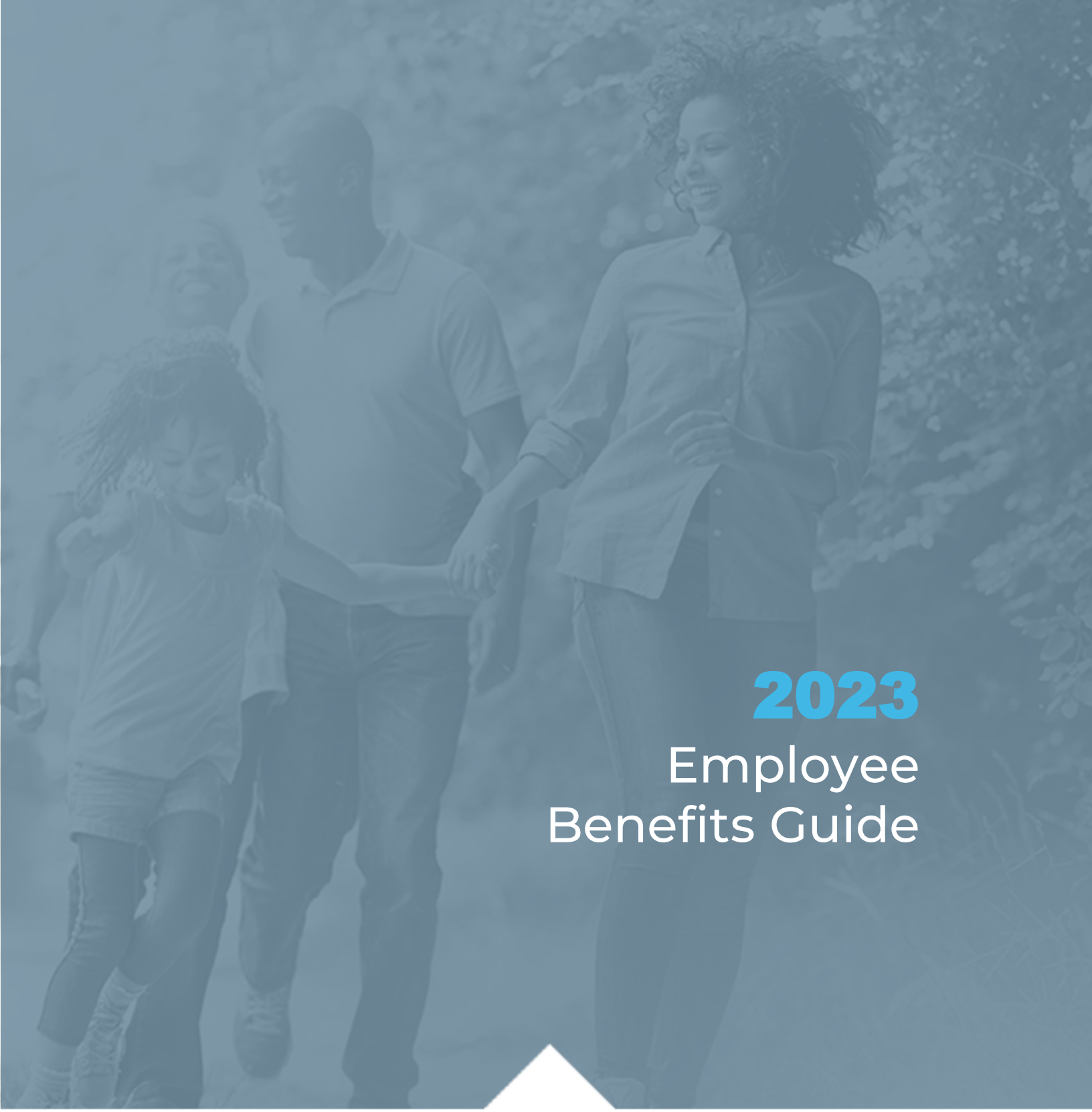


2023
Employee Benefits Guide

Alliance
Physical Therapy Partners

Alliance
Physical Therapy Partners

Welcome to your Benefits

Welcome to the 2023 Alliance Physical Therapy Partners Employee Benefits Guide. This guide offers you and your family members a look into your comprehensive benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage options for you and your family. We have included brief descriptions of our benefit offerings and the cost. If you have any questions, please contact the Human Resources Department at 616-356-5026.

Contents

This Guide provides highlights of the benefits being made available to you. Please review your Plan Certificates for details. Should there be any conflict between this summary and the plan certificates, the plan certificate will govern in all cases.

Eligibility

When to Enroll

- **Timely Applicants:** New Hires will be asked to complete their enrollment online. Your enrollment must be completed within 30 days of your eligibility date.

- **Special Enrollment:** As long as you remain eligible, your benefit elections will be in place from January 1, 2023, until December 31, 2023. However, you may make mid-year changes if you have a ***qualifying event***. Examples of ***qualifying events*** include:
  - Marriage or divorce
  - Birth, adoption or change in the custody of a child
  - Death of your spouse or dependent child
  - A change in the employment status of a spouse, impacting your benefit eligibility
  - A change in your dependent's status (due to age or eligibility for medical coverage through his/her own employer)
  - A significant reduction in the average number of hours worked

IMPORTANT. If you have a *qualifying event*, you must change your benefit elections within 30 days of the event. If you do not make a change within 30 days, you must wait until the next open enrollment period. Please contact Human Resources for more information.

Open Enrollment: Each year, Alliance Physical Therapy conducts a benefits open enrollment, typically in November, which allows employees to make changes to their benefit plan elections. Benefits elected during open enrollment are effective January 1, 2023.

Who is eligible?

To be eligible for benefits, you must be an employee of Alliance Physical Therapy Partners, Inc. working in an eligible class:

Part-time: ***working 20-35 hours per week*** **Full-time:** ***working 36-40 Hours per Week***

Legal Spouses and children are eligible for benefits. Children are defined as natural children, stepchildren, legally adopted children and children for whom you are legal guardian.

Spousal Surcharge:

A spousal surcharge is an additional premium or contribution that an employee must pay for coverage for his or her spouse. The surcharge generally applies if the employee's spouse has other coverage available, such as through his or her employer, and chooses NOT to enroll in that coverage. If your spouse chooses not to enroll in his/her employer sponsored health plan, you will be charged an additional $300 per month to insure your spouse under the medical plan. This surcharge does not apply to dental or vision coverage.

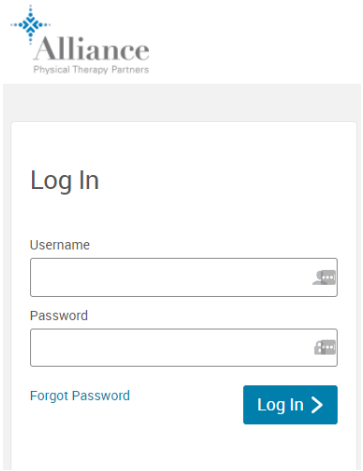
When does coverage become effective? First day of the month following 30 days of employment.

When does coverage end? Your benefit coverage ends on the last day of the month in which you end your employment with Alliance. For children who meet the limiting age, benefits end at the end of the month following the 26th birthday.

Enrollment

How to Enroll in Benefits

This year Alliance Physical Therapy Partners is pleased to offer employees the ability to enroll for their benefits online through Bswift. You will receive an email inviting you to login into the system and begin your benefit selections. As you navigate through the screens it will give you the opportunity to add dependents, verify information and review what your benefit choices were last year. At the end of the process, you will be shown a summary of your choices that you can print. You can make changes to your elections any time during the open enrollment period. Please see instructions below:



Step 1: Log In: https://allianceptp.bswift.com

Enter your Username and Password to enter the site. **For first time users, your *Username = First Initial + Last Name. Password is the last for of your SSN***

Example: ***JSmith***

1234

If you cannot remember your password, please click the Forgot Password to reset at any time.

Step 2: Welcome!

After you login click "Let's Begin" to complete your required tasks.

Step 3: Start Enrollments

After clicking "Start Enrollment", you'll need to complete some personal & dependent information before moving to your benefit elections.

Step 4: Benefit Elections

To enroll dependents in a benefit, click the checkbox next to the dependent's name under "Who am I enrolling"? Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click "Select Plan" underneath the plan cost. "Save & Continue" at the bottom of each screen to save your elections. If you do not want a benefit, click "Don't want this benefit" at the bottom of the screen and select a reason from the drop-down menu. *Reminder, if enrolling in the **Alliance Edge Program**, you must enroll your eligible spouse and or dependent to ensure that they are elected under the Program. The system will not auto enroll.*

Step 5: Forms

If you have elected benefits that require a beneficiary designation, primary care physician, or completion of an evidence of insurability form, you will be prompted to add in those details.

Step 6: Review & Confirm Elections

Review the benefits you selected on the enrollment summary page to make sure they are correct then click "Sign & Agree" to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.

If at any time you have trouble using the platform, please call ebm at 855.400.0792 for assistance. If you have questions about the benefits being offered, please contact Jami Farkas, Vice President of Human Resources at Jami.Farkas@AlliancePTP.com or Colleen VanDam at Colleen.Vandam@AlliancePTP.com.

Introduction

What's Continuing into 2023?

- **Medical -** administered by Auxiant, utilizing the **CIGNA Choice Fund PPO network**.
- **Pharmacy** - administered by TrueRx and delivers enhanced coverage through an advocacy program called SHARx; Members can now access high-cost brand and specialty medications at lower costs, and in many cases, at no cost!
- **Dental** by Delta Dental with no change in plan design
- **Vision** will continue to be insured by Principal with no change in plan design.
- **The Alliance Edge** – current participants of Alliance PT's health plan who are eligible to participate in a working spouse's health plan will receive 100% coverage at comparable monthly costs, if not lower. Participation in The Alliance Edge eliminates the working spouse surcharge of **$300 / month, effective January 1, 2023.**
- **Alliance** will continue help fund the HSA for Yellow Plan participants.
- **Lincoln** will continue to insure the Life and Disability coverage. We are pleased to announce that the short-term disability benefit maximum will increase from $400 to a minimum of $700 per week based on your classification.

What's Changing for 2023?

- The prescription Mail Order program is moving from Prescription Postal Services to WB Rx Express. If you are currently using the mail order program, your prescription history will walk over to WB Rx Express in December. We encourage you to contact WB Rx Express to confirm that information has been received.
- If you want to start a new prescription using Mail Order following these steps:
  - Go to wbrxexpress.com and click 'Get Started'
  - Use the form to enter your name, address, phone number, email address and chick "Submit"
  - WB Rx Express will contact you within two business days to verify your account and medication information.
- **Flexible Spending Accounts** and **Health Savings Accounts** will transfer to **Clarity Benefit Solutions**, effective January 1, 2023
- Adding 2 pet benefit options through **Pet Benefit Solutions**:
  - **Total Pet**: Discount Plan
  - **Wishbone:** Comprehensive Accident and Illness Policy; with optional Routine Care Coverge

Medical Plan Details

Alliance Physical Therapy Partners offers eligible employees a choice between three health insurance plan options.

BLUE PLAN: Traditional PPO Plan features a $2,750 single / $5,500 family deductible. $30 PCP / $40 Specialist Copay, pharmacy copays and coinsurance. The out-of-pocket maximum is $6,350 single / $12,700 for family.

YELLOW PLAN: High Deductible Health Plan with Health Savings Account. Due to IRS regulations, the deductibles are now $3,000 single deductible and $6,000 for family deductible. The family deductible can be met by one or all family members). Once the deductible has been satisfied, the plan pays 80% for eligible services to a maximum out-of-pocket of $4,250 for single or $8,550 for family.

GREEN PLAN: Traditional PPO Plan featuring a $1,400 single / $2,800 family deductible. $25 PCP / $35 Specialist Copay, pharmacy copays and coinsurance. The out-of-pocket maximum is $6,350 single / $12,700 for family.

Section 125 Plan- Q & A

What is the purpose of the Section 125 Plan?

Alliance Physical Therapy Partner's health, vision, dental, life insurance, HSA, and FSA deductions are taken on a pre-tax basis, which qualify the plans as Section 125 Plans, per the IRS. Without the Section 125 plan, your contributions for this coverage would come out of your pay after it had been subject to Income, Social Security, and Medicare taxes.

How do I participate in the Section 125 Plan?

Log onto the ebenefit portal at https://AlliancePTP.bswift.com and make your enrollment choices.

Username: Your first initial followed by your full last name, including any hyphens
(Ex: John Smith's username would be JSmith and Debbie Jones-Williams would be DJones-Williams)
Password: The last four digits of your Social Security Number (for new users)

Who is eligible to participate in the Section 125 Plan?

All employees who work greater than or equal to twenty (20) hours per week who are eligible for coverage under our insurance plans are eligible to participate in the Section 125 Plan.

How will participation in the Section 125 Plan affect my income taxes?

Premiums for these plans will be made on a "pre-tax" basis and the Form W-2 that you receive after the end of each year will list less taxable wages than if you did not participate in the Section 125 Plan. As a result of participating in the Section 125 Plan, your income taxes will be reduced.

How will participation in the Section 125 Plan affect my Social Security taxes?

Premiums for coverage under the Section 125 Plan will not be subject to Social Security taxes. As a result of participating in the Section 125 Plan, your social security taxes will also be reduced.

Will my Social Security benefits be affected by participation in the Section 125 Plan?

Because your Social Security benefits are a function of your taxable wages, participation in the Section 125 Plan ultimately may result in a reduction of your Social Security retirement benefits. Each employee's circumstances are different when it comes to calculating Social Security retirement benefits, which take into account factors such as age, employment history, wage history, etc. For detailed information as to how participation in the Section 125 Plan will affect your Social Security retirement benefits, we suggest that you contact the local Social Security Administration office.

If I elect to participate in the Section 125 Plan, may I change this election?

Under strict IRS rules, an employee cannot change or revoke his or her election until the beginning of the next plan year (January 1) unless you experience a change in status such as death, marriage, divorce, birth or adoption of a child, termination or commencement of employment of spouse, open enrollment of spouse's coverage, change of residence if it affects health benefits, eligibility of Medicare or Medicaid, etc. Contact the Human Resources Office or your supervisor if you think you have such a change in status.

The Alliance Edge

The Alliance Edge offers employees who have access to alternate group medical and prescription drug coverage through their spouse, **100% coverage with $0 out of pocket**. You will be reimbursed for ALL eligible co-pays, co-insurance and deductibles incurred through your alternate medical plan up to the maximum out of pocket limits under the Affordable Care Act ($9,100/single and $18,200/family per year).

PLUS, no premium contribution will be deducted from your pay check and you will not be charged the $300 monthly spousal surcharge when you move to The Alliance Edge.

PLUS, Alliance will reimburse you for the premium contribution paid for the alternate coverage if it exceeds the premium contribution, you would have paid to remain on your employer's medical plan up to a monthly maximum of $200/single, $400/employee + 1 and $600/employee + 2 or more per month. If your spouse is currently enrolled in his/her medical plan, you will be reimbursed for any increase in premium to add you and/or your dependents up to the above monthly maximums. If cost of Alternate Coverage is less than employee would have paid for your Employer Medical Plan, premium contribution reimbursement is $0.

Example: I am currently enrolled in the Blue Plan with family coverage ($200 in monthly premium). My spouse elects to move themselves and our 3 children to their group health plan; while I remain on the Blue plan with single coverage. The cost In this example is calculated off my former plan (in this case the family coverage under Blue Plan).

- Spouse's plan cost: Employee plus child: $450 (sample cost)
- My cost under family Blue plan: $200 (sample cost)
- My cost under single Blue Plan: $60 (sample cost)

The premium reimbursement is $200 - $60 = $140; Then $450 - $140 = $310 Reimbursement.
Premium Reimbursement will be paid by paycheck a month in arrears

Eligibility

- **Current employees** must be enrolled in their Alliance Physical Therapy Medical Plan
- **New employees** must satisfy eligibility requirements
- **Qualifying event** or newly eligible: marriage, birth of child, part time to full time, etc.

Opportunities for Enrollment

- Your annual open enrollment window
- Qualifying event: marriage, spouse's change in employment status, birth of child, part time to full time, etc.
- Spouse's annual open enrollment window
- New employee

IRS Rules

- You may be enrolled in an HRA or FSA. You **CANNOT** be reimbursed from both The Alliance Edge and your HRA or FSA. This violates IRS rules.
- Employees are NOT eligible for The Alliance Edge if their Alternate Coverage is:
  - High Deductible Health Plan (HDHP) **with** active contributions to a Health Savings Account (HSA),
  - Medicare, Tricare or Medicaid
  - Healthcare Exchange Policy made available thru the Affordable Care Act
  - Individual policy
  - Limited Benefit Health Plan

- **Learn more: Click this Video Link**

Interested in enrolling in The Alliance Edge? Talk to your HR representative today.

More information and testimonials are available at **catilize.com/join** or by **scanning the QR code.**

The Alliance Edge

Enrollment

- Enroll in Alternate Coverage and waive coverage on your Alliance Physical Therapy Medical Plan.
- Complete The Alliance Edge enrollment & attestation forms via your online enrollment system. **IMPORTANT**, *if enrolling spouse and/or dependents into the plan in Bswift, you must add them to the benefits. The system will not auto enroll.*
- Provide proof of premium contribution paid for Alternate Coverage.

Premium Contribution Reimbursements Proof Required

- Paystub showing premium contribution amount, pre-tax or post-tax, frequency (other pay information may be blacked out).
- If your spouse does not have a paystub at time of enrollment, the spouse may submit a letter on their employer's letterhead or a Benefit Confirmation outlining information. However, you must submit a paystub once one becomes available.
- If the entire family is not enrolling in The Alliance Edge, then you must provide the tiers of coverage indicating the cost for each tier.

Claims

- The Alliance Edge ID Card:
  - Present Alternate Coverage ID card.
  - Present The Alliance Edge ID card.
  - Provider may bill Catilize Health directly.
- Paper Claims:
  - Present Alternate Coverage ID card.
  - Complete The Alliance Edge claim form and sign.
  - Send completed and signed claim form to Catilize Health with the following:
    - Office visit co-pay, co-insurance or deductible: Explanation of Benefits (EOB) from Alternate Coverage.
    - Prescriptions: "Tab" from pharmacy that includes name of drug, date filled, patient's name and patient responsibility amount.

Helpful Definitions

The Alliance Edge: reimburses employees, spouses and their eligible dependents for eligible out-of-pocket medical care expenses incurred under an **alternate** group medical plan.

Medical Care Expenses: co-pays, co-insurance and deductibles for eligible expenses incurred under the alternate group medical plan.

Alternate Group Medical Plan: any Non-Alliance Physical Therapy group medical plan available to an employee, such as coverage through the spouse's employer, another employer of the employee, or group coverage available to the employee from any other source including but not limited to eligible retiree benefit programs.

Alternate coverage in the following types of medical plans *do not meet The Alliance Edge eligibility requirements*:

- High Deductible Health Plan (HDHP) with an active Health Savings Account (HSA)
- Medicaid, Medicare or Tricare
- Healthcare Exchange Policy made available thru the Affordable Care Act
- Individual policy
- Limited Benefit Health Plan

Maximum Reimbursement: the annual maximum amounts that will be reimbursed for eligible medical care expenses are $8,700/Single *or* $17,400/Family.

How Does The Alliance Edge Work?

Enroll

Enroll in your Alternate Coverage

Complete The Alliance Edge Enrollment & Attestation forms via your online enrollment system

Waive Alliance Physical Therapy medical coverage

Incur

Co-pays

Co-insurance

Deductibles

File

Present your Alternate Coverage Card.

Next, present your Alliance Edge ID Card for co-pays, co-insurance and deductibles.

Your provider may file claims with your Alternate Coverage and The Alliance Edge.

Get Reimbursed

Most claims may be paid directly to the provider through use of the ID card.

If you pay for an eligible expense out of pocket, you may submit a paper claim for reimbursement. You will receive a check mailed to your home.

If your spouse's premium contributions are pre-tax, premium reimbursements will be issued to you through your paycheck. If your spouse's premium contributions are after tax, a check will be mailed to your home.

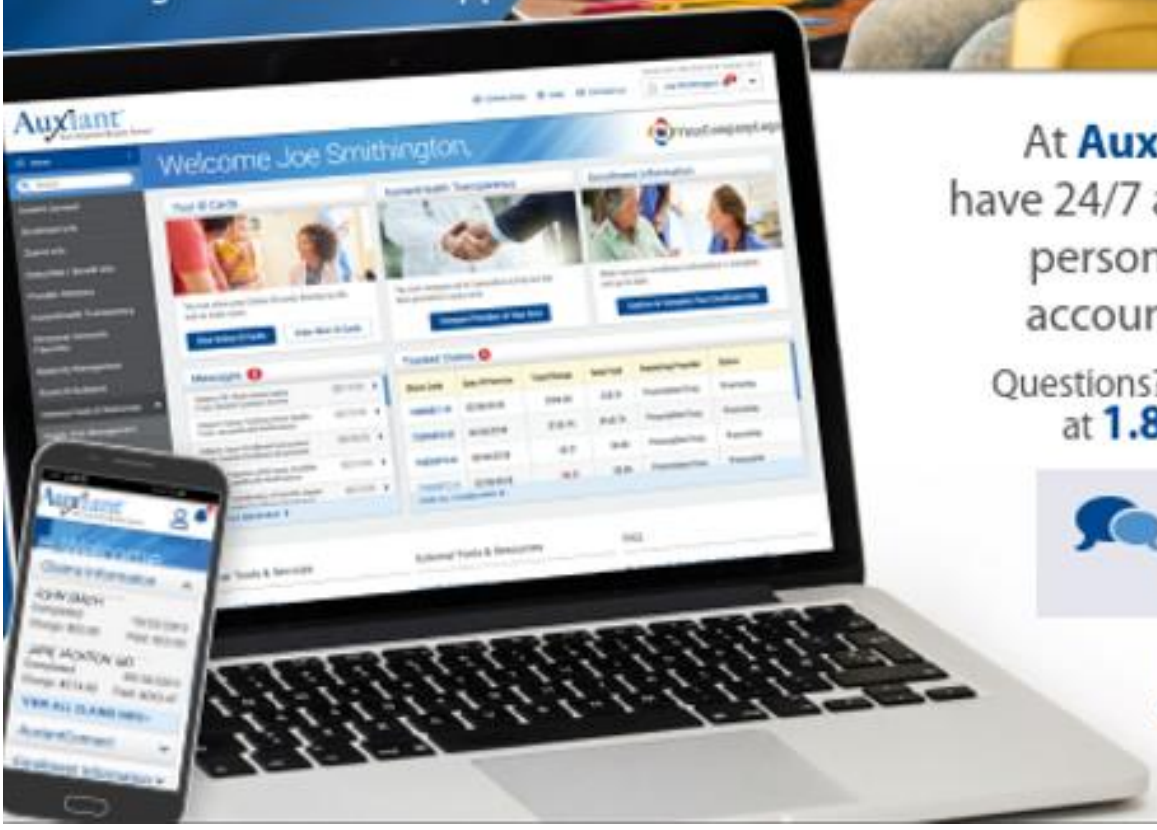
You will not be charged the $300 monthly spousal surcharge when you move to The Alliance Edge.

AuxiantHealth

VISIT US ON THE WEB
auxiant.com

With AuxiantHealth you can:

- Link to network providers
- Contact customer service through Auxiant Live Chat
- View enrollment and claim information, print EOB's, and track claims
- View deductibles and out-of-pocket amounts
- Access plan documents and amendments
- Link to Prescription Benefit Manager
- Get information on the go via our mobile app



At **Auxiant.com** you have 24/7 access to your personal health care account information

Questions? Contact Auxiant at **1.800.279.6772**

Live chat with Auxiant customer service, click **Online Chat** to begin

Auxiant

Medical Plan

Health Plan Benefits Summary: This brief benefit summary includes in-network benefits only. CIGNA is a well-recognized health insurance carrier whose network includes most local physicians and hospitals. To find participating providers in the CIGNA Choice Fund Network log onto www.auxiant.com or www.cigna.com. As always, please check with your health care provider to verify participation before receiving services.

Effective January 1, 2023	BLUE PLAN	YELLOW PLAN	GREEN PLAN
	CIGNA PPO Network	**CIGNA PPO Network**	**CIGNA PPO Network**
Deductible: Individual / Family	$2,750 / $5,500	$3,000 / $6,000	$1,400 / $2,800
Deductible Type	**Embedded:** No member accrues more than the single deductible	**Non-Embedded:** Family deductible can be met by one or all members of the family	**Embedded:** No member accrues more than the single deductible
Coinsurance (Plan Pays)	80%	80%	80%
Coinsurance (You Pay)	20%	20%	20%
Out of Pocket Maximum: Individual / Family	$6,350 / $12,700	$4,250 / $8,500	$6,350 / $12,700
Preventive Care	100%	100%	100%
Primary Care Provider	$30 copay	Deductible & Coinsurance	$25 Copay
Specialist	$40 copay	Deductible & Coinsurance	$35 Copay
Urgent Care	$40 copay	Deductible & Coinsurance	$35 Copay
Emergency Room	$150 copay, Waived if admitted for accident/injury	Deductible & Coinsurance	$150 copay, waived if admitted for accident/injury
Diagnostic Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient / Outpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance

Medical Plan

Prescription Pharmacy Services: The prescription drug formulary is managed by TrueRx Health Strategists. The prescription formulary can be found online at www.truerx.com.

SHARx is a pharmacy advocacy solution. This program was created to extend advocacy designed to find low cost or no cost medications for our members. Their role is to help facilitate the advocacy onboarding process for each eligible member of the health plan and provide access for all specialty medications.

Effective January 1, 2023	BLUE PLAN		YELLOW PLAN		GREEN PLAN	
	Retail	Mail Order	Retail	Mail Order	Retail	Mail Order
Day Supply	Up to 30	Up to 90	Up to 30	Up to 90	Up to 30	Up to 90
Generic	$15	$30	Deductible; then $15	Deductible; then $30	$15 Copay	$30
Formulary Brand	20% Coinsurance Min: $50 Max: $100	20% Coinsurance Min $100 Max: $200	20% Coinsurance Min: $50 Max: $100	20% Coinsurance Min $100 Max: $200	20% Coinsurance Min: $50 Max: $100	20% Coinsurance Min $100 Max: $200
Non-Formulary Brand	50% Coinsurance Min: $75 Max: $150	50% Coinsurance Min $150 Max: $300	50% Coinsurance Min: $75 Max: $150	50% Coinsurance Min $150 Max: $300	50% Coinsurance Min: $75 Max: $150	50% Coinsurance Min $150 Max: $300
Specialty	Specialty Medicine will no longer be covered under the Medical Plan. These medications can be filled using SHARx.					

2023 Health Plan Premiums

Effective January 1, 2023	BLUE PLAN		YELLOW PLAN		GREEN PLAN	
	Full-time	**Part-Time**	**Full-Time**	**Part-Time**	**Full-Time**	**Part-Time**
Employee Only	$61.14	$83.37	$79.52	$99.40	$140.56	$140.56
Two Person (Employee + Spouse or a child)	$146.73	$233.43	$190.85	$238.56	$322.35	$337.34
Family (Employee, Spouse and children)	$183.41	$250.10	$238.56	$298.20	$402.93	$421.67

If your spouse works full-time and is eligible under their employer sponsored health plan but you choose to cover them under the Alliance Physical Therapy plan medical plan, you will have a surcharge of $300 per month or $138.46 per pay in addition to the established premium. This surcharge is waived if you enroll in the Alliance Edge Program. The spousal surcharge does not apply to dental or vision benefits.

Medical Plan

Understanding Health Insurance Terminology

What is a deductible?

It is a set dollar amount determined by your plan that you will pay out of your pocket if you have claims. The deductible accumulates on a calendar year basis and is reset at $0 each January 1.

Let's say that the plan's deductible is $2,000, That means that for most services you will pay 100% of your medical and pharmacy costs until you reach $2,000, After that, the plan will begin picking up 80% of the cost share and you pay 20% of the cost share until you meet your out-of-pocket maximum for the year.

What is coinsurance?

After your deductible is met, you then pay a share of your eligible medical expenses. Coinsurance is the percentage that the plan or you pay for a covered service or supply. For example, Lisa has allergies, so she sees your doctor regularly. The service that she paid accrues toward her annual deductible. Once she meets her deductible, the plan will begin paying 80% of the cost of the service; while she pays 20% of the cost. Assuming that her services cost $150 per treatment, her plan will pay $120 and she will pay $30.

What is a Copay?

A copay is a fixed amount that you pay for a health care service, usually when you receive the service. For example, if the medical plan has a $30 for primary care physicians that is the most your pay at the time of service. This copay can vary if the medical provider is a specialist. Copays will also apply for prescription drugs. Typically, a generic or Tier 1 medication will cost you less.

What is my out-of-pocket maximum?

A plan's out of- pocket maximum is the maximum amount a plan participant will pay out of pocket for covered medical expenses per calendar year, including the deductible. After your share of covered expenses reaches this annual limit, the plan pays 100 percent of the cost for eligible in-network services and supplies for the remainder of the calendar year.

Putting it all Together – Let's do an example, assuming the BLUE Plan.

Let's say that you are in an accident. You have accumulated $50,000 in covered medical expenses. Let's also assume that the network discount is 40%. Leaving the eligible balance of $30,000.

The plan's **Deductible is $2,750.** You will be responsible for the first $2,750 due to the Deductible; Plan eligible balance is now $27,250

The plan's Coinsurance is 20%. This means after the Deductible is applied, the plan will pay 80% and **you will pay 20% coinsurance**. In this case, the plan will pay $21,800. You will pay $3,600.

The plan's **Out-of-Pocket Maximum is $6,350**. This is the most that you would pay in eligible expenses when you add deductible, coinsurance and copays. In this example, you pay $2,750 in deductible expenses and an additional $3,600 in coinsurance. Now that you have met the out-of-pocket maximum, the plan will pay 100% of eligible charges to the end of the plan year.

Medical Plan

FocusHealth is apart of our medical plan. You have access to support tools that feature provider Score Cards. These Score Cards will compare providers giving you options to find the highest quality provider with lower out-of-pocket cost to you. Score Cards are available through HealthJoy.

When you choose the highest quality provider with the lowest cost; you will earn up to $250 gift card.

What can FocusHealth do for you?

- Give you quality and cost information
- Assist you in making informed decisions about your health care
- Helps you find higher quality and more cost-effective providers

Did you know?

You can compare hospital quality and cost for both inpatient and outpatient services

How do I utilize the FocusHealth program?

- Go to a FocusHealth Preferred Plus Provider on your FocusHealth scorecard for an inpatient hospital stay or outpatient surgery
- To search for a Preferred Plus Provider or to do quality and cost comparisons, go to

Auxiant.com or call **800-475-2232**

Questions?

Contact Auxiant at
800-475-2232

Contact customer service through
Auxiant Live Chat

FocusHealth®

Medical Plan

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and incorporating healthy habits into your lifestyle. Some examples include getting regular physical examinations, mammograms and immunizations. Through the plans offered by Alliance Physical Therapy Partners all covered individuals and family members are **eligible to receive routine wellness services like these, at no cost; all copays, coinsurance, and deductibles are waived**

WHICH PREVENTIVE CARE SERVICES ARE COVERED?

Below is a list of common services that are included in the plans offered this year:

"AN OUNCE OF PREVENTION IS WORTH A POUND OF CURE"

- **Routine Physical Exam**
- **Well Baby and Child Care**
- **Well Woman Visits**
- **Immunizations**
- **Routine Bone Density Test**
- **Routine Breast Exam**
- **Routine Gynecological Exam**
- **Screening for Gestational Diabetes**
- **Routine Digital Rectal Exam**
- **Routine Colorectal Cancer Screening**
- **Routine Prostate Test**
- **Routine Lab Procedures**
- **Routine Mammograms**
- **Routine Pap Smear**
- **Smoking Cessation Programs**
- **Testing for HPV and HIV**
- **Routine Colonoscopy**

Medical Plan

The trueDifference:

You're more than a number. At True Rx Health Strategists, you become our patient. Our motivation is your health and quality of life.

Smart medication choices are made by ethical health care providers. Our formularies are designed to keep you healthy and productive.

Affordable specialty. If you take a specialty medication, your dedicated case manager will reach out and share potential savings for your medication.

Our mobile app lets you compare your medication price at different pharmacies and access your medication history.

trueRx HEALTH STRATEGISTS

Everything at your fingertips:

View prescription insurance card.

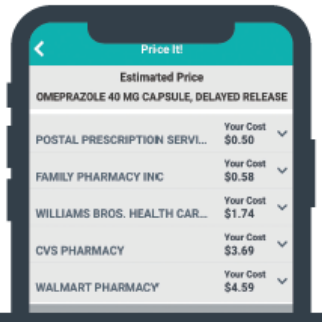
Compare medication pricing.

See coverage and limits.

Review claim history.

Check medication information.

Find pharmacy locator.



Download **trueRx App** by visiting truerx.com/members.

Reach us at hello@truerx.com or 866-921-4047.

trueRx HEALTH STRATEGISTS 866•921•4047 hello@truerx.com truerx.com

WELCOME TO YOUR NEW MAIL ORDER PHARMACY

Your pharmacy benefit plan offers the convenience of medications delivered to your home through WB Rx Express.

WB Rx Express is a family-run pharmacy serving communities for decades. We are the place to go if you want personalized and friendly service that is convenient and accessible. Transfer pharmacies today for the personalized attention you and your loved ones deserve.

WB Rx EXPRESS

1998 State Street, Washington, IN 47501
Phone: 833-391-0126
Fax: 855-899-3925

SHARx Prescription Assistance

SHARx is a pharmacy advocacy solution offered by your employer. This program was created to extend advocacy program benefits to associates like you. Their role is to help facilitate the advocacy onboarding process for each eligible member of the health plan and provide access for all specialty medications.

This program is scheduled to start on January 1, 2023. Because it can take a few weeks to get set up, now is the time to begin the process.

Who is eligible?

Your employer is making this program available to members enrolled in the health plan. If you are currently on a specialty medication, you will want to follow the steps for potential cost savings to you.

What are the costs?

There are no costs to you to participate in the SHARx program. Your employer has paid 100% of the cost of this service for you and your family as long as you are enrolled in the health plan. Prescriptions obtained through this service could be free or low cost for you and your family.

What is considered a Specialty Prescription?

Any medication that is high cost, high complexity, or high touch is included under the specialty medication designation. These include Actemra, Atripla, Avastin, Betaseron, Botox, capecitabine, Cellcept, Capaxone, Enbrel, Entyvio, Forteo, Gammagard, Genvoya, Gilenya, Glatopa, Harvoni, HP Acthar, Hizentra, Humatrope, Humira, In Lectra, Lupron Depot, Orencia, Otezla, Prolia, Remicade, Revlimid, Sprycel, Stelara, Stribild, Taltz, Tecfidera, Truvada, Zeljanz, and MORE.

What happens if I don't enroll in the SHARx Program?

Your specialty medications will no longer be covered by your employer pharmacy benefit plan. When you participate, certain manufactures will require additional information to verify your income. Please respond right away to these requests to ensure that there is no delay with your medication fill. The goal is for everyone to receive your medications as quickly as possible at the lowest price possible. This is only accomplished with your help.

SHARx Is:

- An alternative access point to Medications
- A program that works through multiple avenues to find your medication
- A way for members to often get their medications for FREE!
- Drugs that are not free are typically available at 75% to 90% off retail costs.
- Access to just about any maintenance medications.
- Access to medical mediations and orphan drugs.
- Freedom from being financially crippled by high-cost drug expenses.

SHARx is NOT:

- SHARx is not a Drug Card
- SHARx cannot access medication at your pharmacy
- SHARx is not a discount program.
- SHARx is not insurance
- SHARx cannot guarantee access to all free medications

ENROLL TODAY!

Visit: www.sharxplan.com

or

Call (314) 451-3555

HealthJoy is your easy-to-use, chat-based app that gives you access to board-certified doctors, personal Healthcare concierges, and your company's Benefit Wallet.

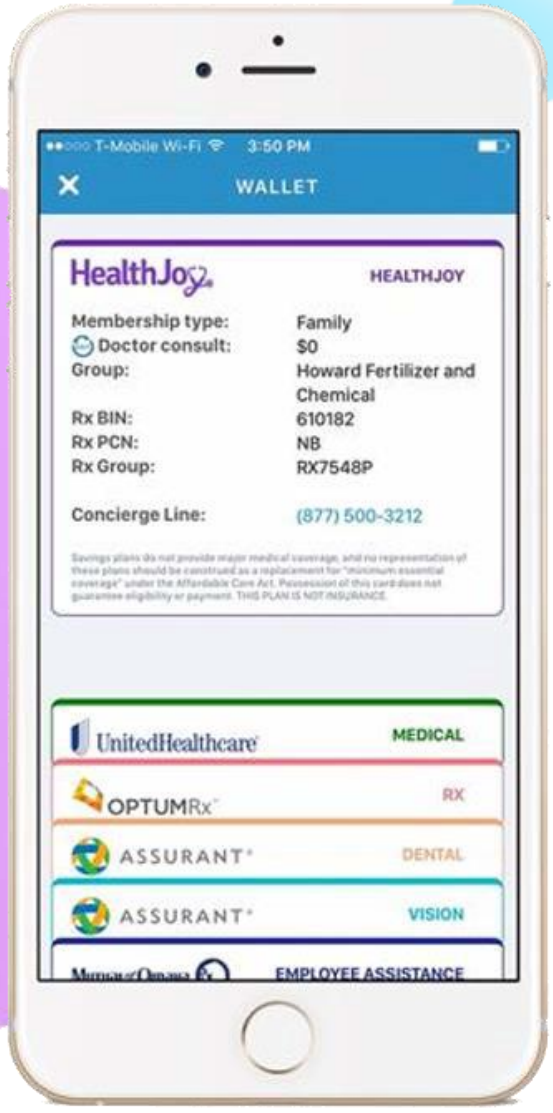
Download the mobile app at http://Downoad.HealthJoy.com

Your Healthcare Concierge will assist you by clarifying your benefits, finding providers, Care Coordination and more!

You will have access to a benefits wallet on the app that will have your membership card for all your benefits virtually.

Through this app you will have access to a board-certified physician similar to what was offered with Telemed

No Smartphone? No Worries! You can get the same services if you call HealthJoy at 877.500.3212 or email at groups@healthjoy.com.



Flexible Spending Account (FSA)

Flexible Spending Accounts are a way of making pre-tax payroll deductions for either dependent care or non-reimbursable health care expenses. FSAs allow you to increase your disposable income. You do not pay taxes, or Social Security on the amounts of your FSA payroll deductions. The FSA plans at Alliance Physical Therapy Partners are administered by Clarity.

Once you elect to participate in an FSA, you must continue to participate throughout the plan year, unless you experience a Qualifying Event. You will receive a Debit Card from Clarity following your enrollment. You may use the Debit card for Eligible services. **From time to time, Clarity may require substantiation of expenses. Receipts should be submitted to Clarity. Failure substantiate expenses will cause your FSA card to 'freeze'.**

Health Care FSA: You may set aside up to the IRS maximum annually into your Health Care Spending Account. You may use these funds for qualified out-of-pocket expenses. Eligibility for the Health Care FSA is limited to enrollment in the Blue or Green Traditional PPO plans. If you are enrolled in the Yellow Plan, you may not enroll in the FSA unless you are not eligible to open an HSA.

You may use this Health Care FSA for non-reimbursable medically qualified out-of-pocket expenses. This includes, but is not limited to:

- Deductibles
- Co-pays
- Dental
- Orthodontia
- Vision
- Hearing
- Over the Counter medicines including pain relievers, cold & flu, heartburn, allergy relief
- Vitamins and Supplements require physician's prescription

Clarity | BENEFIT SOLUTIONS™

https://clarity.wealthcareportal.com/Authentication/Handshake

Phone: 888-423-6359

The FSA Health Care plan allows enrollees to rollover up to $570 into the next plan year for approved expenses. Please note that there is NO 2 ½ month grace period for the FSA Health Care plan. This means expenses must be incurred within the plan year and submitted for reimbursement in a timely fashion.

Dependent Care FSA: Like the Health Care FSA, you can set aside pre-tax dollars to help pay for childcare services. The most that you can set aside is $5,000 (if married filing joint tax return); or $2,500 (if married filing separate tax returns). You may use this FSA for reimbursement of dependent care expenses that are provided to allow you to attend work. The services may either take place in or outside your home, but only for:

- Dependents under the age of thirteen
- Children thirteen or older who are mentally or physically incapable of self-care
- Dependent adults

*Note: Please retain all of your receipts for proof of eligible expenses until the plan year is over.

The FSA Dependent Care plan includes a two and a half (2 ½) month grace period that allows you to be paid or reimbursed for qualified expenses incurred during the grace period as if the expenses had been incurred in the immediately preceding plan year.

Remember that the Flexible Spending Account has a "Use-it-or-Lose-It" rule. Simply, put, If you do not use the money set aside by the end of the applicable terms, you will forfeit your dollars if you don't have qualified expenses to submit. Please be conservative in your estimates.***

Health Savings Account

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https://clarity.wealthcareportal.com/Authentication/Handshake

Phone: 888-423-6359

Understanding A Health Savings Account

What is an HSA?

It is your personal tax-exempt account used to pay for qualified out-of-pocket expenses.

Am I eligible to establish an HSA?

You are eligible to open and Health Savings Account if you are enrolled in the ***Yellow Plan***. As a Yellow plan participant, you are not eligible to participate in the Flexible Spending Health Care Account, unless you are not eligible to open a Health Spending Account. Please note that if you are enrolled in the Yellow Plan, you are eligible to participate in the Child Care Flexible Spending Account.

IRS Regulations regarding the HSA program allow you and your employer to contribute to your HSA account. The 2023 IRS maximum is $3,850 for employee only coverage and $7,750 for two-person or family coverage.

Alliance Physical Therapy Partners will help contribute to your HSA. Alliance contributes a portion of the funding toward your HSA, which is deposited on a quarterly basis. Funding allowances are prorated according to the month your coverage begins.

Coverage Level	Alliance Physical Therapy Contribution	2023 Employee Maximum Contribution	2023 IRS Maximum
Employee Only	$600 ($150 per Quarter)	$3,250*	$3,850
Two-Person/Family	$1,200 ($300 per quarter)	$6,550*	$7,750

* Employees over the age of 55 may contribute an additional $1,000 to the HSA as a catch-up contribution.

You cannot open an HSA or make contributions to an HSA if you are enrolled in a health plan that is not a qualified "High Deductible Health Plan" ("HDHP") as defined by the IRS. The Blue and Green Plan are not qualifying plans.

You are not eligible for an HSA if you are:

- Covered under another medical plan that is not an HDHP (Blue or Green Plans);
- Entitled to (eligible for AND enrolled in) Medicare benefits; or
- Eligible to be claimed on another person's tax return.

Who holds my HSA funds?

The HSA is an individual bank account owned by you. Alliance Physical Therapy Partners has chosen Clarity as our preferred bank to administer all HSA accounts for our employees. After you open a Health Savings Account at Clarity, any pre-tax payroll deductions are deposited into the account by Alliance Physical Therapy Partners. If you are not approved by Clarity for an account, please contact Human Resources.

How and when do I make contributions to my HSA?

You may have contributions direct deposited from your paycheck on a pre-tax basis. You may also make contributions directly into your HSA on an after-tax basis. You will receive a Form 1099 from your HSA bank annually that will show your annual HSA contribution. You then report your HSA contribution by completing Form 8889 with your annual federal income tax return.

Health Savings Account

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What can I spend my HSA funds on?

The IRS allows you to use your HSA funds to pay for your out-of-pocket costs for qualified medical, dental, and vision expenses that are incurred after your HSA is established. Qualified expenses are those as defined by IRC Section 213(d). Visit https://www.irs.gov/pub/irs-pdf/p502.pdf for a list of allowed expenses. Amounts distributed from your HSA for any other reason are subject to income tax and an additional 20% penalty tax.

How do I access my HSA funds?

The bank will provide you with a debit card and check book (if requested). Remember, in the event of an IRS audit, you are responsible for providing your receipts for services and other items purchased with money from your HSA.

What if I don't have enough money in my HSA account to pay for my medical expenses during the year which apply toward my deductible and coinsurance out-of-pocket?

The good thing about an HSA is that it is flexible and allows you to add additional money (up to the maximum below) if your medical claims are more than you had anticipated. You can either request a change in the amount of your pre-tax payroll deduction during the year, or you can deposit after-tax money and generally take a deduction when you file your taxes. Talk to your tax advisor about this option.

How much can I contribute to an HSA?

The annual HSA contribution limits for 2023 are:

- $3,850 for individual coverage and $7,7500 for family coverage
- Individuals age 55 or older may be eligible to make a catch-up contribution of $1,000.
- Remember, Alliance Physical Therapy Partners contributes to your HSA. Keep this in mind, when making deposits into your bank account.

What if I enroll in an HSA in the middle of the year?

Your HSA contributions are generally determined on a monthly basis. However, if you enroll in an HSA mid-year, you are allowed to make a full year's contribution, provided you are eligible on Dec. 1 of that year and you remain eligible for HSA contributions for at least the 12-month period following that year.

Who is eligible to use my HSA funds?

You can use your HSA funds to reimburse Qualified Medical Expenses incurred by you, your spouse, and your tax dependents, as long as the expenses are incurred after the date that your HSA is established.

What happens to my HSA funds if I leave?

You take your HSA account and funds with you because it's your personal bank account. Remaining HSA funds may continue to be spent on qualified out-of-pocket medical, dental, and vision expenses.

For further information and a list of HSA qualified medical expenses, please visit https://www.irs.gov/pub/irs-pdf/p502.pdf

Dental Insurance

You have the option to enroll in a comprehensive dental insurance plan, administered by DeltaDental. You do not need to be enrolled in the health insurance plan to enroll in dental insurance. The dental plan uses the **DeltaDental Premiere or Delta Dental PPO network**. You have the freedom to use any dental provider; but, you will pay more when you use a non-participating dentist. To find participating providers, log onto www.deltadentalmi.com

Type of Service	Delta Dental PPO Provider	Delta Dental Premier Provider	Non-Particpating Provider
Calendar Year Deductible Single Family	$25 $75	$50 $150	$50 $150
Annual Dental Maximum per Person	$1,000		
Orthdontia Lifetime Maximum	$1,000		
Class 1: Preventive Services Oral Exams & Cleanings, Bitewing X-rays, Emergency Palliative Treatment, Fluoride Treatments, Sealants (children up to age 19), Space Maintainer for children under age 18	Plan Pays 100%	Plan Pays 100%	Plan Pays100% (of Contracted Rate)
Class II: Basic Services Fillings, Crowns, Endodontic and Periodontic Services, Oral Surgery and Oral Extractions, Crowns, Inlays, Onlays, and Repairs to Prosthetic Appliances	Plan Pays 100%	Plan Pays 80%	Plan Pays 80% (of Contracted Rate)
Major Services Complete Removable Dentures, Bridges, Endosteal Implants for age 16+ who were covered at the time of placement	Plan Pays 60%	Plan pays 50%	Plan Pays 50% (of Contracted Rate)
Orthodontia for Children to Age 19	Plan Pays 50%	Plan pays 50%	Plan Pays 50% (of Contracted Rate

This is a partial listing of benefits and services only. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of the Dental Certificate. Children are covered to the end of the month following their 26th birthday.

2023 Weekly Dental Payroll Deductions	Full Time Employee	Part Time Employee
Employee Only	$5.20	$8.21
Two Person	$12.40	$19.68
Family	$15.49	$24.60

Vision Insurance

Vision Service Plan: You have the option to enroll in a vision insurance plan through Vision Service Plan (VSP). You may visit www.prinipcal.com or www.vsp.com to find participating providers in your area. Choose the VSP Choice Network. No ID Card is necessary for your provider to file claims with VSP.

Benefits When Using a Participating VSP Choice Provider		VSP Choice Provider	Non-VSP Provider
Well Vision Exam	• Focuses on your eyes and overall wellness • **One eye exam in any period of 12 consecutive months**	$10 Copay	Reimbursement up to $45 less a $10 copay (member responsible for the difference)
Prescription Glasses	• **One Pair of Prescription Lenses, with or without Frames, in any period of 12 consecutive months**.	$10 (one copay applies to both Lenses and Frames	Member responsible for difference between approved amount and providers charges after a $10 copay
Standard Frame	• **1 Frame every 24 months** • $130 allowance applies toward the cost of the frame; 20% off amount over the allowance	Included	Reimbursement up to $70 less $10 copay (member responsible for the difference)
Standard Lenses	• Single Vision Lenses • Lined Bifocal Lenses • Lined Trifocal Lenses • Lenticular Lenses • Polycarbonate lenses for children to age 18	Included	Reimbursement up to the approved amount on the lens type less $10 copay (member responsible for the difference)
Lens Enhancements	• Standard Progressive lenses covered once every 12 months with $0 copay; • Other Lens Enhancements are covered after a copay, saving members an average of 30%	Discounts apply	
Lens Fitting and Evaluation	• Contact lens evaluation and fitting fee	$60 Copay	
Medically Necessary Contacts	• One pair of contact lenses, in lieu of glasses, in any period of 12 consecutive months.	$10 Copay	Reimbursement up to $210 less $10 copay (member responsible for the balance)
Elective Contacts	• Covered up to $130 allowance every 12 months. Contact Lenses can e chosen instead of glasses.	Included	Reimbursement up to $105 less $10 copay (member responsible for the balance).

This is a partial listing of benefits and services only. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of the Vision Certificate. Children are covered to the end of the month following their 26th birthday.

2023 Weekly Vision Payroll Deductions	Full Time & Part Time Employee
Employee Only	$3.12
Two Person	$6.21
Family	$10.31

Life Insurance

Basic Life and AD&D Insurance

Alliance Physical Therapy Partners provides you with Life and AD&D insurance benefit equal to one and a half (1 ½) times your annual earnings, rounded to the next higher $1,000 up to $500,000. This insurance is at no cost to the employee, with the exception of the required taxes for coverage exceeding $50,000.

At age 65, the life insurance benefit will be reduced by 35%. At age 70, the life insurance benefit will be reduced by 50%.

Supplemental Term Life Insurance

Term Life insurance is an important part of your benefits. It's not easy to think about, but an unexpected death in the family could burden the surviving family members with large expenses on less income. Purchasing additional term life insurance could assist your loved ones with mortgage payments, funeral expenses, medical expenses, childcare expenses, etc.

At age 70, the life insurance benefit will be reduced by 35%. At age 75, the life insurance benefit will be reduced by 50%.

Guaranteed issue amounts are available to you one time as a new hire at your initial benefits eligibility. Medical underwriting will be required for late applicants.

Term Life Benefit*	Employee	Spouse	Dependent Child
*Term Life: Benefit paid to designated beneficiary upon death of insured. Coverage is for a certain term and has no cash value.	One (1) or Two (2) times your annual earnings, rounded to the next higher $1,000, up to $500,000.	Increments of $10,000 not to exceed 50% of your election, up to $100,000 maximum. Employee must elect coverage for spouse to be eligible.	Increments of $2,000 not to exceed $10,000. There is a $500 limit for children at birth to age 6 mos of age. Employee must elect coverage for children to be eligible.
Minimum Amount	$10,000	$10,000	$2,000
Maximum Amount	$500,000	$100,000	$10,000
Guarantee Issue* *Available amounts shown are offered to any eligible applicant (employee and dependent(s) without regard to health status if you enroll during the initial new employee waiting period. No medical questions are asked on the application unless the amount applied for exceeds the amounts shown.	$300,000 of coverage is available on a guaranteed acceptance basis within your new employee election period. *During Open Enrollment, Any increase more than one level above the current benefit level will require Evidence of Insurability.*	$30,000 of coverage is available on a guaranteed acceptance basis within your new employee election period. *During Open Enrollment, Any increase more than one level above the current benefit level will require Evidence of Insurability.*	$10,000
Payroll Deductions	If you elect a benefit that exceed the Guarantee Issue, we will deduct up to the Guarantee Issue. Once coverage is approved, your payroll deductions will be adjusted to your full election. Payroll deductions for your spouse's coverage is calculated off the employee's age.		

Life Insurance

AD&D Benefit*	Employee	Spouse	Dependent Child
Amount *AD&D (Accidental Death & Dismemberment): Double indemnity for accidental death or a percentage of the benefit payable per covered non-work-related accidental injury.	The benefit amount is equal to the life amount elected by you. Cost included in the schedule.	Employee must elect coverage for dependent to be eligible.	Employee must elect coverage for dependent to be eligible.

Benefit Reduction	Employee	Spouse	Dependent Child
Benefits will reduce on the plan anniversary following the date you attain the applicable age.	• 35% at age 70 • 50% at age 75	• 35% when employee reaches age 70 • 50% when employee reaches age 75	N/A

Additional Definitions and Benefits	
Earnings Definition	Means your annual rate of earnings from Alliance Physical Therapy. Earnings excludes bonuses, commissions, overtime pay and extra compensation.
Dependent	Means your lawful spouse. Unmarried children (natural, adopted, step-children and disabled children. A dependent does not include a person who is an eligible employee or member of the armed forces.
Accelerated Death Benefit	Cash advance against the death benefit available if insured has a terminal illness.
Portability	You may continue your term insurance coverage when employment ends by paying the required premiums.
Conversion	You may apply to convert your term life insurance to a whole life policy at termination of employment if you have been covered by the plan for at least 5 years.
Waiver of Premium	If you become Totally Disabled while insured under the plan you may be eligible to continue the life insurance at no cost to you. Eligibility Requirements: • You become Totally Disabled while insured and before age 60 • Totally Disabled for 9 months or more. Proof of disability must be submitted within one year from the date you were no longer actively at work. • Lincoln received Proof of continuation of Total Disability within 3 months before each plan anniversary.

Eligibility	Employee	Spouse & Dependents
	All full-time active employees working 20 or more hours per week in an eligible class are eligible for coverage on the policy effective date. A delayed effective date will apply if the employee is not actively at work.	Cannot be in a period of limited activity* on the day coverage takes effect. *Period during which a dependent is confined to a health care facility and/or unable to perform what would be considered regular.

Life Insurance

The employee paid premium rates are as follows: Rates are for both Employee and Spouse.
Note: Spousal Voluntary Life Insurance is calculated based on the Employee's Age.

Age	Monthly Rates (rate per $1,000)	Biweekly Payroll Amount Based on $100,000 of life insurance
0-29	$0.06	$2.77
30-34	$0.08	$3.69
35-39	$0.09	$4.15
40-44	$0.11	$5.08
45-49	$0.16	$7.38
50-54	$0.24	$11.08
55-59	$0.441	$20.31
60-64	$0.661	$30.51
65-69	$1.272	$58.71
70+	$2.063	$95.22
Child(ren) Rate	**$0.20**	**N/A**

	Age	Monthly Rate based upon age (see chart above)	Amount of Insurance (1x or 2x salary)	Units: Per $1,000 of Life Insurance	Per Pay Period Cost: 26 Pays
Example:	34	$0.08	$50,000	50	{($0.08 X 50) X 12} / 26 + $1.85

Disability Insurance

Short Term Disability (STD) – Employer Paid Plan Features

Short-Term disability insurance provides you with weekly income if you become disabled due to injury or illness, including maternity.

- The STD benefit is administered by Lincoln Financial Group and is provided by Alliance Physical Therapy Partners at **no cost to you.**
- STD benefits begin on the 8th day of a disability, whether your disability is due to injury or sickness.
- Your weekly benefit is equal to 60% of your salary, to a maximum of $700 to $1,000, based on your employment classification.
- You are eligible to receive STD benefits for up to 13 weeks, provided you remain disabled.

Please carefully consider this benefit- your ability to work and provide an income for yourself and your family is one of your most important assets. If you are unable to work due to an illness, or non-work-related injury, this benefit helps replace your lost income.

Long Term Disability (LTD) – Employer Paid Plan Features

Long Term Disability insurance helps protect you and your family's income in the event of a long-term illness or disability. This core LTD benefit is administered by Lincoln Financial Group and provided by Alliance Physical Therapy Partners **at no cost to you.**

- LTD benefits begin on the 91st day of a disability due to an injury or illness.
- Your monthly benefit is equal to 60% of your salary to a maximum of $10,000.
- The monthly benefit is reduced by Social Security or other income you receive.
- LTD benefits continue to your normal social security retirement age, provided you remain disabled.
- Pre-existing condition limitation: If you become disabled due to a pre-existing condition during the first 3 months that you are covered, the benefit will not be paid until you have been insured for 12 continuous months.

Pet Insurance

Cost:

Single Pet: $11.75 per month or $5.42

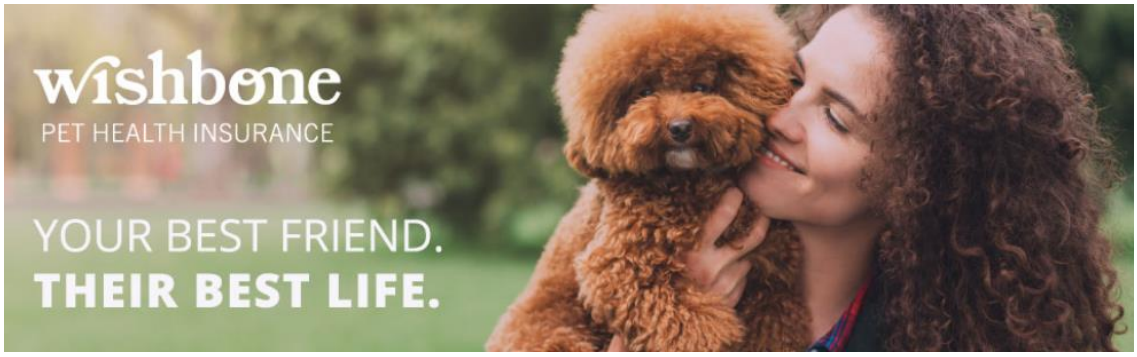
Family Plan: (2 or more pets): $18.50 per month or $8.53 per pay

Enrollment made easy by Bswift.

What does Total Pet cover?

As a Total Pet Plan member, you'll receive:

- PetPlus: Up to 40% off and free shipping on all orders from PetCareRx.com
- Pet Assure: 25% savings on in-house veterinary care at participating vets
- AskVet: Chat with a US-based Veterinarian for questions on your pet's health, wellness, behavior and more
- ThePetTag: Durable ID tag that can be scanned if your pet goes missing, bringing them home faster than a microchip



Wishbone Pet Health Insurance offers 90% reimbursement on accidents and illnesses, including office visits and prescription medications. You can choose to add coverage for routine care.

Group Rates: Wishbone pet Insurance is only available as an employee benefit and rates are exclusive to Alliance Physical Therapy through Pet Benefit Solutions. **Rates are based on age, breed and location of the pet.** You can choose to add routine care for additional premium. If you enroll for more than one pet you are eligible for a 5% multi-pet discount.

Plan of Benefits: Accident and Illness Coverage

- Reimbursement: 90%
- Annual Deductible: $250
- Annual limit: $25,000
- No Lifetime Maximum

Get a quote and enroll at
www.wishboneinsurance.com/allianceptp

Why Wishbone?

- Simple enrollment process designed for employees
- Easy claims submission at www.wishboneinsurance.com
- Claims processed within 5 business days with some claims processed din as little as 24 hours
- 30-day free look period
- Coverage on hereditary and congenital conditions
- Includes 24/7 telehealth from **AskVet** and lost pet recovery services from **ThePetTag**
- Pet insurance is designed to protect pet owners from their pet's unexpected illnesses or injuries.
- Exclusion for Pre-existing conditions will apply
- Wishbone has no waiting periods or injuries and illnesses, and just 6 months waiting period for cruciate ligament events. Waiting periods start on the policy effective date.

Contributions

Medical

Effective January 1, 2023	BLUE PLAN		YELLOW PLAN		GREEN PLAN	
	Full-time	**Part-Time**	**Full-Time**	**Part-Time**	**Full-Time**	**Part-Time**
Employee Only	$61.14	$83.37	$79.52	$99.40	$140.56	$140.56
Two Person (Employee + Spouse or a child)	$146.73	$233.43	$190.85	$238.56	$322.35	$337.34
Family (Employee, Spouse and children)	$183.41	$250.10	$238.56	$298.20	$402.93	$421.67

Dental

2023 Bi-Weekly Dental Payroll Deductions	Full Time Employee	Part Time Employee
Employee Only	$5.20	$8.21
Two Person	$12.40	$19.68
Family	$15.49	$24.60

Vision

2023 Bi-Weekly Vision Payroll Deductions	Full Time & Part Time Employee
Employee Only	$3.12
Two Person	$6.21
Family	$10.31

Supplemental Benefits

The following supplemental benefit plans are offered through Lincoln Financial Group Benefits. These benefits are offered during our annual open enrollment. Please watch for an announcement and more details.

Group Accident Insurance

- Pays cash benefits if you or a covered family member is accidently injured while off the job.
- This benefit can help offset the out-of-pocket expenses that health insurance doesn't pay, such as deductibles and coinsurance
- You have the choice of two plan options: Low Plan or High Plan. Below is a sample of the cash benefits. Please see the benefit summary for complete plan details include premium costs.

	Low Plan	High Plan
Ambulance	$225	$300
Emergency care/treatment	$150	$200
X-Ray	$30	$40
Fracture Ankle, Arm (elbow to wrist, elbow, foot (except toes), hand except fingers), kneecap, rib, shoulder blade, vertebral process, wrist	$450	$575

Group Critical Illness Insurance

- Pays money directly to you when you are diagnosed with specific critical illnesses including heart attack, stroke, invasive cancer, end stage renal failure, major organ failure (heart, lung, liver, pancreas, or intestine), arterial vascular disease, non-invasive cancer.
- This money can help you pay out-of-pocket medical expenses and help with other out-of-pocket costs that aren't covered by health insurance.
- Please see the benefit summary for complete plan details including premium costs.
  - ✓ Coverage for Employee: You can elect $10,000 or $20,000 in benefit protection. Coverage for new hires is guaranteed. If you choose to add coverage at any other time, Evidence of Insurability is required.
  - ✓ Coverage for Spouse: You can elect $5,000 or $10,000 in benefit protection. Coverage for new hires is guaranteed. If you choose to add coverage at any other time, Evidence of Insurability is required.
  - ✓ Coverage for child(ren); You can choose $5,000 or $10,000 (up to 50% of employee's election)

401 (k) Retirement Savings

The 401(k) plan is a great way to contribute toward your long-term financial goals. The fundamental principal of a 401(k) plan is to allow you to contribute a portion of your salary into various investment options through payroll deduction, pre-tax. The money then grows tax-deferred until you take it out at retirement age. The information below gives you an overview of the Plan.

Plan Eligibility and Participation

Employees regularly scheduled to work twenty (20) hours per week or more are immediately eligible to defer employee contributions.

Automatic enrollment: An enrollment letter will be sent to your mailing address on file. The letter will detail information regarding automatic enrollment for 4% of your income. Subsequently, you will be sent a reminder postcard approximately two (2) weeks later regarding the automatic enrollment. The first automatic deduction will occur approximately forty-five (45) days after your date of hire. You can opt out of the automatic enrollment prior to the first deduction by contacting Fidelity Investments directly at 800-835-5097 or www.401k.com.

The Plan has both defined and discretionary portions. Both will be subject to a vesting schedule.

- Under the defined match, Alliance will fund $0.50 for each dollar you contribute, up to 4% of your eligible pay deferral. This means that if you contribute 4% or more, The company will contribute 2% to your account. The defined match contributions will be made each payroll period.
- The discretionary match will be dependent on the company achieving the financial targets we've set for the year. If those goals are met, an additional 1% match is possible. This match will be calculated on deferrals from 5-6%. Discretionary match contributions will be made after the close of the fiscal year.

Company matching contributions and earnings are subject to a 5-year vesting schedule. See plan documents for details.

Employees may contribute up to 75% of their income into the Plan, subject to the IRS maximums. For 2023, the IRS allows salary deferrals up to $19,500 for employees under age 50, and $26,000 for employees age 50 and older.

Transfer of Existing 401(k) and 403(b) Plan Funds

Once eligible to participate in the plan, you have the option to transfer 401(k) and 403(b) funds from a previous employer into the plan. Please contact Fidelity directly to transfer funds by calling 800-835-5097.

Changing Investment Options/Fund Transfers

You may change your investment option mix for your existing account balances and future contributions any day at any time by calling 800-835-5097 or going to www.401k.com.

Fund Elections

Your 401(k) plan offers twenty-four (24) investment options ranging from conservative to aggressive. We offer managed funds, index funds, and Fidelity Freedom funds. You may choose a combination of any or all of the options to suit your personal needs and goals. Our goal in choosing the offered funds is to provide you with a diversified portfolio of solid performing, cost effective funds. You may obtain full information on the fund objectives and historical investment results by utilizing the website or contacting Fidelity Investments.

Employee Assistance Program

Lincoln Financial Group

Alliance Physical Therapy Partners pays the full cost of this coverage for you.

The Employee Assistance Program (EAP) is designed to help you with life challenges. The EAP gives you and your dependents access to a network of licensed and/or certified professionals who can provide confidential support for a variety of matters like:

- Family and relationships: Marriage and partners, divorce, parenting, childcare and elder care assistance, domestic violence
- Emotional well-being: Anger management, coping with stress and anxiety, coping with depression, working through grief, traumatic life events
- Financial wellness: Managing finances
- Substance Abuse and Addiction: Alcohol, drugs, gambling and other addictions, support for families
- Physical Health: Diet and nutrition, exercise and fitness, sleep, smoking cessation
- Work and Career: Relationships in the workplace, work stress and transitions, career development

Information gathered by the EAP is confidential – it is not shared with Alliance Physical Therapy Partners unless there is a risk of harm to you or others.

To learn more or get help, visit GuidanceResources.com or call 888-628-4824.

*EmployeeConnect*SM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

Confidential help 24 hours a day, seven days a week for employees and their family members. Get help with:

- Family
- Parenting
- Addictions
- Emotional
- Legal
- Financial
- Relationships
- Stress

Take advantage of *EmployeeConnect*

For more information about the program, visit **GuidanceResources.com**, download the **GuidanceNow** mobile app, or call **888-628-4824**.

GuidanceResources.com login credentials:

Username: LFGSupport Password: LFGSupport1

The resources you need to meet life's challenges

*EmployeeConnect*SM offers professional, confidential services to help you and your loved ones improve your quality of life.

Compliance Notices

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

If you are declining enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance.

Notice of Patient Protection

If your health plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, the health plan generally may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Human Resources Department.

You do not need prior authorization from the health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Human Resources Department.

Women's Health and Cancer Rights Act Notice

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

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

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

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following 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).

Michelle's Law Notice

Michelle's Law was signed into law effective January 1, 2010. This law generally allows seriously ill or injured fulltime college students, who are covered under their parent's health insurance plan, to take up to one year of medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

*Under the Patient Protection and Affordable Care Act, group health plans are required to offer coverage to dependent children up to age 26, regardless of student status.

Important Notice from Alliance Physical Therapy Partners About Your Prescription Drug Coverage and Medicare (CREDITABLE)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Alliance Physical Therapy Partners 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. Alliance Physical Therapy Partners has determined that the prescription drug coverage offered by the Auxiant is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Alliance Physical Therapy Partners coverage will not be affected. As long as you are actively working for Alliance Physical Therapy Partners, coverage under the Medical Plans will usually be your secondary coverage. Therefore, you will want to enroll in a Medicare prescription drug plan while you are actively working for Alliance Physical Therapy Partners.

If you do decide to join a Medicare drug plan and drop your current Alliance Physical Therapy Partners coverage, be aware that you and your dependents will be able to get this coverage back but generally only at your next open enrollment period.

Compliance Notices

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Alliance Physical Therapy Partners and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information or call Charlie Smodic at 616-356-5010. **Note:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Alliance Physical Therapy Partners changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription

drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 1, 2022
Name of Entity/Sender:	Alliance Physical Therapy Group, LLC
Contact--Position/Office:	Human Resources Director
Address:	625 Kenmoor Ave, S.E., Grand Rapids, MI 49504
Phone Number:	616-356-5010

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, 2022. Contact your State for more information on eligibility.

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	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 711Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

Compliance Notices

GEORGIA-Medicaid	MAINE-Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone:678-564-1162 Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	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: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-Medicaid**
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 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-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: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA-Medicaid	**SOUTH CAROLINA-Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

Compliance Notices

NEW HAMPSHIRE-Medicaid	SOUTH DAKOTA-Medicaid
Website: https://www.dhhs.nh.gov/programs-Services/Medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
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	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com Medicaid Phone 304-355-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8847
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website:https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website:https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, 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

Compliance Notices

HIPAA Notice of Privacy Practices

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. Participants in insured group health plans may also receive a notice of privacy practices from those plans. 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.

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (“GINA”) prohibits the Plan from discriminating against individuals on the basis of genetic information in providing any the benefits under included benefit plans. GINA generally:

- Prohibits the Plan from adjusting premium or contribution amounts for a group on the basis of genetic information;
- Prohibits the Plan from requesting or mandating that an individual or family member of an individual undergo a genetic test, provided that such prohibition does not limit the authority of a health care professional to request an individual to undergo a genetic test, or preclude a group health plan from obtaining or using the results of a genetic test in making a determination regarding payment;
- Allows the Plan to request, but not mandate, that a participant or beneficiary undergo a genetic test for research purposes if the Plan does not use the information for underwriting purposes and meets certain disclosure requirements; and
- Prohibits the Plan from requesting, requiring, or purchasing genetic information for underwriting purposes, or with respect to any individual in advance of or in connection with such individual’s enrollment.

Qualified Medical Child Support Order Notice

A Qualified Medical Child Support Order (QMCSO) is a court order or an order issued by a state administrative agency in accordance with federal and state laws that requires an alternate beneficiary (for example, a child or stepchild) to be covered by a plan participant’s group health plan. The Plan honors QMCSOs that meet the legal requirements for such orders. It is important to note that a QMCSO cannot require a plan to provide a type or form of benefit, or an option, that is not currently available from the plan to which the order is directed, unless receiving this benefit or option is necessary to meet the requirements of the Social Security Act, which relates to the enforcement of state child support laws and reimbursement of Medicaid. A QMCSO must be provided to the Plan Administrator to determine if it meets the legal requirements for a QMCSO. If it does, the alternate beneficiary is considered a beneficiary for the purposes of ERISA and is enrolled as a dependent of the employee participant. If the Plan Administrator receives a medical child support order that relates to you, you will be notified and then informed of the decision as to whether the order is qualified.

Compliance Notices

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you take leave under USERRA, to the extent required by USERRA, your Employer may continue to maintain your benefits on the same terms and conditions as if you were still an active employee.

Employees going into or returning from service in the uniformed services may have Plan rights mandated by USERRA. These rights apply only to employees and their dependents covered under the Plan before the employee left for military service. To be entitled to USERRA rights, the employee must give the employer advanced notice of the employee's absence from employment for uniformed service, unless precluded by military necessity or if it is otherwise impossible or unreasonable under all the circumstances. Additionally, subject to certain exceptions, the employee's absence from work may not exceed five years.

USERRA rights include up to 24 months of continued health care coverage. For periods of leave less than 31 days, the employee only needs to pay his or her normal portion of the premium. For periods of leave 31 days or more, coverage will only be extended upon payment of the entire cost of coverage plus a reasonable administrative fee.

If you comply with USERRA upon returning to active employment after military service, you may re-enroll yourself and your eligible dependents in health coverage immediately upon returning to active employment, even if you and your eligible dependents did not elect USERRA continuation coverage during your military service. Reinstatement will occur without any waiting periods or pre-existing condition exclusions, except for illnesses or injuries connected to the military service.

USERRA rights terminate if the employee's discharge from the uniformed service was a result of "dishonorable" or other undesirable conduct, the employee fails to report back to work or apply for reemployment within the time period required under USERRA, or if the employee fails to pay coverage premiums.

The time periods within which to elect and pay for USERRA continuation of coverage shall be the same time periods within which to elect and pay for COBRA coverage under the Plan. If both USERRA and COBRA apply, an election for continuation coverage will be an election to take concurrent COBRA/USERRA coverage. Note also that state law may provide continuation and/or conversion coverage.

Mental Health Parity Act Notice

The Mental Health Parity Act ("MHPA") requires that the annual or lifetime dollar limits on mental health benefits may not be lower than any such dollar limits for health and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. The lifetime limit ceased to apply effective January 1, 2011 and the annual limit ceased to apply effective January 1, 2014. Beginning with the 2010 plan year, federal law also will require that plans providing both health/surgical and mental health benefits may not impose more restrictive financial requirements (such as deductibles and copayments) and treatment limitations (such as limits on days of coverage) on mental health benefits than are imposed on health/surgical benefits.

Compliance Notices

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

Compliance Notices

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Employee Benefits Security Administration at askebsa.dol.gov or 1-866-444-3272.

Visit www.dol.gov/agencies/ebsa for more information about your rights under federal law.

Benefits Contact Information

Carrier	Website	Customer Service
Auxiant– Medical/Rx	www.auxiant.com	800-295-4119

Carrier	Website	Customer Service
TrueRx **WB Rx Express** Mail Order **SHARx** Specialty Advocacy	www.truerx.com www.wbrxexpress.com www.sharxplan.com	866-921-4947 833-391-0126 314-451-2555

Carrier	Website	Customer Service
Delta Dental– Dental	www.DeltaDentalMI.com	800-524-0149

Carrier	Website	Customer Service
VSP through Principal– Vision	www.vsp.com	800-877-7195

Carrier	Website	Customer Service
Lincoln Financial Group – Core & Voluntary Life and AD&D, Core STD & LTD, Voluntary Critical Illness & Accident Insurance	www.MyLincolnPortal.com	888-580-5579

Carrier	Website	Customer Service
Clarity Benefit Solutions – Flexible Spending Account	https://claritybenefitsolutions.com	888-423-6359

Carrier	Website	Customer Service
Clarity Benefit Solutions – Health Savings Account	https://claritybenefitsolutions.com	888-423-6359

Carrier	Website	Customer Service
Fidelity Investments – 401 (k) Retirement Savings	www.401k.com	800-835-5097

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Notes

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