



TLC TRAVEL STAFF

BENEFIT GUIDE



JUNE 1, 2022 - MAY 31, 2023



Dear Valued Employee,

We are happy to provide you with this Benefit Guide to summarize your employee benefits for the 2022-2023 plan year.

TLC Travel Staff recognizes that benefits are an important part of your life as an employee. Our benefits program will help you choose what works best for your needs and your budget.

This document is not just an enrollment guide; it is a resource for you and your family to use throughout the year. Inside you will find a summary of each benefit plan and helpful tips you may not have known about in the past. This guide is designed to break down the insurance benefits to help you make an informed decision regarding the selection and management of the services and benefits provided to you as an employee of TLC Travel Staff.



IMPORTANT NOTICE TO EMPLOYEES:



This Benefit Guide provides a general description of the various benefits available to you through the TLC Travel Staff Employee Benefits program. The details of these plans and policies are contained in the official plan and policy documents.

This guide is meant only to cover the major points of each plan or policy, for illustrative purposes only. It does not contain all of the facts regarding coverage, limitations, or exclusions that are contained in the policy documents. In the event of a conflict between the information in this guide and the formal policy documents, the formal documents will govern.

CONTENTS

- 4..... Eligibility
- 5..... Enrollment
- 6..... Medical Insurance
- 7..... Pharmacy Savings
- 8..... Good Rx App
- 9..... Know Your Options
- 10..... Dental Insurance
- 11..... Vision Insurance
- 12..... Terms to Know
- 13..... Mandatory Notices
- 14..... Medicare Part D Creditable Coverage
Disclosure
- 22..... Contacts



ELIGIBILITY

FOR YOU

All full time employees working an average of 30 hours per week are eligible to enroll in benefits.

For specific details, please refer to the plan documents.

New full time employees' benefits for all lines of coverage will begin on date of hire.

FOR YOUR FAMILY

Legislation regulates eligibility requirements for dependent coverage on Medical insurance plans. It is important for everyone to understand what constitutes eligibility and what the implications could be for not following the eligibility guidelines.

 Examples of Eligible Dependents includes:

- Legal Spouse
- Domestic Partner
- Dependent children

Healthcare reform legislation restricts a plan or issuer from denying coverage for a child under age 26 based on any of the following factors:

- Financial dependence on the employee
- Residency with the employee
- Student status
- Marital status
- Employment status

QUALIFYING EVENT DOCUMENTATION

When you first enroll, and/or if you change coverage mid-year due to a qualifying event, you may be asked to provide the applicable documents from the following list:

Spouse Verification Documentation:

Marriage Certificate

Child Verification Documentation:

Birth Certificate, court document awarding custody or requiring coverage

Domestic Partner Documentation:

Completed and signed affidavit of Domestic Partnership

You can provide these documents to your HR department.



ENROLLMENT

When can I apply for my Benefits?

- During your initial new hire eligibility period
- During the annual open enrollment period
- Within 30 days of a qualified life event



MID-YEAR ENROLLMENT CHANGES - Section 125 Cafeteria Plan

Employees receive the tax benefits of a Section 125 Cafeteria Plan. This plan allows you to pay for your employee benefits on a pre-tax basis to be deducted from your paycheck.

When you elect to pay for these authorized benefits pre-tax, you save because you are paying less in taxes. You do not pay Federal Income or Social Security taxes on these designated benefit dollars. Therefore, you lower your taxable income. This will allow you to take home more of your paycheck, decreasing the net cost of the benefit you are purchasing.



IRS regulations state that benefit choices cannot be changed in the middle of a plan year unless you experience a qualifying life event.

Changes must be reported within 30 days of the actual event.



Some common qualifying events may include:

- Marriage, Divorce or Death of Spouse
- Birth, Adoption or change in legal custody
- Loss of other coverage
- Enrollment in the Marketplace Exchange
- Change in Medicare or Medicaid entitlement
- FMLA or Military Leave

Please Note:

The IRS does not consider financial hardship a qualifying event to drop coverage.

To determine if any of these apply to you, please check with your Human Resources representative.



MEDICAL INSURANCE



UNITED HEALTHCARE



IN-NETWORK MEDICAL BENEFITS

AXKQ

AXKO

Deductible (Individual / Family)	\$5,000 / \$10,000	\$2,000 / \$4,000
Is Deductible Calendar Year or Policy Year?	Calendar Year	Calendar Year
Is Deductible Embedded or Non Embedded	Embedded	Embedded
Out of Pocket Maximum (Individual / Family)	\$7,150 / \$14,300	\$7,150 / \$14,300
Coinsurance	20%	20%
Prescription Drugs	\$15 / \$45 / \$85 / \$200	\$15 / \$45 / \$85 / \$200
Mail Order Drugs (90 Day Supply)	\$37.50 / \$112.50 / \$212.50 / \$500	\$37.50 / \$112.50 / \$212.50 / \$500

PHYSICIAN OFFICE VISITS

Primary Care Physician	\$15 (\$0 if under age 19)	\$15 (\$0 if under age 19)
Virtual Visits	\$0	\$0
Specialist	\$50/100	\$50/100
Referral Needed for Specialist?	No	No

PREVENTIVE CARE

Routine Adult Physical Exams	Covered 100%	Covered 100%
Well Woman Exams		
Routine Mammograms and Colonoscopy		
Well Child Exam & Immunizations		

DIAGNOSTIC / LABORATORY

Independent Clinical Lab (Blood Work)	Deductible + Coinsurance	Deductible + Coinsurance
Independent Diagnostic Testing Facility (X-rays)	Deductible + Coinsurance	Deductible + Coinsurance
Advanced Imaging (MRI, PET, CT Scan, Nuclear Medicine)	Deductible + Coinsurance	Deductible + Coinsurance

HOSPITALIZATION / OUTPATIENT SERVICES

Inpatient Hospitalization (Facility)	Deductible + Coinsurance	Deductible + Coinsurance
Outpatient Surgical Care (Hospital Facility)	Deductible + Coinsurance	Deductible + Coinsurance
Emergency Room	\$300 + Deductible + Coinsurance	\$300 + Deductible + Coinsurance
Urgent Care	\$25	\$25

OUT-OF-NETWORK BENEFITS

Deductible (Individual / Family)	\$10,000 / \$20,000	\$5,000 / \$10,000
Out of Pocket Maximum (Individual / Family)	\$20,000 / \$40,000	\$10,000 / \$20,000
Coinsurance	50%	50%

EMPLOYEE WEEKLY PAYROLL DEDUCTIONS

Employee Only	\$70.20	\$76.08
Employee + Spouse	\$210.60	\$228.24
Employee + Child(ren)	\$210.60	\$228.24
Employee + Family	\$350.99	\$380.40



PHARMACY SAVINGS

How to make the most of your medical and pharmacy benefits for your plan year.



Walmart Pharmacy Savings

Generic \$4 Program

\$4 Generic Medication for 30 Day Supply

\$10 Generic Medication for 90 Day Supply

The price is available in select stores only. For more information, please visit www.walmart.com/pharmacy



GoodRx Pharmacy Savings

GoodRx will allow you to compare the cost of medication between many of your local pharmacies. Good Rx can provide coupons to use at the pharmacy as well as a drug savings card that can be used to access other discounts

Good Rx can be used for pet medications too!



GoodRx

You can find the lowest price on prescriptions right from your cell phone!

Best of all - it's FREE!

How GoodRx can help

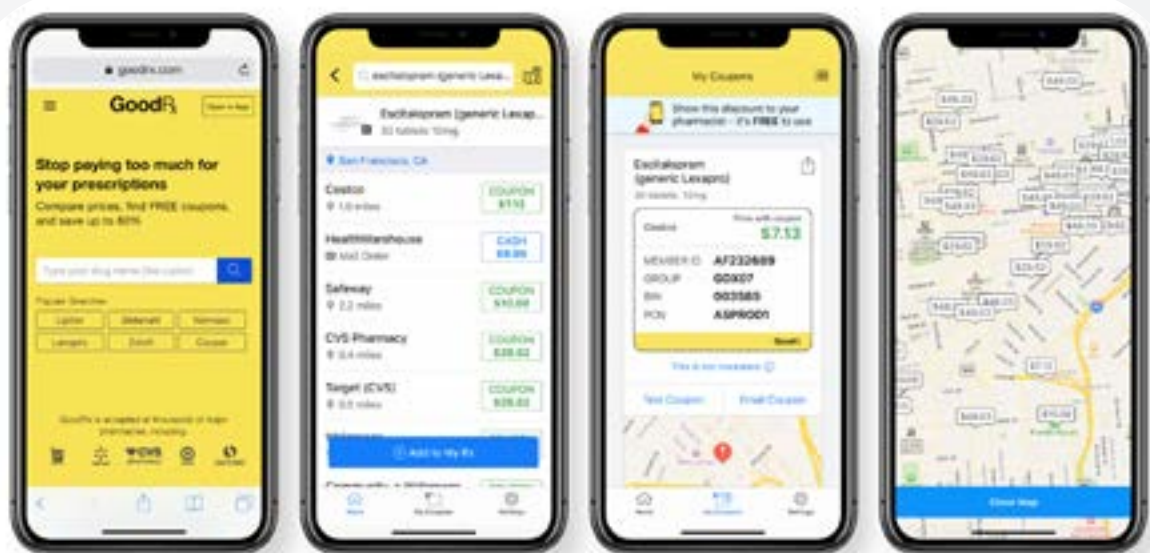
Every week, GoodRx collects millions of prices and discounts from pharmacies, drug manufacturers and other sources. Use their app to compare prices at pharmacies near you. GoodRx will show you prices*, coupons, discounts, and saving tips.

Don't pay too much!

Prices for prescription drugs vary widely between pharmacies. U.S. drug prices are neither fixed nor regulated. The cost of a prescription may differ **more than \$100** between two pharmacies across the street from each other.

Free and easy to use

- Instant access to the lowest prices for prescription drugs at more than 75,000 pharmacies
- Coupons and savings tips that can cut your prescription costs by 50% or more
- Side effects, pharmacy hours and locations, pill images, and much more



KNOW YOUR OPTIONS

5 HEALTHCARE OPTIONS

to help you make the best decision for your medical needs

Virtual Visits \$

24/7/365 access to a doctor

through the convenience of phone or video consults

You can receive care for:

- Cough, Cold & Flu • Allergies • Skin Problems
- Sinus Problems • Minor Fevers



Convenience Care Clinic \$

Your condition is not urgent or an emergency.

Conveniently located in Walgreen's*, Walmart* and Target*

*Check with your carrier to see which Convenience Care locations are in your network.

You can receive care for:

- Cough, Cold & Flu • Pink Eye • Urinary Tract Infections
- Ear Infections • Head Lice • Insect Bites
- Minor Burns, Cuts, and Scrapes • Sprains and Strains



Doctor's Office \$\$

Routine care or treatment for a current health issue

You can receive care for:

- Routine Checkups • Immunizations • Preventive Services
- Manage Medications



Urgent Care Center \$\$\$

You need medical care fast for a non-emergent medical issue

You can receive care for:

- Migraines • Severe Back Pain • Vomiting and Diarrhea
- Minor Broken Bones • Asthma Attacks • Severe Cough
- Animal Bites • Wounds Requiring Stitches

Emergency Room \$\$\$\$

For a true medical emergency that results in serious jeopardy to your health, impairment of bodily functions or organs

You can receive care for:

- Head Trauma or Loss of Consciousness • Chest Pain
- Numbness or Difficulty Speaking • Severe Abdominal Pain
- Coughing or Vomiting Blood • Severe Bleeding and Burns





DENTAL INSURANCE

GUARDIAN



BENEFITS SUMMARY

Annual Deductible (Individual/Family)
Annual Benefit Maximum
Orthodontia Lifetime Maximum
Waiting Period
Maximum Rollover

DENTALGUARD PREFERRED

\$50 / \$150
\$2,000
\$1,000
None
Included

IN-NETWORK

OUT-OF-NETWORK

PREVENTIVE SERVICES-DEDUCTIBLE WAIVED

Oral Evaluations		
Prophylaxis: Cleanings		
Fluoride Treatment (child only)	Plan pays 100%	Plan pays 100%
Bitewing X-rays, Full Mouth X-rays		
Sealants		
Space Maintainers		

BASIC SERVICES

Amalgam Restorations (Silver Fillings)		
Resin Based Restorations (anterior and posterior)	Plan pays 90% after Deductible	Plan pays 80% after Deductible
Extractions (routine and surgical)		
Endodontic Treatments		
Periodontic Treatments		

MAJOR SERVICES

Crowns		
Dentures	Plan pays 60% after Deductible	Plan pays 50% after Deductible
Bridges		
Implants		

ORTHODONTIA SERVICES

Diagnostics and Treatments (child to age 19)	50%	50%
--	-----	-----

EMPLOYEE WEEKLY PAYROLL DEDUCTIONS

Employee Only	\$6.94
Employee + Spouse	\$14.09
Employee + Child(ren)	\$17.26
Employee + Family	\$25.99



BENEFIT SUMMARY	IN-NETWORK	FREQUENCY
Eye Examination	\$10	12 Months
Materials Copay	\$25	
Eyeglass Frames	\$130 Retail allowance; 20% off amount over allowance	24 Months
STANDARD EYEGLASS LENSES		
Single Vision	Covered 100% after \$25 Copay	12 Months
Bifocal		
Trifocal		
Progressive	\$55	
CONTACT LENSES (IN LIEU OF EYEGLASSES)		
Elective	\$130 Retail Allowance	12 Months
Contact Fitting & Evaluation	15% Off Professional Fee	
Medically Necessary	Covered 100% after \$25 Copay	
EMPLOYEE WEEKLY PAYROLL DEDUCTIONS		
Employee Only	\$1.72	
Employee + Spouse	\$2.90	
Employee + Child(ren)	\$2.96	
Employee + Family	\$4.68	



Elective Contact Lenses are in lieu of glasses (lenses & frames). You are not eligible for glasses under our plan until 12 months after you receive contacts and vice versa.



TERMS TO KNOW



SCAN OR CLICK THE QR CODE TO WATCH A [SHORT VIDEO](#) ON THE TERM YOU WOULD LIKE TO KNOW

ANNUAL ENROLLMENT: Designated period of time during which an employee may enroll in group health coverage. Also, designated period of time during the year when individuals without group coverage may enroll in health coverage without needing medical underwriting.

AD&D: Accidental Death & Dismemberment

CARRIER: The insurance company.

CLAIM: The request for payment for benefits received in accordance with an insurance policy.

COPAY: A co-payment, or copay, is a capped contribution defined in the policy and paid by an insured person each time a medical service is accessed. It must be paid before any policy benefit is payable by an insurance company.

COINSURANCE: A payment made by the covered person in addition to the payment made by the health plan on covered charges, shared on a percentage basis. For example, the health plan may pay 80% of the allowable charge, with the covered person responsible for the remaining 20%. The 20% amount is then referred to as the coinsurance amount.

DEDUCTIBLE: A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have a PPO plan, there is usually a separate higher deductible for using out of network providers.

ELIMINATION PERIOD: This is the time period between injury or illness and the receipt of benefit payments.

EMBEDDED DEDUCTIBLE: An embedded deductible is a system that combines individual and family deductibles in a family health insurance policy. When a health plan has embedded deductibles, it just means that a single member of a family doesn't have to meet the full family deductible in order for after-deductible benefits to kick in, each individual only needs to meet the individual deductible in order for after-deductible benefits to kick in.

EOB (Explanation of Benefits): EOB stands for Explanation of Benefits. This is a document produced by your medical insurance carrier that explains their response and action (whether it is payment, denial, or pending) to a medical claim processed on your behalf.

EVIDENCE OF INSURABILITY (EOI): This is the medical information you must provide that requires review and approval by the insurance company BEFORE coverage becomes effective. This may include medical records and a physical exam.

HMO: Health Maintenance Organization, this type of medical plan is Network exclusive. A participant must receive services from in-network providers except in a case of medical emergency.

IN-NETWORK: Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.

MAC: Maximum allowable charge

MAIL ORDER PRESCRIPTIONS: Used for maintenance drugs, members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member's home.

MAINTENANCE DRUGS: A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure and asthma, this also includes birth control.

NON-EMBEDDED DEDUCTIBLE: A non-embedded deductible is also referred to as an aggregate deductible. Under an aggregate deductible, the total family deductible must be paid out-of-pocket before after-deductible benefits kick in for the health care services incurred by any family member.

OUT-OF-NETWORK: The use of health care providers who have not contracted with the health plan to provide services. HMO members are generally not covered for out-of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point-of-Service (POS) coverage can go out-of-network, but will pay higher out-of-pocket costs.

OUT-OF-POCKET MAXIMUM: The total amount a covered person must pay before his or her benefits are paid at 100%. Deductible, copayments, and coinsurance may apply towards the maximum out of pocket, depending on the plan.

PARTICIPATING PROVIDER: Individual physicians, hospitals and professional health care providers who have a contract to provide services to its members at a discounted rate and to be paid directly for covered services.

PCP (PRIMARY CARE PHYSICIAN): A physician selected by the member, who is part of the plan network, who provides routine care and coordinates other specialized care. The PCP should be selected from the network that corresponds to the plan in which you are a member. The physician you choose as your PCP may be a family or general practitioner, internist, gynecologist or pediatrician.

PPO: Benefits paid for both in and out of a network of doctors. Member makes choice with knowledge that better benefits are available in network. Plans feature office visit copays, deductibles at a variety of levels and then coinsurance to a maximum out of pocket expense. Usually includes copays for prescription drugs.

PREVENTIVE CARE: Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Examples are routine physical examinations and immunizations.

REFERRAL: A written recommendation by a physician that a member may receive care from a specialty physician or facility.

SPECIALIST: A participating physician who provides non-routine care, such as a dermatologist or orthopedist.

UCR: Usual, customary, reasonable

MANDATORY NOTICES

IMPORTANT NOTICE ABOUT THIS GUIDE AND THE LEGISLATIVE NOTICES INCLUDED

A Plan Sponsor's responsibilities include making sure the health plan complies with ERISA, ACA and other federal and state regulations. Various federal notices are set forth below. Even if employers use third-party service providers to manage the plan, there are still certain functions that may make the employer responsible as a fiduciary. Plan Sponsors are recommended to maintain comprehensive record-keeping documents for up to seven years.

Insurance Office of America does not intend for you to use this guide as a substitute for legal counsel. Should you have any questions or concerns, you should contact your legal counsel for further guidance on all matters pertaining to compliance. Importantly, since this information is intended as a brief overview, please refer to the applicable federal regulations for more specific and detailed information. In addition, please note that States may have additional laws, restrictions and benefits that are more protective of individuals. You should always consult your State's benefits and insurance laws for further guidance.

IF you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 14-15 for more details.

Mandatory Notices

Important Notice:

Medicare Part D Creditable Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with TLC Travel Staff and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. TLC Travel Staff has determined that the prescription drug coverage offered by the **AXKQ, AXKO** plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of

your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your group plan coverage as an employee, or dependent or spouse of an active employee **will not be affected**. There is coordination of benefits and the group plan will be your primary coverage and Medicare will be your secondary coverage. However, if you drop current coverage under the group plan and enroll in a Medicare prescription drug plan, you will not be able to re-enroll for medical and prescription drug coverage until the next annual enrollment period, or upon a qualifying life event for which enrollment is permitted, if earlier (and only if you are eligible for coverage at the time your reenrollment would be effective). In addition, your current coverage pays for medical expenses, in addition to prescription drugs, and if you choose to drop prescription drug coverage, you must also drop your medical coverage as well.

If you (or a dependent/spouse) are covered under the group plan through COBRA and later are covered by Medicare, the medical and prescription drug coverage under the group plan will be cancelled, if permitted by law. Once you cease to be covered under COBRA, you may not reinstate your COBRA coverage under the group plan.

Therefore, before deciding whether to join a Medicare drug plan, you should carefully compare your current coverage, including which drugs are covered, with the coverage and cost of the Medicare drug plans in your area. Please refer to group plan's summary plan description for information about coverage, how the group plan coordinates with Medicare and when coverage terminates under the group plan.

Mandatory Notices

Important Notice:

Medicare Part D Creditable Coverage Disclosure

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 under the group plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact your Human Resources 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 the group plan coverage changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov

- 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)**.

For questions about Medicare prescription drug coverage,

Grace Agency is here to help.



MEDICARE INSURANCE CONSULTANTS



Educating you about Medicare insurance options and resources to meet your health and wellness goals.



OURS IS A KINDER AND GENTLER APPROACH TO THE WORLD OF MEDICARE INSURANCE



800-791-4840 | info@graceagency.org

Mandatory Notices

HIPAA Notice of 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 toward your or your dependents other coverage). However, you must request enrollment within 30 days after your or your dependents other coverage ends.

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

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.

To request special enrollment or obtain more information, please contact Human Resources.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

If not attached to this document, you may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

Model General Notice of COBRA Continuation of Coverage Rights

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

Mandatory Notices

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.**

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an

additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

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

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

Mandatory Notices

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/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

Plan and COBRA continuation coverage can be obtained on request:

TLC Travel Staff

Dawn Taylor

2143 Park Crescent Dr., Land O' Lakes, FL 34639

727-741-6495

¹<https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>

Health Insurance Marketplace Coverage Options and Your Health Coverage

Beginning in 2014, there is a new 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.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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 9.5 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.

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

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.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.

Women's Health and Cancer Rights Act of 1998

If you are enrolled in a health plan that covers the medical and surgical costs of a mastectomy, the WHCRA states that your plan must also cover the costs of certain

Mandatory Notices

reconstructive surgery and other post-mastectomy benefits.

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 (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 deductibles and coinsurance of your enrolled plan will apply.

If you would like more information on WHCRA benefits, contact your plan administrator or Human Resources.

Newborns' and Mothers' Health Protection Act

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).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

If you or your dependents are NOT currently enrolled

in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility.

Mandatory Notices

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program

Website: <http://myakhipp.com/>

Phone: 1-866-251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility:

<http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>

Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx

Phone: 916-440-5676

COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:

<https://www.healthfirstcolorado.com/>

Health First Colorado Member Contact Center:

1-800-221-3943/ State Relay 711

CHP+: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>

CHP+ Customer Service: 1-800-359-1991 / State Relay 711

Health Insurance Buy-In Program (HIBI):

<https://www.colorado.gov/pacific/hcpf/health-insurancebuy-program>

HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html>

Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>

Phone: 678-564-1162 ext 2131

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64

Website: <http://www.in.gov/fssa/hip/>

Phone: 1-877-438-4479

All other Medicaid- Website: <https://www.in.gov/medicaid/>

Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: <https://dhs.iowa.gov/ime/members>

Medicaid Phone: 1-800-338-8366

Hawki Website: <http://dhs.iowa.gov/Hawki>

Hawki Phone: 1-800-257-8563

KANSAS – Medicaid

Website: <http://www.kdheks.gov/hcf/default.htm>

Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:

<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>

Phone: 1-855-459-6328

Email: KIHIPPPROGRAM@ky.gov

KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>

Phone: 1-877-524-4718

Kentucky Medicaid Website: <https://chfs.ky.gov>

LOUISIANA – Medicaid

Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website:

<https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 1-800-442-6003 TTY: Maine relay 711

Private Health Insurance Premium Webpage:

<https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website:

<http://www.mass.gov/eohhs/gov/departments/masshealth/>

Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/people-we-serve/children-andfamilies/health-care/health-care-programs/programsand-services/other-insurance.jsp>

<https://mn.gov/dhs/people-we-serve/children-andfamilies/health-care/health-care-programs/programsand-services/other-insurance.jsp>

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website:

<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 573-751-2005

MONTANA – Medicaid

Website:

<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: (855) 632-7633

Lincoln: (402) 473-7000

Omaha: (402) 595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcnp.nv.gov>

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/oii/hipp.htm>

Phone: 603-271-5218

Toll free number for the HIPP program:

1-800-852-3345, ext 5218

Mandatory Notices

NEW JERSEY - Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
 Medicaid Phone: 609-631-2392
CHIP Website: <http://www.njfamilycare.org/index.html>
 CHIP Phone: 1-800-701-0710

NEW YORK - Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
 Phone: 1-800-541-2831

NORTH CAROLINA - Medicaid

Website: <https://medicaid.ncdhhs.gov/>
 Phone: 919-855-4100

NORTH DAKOTA - Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
 Phone: 1-844-854-4825

OKLAHOMA - Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
 Phone: 1-888-365-3742

OREGON - Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
 Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid

Website: <https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx>
 Phone: 1-800-692-7462

RHODE ISLAND - Medicaid

Website: <http://www.eohhs.ri.gov/>
 Phone: 1-855-697-4347, or
 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA - Medicaid

Website: <https://www.scdhhs.gov>
 Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: <http://dss.sd.gov>
 Phone: 1-888-828-0059

TEXAS - Medicaid

Website: <http://gethiptexas.com/>
 Phone: 1-800-440-0493

UTAH - Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov/>
CHIP Website: <http://health.utah.gov/chip>
 Phone: 1-877-543-7669

VERMONT- Medicaid

Website: <http://www.greenmountaincare.org/>
 Phone: 1-800-250-8427

VIRGINIA - Medicaid and CHIP

Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON - Medicaid

Website: <https://www.hca.wa.gov/>
 Phone: 1-800-562-3022

WEST VIRGINIA - Medicaid

Website: <http://mywvhipp.com/>
 Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid and CHIP

Website:
<https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>
 Phone: 1-800-362-3002

WYOMING - Medicaid

Website: <https://wyequalitycare.acs-inc.com/>
 Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2020, 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 four 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, 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 1210-0123.

OMB Control Number 1210-0123 (expires 1/31/2023)



CONTACTS



LINE OF COVERAGE	CARRIER	CUSTOMER SERVICE
Medical	United Healthcare	866-414-1959 www.myuhc.com
Dental	Guardian	888-Guardian www.guardiananytime.com
Vision	Guardian	888-Guardian www.guardiananytime.com

INSURANCE OFFICE OF AMERICA

For assistance with benefits questions, membership card issues, claims, and billing inquiries please contact one of your IOA service team members per the contact information below:

NAME - TITLE	PHONE	EMAIL
Rod Metz <i>Account Manager</i>	407-998-5165	Rod.Metz@ioausa.com

BENEPLACE



BENEPLACE is a best-in-class savings platform that's reliable, budget-friendly, and focused on one thing: rewarding you with discounts on products and services from the brands you love!

Visit <https://ioausa.savings.beneplace.com> to find out more.



TLC TRAVEL STAFF BENEFIT GUIDE

JUNE 1, 2022 - MAY 31, 2023