment or Reimbursement	• Claims must be incurred during the plan year to be paid from the DCA • You will receive a pre-paid credit card which may be used to pay your provider for eligible expenses at the time of service. • You may also submit a paper claim to MedCom for reimbursement if the card is not used. • You have 90 days following the end of the plan year to submit a reimbursement request for claims incurred during the plan year.
No carry over	• Plan your contributions carefully. The IRS requires that you forfeit any money left at the end of the year. You will have 60 days at the end of the year to submit claims for this year.
Childcare Tax Credit vs Spending Account	Dependent care expenses that are eligible for reimbursement may also be eligible for a federal income tax credit. You can apply one of these tax treatments, but not both for the same expenses. Please consult a tax accountant to determine which would be more beneficial to you.

SUPPLEMENTAL INSURANCE

We offer Supplemental Insurance polices through Voya. These policies pay benefits directly to you and allow you to use the funds however you need, whether that means you use it to pay your health plan copays and deductible or your electric bill, car payment, or at the grocery store.

Available Plans	Critical Illness, Accident, and Hospital Indemnity
Family Coverage	Coverage is available for you, your spouse, and your dependent children up to age 26.
Stackable	Each of the Voya plans pay benefits in addition to any other plans you have. This means if you incur an expense that is covered by your medical plan and your Voya plans, your Voya plans will still pay the benefit shown in the policy. If you incur an expense that is covered under more than one Voya plan, each of the Voya plans will pay the available benefit.
Pre-Existing Condition Limitation	If you incur an expense during the first twelve months you are enrolled in the Voya plan that was due to a pre-existing condition it won't be covered. A pre-existing condition is a condition that you were treated for in the 12 months immediately prior to your effective date. The plan will cover expenses during this period that are not related to a pre-existing condition. Claims incurred after you have been enrolled in the plan for 12 months due to a pre-existing condition will also be covered.

What to know about plans through Voya

- You may choose one, two, or all of the plans to best meet your needs.
- The benefits paid by these plans can be used to help pay expenses that other insurance plans don't cover.
- These plans are designed to supplement your major medical insurance, not replace it.
- If you incur a claim that is covered under more than one of your Voya plans, they will all pay the benefit specified in the policy!

SUPPLEMENTAL INSURANCE

Critical Illness Insurance

This plan pays you a cash benefit when you are diagnosed with a covered critical illness. It also includes an annual wellness benefit.

$10,000 or $20,000 Lump Sum Benefit	The plan pays this Lump Sum Benefit the 1st time you are diagnosed with a covered illness while insured under this plan. Some covered illness included (but aren't limited to) Heart Attack, Stroke, Major Organ Failure, End Stage Renal Disease, Coma, Blindness, and other serious illnesses.
Spouse and Child Benefits	If you enroll your spouse or child in the plan and they are diagnosed with a covered illness, the plan pays a lump sum benefit up to 50% of your benefit amount for your spouse and 50% of your benefit amount for your child the 1st time they are diagnosed with a covered illness.
Premiums	The cost of this coverage is based on your age refer to the grid below for your estimated cost.

Employee Bi-Weekly		
ISSUE AGE	**$10,000**	**$20,000**
Under 30	$1.98	$3.97
30-39	$2.31	$4.62
40-49	$4.38	$8.77
50-59	$8.54	$17.08
60-64	$12.18	$24.37
65-69	$16.29	$32.58
70+	$22.62	$45.23

Spouse Bi-Weekly		
ISSUE AGE	**$10,000**	**$20,000**
Under 30	$2.35	$4.71
30-39	$2.68	$5.35
40-49	$5.03	$10.06
50-59	$10.71	$21.42
60-64	$15.92	$31.85
65-69	$17.77	$35.08
70+	$27.32	$54.65

Children Bi-Weekly	
$5,000	**$10,000**
$0.60	**$1.20**

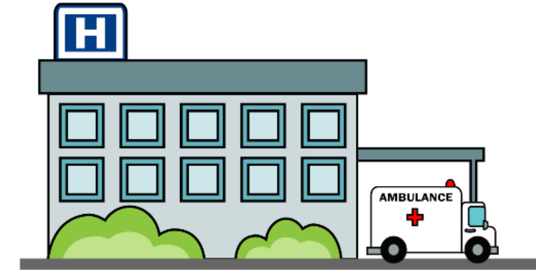
SUPPLEMENTAL INSURANCE

Accident Insurance

This plan pays you a cash benefit when you experience a covered accident off the job. Benefits include (but aren't limited to):

Emergency Room	The plan pays you $150 per accident
Hospital Admission	The plan pays you $1,400 upon admission and then $300 per day you remain hospitalized for up to one year per accident.
Accidental Death	Employee: $60,000; Spouse: $24,000, Child: $12,000
Wellness Benefit	The plan pays you $60 when you submit a claim showing you had a covered health screening tests. Payable once per calendar year per person.

Accident Payroll Deductions			
Employee Only	Employee & Spouse	Employee & Child (ren)	Employee & Family
$5.42	$8.91	$9.71	$13.20



Hospital Confinement Indemnity Insurance

This plan pays you a cash benefit when you are admitted to a hospital. This plan also includes an annual health screening benefit. Benefits Include:

Hospital Admission	$1,500 per admission Limited to 1 per person and 3 per family per year.
Hospital Confinement Benefit	$150 per day for up to 30 days per person per year.

Hospital Confinement Payroll Deductions			
Employee Only	Employee & Spouse	Employee & Child (ren)	Employee & Family
$8.88	$17.23	$13.71	$22.07

VOYA ADDED BENEFITS

Employee Connect Employee Assistance Program (EAP)

Designed specifically for employees, this program is offered in partnership with ComPsych® Corporation. Our program also gives employees access to services that address personal life challenges – including financial and legal assistance - and improves workplace productivity and performance.
EAP: www.GuidanceResources.com / Web ID: MY5848i
EAP: 877-533-2363

Will Prep, Funeral Planning & Concierge Services
Voya Employee Benefits works with Everest Funeral Package, LLC* to offer funeral planning and concierge services. This is a unique opportunity for you to discuss and obtain information from independent experts regarding the planning of a funeral. You will have the ability to contact professionals who will aid them with funeral planning for themselves and eligible family members.
Funeral Planning: www.EverestFuneral.com/VoyA -P: 800-913-8318

Online Will Prep:

- **Online tool allows users to create customized legal documents such as a Will, Health Care Directive, Power of Attorney, and more**
- **Users are asked a series of easy-to-answer questions with helpful explanations and examples**
- **Based on responses, a customized legal document unique to the individual's situation is created**

Travel Assistance Program
When traveling more than 100 miles from home, whether domestic or international travel, Voya Travel Assistance provides employees and their dependents four types of services: Emergency Transportation Services, Medical Assistance Services, Emergency Personal Services, and Pre-trip Information. These services are described in further detail on your Voya posted flyers. Covered employees and their dependents will have toll-free access to the Voya Travel Assistance customer service center 24 hours a day from anywhere in the world.

Travel Assistance: www.EuropeAssistance-usa.com

Travel Assistance: 800-859-2821

RETIREMENT PLAN

403(b) RETIREMENT PLAN

Providing a retirement plan that lets you save for the future is important. To better serve all of our Aspire employees and offer the best possible services and benefits we have teamed up with Empower Retirement.

New Hire note: Aspire Health Partners will auto enroll new hires at 2% contribution in the 403(b)-retirement plan. You will have a 45 -day period to opt out of the auto enrolled. .

Bi-weekly Pay	Employee Contribution %	Bi-weekly Employee Payroll Deduction	Bi-weekly Company Matching Contribution %	Bi-weekly Company Matching Contribution
$1,000	2%	$20.	1%	$10.
$1,000	4%	$40.	2%	$20.
$1,000	6%	$60.	3%	$30.
$1,000	8%	$80.	4%	$40.
$1,000	10%	$100.	5%	$50.
$1,000	12%	$120.	5%	$50.

What to do to get started:	
Step 1	**Review the highlights of the Aspire Health Partners Retirement Plan. You can find them along with other valuable information in the enrollment book located under the plan information tab at https://www.empowermyretirement.com**
Step 2	Join the plan by visiting https://www.empowermyretirement.com and selecting "New user/ Get started now." Establish a customer ID and password.
Step 3	You may choose to make pretax contributions up to the maximum allowed by law. Empower Retirement Solution's free auto-increase service allows you to raise your plan contribution rate once a year by an amount you choose. You can sign up for the auto-increase service online at ttps://www.empowermyretirement.com
Step 4	Contribute enough to take full advantage of your employer's contribution after one year of service. You are eligible to take advantage of your employer's 50% matching contribution up to 10% of your annual income, which is based on your level of contribution: • 4% Employee Contribution (payroll deduction) 2% (50% match on Employee's 4%) • 8% Employee Contribution (payroll deduction) 4% (50% match on Employee's 8%)
Step 5	Decide how your contributions will be invested among the available investment options. Designating a beneficiary: Designate at least one beneficiary for your retirement account, so that your assets can be distributed according to your wishes upon your death. You can find the Beneficiary Designation form under the plan information tab at https://www.empowermyretirement.com.

PAID TIME OFF

WHAT IS PAID TIME OFF?	To reward employees for loyal and continuous service, Aspire Health Partners provides a pre-determined number of paid days off to observe such occasions as vacations, illness, medical appointments, personal business or leave of absence. The Paid Time Off (PTO) program gives you flexibility in taking paid time off from work. Time away from work will make you more productive when you are working. Under the PTO program, you decide, with your supervisor's approval at least two weeks in advance, when and how you will use your PTO hours.
HERE'S HOW IT WORKS	Time off for vacation, personal business, or personal and family illness is taken utilizing PTO hours. You need to schedule your time off at least two weeks in advance to allow more efficient staffing throughout Aspire Health Partners.
ELIGIBILITY	If you are classified as a Full-Time (30+ hours) employee, you are eligible to accrue PTO based upon length of service to the organization. A staff member is not eligible to use PTO hours for the first 90 days of employment. You may schedule time off based on your available hours. Under no circumstances will you be able to borrow against PTO hours to be earned in the future or paid in advance of the regular payday for PTO hours.
PAYMENT METHOD	PTO hours are paid at your base hourly rate of pay in effect at the time you use the hours.
PERIOD OF ACCRUAL	You accrue hours each pay period to a maximum amount of 320. When your accrued hours fall below 320, you will start accruing again. The CSD (normally your date of hire) will change if your status changes from a regular to a non-benefit eligible position or vice versa.

SCHEDULED TIME OFF Earned PTO hours will be used for personal business any time during the year, provided such time off has management's approval. Jury duty and bereavement times are covered under separate policies and do not come from the PTO bank. Requests for PTO hours must be submitted on the appropriate form with management authorization obtained in advance. Approvals are made by the employee's manager based on periods convenient to the operations of the department. Preferences for PTO hours will be granted whenever possible. The approval of request for PTO hours is based on departmental needs.

PTO HARDSHIP CASH-OUT PROVISIONS is defined as an unexpected expense which would cause an interruption in the course of everyday living such as a foreclosure or repossession of property, major repair for living quarters or transportation. In order to be eligible to cash out PTO hours due to a hardship case, the employee must complete a PTO Hardship Request Form and have it approved by Human Resources. The employee needs to have been employed for over one year and leave a minimum balance of 80 hours after the cash out of PTO for hardship. Details explaining the hardship will be required when completing the PTO Hardship Request Form. Please note a PTO hardship is paid at 75% of the gross amount. A Hardship is not defined as: Needing to lower the balance of PTO to prevent stoppage of accrual / Payments for recurring expenses / Purchase of personal merchandise such as a car or furniture

The maximums are based on a 80 hours per pay period.

Years of Service	Hours per pay period	ANNUAL		
		Hour	Days	Weeks
0-1.99	3.85	100	12.50	2.5
2-4.99	6.15	160	20.00	4.0
5-8.99	7.08	184	23.00	4.6
9-13.99	8.00	208	26.00	5.2
14+	9.24	240	30.00	6

IMPORTANT NOTICES

Changing your Benefit Choices

Your benefit choices will stay in effect for a full plan year (as long as you remain eligible). However, if you have a qualified change in family status, you may be able to change some of your benefit elections. Qualified family status changes include, but are not limited to:

- Marriage or divorce
- Birth, adoption or legal custody of an eligible dependent
- Death of your spouse or dependent
- Dependent covered by the plan becomes ineligible
- Change from full-time to part-time status, or vice versa, by you or your spouse
- Unpaid leave of absence by you or your spouse
- Significant change in your spouse's coverage attributable to employment
- Termination or commencement of spouse's employment

If you experience a qualified family status change during the plan year, it is possible that you may add or remove yourself and/or dependents to/from coverage. If you wish to make changes to your benefits as the result of a qualified family status change, you must notify Human Resources within 31 days of the change. *If you do not notify Human Resources within 31 days of the qualifying event, you must wait until the next annual enrollment period to make any desired changes*. Please keep in mind that documentation may be required and the requested change must be consistent with the Qualified Family Status Change.

Special Enrollment Rights

If you are declining enrollment 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 towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself or your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. To request a special enrollment or obtain more information, contact your Human Resources Department.

IMPORTANT NOTICES

Uniformed Services Employment and Reemployment Rights Act

The Uniformed Services Employment and Reemployment Rights Act (USERRA) prohibits discrimination against anyone for serving in the armed forces or for taking military leave from a civilian job. This includes discrimination in hiring, promotion, reemployment, or any other benefit of employment. USERRA also prohibits retaliation against anyone who seeks to enforce their rights under USERRA or assists another in enforcing those rights.

Women's Health and Cancer Rights Act of '98

Under federal law, group plans providing benefits for a mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

Prosthesis and physical complications of mastectomy, including lymph edemas, in a manner determined in consultation between the attending physician and the patient.

Newborns and Mothers' Health Protection Act of 1996 (NMHPA)

Under Federal law, you and your newborn child are covered for a hospital stay following childbirth. The law applies both to persons enrolled in group health plans and to persons who have individual health care coverage. In general, plans and health insurance issuers that are subject to NMHPA may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a normal delivery or 96 hours following a delivery by cesarean section.

Michelle's Law

This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to medical plans that condition dependent eligibility upon student status. The dependent child's change in college enrollment must meet the following requirements:

- The dependent is suffering from a serious illness or injury.
- The leave is medically necessary.
- The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary.

IMPORTANT NOTICES

HIPAA Privacy Notice

This Notice is provided as required by the Federal Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”) and its regulations issued at 45 CFR Parts 160 through 164 (the “Privacy Regulations”). It is for participants and beneficiaries in the (referred to as the “Plan”). You are entitled to receive a notice of our procedures for protecting the privacy of your health information. “Protected Health Information” is information that identifies you and is related to your medical history for health care you receive or the payment for that care. We must follow the terms of the notice currently in effect. This notice describes how we may use or disclose your Protected Health Information and your rights regarding the use and disclosure of that information. You may also receive privacy notices from others, such as other health care plans, insurers (including HMOs) and providers about their use and disclosure of your health information.

HOW THE PLAN MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Plan may use and disclose your Protected Health Information for different purposes. The examples below illustrate the types of uses and disclosures we may make without your authorization for treatment, payment and health care operations.

- Treatment. The Plan may disclose your Protected Health Information to assist your health care providers (doctors, pharmacies, hospitals and others) in your diagnosis and treatment. For example, The Plan may disclose to one treating physician the name of another treating physician so that he or she can obtain records or other information needed for diagnosis or treatment.
- Payment. The Plan may use and disclose your Protected Health Information in order to pay for your covered health expenses. For example, we may use your Protected Health Information to enroll you for coverage or to determine if a claim for benefits is covered under the Plan (e.g., if treatment is medically necessary).
- Health Care Operations. The Plan may use and disclose your Protected Health Information in order to perform Plan activities, such as quality assessment and improvement activities, reviewing competence or qualifications of health care providers, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. Other activities include disease management, case management, conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, The Plan may use information about your claims to refer you to a disease management program.
- Plan Sponsor. The Plan discloses your medical information to , which sponsors the Plan, for Plan administration purposes that are described in the document that governs the specific Plan. The Plan Sponsor will be required to certify to us that it will use your medical information in accordance with the Privacy Regulations.
- Enrolled Dependents and Family Members. The Plan will mail explanation of benefits forms and other mailings containing Protected Health Information to the address we have on record for the employee who is enrolled in the health plan.

OTHER PERMITTED OR REQUIRED DISCLOSURES

- To Your Family Member, Other Relative or Close Personal Friend. The Plan may disclose Protected Health Information to a family member, other relative or close personal friend provided that information is directly relevant to that person’s involvement in your health care or to notify them of your location, general condition or death. The Plan will not make any such disclosure unless you are given a reasonable opportunity under the circumstances to object and did, in fact, object.
- As Required by Law. The Plan must disclose Protected Health Information about you when we are required to do so by law.
- Public Health Activities. The Plan may disclose Protected Health Information to public health agencies for reasons such as preventing or controlling disease, injury or disability. This includes disclosures necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Protected Health Information may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- Victims of Abuse, Neglect or Domestic Violence. The Plan may disclose Protected Health Information to government agencies about abuse, neglect or domestic violence if there is a reasonable belief that you may be a victim of abuse, neglect to domestic violence. In that case, The Plan will promptly inform you that a disclosure has been or will be made unless that notice would cause a risk of serious harm. For purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such disclosure has been or will be made. Disclosure may generally be made to the minor’s parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor’s Protected Health Information.
- Health Oversight Activities. The Plan may disclose Protected Health Information to government oversight agencies (e.g., U.S. Department of Labor) for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs.
- Judicial and Administrative Proceedings. The Plan may disclose Protected Health Information in response to a court or administrative order. The Plan may also disclose Protected Health Information about you in certain cases in response to a subpoena, discovery request or other lawful process. In such case, The Plan will require satisfactory assurances that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised, or if any were raised, that they were resolved in favor of disclosure by the court or tribunal.

IMPORTANT NOTICES

HIPAA Privacy Notice (continued)

OTHER PERMITTED OR REQUIRED DISCLOSURES (continued)

- Law Enforcement. The Plan may disclose Protected Health Information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect or witness; or to provide information about the victim of a crime. Such disclosures include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances. The law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by us in our sole discretion.
- Coroners, Funeral Directors, Organ Donation. The Plan may release Protected Health Information to coroners or funeral directors as necessary to allow them to carry out their duties. The Plan may also disclose Protected Health Information in connection with organ or tissue donation.
- Plan Information and Programs. The Plan may contact you to provide information about alternative treatment programs or other health-related benefits and services that may be of interest to you.
- Research. Under certain circumstances, the Plan may disclose Protected Health Information about you for research purposes, provided certain measures have been taken to protect your privacy.
- To Business Associates. We may disclose Protected Health Information to a "business associate", provided that person or entity enters into an agreement as described in the Privacy Regulations. A "business associate" is a vendor that provides certain services (typically Plan administration services) to or on behalf of the Plan.
- To Limited Data Recipients. The Plan may disclose Protected Health Information to a "limited data recipient", provided that person or entity enters into an agreement as described in the Privacy Regulations. A "limited date recipient" is a person or entity that receives Protected Health Information that is partially de-identified in accordance with the Privacy Regulations and used for purposes of research, public health or health care operations.
- Marketing. The Plan may use Protected Health Information for purposes of marketing where it is face-to-face and involves a matter of nominal value.
- To Avert a Serious Threat to Health or Safety. The Plan may disclose your Protected Health Information, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- Special Government Functions. The Plan may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- Workers' Compensation. The Plan may disclose Protected Health Information to the extent necessary to comply with state law for workers' compensation programs or similar programs established by law.
- Incidental to Another Permitted Use. The Plan may disclose Protected Health Information as permitted by the Privacy Regulations to be incidental to another permitted use.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have certain rights regarding Protected Health Information that the Plan maintains about you.

- Right To Access Your Protected Health Information. You have the right to review or obtain copies of your Protected Health Information from a "designated record set" with some limited exceptions. A designated record set includes the medical and billing records about you that a covered health care provider maintains. It includes enrollment, billing, claims payment and case or medical management records maintained by us or for the Plan. Your request to review and/or obtain a copy of Protected Health Information in your designated record set must be made in writing. The Plan may charge a fee for the costs of producing, copying and mailing your requested information, but the Plan will tell you the cost in advance. If access is denied, you will be provided with a written denial explaining the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.
- Right To Amend Your Protected Health Information. If you believe that Protected Health Information about you in a designated record set (maintained by the Plan) is incorrect or incomplete, you may request that the Plan amend the information. Your request must be made in writing and must include the reason you are requesting a change. Your request may be denied, for example, you ask the Plan to amend information that was not created by the Plan or that is already accurate and complete. If the request is denied, you must be provided with a written denial that explains the basis for the denial. You may then submit a written statement of disagreement.

IMPORTANT NOTICES

HIPAA Privacy Notice (continued)

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION (continued)

· Right to an Accounting of Disclosures by the Plan. You have the right to request a list of certain disclosures the Plan has made of your Protected Health Information. The request must be in writing. If you request an accounting for the same time period more than once within a 12-month period, the Plan may charge a reasonable fee.

· Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information. You have the right to request that the Plan restrict the way it uses or discloses your Protected Health Information for treatment, payment or health care operations. *The Plan may not agree to your request.* Your request for a restriction must be made in writing. In your request you must tell the Plan (1) what information you want to limit; (2) whether you want to limit how the Plan uses or discloses your information, or both; and (3) to whom you want the restrictions to apply.

· Right To Receive Confidential Communications. You have the right to request that the Plan use a certain method to communicate with you or that information be sent to a certain location. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from the Plan could endanger you. The Plan will accommodate all reasonable requests.

· Right to a Paper Copy of This Notice. You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy. To request a paper copy of this Notice, you must contact the Privacy and Complaint Officer identified at the end of this Notice.

· Contact Information for Exercising Your Rights. You may exercise any of the rights described above by contacting your companies Privacy and Complaint Officer.

PERSONAL REPRESENTATIVES

Your personal representative may exercise your rights. The representative must produce evidence of his/her authority to act on your behalf before that person will be given access to your Protected Health Information. Proof of such authority may be in one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- the parent of a minor child.

The Plan may deny access to your Protected Health Information to a personal representative in order to protect certain individuals who depend on others to exercise their rights under the Privacy Regulations and who may be subject to abuse or neglect, including minors.

Information Provided by:

This Benefits Guide is designed to provide select information about the benefit plans and programs offered by Aspire Health Partners from December 1, 2022 - November 30, 2023. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs described herein. This booklet does not constitute a Summary Plan Description (SPD) or Plan Document as defined by the Employee Retirement Income Security Act (ERISA). If there is a conflict between this document and the SPD, the SPD shall prevail.