Orange Park Rehabilitation and Nursing Center

2025 Benefit Enrollment Guide

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Welcome!

As a new employee, I want to welcome you to a new career with our company. You can take pride in the fact that you are now a team member of a premier provider of skilled health care services. We strive to provide excellent care for our residents and will help you attain excellence in your career with us.

An important part of your compensation package are the employee benefits made available to all eligible employees. Eligible employees are those employees who are scheduled to work 30 or more hours per week. Eligible employees are benefits eligible on the first of the month following 60 days of full-time employment. This guide will give you an overview of all of your available insurance benefit choices. Our H.R./ Benefits Team has worked hard to provide you with a broad choice of insurance benefits to protect you and your family in time of need. Please take the time to review the important information in this guide so you can make informed choices when selecting your benefits.

Please note, it is your decision whether to participate in any of the benefits offered. **It is mandatory to review the benefit offerings during the month prior to your benefit eligibility and review your benefit choices.** You can then enroll or decline any or all of the offerings.

To make the interview process as easy as possible, we have two ways for you to enroll:

By Phone

Call the Enrollment Call Center at (239) 399-6252. The enrollment call center is open for you to enroll or ask any benefit related questions from 9am-6pm EST, Monday - Friday.

Online

Visit chubb.benselect.com/GR.

Enter your Username: your full Social Security Number (SSN)

Enter your PIN (Password): the last 4 digits of your SSN + the last 2 digits of your year of birth

Example: If your SSN is 123-45-6789 and you were born in 1975, your PIN would be 678975

Follow the on-screen instructions to review your options, make your selections, and submit your enrollment.

Plan Documents and Notices

Please visit the forms library section at chubb.benselect.com/GR to review important benefit documentation for our plans, including the Benefit Guide, the Health and Welfare Plan Summary, the Medical Plan Summary, Dental and Vision plan summaries and other plan documents and required notices. The benefit guide provides a detailed description of each benefit. The forms library can be reached by clicking on the book icon in the upper right corner of the screen.

Again, welcome aboard! Wishing you much success!

This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits.

While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

RELIANCE STANDARD
LIFE INSURANCE COMPANY

Employer Paid Life and AD&D Insurance

Benefit Descriptions	
*Benefit Amount:	$50,000
Age Reduction:	35% of the pre-age 65 amount at age 65; and an additional 25% of the pre-age 65 amount at age 70; and an additional 20% of the pre-age 65 amount at age 75. Terminates at Retirement.
Family Medical Leave Ext.:	Yes
Bereavement Counseling:	Yes
Travel Assistance:	Yes
Portability:	No
AD&D Coverage:	24 Hour, excludes retirees.
Seat Belt Benefit:	10%
Seat Belt/Air Bag Max:	$25,000

*Flat/Incremental benefits may be subject to an earnings cap, see full plan summary for more details.
**This may be expressed as Accelerated Benefit or Imminent Death Benefit.

MetLife

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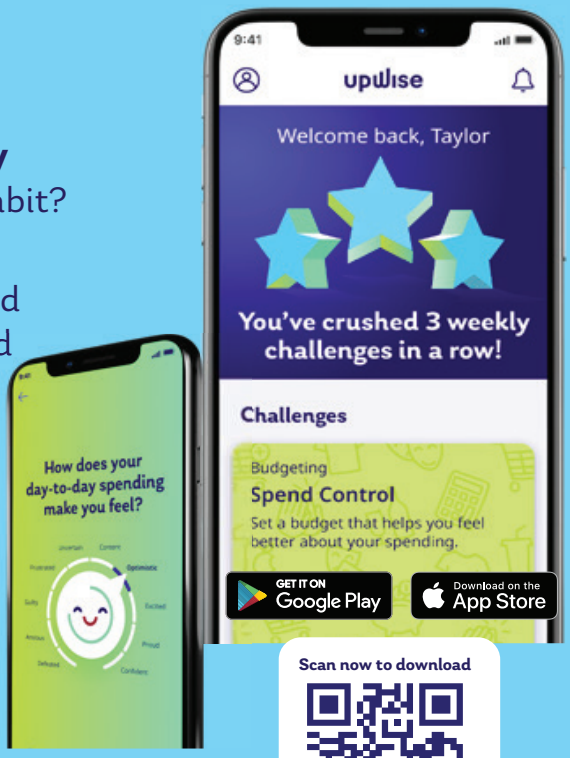
What if making financial progress became a routine habit? With Upwise™, it's possible.

Upwise helps users get the most out of their money and makes managing their financial life more enjoyable and rewarding—one step at a time.

Develop good money habits.
Upwise guides you through simple, easy actions that can add up to real change. We call these challenges, but not the hard kind.

Enjoy a personalized experience.
The more you participate in features of the app, the more tailored the recommendations and actions will become. You may discover spending and saving opportunities you hadn't seen before.

Boost your Money Mood.
Feeling uncertain? You're not alone. Upwise is designed to celebrate small wins along the way so you can feel more optimistic about what your money can do for you.



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Use employer name Gulf Reserve to log in and access more features

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Medical Insurance

	Essential Plan In-Network	Base Plan In-Network	Premium Plan In-Network	Premium Plus Plan In-Network
Deductible (Single/Family)	N/A	$5,000/$10,000	$3,000/$6,000	$1,750/$3,500
Out-of-Pocket Limit (Single/Family)	N/A	$7,000/$14,000	$5,500/$11,000	$5,500/$11,000
Health care provider's office or clinic visit				
Primary care visit to treat an injury or illness	Plan pays $70 per visit	$35 co-pay/ visit; deductible doesn't apply	$25 co-pay/ visit; deductible doesn't apply	$25 co-pay/ visit; deductible doesn't apply
Specialist visit	Plan pays $70 per visit Limit 10 visits per year	$65 co-pay/ visit; deductible doesn't apply	$50 co-pay/ visit; deductible doesn't apply	$40 co-pay/ visit; deductible doesn't apply
		Chiropractic Care – Limit 25 visits per plan year		
Preventive care/screening/ immunization	Plan pays 100%	No charge	No charge	No charge
		You may have to pay for services that aren't preventive.		
Lab Tests				
Diagnostic test (x-ray, blood work)	Not Covered	Lab / Blood Work: $35 co-pay; deductible doesn't apply X-Ray: $65 co-pay; deductible doesn't apply	Lab / Blood Work: $25 co-pay; deductible doesn't apply X-Ray: $50 co-pay; deductible doesn't apply	Lab / Blood Work: $25 co-pay; deductible doesn't apply X-Ray: $40 co-pay; deductible doesn't apply
Imaging (CT/PET scans, MRIs)	Not Covered	30% coinsurance after deductible *Preauthorization is required*	20% coinsurance after deductible *Preauthorization is required*	20% coinsurance after deductible *Preauthorization is required*
Perscription Drugs				
Generic drugs	Plan pays up to $15 per script	$15 co-pay Retail $30 co-pay Mail Order	$10 co-pay Retail $20 co-pay Mail Order	$10 co-pay Retail $20 co-pay Mail Order
Preferred brand drugs	Plan pays up to $75 per script	$60 co-pay Retail $120 co-pay Mail Order	$50 co-pay Retail $100 co-pay Mail Order	$50 co-pay Retail $100 co-pay Mail Order
Non-preferred brand drugs	Plan pays up to $75 per script	$100 co-pay Retail $200 co-pay Mail Order	$75 co-pay Retail $150 co-pay Mail Order	$75 co-pay Retail $150 co-pay Mail Order
Specialty drugs	Not Covered	$200 co-pay Retail $400 co-pay Mail Order	$150 co-pay Retail $300 co-pay Mail Order	$100 co-pay Retail $200 co-pay Mail Order
More information about prescription drug coverage is available at 877-226-2378.		*Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). Deductible waived for Rx.*		
Outpatient Surgery				
Facility fee (e.g., ambulatory surgery center)	Not Covered	30% coinsurance after deductible *Preauthorization is required*	20% coinsurance after deductible *Preauthorization is required*	20% coinsurance after deductible *Preauthorization is required*
Physician/surgeon fees	Not Covered	$65 co-pay/ visit; deductible doesn't apply	$50 co-pay/ visit; deductible doesn't apply	$40 co-pay/ visit; deductible doesn't apply
Immediate Medical Attention				
Emergency room services	Not Covered	$500 co-pay; deductible doesn't apply	$500 co-pay; deductible doesn't apply	$500 co-pay; deductible doesn't apply
		co-pay is waived if admitted as inpatient from ER. All facilities are covered as in-network subject to meeting "emergency" criteria		
Emergency medical transportation	Not Covered	30% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Urgent care	Plan pays $70 per visit 4 visits per Benefit Period	$65 co-pay/ visit; deductible doesn't apply	$50 co-pay/ visit; deductible doesn't apply	$40 co-pay/ visit; deductible doesn't apply
Hospital Stay				
Facility fee (e.g., hospital room)	Not Covered	30% coinsurance after deductible *Preauthorization is required*	20% coinsurance after deductible *Preauthorization is required*	20% coinsurance after deductible *Preauthorization is required*
Physician/surgeon fee	Not Covered	30% coinsurance after deductible *Preauthorization is required*	20% coinsurance after deductible *Preauthorization is required*	20% coinsurance after deductible *Preauthorization is required*

Mental Health, Behavioral Health, Or Substance Abuse Needs				
Outpatient services	Not Covered	$65 co-pay; deductible doesn't apply	$50 co-pay; deductible doesn't apply	$50 co-pay; deductible doesn't apply
		Preauthorization is required for intensive care outpatient service; 30 visit limit for ABA Therapy		
Inpatient services - *Preauthorization is required*	Not Covered	30% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Pregnancy				
Office visits	Not Covered	$35 co-pay/ 1st Visit; deductible doesn't apply	$25 co-pay/ 1st Visit; deductible doesn't apply	$25 co-pay/ 1st Visit; deductible doesn't apply
		Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).		
Childbirth/delivery professional services - *Preauthorization is required*	Not Covered	30% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Childbirth/delivery facility services - *Preauthorization is required*	Not Covered	30% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Recovery or Other Special Health Needs				
Home health care	Not Covered	$65 co-pay/ Visit; deductible doesn't apply	$50 co-pay/ Visit; deductible doesn't apply	$40 co-pay/ Visit; deductible doesn't apply
		Preauthorization is required. Maximum 60 visits per plan year		
Rehabilitation services	Not Covered	$65 co-pay/ Visit; deductible doesn't apply	$50 co-pay/ Visit; deductible doesn't apply	$40 co-pay/ Visit; deductible doesn't apply
		Preauthorization is required. Maximum 30 visits per therapy per plan year. Includes physical therapy, speech therapy, and occupational therapy.		
Habilitation services	Not covered	$65 co-pay/ Visit; deductible doesn't apply	$50 co-pay/ Visit; deductible doesn't apply	$40 co-pay/ Visit; deductible doesn't apply
		Preauthorization is required. Maximum 30 visits per plan year		
Skilled nursing care - *Preauthorization is required*	Not Covered	30% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
		60 day maximum per plan year.		
Durable medical equipment - *Preauthorization is required*	Not Covered	30% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Hospice service - *Preauthorization is required*	Not Covered	30% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Children's Dental or Eye Care				
Children's eye exam	Not Covered	Not Covered	Not Covered	Not Covered
Children's glasses	Not covered	Not Covered	Not covered	Not covered
Children's dental check-up	Not covered	Not Covered	Not covered	Not covered
Services Your Plan Does NOT Cover				
	• Acupuncture • Bariatric Surgery • Chiropractic Care • Cosmetic Surgery • Hearing Aids • Infertility Services • Long-Term Care • Non-Emergency Care outside US • Routine Dental Care • Routine Eye Care • Routine Foot Care • Private Duty Nursing • Weight Loss Programs	• Acupuncture • Bariatric Surgery • Cosmetic Surgery • Hearing Aids • Long-Term Care • Non-Emergency Care outside US • Routine Dental Care • Routine Eye Care • Routine Foot Care • Weight Loss Programs		
Other Covered Services *(Limitations may apply to these services)*				
		• Chiropractic care	• Infertility Services (Basic)	

Dear Base, Premium, and Premium Plus Plan Member:

This document provides helpful information concerning accessing and using your health benefits.

Your health plan is an Open Access arrangement which allows members access to any provider **regardless** of network participation. The plan separates claims & providers into three categories:

- Professional Claims
- Facility Claims
- Pharmacy Claims

I. Professional Claims

a. **Providers**: The following providers fall under the category of Professional Claims:

- Primary Care Doctor
- OB/GYN
- Specialist
- Chiropractor

b. **Network Access**: MultiPlan® Private Health Care Systems (PHCS) Practitioner and Ancillary Network will be the Preferred Provider Organization (PPO) for all "professional claims". This does not apply to facility-based claims such as Freestanding facilities or Hospitals.

Members can search providers in the MultiPlan® PHCS network

Via Website: https://www.multiplan.com/webcenter/portal/ProviderSearch.

- Click on the "For Health Plan Members" button
- Select "Find a Provider"
- Select "PHCS" and then Select "Physician and Ancillary" network
- Follow the prompts to enter your search criteria

Via Phone: Call the Benefit Customer Service number – 877-952-7427 - located on your Medical ID Card or call 866-930-7427.

c. **Non-Network Providers**: The plan also allows access to non-network providers. If your provider does not participate in MultiPlan® PHCS Physician and Ancillary network, the plan will still reimburse the provider for covered services and the member will only be obligated to pay the applicable co-pay. In this situation, contact UHP Administrators at **855-375-7125** to make payment arrangements with the provider. Members are only responsible to pay all cost sharing as outlined in benefit summary. This includes any applicable co-pay, deductible or co-insurance. Refer to your Explanation of Benefits (EOB) for payment due.

II. Facility Claims

a. **Providers**: The following providers fall under the category of Facility Claims:

- Hospital: Inpatient and Outpatient Services
- Emergency Room
- Freestanding Ambulatory Surgery Centers
- Urgent Care Centers

b. **Network / Non-Network Providers**: There is NO specific network associated with Facility Claims. The plan will reimburse any provider for covered services and the member will only be held responsible for applicable cost sharing amounts (i.e. co-pay or deductible and co-insurance).
If the provider refuses to accept this insurance or has questions regarding the insurance, please call UHP Administrators Customer Service 855-375-7125 and plan information will be verified to the provider. Additionally, providers can call UHP Administrators Customer Service to address reimbursement questions on claims.

III. Pharmacy Claims

The Pharmacy benefits are managed through **medtipster**

RxBin: 018711 **RxPCN: MPL** **ClientID: MDTPSR**

Any questions concerning Rx eligibility or benefits, please call medtipster Customer Service line – 877-226-2378. Please provide the plan information and member ID (which appears on ID card) to verify eligibility.

Member Out-Of-Pocket Obligations / Balance Billing

The plan will reimburse providers for covered services. The member is still responsible for applicable co-pays, deductible and co-insurance as described in the benefit summary. Under the plan, the member will have NO obligation to any balance billing arising from covered services. Should the member receive a balance bill, please contact **Claim Watcher Customer Service at 844-307-6755**. You will be asked to forward a copy of the balance bill to Claim Watcher. The team at Claim Watcher will take over handling the balance billing so that the provider is properly reimbursed, and member will not receive further correspondence from the provider as long as they have promptly paid their required co-pays, deductibles and co-insurance as outlined in the benefit summary.

How to File a Claim: All claims – network or non-network – should be submitted to the address on back of ID card:

UHP Administrators
PO Box 190394
Brooklyn, NY 11219

Dear Base, Premium, and Premium Plus Plan Subscribers,

UHP Administrator plans provide open access to your healthcare providers. To make sure that everything goes smoothly, we have enhanced our plan's Customer Service. Our concierge service will help explain your benefit plan coverage to your healthcare providers before your next appointment.

Shortly after enrolling in the medical plan, you should be receiving a welcome call from **855-375-7125**. **Please make note of this phone number and answer or return the call.** This phone call is to welcome you to the updated medical plan and work with you to ease the transition to the new Customer Service program.

During the phone conversation, we will discuss 3 topics:

1. How to make this insurance plan work for you
2. How you can save money on your healthcare needs
3. Review the providers you utilize so we can work with your providers in advance of any scheduled appointment

The new Customer Service number is: **855-375-7125**. Our customer service representatives speak multiple languages including Spanish, Russian, Chinese, and Polish. Feel free to call us whenever you have any questions about your benefits or providers.

Are you concerned about an upcoming appointment? Need help finding a provider? Call us on the customer service line at **(855) 375-7125.** We'll be with you every step of the way! Please register on the employee portal at www.uhpadministrators.com using your social security number, where you can download an ID Card, view claims, and review benefits.

To get started,

(1) Use this tool to see if your doctors already participate with your plan: https://tinyurl.com/UHPProviderSearch
If you find your doctor, you are all set! Your provider participates with the *PHCS Practitioner & Ancillary network* or our Claim Watcher program. The directory indicates the affiliation of the provider. Please mention the appropriate logo on your ID card when scheduling an appointment**.**

(2) If you don't find your doctor using that tool, we're here to help you! All we need to get started is your healthcare provider's information. Use the link or QR code below to fill out the form:

https://tinyurl.com/UHPGR

If you fill out the form for providers not found at https://tinyurl.com/UHPGR you will receive a follow up call close to your appointment date or effective date. We will let you know that our concierge team has reached out to your provider. You will be all set!

Do not pay full charges at time of service.

There are no additional costs to see a provider outside the PHCS Practitioner & Ancillary network or Claim Watcher program, as long as you fill out the form or call Customer Service prior to your appointment. We will work with your provider to ensure that you are not required to pay the full charged amount. UHP's customer service team has a 98% success rate in getting our clients seen by the provider of their choice. On the rare occasion when a provider is not willing to work with us, our team will find you alternate providers willing to work with the plan.

If any of the following scenarios apply:

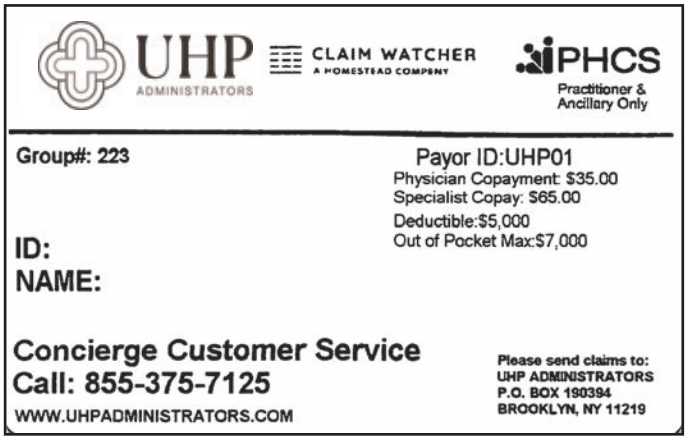
- **Your physician is not in the network**
- **You are in need of hospital services – inpatient or outpatient surgery**
- **You are in need of radiology services in a freestanding facility**

Please call **855.375.7125** in advance of the scheduled service so we can facilitate arrangements with the provider.

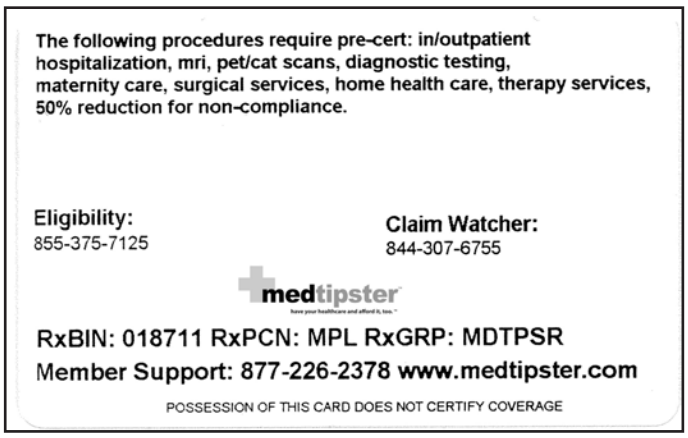
If you have questions, call us at (855)375-7125 and we will be happy to assist you.

Essential Plan Card Front

Base Plan Card Front

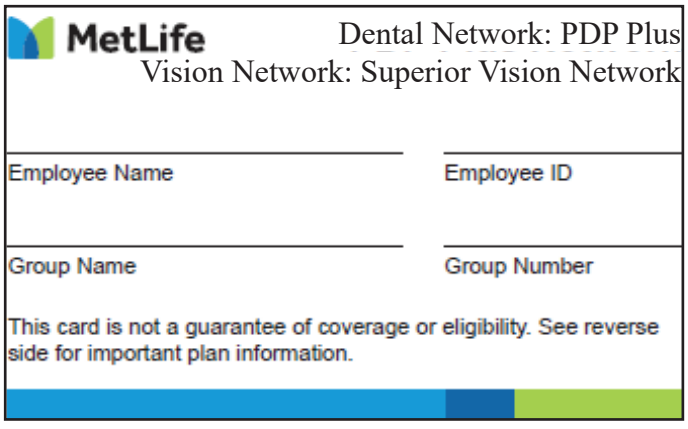


Essential Plan Back

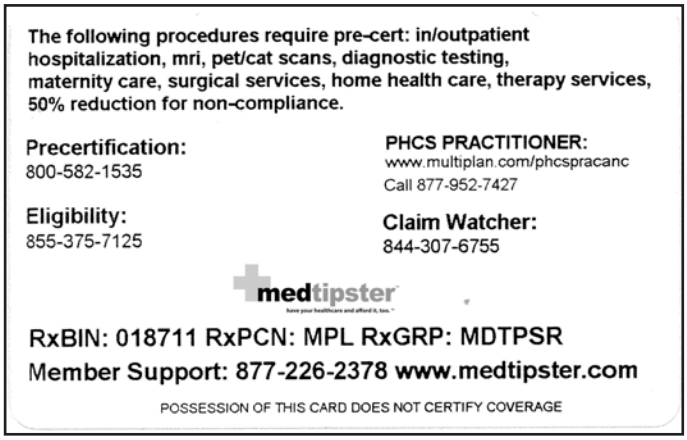


Premium/Premium Plus Plan Card Sample Front

Dental/Vision ID Card Front And Back



Base, Premium and Premium Plus Plan Card Back



metlife.com/mybenefits

- Locate a participating dentist.
- Verify eligibility and plan design information.
- Review claim status and claim history for your entire family.
- View and print processed claims with one click.
- Obtain claims forms and educational information (including interactive risk assessment).
- Get instant answers to Frequently Asked Questions.
- Access trained customer service representatives.

1-800-942-0854

- Virtually 24 hours a day, 7 days a week to confirm eligibility, order claim forms or request dentist directories
- Monday-Friday, 8 a.m. to 11 p.m., Eastern Time, to speak with a live customer service representative
- MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282
- For International Dental Travel Assistance call 1-312-356-5970 (collect)

00760522

UHP ADMINISTRATORS

(888) 596-4325
Call for benefit questions, eligibility, or to request ID cards and verify claim payments.

PHCS Practitioner Only

(877) 952-7427
Call to find out if a doctor is in the network or go to www.multiplan.com/phcspracanc - click on the PHCS Practitioner Only logo and follow prompts to find a doctor.

CLAIM WATCHER A HOMESTEAD COMPANY

(844) 307-6755
Fax (267) 514-2242

Call Claim Watcher if you are refused treatment.

Dental Insurance

Plan Features:	High Plan		Low Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Individual/Family) *Applies to Basic & Major services*	$50/$150	$50/$150	$50/$150	$50/$150
Preventive Services	100%	100%	100%	100%
Basic Services	80%	80%	80%	80%
Major Services	50%	50%	0%	0%
Calendar Year Maximum	$1,750	$1,750	$1,500	$1,500
Orthodontia	50%	50%	Not Covered	Not Covered
Orthodontia Lifetime Maximum	$1,500	$1,500	Not Covered	Not Covered

High Plan
Preventive Services
Benefits are payable immediately from the start date of an individual's benefits
Examinations *1 time in 6 months*
Examinations – Problem Focused *Combined with Examinations Limit*
Prophylaxis: Cleanings *1 time in 6 months*
Sealants *1 per molar in 60 months for a child under age 16*
Space Maintainers *1 per lifetime for a child under age 16*
Fluoride *1 time in 12 months for a dependent child under age 16*
Full Mouth X-Rays *Once in 60 months*
Bitewing X-Rays *For a child under 14: 1 time in 12 months, Adult: 1 time in 12 months*
Periapical X-Rays
Other X-Rays
Basic Services
Benefits are payable immediately from the start date of an individual's benefits
Amalgam Fillings *1 replacement per surface in 24 Months*
Root Canal *1 per tooth per lifetime*
Periodontal Maintenance *2 perio. Treatments in 1 calendar yr, includes 2 cleanings (total comb: 2)*
Scaling & Root Planing *1 per quadrant in any 24 month period*
Labs & Other Tests
Emergency Palliative Treatment
Resin Composite Fillings *(excludes coverage for composite fillings on molars)*
Pulpotomy
Pulp Capping
Pulp Therapy
Apexification & Recalcification

Low Plan
Preventive Services
Benefits are payable immediately from the start date of an individual's benefits
Examinations *1 time in 6 months*
Examinations – Problem Focused *Combined with Examinations Limit*
Prophylaxis: Cleanings *1 time in 6 months*
Fluoride *1 time in 12 months for a dependent child under age 14*
Bitewing X-Rays *For a child under 14: 1 time in 12 months, Adult: 1 time in 12 months*
Basic Services
Benefits are payable immediately from the start date of an individual's benefits
Sealants *1 per molar in 60 months for a child under age 14*
Space Maintainers *1 per lifetime for a child under age 14*
Full Mouth X-Rays *Once in 60 months*
Amalgam Fillings *1 replacement per surface in 24 Months*
Labs & Other Tests
Emergency Palliative Treatment
Periapical X-Rays
Other X-Rays
Resin Composite Fillings *(excludes coverage for composite fillings on molars)*
Oral Surgery: Simple Extractions
Oral Surgery: Surgical Extractions
Other Oral Surgery
General Services
Major Services
Services are not provided with this plan

High Plan
Basic Services - *continued*
Periodontics – Non-Surgical
Oral Surgery: Simple Extractions
Oral Surgery: Surgical Extractions
Other Oral Surgery
General Services
Major Services
Benefits are payable immediately from the start date of an individual's benefits
Consultations *1 in 12 months*
Periodontal Surgery *1 per quadrant in any 36 month period*
Prefabricated Crowns *1 per tooth in 10 calendar years*
Crown Buildups / Post Core *1 per tooth in 10 calendar years*
Repairs *1 in 12 months*
Recementations *1 in 12 months*
Dentures *1 in 10 calendar years*
Immediate Temporary Dentures – Complete / Partial *1 replacement in 12 months*
Dentures – Rebases / Relines *1 in 36 months*
Denture Adjustments *1 in 12 months*
Fixed Bridges *1 in 10 calendar years*
Inlays / Onlays /Crowns *1 replacement per tooth in 10 calendar years*
Implant Services *1 per tooth position in 10 calendar years*
Implant Repairs *1 per tooth in 10 calendar years*
Implant Supported Prosthetic *1 per tooth in 10 calendar years*
Tissue Conditioning *1 in 36 months*
Occlusal Adjustments *1 in 12 months*
General Anesthesia
Periodontal Surgery – Soft & Connective Tissue Grafts
Orthodontics
Benefits are payable immediately from the start date of an individual's benefits
Orthodontic Diagnostics
Orthodontic Treatment

Vision Insurance

Vision care services	IN-NETWORK	OUT-OF-NETWORK
Eye Examination		
Comprehensive exam of visual functions and prescription of corrective eyewear.	$10 Copay	$45 allowance after $0 copay
Retinal Imaging This screening is used to take pictures of the inside of the eye particularly the retina to look for possible changes.	Up to $39 copay	Applied to the exam allowance
Materials / Eyewear Glasses		
Single Vision	$10 Copay	$30 allowance after $0 copay
Lined bifocal	$10 Copay	$50 allowance after $0 copay
Lined trifocal	$10 Copay	$65 allowance after $0 copay
Lenticular	$10 Copay	$100 allowance after $0 copay
Standard Lens Enhancement		
Ultraviolet coating	Up to $12	Applied to the allowance for the applicable corrective lens
Standard Polycarbonate *(child up to age 18)*	Covered in Full	Applied to the allowance for the applicable corrective lens
Additional Lens Enhancements[1]		
Progressive Standard	Up to $55	$50 allowance
Progressive Premium	Up to $110	$50 allowance
Progressive Ultra	Up to $150	$50 allowance
Progressive Ultimate	Up to $225	$50 allowance
Standard Polycarbonate (adult)	Up to $40	Applied to the allowance for the applicable corrective lens
Scratch-resistant coating (variable by type)	Up to $15 - $30	Applied to the allowance for the applicable corrective lens
Tints (plastic lenses – Solid)	Up to $15	Applied to the allowance for the applicable corrective lens
Tints (plastic lenses) – Gradient	Up to $18	Applied to the allowance for the applicable corrective lens
Anti-reflective coating (variable by type)	Up to $50 - $120	Applied to the allowance for the applicable corrective lens
Photochromic (variable by type)	Up to $80	Applied to the allowance for the applicable corrective lens
Blue Light Filtering	Up to $15	Applied to the allowance for the applicable corrective lens
Digital Single Vision	Up to $30	Applied to the allowance for the applicable corrective lens
Polarized	Up to $75	Applied to the allowance for the applicable corrective lens
High Index (1.67/1.74)	Up to $80 / $120	Applied to the allowance for the applicable corrective lens
Frames		
Frame Allowance *(You will receive an additional 20% off any amount that you pay over your allowance. This offer is available from all participating locations except Costco, Walmart and Sam's Club.)*	$150 allowance	$70 allowance

Vision care services	IN-NETWORK	OUT-OF-NETWORK
Contact Lenses		
Elective	$150 allowance	$105 allowance
Necessary	Covered in full	$210 allowance
Contact Fitting and Evaluation	Standard: Covered in Full after $25 copay Specialty: $50 allowance after $25 copay	Applied to the contact lens allowance
Value Added Features		
LASER VISION CORRECTION	Savings of 40% - 50% off the national average price of traditional LASIK are available at over 1,000 locations across our nationwide network of laser vision correction providers.	
ADDITIONAL SAVINGS ON GLASSES AND SUNGLASSES	20% savings on additional pairs of prescription glasses and nonprescription sunglasses, including lens enhancements.[2]	
ADDITIONAL SAVINGS ON LENS ENHANCEMENTS	Average 20-25% savings on all lens enhancements not otherwise covered under the Superior Vision by MetLife vision benefit program. [2]	
ADDITIONAL SAVINGS ON FRAMES	20% off any amount over your frames allowance. [2]	
SAVINGS ON ADDITIONAL EXAMS	30% savings on additional exams.[2]	
ADDITIONAL SAVINGS ON CONTACTS	10% off any amount over your disposable contact lens allowance or 20% off any amount over your conventional contact lens allowance.[2] 10% - 20% discount on additional contacts.[2]	

[1]Not all providers participate in vision program discounts, including the member out-of-pocket features. Call your provider prior to scheduling an appointment to confirm if the discount and member out-of-pocket features are offered at that location. Discounts and member out-of-pocket are not insurance and subject to change without notice.

[2]These features may not be available in all states and with all In-Network Vision Providers. Please check with Your In-Network Vision Provider.

Frequencies	
Examinations	1 per 12 Months
Standard Corrective Lenses	1 per 12 Months
Frames	1 per 12 Months
Contact Lenses	1 per 12 Months

Exclusions

- *Services and/or materials not specifically included in the Summary of Benefits as covered Plan Benefits.*
- *Any portion of a charge in excess of the Maximum Benefit Allowance or reimbursement indicated in the Summary of Benefits.*
- *Plano lenses (lenses with refractive correction of less than ± .50 diopter)*
- *Two pairs of glasses instead of bifocals.*
- *Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost, stolen or damaged, except at the normal intervals when Plan Benefits are otherwise available.*
- *Orthoptics or vision training and any associated supplemental testing.*
- *Medical or surgical treatment of the eyes.*
- *Prescription and non-prescription medications.*
- *Contact lens insurance policies or service agreements.*
- *Refitting of contact lenses after the initial (90-day) fitting period.*
- *Contact lens modification, polishing or cleaning.*
- *Local, state and/or federal taxes, except where MetLife is required by law to pay.*
- *Any eye examination or any corrective eyewear required as a condition of employment.*
- *Services and supplies received by You or Your Dependent before the Vision Insurance starts for that person.*
- *Missed appointments.*
- *Services or materials resulting from or in the course of a Covered Person's regular occupation for pay or profit for which the Covered Person is entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.*
- *Services: (a) for which the employer of the person receiving such services is not required to pay; or (b) received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital.*
- *Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.*
- *Services and materials obtained while outside the United States, except for emergency vision care.*
- *Services, procedures, or materials for which a charge would not have been made in the absence of insurance.*

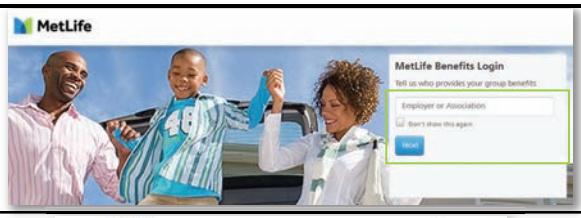
How To Register On MyBenefits

MyBenefits provides you with a personalized, integrated and secure view of your MetLife delivered benefits. You can take advantage of a number of self-service capabilities as well as easy to access information. As a first-time user, you will need to register on MyBenefits by following the steps outlined below:

Registration Process For MyBenefits:

STEP 1 – Provide A Group Name

Access MyBenefits at mybenefits.metlife.com. Enter your employer name, select it in the drop down and select 'Next'. Save this URL to access your MyBenefits account in the future.



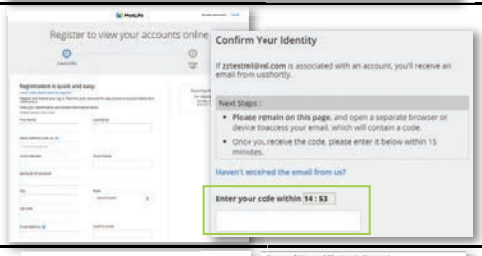
STEP 2 – Register

Once you have selected your employer, from the MyBenefits Home Page you will then select the 'Register' button.

Note – Current users will select 'Log In' and enter their username and password.

STEP 3 – Enter Authentication Information

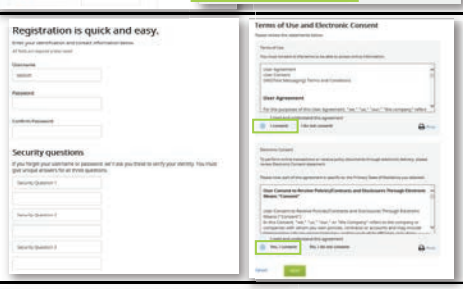
The next screen will begin by entering your name, address, phone number, e-mail (required) and unique security identifiers to confirm your identity. You will then receive a security code, via email or text, that you will need to enter to continue the registration process.



STEP 4 – Establish Account Credentials

You will then be prompted to create a unique username and password for future access to MyBenefits, as well as choose and answer three identity verifications questions that will be used in the event you forget your password.

In addition to reading and agreeing to the Terms of Use, you will be asked to opt into electronic consent.



STEP 5 – Registration Is Complete

Once you have completed the process a 'congratulations' message window will display. You are now registered on MyBenefits! A registration confirmation email will be sent to the email address provided for your registration. You can immediately access your account information by selecting the 'Go To My Account' button within the congratulations window.

PLEASE NOTE, *MetLife does not mail dental or vision cards to plan members. Members can register online to view and print their cards.*

Temporary Card

MetLife

Your Dental Plan:

Gulf Reserve LLC

Company Name

5395472

MetLife Group #

04/01/2025

Effective Date

See reverse side for helpful self-service options once your plan is fully installed.

Once your plan is fully installed, you may print a personalized ID card by visiting www.metlife.com/mybenefits

Use MyBenefits to:

- Locate a participating dentist.
- Verify eligibility and plan design information.
- Review claim status and claim history for your entire family.
- View and print processed claims with one click.
- Obtain claims forms and educational information.
- Get instant answers to Frequently Asked Questions.

MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

For International Dental Travel Assistance call 1-312-356-5970

Medical Rates

	Essential	Base	Premium	Premium Plus
Employee	$ 20.00	$ 39.10	$81.65	$108.10
Employee + Spouse	$ 70.00	$ 249.02	$ 424.00	$464.18
Employee + Child(ren)	$ 67.00	$206.29	$ 304.57	$350.13
Family	$ 95.00	$431.07	$ 616.67	$689.82

Dental Rates

	Low	High
Employee	$8.37	$14.15
Employee + Spouse	$19.00	$29.69
Employee + Child(ren)	$18.41	$28.59
Family	$33.24	$42.71

Vision Rates

Employee	$3.63
Employee + Spouse	$7.25
Employee + Child(ren)	$8.49
Family	$13.02

Bereavement Support Services
Comfort and Guidance for Challenging Times

Bereavement Support Services provide confidential and professional support services to all covered employees and family members to cope with the loss of a loved one—at no extra cost.

Along with your coverage from Reliance Standard Life Insurance Company, you are offered access to unlimited and confidential telephonic grief counseling, legal and financial consultation through ACI Specialty Benefits just when you need it most.

Grief Counseling

- ***Unlimited*** Telephonic Assessment and Referral

Legal and Financial Services

- ***Unlimited*** Phone Consultation for Any Financial Issue
- ***Unlimited*** Phone Consultation for Any Legal Issue
- Online Legal and Financial Resource Center Including Document Preparation

Program Access

- All Covered Employees and Family Members Eligible, Regardless of Location or Relationship
- 24/7, 365 Days-a-year Dedicated Toll-Free Line, Always Live Answer

Questions or to Access Services

Contact ACI Specialty Benefits toll-free at

855-RSL-HELP

(855-775-4357)

rsli@acieap.com

Life comes with challenges.

Your Employee Assistance Program is here to help.

Available to all employees working +30 hours a week and enrolled in the Basic Life and AD&D.

Reach out to your Assistance Program for short-term counseling, financial coaching, caregiving referrals and a wide range of well-being benefits to reduce stress, improve mental health and make life easier.

The following services are free to use, confidential, and available to you and your family members:

Mental Health Sessions
Up to 3 telephonic sessions to help manage stress, anxiety and depression, resolve conflict, improve relationships, overcome substance abuse and address any personal issues.

Life Coaching
To help reach personal and professional goals, manage life transitions, overcome obstacles, strengthen relationships, and build balance.

Financial Consultation
To help build financial wellness related to budgeting, buying a home, paying off debt, managing taxes, preventing identify theft, and saving for retirement or tuition.

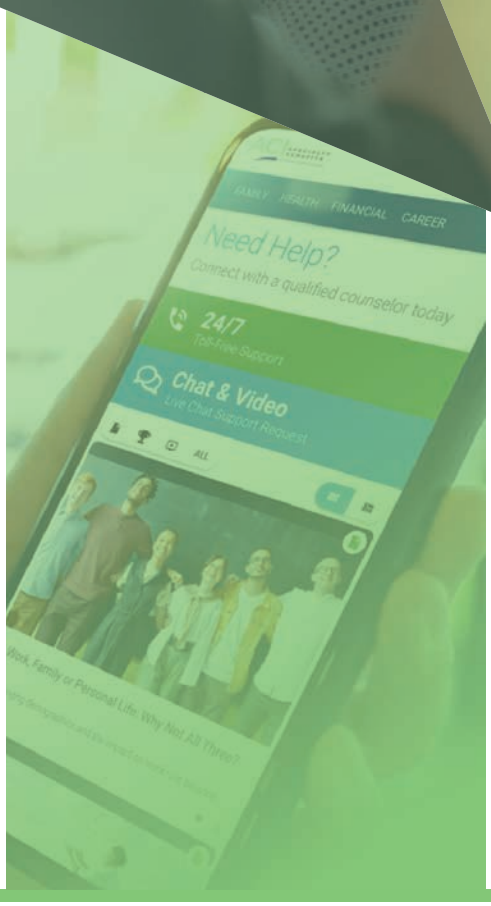
Legal Consultation
To help with a variety of personal legal matters including estate planning, wills, real estate, bankruptcy, divorce, custody, and more.

Life Management
To provide information and referrals when seeking childcare, adoption, special needs support, eldercare, housing, transportation, education, and pet care.

Personal Assistant
To help manage everyday tasks and give back time by providing information and referrals for home services, repairs, travel, entertainment, dining and personal services.

Medical Advocacy
To help navigate insurance, obtain doctor referrals, secure medical equipment or transportation, and plan for transitional care and discharge.

Member Portal and App
Access your benefits 24/7/365 with online requests and chat options, and explore thousands of articles, webinars, podcasts and tools covering total well-being.



Getting Started Is Easy

1. Visit your landing page, **http://rsli.acieap.com**, and click on “Select Portal & App” in the top menu

2. Register to create a new account using your company code: **RSLI859**

3. A confirmation email will be sent to complete the process

Contact ACI Specialty Benefits
855-RSL-HELP (855-775-4357)
rsli@acieap.com
http://rsli.acieap.com
Company Code: RSLI859

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

Powered by
ACI SPECIALTY BENEFITS
An AllOne Health Company

RS-2505 (12/2021)

ID Theft Recovery Services

ID Theft Recovery Services

Should you or anyone in your family fall victim to identity theft, InfoArmor® Identity Protection Experts will provide restoration services including:

- Dedicated InfoArmor Privacy Advocates® to act on your behalf
- Identity restoration experts trained by the Identity Theft Resource Center
- Investigation and confirmation of fraudulent activity including known, unknown, and potentially complicated sources of identity theft
- Resolution of key issues by maintaining and explaining your rights
- Placing phone calls and preparing appropriate documentation on your behalf including anything from dispute letters to defensible complaints
- Assist in issuing fraud alerts and victim's statements when necessary, with the three consumer credit reporting agencies, Federal Trade Commission, Social Security Administration and the U.S. Postal Service
- Completing and providing copies of all documentation, correspondence, forms and letters for your records
- Contacting, following up and escalating issues with affected agencies and institutions
- Providing restoration beyond just credit including criminal, DMV, medical

WalletArmor®

WalletArmor® provides 24/7 Online Credential Monitoring on the Internet's Underground economy. We'll know quickly if there is fraudulent activity. You'll receive a call from our Privacy Advocates® letting you know your personal information has been compromised. We work with businesses to identify and replace essential cards and documents, and we contact the authorities. WalletArmor stores and secures valuable information for easy retrieval.

The WalletArmor® encrypted vault secures and monitors:

- User IDs & Passwords
- ATM Cards
- Credit Cards
- Checking Accounts
- Driver's Licenses
- Health Insurance Cards
- Vehicle Insurance Cards records, etc.

Do you suspect your personal information has been compromised?
Call toll free: **1.855.246.7347**

Want to protect the contents of your wallet and important personal documents? Enroll in WalletArmor® today!

www.reliancestandard.com/walletarmor

24-Hour Travel Assistance Services

Through your group coverage with Reliance Standard, you automatically receive travel assistance services provided by On Call International (On Call), pursuant to an agreement between Reliance Standard and On Call. On Call is a 24-hour, toll-free service that provides a comprehensive range of information, referral, coordination and arrangement services designed to respond to most medical care situations and many other emergencies you may encounter when you travel. On Call also offers pre-trip assistance including passport/visa requirements, foreign currency and weather information. The following is an outline of the On Call emergency travel assistance service program. For a complete description of all services and the program terms and limitations, please request a Description of Covered Services from your employer.

Covered Services

When traveling more than 100 miles from home or in a foreign country, On Call offers you and your dependents the following services:

Pre-Trip Assistance

- Inoculation requirements information
- Passport/visa requirements
- Currency exchange rates
- Consulate/embassy referral
- Health hazard advisory
- Weather information

Emergency Medical Transportation*

- Emergency evacuation
- Medically necessary repatriation
- Visit by family member or friend
- Return of traveling companion
- Return of dependent children
- Return of vehicle
- Return of mortal remains

Emergency Personal Services

- Urgent message relay
- Interpretation/translation services
- Emergency travel arrangements
- Recovery of lost or stolen luggage/personal possessions
- Legal assistance and/or bail bond

Medical Services Include:

- Medical referrals for local physicians/dentists
- Medical case monitoring
- Prescription assistance and eyeglasses replacement
- Convalescence arrangements

*The services listed above are subject to a maximum combined single limit of $250,000. Return of vehicle is subject to $2,500 maximum limit.

Identity Fraud Protection

- Expanding your benefit offering - The agreement between Aura and MetLife comes at a time when the workforce prioritizes companies that provide a wide range of benefits and recognize their role in supporting employees' holistic well-being.
- Enabling more personalized proactive actions - Beyond traditional identity theft protection services to meet the everyday needs of employees, bringing more solutions together on a unified platform to enable more personalized proactive actions that can help to prevent identity theft and digital fraud before it even happens. Aura's product is a simple to set up, easy-to-use mobile application and website, and includes 24/7/365 U.S.-based Customer Support with dedicated specialists available to guide victims of digital theft or fraud through every step of the resolution process.
- Top rated, all-in-one digital security product - MetLife understands the importance of continuing to evolve to meet employee needs by protecting and supporting what matters most. That is why we are collaborating with Aura to provide customers with a top rated, all-in-one digital security product to provide proactive identity theft and fraud protection for employees' finances, personal information, and mobile devices.

	Protection	Protection Plus
Identity Theft Protection		
Personal Information and ID Monitoring	•	•
Online Account and Breach Monitoring	•	•
SSN Authentication Alerts	•	•
Criminal and Court Record Monitoring	•	•
Home Title and Address Monitoring	•	•
Social Media Monitoring		•
Financial Fraud Protection		
Credit Monitoring & Alerts	Bureau 1	Bureaus 3
Monthly Credit Score	•	•
High Risk Transaction Alerts	•	•
3B Credit Report		•
Experian Credit Lock		•
Transaction Monitoring		•
Privacy and Device Protection		
Data Broker List Removal	•	•
WiFi Security/VPN	Device 1	Up to 10 Devices
AntiVirus	Device 1	Up to 10 Devices
Password Manager	•	•
Safe Browsing		•
Services and Support		
All-in-one Mobile Application	•	•
Customer Support 24/7/365	•	•
White Glove Resolution Service	•	•
*Identity Theft Insurance for Eligible Losses	*Up to $1M	*Up to $1M
Lost Wallet Protection	•	•
Personalized onboarding		
Dedicated security concierge		
Account delegation		
Proactive outreach for high-risk alerts		

Pet Insurance

Enrollment Experience	
Covers[19] All Breed & Ages	✓
No Initial Exam/Past Vet Notes Required	✓
No Cancellation Fee	✓
Accident Coverage Starts at Midnight	✓[16, 17]
No Annual Care Requirements to Keep Coverage	✓
No Neuter/Spay Requirement	✓
Benefits and Limits	
No Schedule of Benefits	✓
No Lifetime Limit	✓
No Per-Incident Limit	✓
Optional Wellness Coverage (Preventive Care)	Included in annual limit[10]
No Diagnostic Test Limit	✓
No Customary Charge Restrictions	✓
Healthy Pet Incentive (previously Deductible Savings)	$50[12]
Automatic Annual Limit Increase	✓[13]
Pricing	
Pricing Structure	Customized to every pet (varies by species, age, breed, zip code)
Employer Benefit Discount	10% for Employer Groups of all sizes[11]
Affinity Group Discount	5% for Associations of all sizes[11]
Family Plan (Cover multiple pets on single policy)	✓
Multi-policy discount	✓[20]
Internet Purchase Discount	✓[21]
Military, Veteran & First Responder Discount	✓[22]
Healthcare Workers Discount	✓[23]
Animal Care Discount	✓[24]
Deductible	Flexible ($0-$2,500)[25]
Annual Limit	Flexible ($500-Unlimited)[9]
Reimbursement	Flexible (50% to 100%)[26]

RELIANCE STANDARD
LIFE INSURANCE COMPANY

Short-Term Disability Insurance

Disability can often result in loss of income and increased medical bills. Short term disability protects your most important asset - your income. This plan will pay cash benefits to you if you are unable to work due to illness or injury so you can pay your regular bills and any medical bills resulting from your disability.	
Benefit Amount:	$100 - $1,000 per week in Increments of $25
Benefit Duration:	24 weeks
Injury Benefits Begin:	The 15th consecutive day of disability
Sickness Benefits Begin:	The 15th consecutive day of disability
Maternity Coverage:	Full
Coverage:	Non-occupational
Partial Disability:	Yes, with zero day residual
Pre Existing Limitation:	3/12
Transfer of Insurance Coverage:	Yes
Family & Medical Leave:	Yes

Partial Disability Benefit

You may opt to include a Partial Disability Benefit in this STD plan. Partial Disability benefits are payable if: 1) the insured has been disabled for the required period of time specified in the Policy; 2) a benefit is payable under the Policy for such period of disability; and 3) the insured accepts rehabilitative employment. These requirements may vary depending upon the provision chosen, as shown on the Plan Description.
If the insured receives earnings from rehabilitative employment, RSL will not reduce benefits based on these earnings until his or her income from all sources exceeds 100% of pre-disability earnings. If total earnings exceed this level, there will be a dollar for dollar reduction.

Pre-existing Condition Limitation

A pre-existing condition is defined as any sickness or injury (whether specifically diagnosed or not) for which the Insured received medical treatment, during a specific period (as outlined in the policy) immediately prior to the Insured's effective date of coverage.
An insured is covered for pre-existing condition if he / she has been actively at work for one full day following the end of the specific period (as outlined in the policy) from the date he / she becomes an Insured. An Insured is not covered for a pre-existing condition if the requirement is not met.

Long-Term Disability Insurance

Long Term Disability Insurance is designed to support you if you are disabled for an extended period of time Plan Descriptions	
Benefit Amount:	60% of Covered Monthly Earnings
Monthly Maximum:	$7,000
Elimination Period:	180 days
Benefit Duration:	Until normal retirement age. See full plan summary for more details.
Family Leave:	Yes
Mental & Nervous Limitation:	24 month limit
Drug & Alcohol Limitation:	24 month limit
Limited Benefit Option:	24 Months
Pre-Existing Limitation:	3/12
Survivor Benefit:	3 Months
Managed Rehab Option:	Included
Work Incentive Benefit:	12 Months
Child Care:	to age 14/$250
Worksite Mod Benefit:	100% up to $2,000
Own Occupation Coverage:	24 Months
Partial Disability, Specific Indemnity, Travel Assistance:	Yes

CHUBB®

Accident Insurance

Accident insurance offers an extra layer of protection from unexpected expenses. It pays cash directly to you when you suffer an unexpected, qualifying accident. The money helps cover the extra, out-of-pocket expenses associated with your injury	
Coverage Type	Off Job Only
Sports Package	Benefits are 25% higher when accident is due to organized sports. Up to $2,000 per person/per year
Initial Care Benefits	
Emergency Room / Urgent Care	$200
Initial Dr. Visit	$100
Telemedicine Services	$75
Hospital/Facility Benefits	
Standard Hospital Admission	$1,250
Hospital Confinement (per day, up to 365 days), Outpatient Surgery Facility	$300
ICU Confinement (per day, up to 30 days)	$600
Rehab Confinement (per day, up to 30 days)	$200
Additional Benefits	
Ambulance (air/ground)	$1,500/ $360
Appliance	$120
Blood, Plasma, Platelets	$600
Level 1/ Level 2/ Level 3 Burns	$1,250/ $7,500/ $10,000
Skin Graft	25%
Coma	$10,000
Dislocations (up to)	$7,700
Emergency Dental - Crown, Dentures, Implants	$350
Extraction	$90
Eye Injury	$350
Family Care (up to 30 days)	$25 per day, per child in child care center
Follow-up Treatment (per visit) (Maximum 3 Visits)	$90
Fractures (up to)	$6,720
Herniated Disc Surgery	$800
Knee Cartilage – Torn	$800
Lacerations	$30-$480
Lodging (per night, 100 or more miles) (Maximum 30 Nights)	$180
Loss of hands, feet, sight	$24,000
Loss of fingers or toes	$1,500
Major Diagnostic Exam (CT, MRI, etc.)	$300
Medical Supplies, Medicine	$20
Paralysis - Two limbs (paraplegia or hemiplegia) / Four limbs (quadriplegia)	$10,000/ $15,000
Post – Traumatic Stress Disorder (Maximum 6 Visits)	$50
Prosthetics	$750
Residence/Vehicle Modification	$1,000
Surgery - Abdominal, Cranial, and Thoracic	$1,200
Hernia	$175
Tendon, Ligament, Rotator Cuff	$825
Therapy – Physical, Occupational, or Speech (Maximum 6 Visits)	$45
Transportation (per trip, 100 or more miles) (Maximum 3 Trips)	$750
Traumatic Brain Injury	$225
X-Ray	$124

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Critical Illness Insurance

Critical Illness Insurance pays a lump sum directly to you upon diagnosis of a covered critical illness. This benefit is designed to keep your finances stable even with unexpected expenses	
Employee Face Amounts	• Minimum Face Amount: $5,000 Employee ($2,500 for Spouse) • Maximum Face Amount: $30,000 Employee ($15,000 Spouse) • Available in $5,000 increments
Spouse Face Amounts	equals 50% of the Employee Face Amount.
Child(ren) Face Amounts	• Equals 50% of the Employee Face Amount • Child coverage is included in the Employee rate
Guarantee Issue Amount:	$30,000
Expected Participation:	15% employee participation

Critical Illness Benefits	Custom Diamond Plan
Maximum Benefit Amount (X Face Amount)	Unlimited
Covered Conditions – Pays a percentage of face amount,	100%
ALS, Benign Brain Tumor, Breast Cancer Carcinoma In Situ, Cancer (except skin cancer), Coma, Coronary Artery Obstruction, End Stage Renal Failure, Heart Attack, Loss of Sight, Speech, or Hearing, Major Organ Failure, Paralysis or Dismemberment, Severe Burns, Stroke, Sudden Cardiac Arrest	100%
Alzheimer's Disease, Carcinoma In Situ, Multiple Sclerosis, Parkinson's Disease	25%
Transient Ischemic Attacks	10%
Skin Cancer Benefit - Payable once per insured per year	$250
Occupational Package - Pays 100% of the face amount; Benefits payable for HIV or Hepatitis B, C, or D, MRSA, Rabies, Tetanus, or Tuberculosis contracted on the job.	Included
Childhood Conditions - Pays 100% of the dependent child face amount; Provides benefits for childhood conditions (Autism Spectrum Disorder; Cerebral Palsy; Congenital Birth Defects; Heart, Lung, Cleft Lip, Palate, etc; Cystic Fibrosis; Down Syndrome; Muscular Dystrophy; Type 1 Diabetes).	Included
Recurrence Benefit	
Benefits are payable for a subsequent diagnosis of Aneurysm - Cerebral or Aortic, Benign Brain Tumor, Cancer, Coma, Coronary Artery Obstruction, Heart Attack, Major Organ Failure, Severe Burns, Stroke, or Sudden Cardiac Arrest.	100%
Advocacy Package	
Best Doctors Physician Referrals Ask the Expert Hotline provides 24 hour advice from experts about a particular medical condition. In-Depth Medical Review offers a full review of diagnosis and treatment plan.	Yes
Additional Benefits	
Waiver of Premium Waives premium while the insured is totally disabled.	Included
Wellness Benefit- Payable once per insured per year	$50
Benefit Limitations	
Continuity of Coverage (Takeover)	Included
Pre-Existing Conditions Limitation	6/12

Covered Health Screening Tests Include:	
• CA 15-3 (blood test for breast cancer) • CA-125 (blood test for ovarian cancer) • CEA (carcinoembryonic antigen - blood test for colon cancer) • Chest x-ray • Colonoscopy • Doppler screening for peripheral vascular disease • Echocardiogram • Fasting blood glucose test	• Hemoccult stool analysis • Human Papillomavirus (HPV) Testing • Mammography • Pap Smear • PSA (blood test for prostate cancer) • Skin cancer biopsy • Stress test on a bicycle or treadmill • Whole body skin cancer screening

RELIANCE STANDARD
LIFE INSURANCE COMPANY

Supplemental Life Insurance

Benefit Descriptions	
***Benefit Amount:**	From $10,000 to $500,000 in increments of $10,000
Age Reduction:	35% of the pre-age 65 amount at age 65; and an additional 25% of the pre-age 65 amount at age 70; and an additional 20% of the pre-age 65 amount at age 75.
Guarantee Issue:	$150,000
****Living Benefit Rider:**	75% to $500,000
Waiver of Premium:	Included, disability starts before age 60 and lasts 9 months.
Family Medical Leave Ext.:	Yes
Bereavement Counseling:	No
Portability:	Lesser of 2 yrs or case term
Spouse Benefit***	From $5,000 to $250,000 in increments of $5,000
Guarantee Issue:	$50,000
Child(ren) 14 days but less than 6 months $10,000 6 months through Age 19 (up to age 26 if a full time student)	 $10,000 $10,000

**Flat/Incremental benefits may be subject to an earnings cap, see full plan summary for more details.*
***This may be expressed as Accelerated Benefit or Imminent Death Benefit.*
**** Spouse amount may be limited to 50% of the employee amount dependent on the state regulations, and will reduce in the same manner as the employee amount, upon the spouse's attainment of the reducing ages.*

CHUBB®

Hospital Indemnity Insurance

This plan pays cash directly to you upon admission to a hospital. This money can be used to help cover copays, deductibles, or for regular expenses like food and rent.

Hospitalization and Rehabilitation Benefits	Low	High
Hospital Admission Benefit This benefit is for admission to a hospital or hospital sub-acute intensive care unit.	$800 Maximum Benefit Per Calendar Year: 1	$2000 Maximum Benefit Per Calendar Year: 1
Hospital Admission ICU Benefit This benefit is for admission to a hospital intensive care unit.	$1600 Maximum Benefit Per Calendar Year: 1	$4000 Maximum Benefit Per Calendar Year: 1
Hospital Confinement Benefit This benefit is for confinement in hospital or hospital sub-acute intensive care unit.	$100 Per Day Maximum Days Per Calendar Year: 10	$200 Per Day Maximum Days Per Calendar Year: 10
Hospital Confinement ICU Benefit The benefit for confinement in a hospital intensive care unit.	$200 Per Day Maximum Days Per Calendar Year: 10	$400 Per Day Maximum Days Per Calendar Year: 10
Newborn Nursery Benefit This benefit is payable for an insured newborn baby receiving newborn nursery care and who is not confined for treatment of a physical illness, infirmity, disease or injury.	$100 Per Day Maximum Days per Confinement Normal Delivery: 1 Caesarean Section: 1	$200 Per Day Maximum Days per Confinement Normal Delivery: 1 Caesarean Section: 1
Rehabilitation Unit Confinement Benefit This benefit is for confinement in a rehabilitation unit.	$50 Per Day Maximum Days Per Calendar Year: 10	$100 Per Day Maximum Days Per Calendar Year: 10
Additional Provisions		
Pre-Existing Conditions Limitation	12/12	

CHUBB®

Lifetime Benefit Term Life Insurance

Product Features

- Permanent and Guaranteed Renewable
- Full Portability
- Level Premium- Life insurance premium will never increase and are guaranteed through age 100. After age 100 no premium is due.

Eligibility

- Actively employed working at least 30 hours per week
- Ages 19 through 80
- Service wait period for benefit eligibility: 60 days.

Spouse

- Includes legally married spouse, domestic partner and civil union partner
- Ages 19 through 70

Children

- Ages 15 days through 25 years

Issue Limits

Employee Coverage **Issue Type**	**Issue Age**	**Maximum Benefit Amount**
Guaranteed Issue	19 through 70	$75,000
Conditional Guaranteed Issue	19 through 70	$125,000
Simplified Issue	19 through 70	$225,000
Simplified Issue	71 through 80	$50,000
Spouse Coverage **Issue Type**	**Issue Age**	**Maximum Benefit Amount**
Conditional Guaranteed Issue	19 through 70	$62,500
Simplified Issue	19 through 70	$112,500
Dependent Child Coverage **Type of Coverage**	**Issue Age**	**Maximum Benefit Amount**
Child Term Rider	15 days through 25 years	$25,000
LifeTime Benefit Term Certificate	15 days through 18 years 19 years through 25 years	$25,000 The amount $3/week will purchase

Employee Eligibility

- **Minimum Coverage Limit** – The greater of $5,000 or the amount of coverage $3.00/week will purchase
- **Issue Types:**
  - **Guaranteed Issue (GI) Eligibility:** Eligible employees may apply for coverage on a GI basis as long as the GI participation is met and they are actively at work as of their enrollment date, subject to the GI participation requirement.
    - Required Participation for Guaranteed Issue(GI): 20% of employee participation
    - Enrollment process equivalent to 70% of employees actively engaged in a response is required.
    - Guaranteed Issue is subject to meeting the required participation requirement. If not met, employees will be underwritten subject to the amount applied for. GI is for the initial open enrollment period of up to 30 days. GI for new hires in the first year following open enrollment is subject to evaluation of GI being extended for the initial open enrollment. The GI offer will be re-evaluated separately for future enrollments.
  - **Conditional Guaranteed Issue (CGI) Eligibility:** Eligible employees may apply for coverage on a CGI basis as long as they are actively at work as of their enrollment date and the MGI and CGI questions are answered.
  - **Simplified Issue (SI) Eligibility:** Eligible employees may apply for coverage on a SI basis as long as they are actively at work as of their enrollment date and all questions are answered.
  - Late Entrants are underwritten on a Simplified Issue basis.

Spouse Eligibility

- **Minimum Coverage Limit –** The greater of $5,000 or the amount of coverage $3.00/week will purchase
- **Issue Types:**
  - **Spouse Conditional Guaranteed Issue (CGI) Eligibility:** Eligible employees may apply for coverage on a CGI basis as long as they are actively at work as of their enrollment date and the MGI and CGI questions are answered.
  - **Spouse Simplified Issue (SI) Eligibility:** Eligible employees may apply for coverage on a SI basis as long as they are actively at work as of their enrollment date and all questions are answered.
  - Late Entrants are underwritten on a Simplified Issue basis.
- **Restrictions on Spouse Coverage** - State law limit the amount of coverage an employee can purchase on a spouse.
- **Spouse Restriction States:** premium less than $3.00 per week will be allowed to meet coverage restrictions
  - A participating employee can purchase spouse coverage up to the amount the employee purchases, not to exceed the spouse coverage limits for the case.

CHUBB®

Dependent Child Eligibility

- **Dependent Child Coverage and Eligibility:**
  - Child coverage is available on a Guarantee Issue (GI) basis during the employee's initial eligibility period.
  - Child coverage is available on a GI basis for a newborn child, new step child, or newly adopted child after the employee's initial eligibility period.
  - After the employee's initial eligibility period, employees may apply for dependent child coverage on a Simplified Issue basis.
  - Children may be covered with a Lifetime Benefit Term Certificate or with a Child Term Rider but not both.
  - The Child Term Rider covers all dependent children of the employee at the same rates regardless of the number of children.
  - Child LBT Certificate rates are based on the age of each dependent child.
  - All eligible dependent children must be insured.
- **Minimum Coverage Limit -** The greater of $5,000 or the amount of coverage $3.00/week will purchase.
- **Restrictions on Dependent Child Coverage** - State law limit the amount of coverage an employee can purchase on a dependent child.
  - Dependent Child States: premium less than $3.00 per week will be allowed to meet coverage restrictions
  - A participating employee can purchase dependent child coverage up to the amount the employee purchases, not to exceed the dependent child coverage limits for the case.

Built-in Benefits	Benefit Issue Age		
	Employee	**Spouse**	**Child**
LifeTime Benefit Term	19 - 80	19 - 70	15 days – 25 years
Accelerated Death Benefit Rider for Terminal Illness After coverage has been in force for two years, employees can receive 50% of their death benefit immediately, up to $100,000, if they are diagnosed as terminally ill.	19 - 80	19 - 70	15 days – 25 years
Accelerated Death Benefit for Long Term Care When employees need LTC, death benefits can be paid early for home health care, assisted living, adult day care and nursing home care. Early payments equal 4% of the death benefit per month for up to 25 months. Premiums are waived while this benefit is being paid.	19 - 80	19 - 70	Not Available
Extension of Benefits (EOB1) Once the full death benefit has been paid in advance for LTC, payments can be extended. Extension of Benefit may extend the same monthly LTC benefit for up to an additional 25 months, doubling the value	19 – 70	19 - 70	Not Available
Restoration of Death Benefit (50%) Accelerating the life coverage for LTC benefits can reduce the death benefit to $0. This rider restores the life coverage to 50% of the death benefit, up to a maximum of $50,000 on which the LTC benefits were based, therefore assuring a death benefit available up to the insured's age 121.	19 - 80	19 - 70	Not Available
Employee Optional Benefits			
Child Term Rider Death Benefits available up to $25,000. Guaranteed conversion to individual coverage at age 26 – up to 5 times the benefit amount.	Base Insured 19 – 70	Base Insured 19 – 70	15 days – 25 years

Metlaw Legal Plan

Plan Features and Rates

The legal plan provides full coverage of attorney fees for the most common personal legal matters with no additional out-of-pocket cost to you.

To access a lawyer, create an account online at Login.LegalPlans.com to see coverage and select an attorney.

Money Matters

- Debt Collection Defense
- Identity Management Services[2]
- Identity Theft Defense
- Negotiations with Creditors
- Personal Bankruptcy
- Promissory Notes
- Tax Audit Representation
- Tax Collection Defense

Home & Real Estate

- Boundary & Title Disputes
- Deeds
- Eviction Defense
- Foreclosure
- Mortgages
- Property Tax Assessments
- Refinancing & Home Equity Loan
- Sale or Purchase of Home
- Security Deposit Assistance
- Tenant Negotiations
- Zoning Applications

Estate Planning

- Codicils
- Complex Wills
- Healthcare Proxies
- Living Wills
- Powers of Attorney (Healthcare, Financial, Childcare, Immigration)
- Revocable & Irrevocable Trusts
- Simple Wills

Family & Personal

- Adoption
- Affidavits
- Conservatorship
- Demand Letters
- Garnishment Defense
- Guardianship
- Immigration Assistance
- Juvenile Court Defense, Including Criminal Matters
- Name Change
- Parental Responsibility Matters
- Personal Properties Issues
- Prenuptial Agreement
- Protection from Domestic Violence
- Review of ANY Personal Legal Document
- School Hearings

Civil Lawsuits

- Administrative Hearings
- Civil Litigation Defense
- Disputes Over Consumer Goods & Services
- Incompetency Defense
- Pet Liabilities
- Small Claims Assistance

Elder-care Issues

Consultation & Document Review for Issues Related to Your Parents:
- Deeds
- Leases
- Medicaid
- Medicare
- Notes
- Nursing Home Agreements
- Powers of Attorney
- Prescription Plans
- Wills

Traffic & Other Matters

- Defense of Traffic Tickets[3]
- Driving Privileges Restoration
- Habeas Corpus
- License Suspension Due to DUI
- Repossession

Rate[4]

$19.75 per employee per month (Covers spouse and dependents)

Additional features:

Telephone advice, office consultations, demand letters and document review on an unlimited number of personal legal matters.

Reduced fees for personal injury, probate and estate administration matters, provided by network attorneys.

Access to a digital estate planning solution for wills, living wills, power of attorney and living trusts.

As a part of our standard plan, we also offer:

A three-year rate guarantee.

Reporting: Usage reports, analysis and evaluation of the reports.

1. Exclusions apply.
2. These benefits provide the Participant with access to services provided by Cyberscout, LLC. Cyberscout is not a corporate affiliate of MetLife Legal Plans.
3. Does not cover DUI.
4. Rate is standard and subject to change.

Farmers GroupSelect SM

Auto Insurance

Special Ways to Save
• Employee discounts • Employment tenure discounts • Good driver rewards • Multi-policy and multi-product discounts
Protecting What's Important
The Program offers a broad line of insurance policies, including: • Auto • Renters • Condo • Boat Insurance • Flood • Motorcycle • Personal Excess Liability • Recreational Vehicle
Industry Leading Coverage Options:
Replacement Cost for Total Loss Coverage on new vehicles with no deduction for depreciation. In a covered total loss, a new vehicle is repaired or replaced with a new vehicle.
Replacement Costs for Special Parts provides the repair or replacement of certain parts, regardless of their wear and tear at the time of the accident.
Value Added Benefits:
Identity Protection Services: An automatic service provided to automobile insurance customers, at no extra charge.
Farmers GroupSelect Concierge Auto Repair Experience® (CARE) — Guarantees repairs done by our CARE shops for as long as you own your vehicle.
Roadside assistance, towing coverage, windshield repairs (if possible) without a deductible, and much, much more...
High Quality, Streamlined Service
Quick and Easy - Employees can get quotes and information any way they choose – phone, or online. Plus, on-line purchasing is available in select states.
Simple Claim Experience- One toll-free number, file auto claims using our app, home field adjusters
How To Enroll
Eligible employees will be mailed more information from Farmers Insurance. Employees can also call 800.438.6381 and mention your facility

Benefit Contact Information

Benefit Enrollment Call Center		(239) 399-6252
Medical Insurance	UHP	(855) 375-7125
Prescription Drugs	medtipster	(877) 226-2378
Dental Insurance	MetLife - PDP Plus Network	(800) 438-6388
Vision Insurance	MetLife - Superior Vision Network	(833) 393-5433
Legal Services, Pet Insurance, ID Fraud Protection	MetLife	(800) 929-1492
Short-Term Disability, Long-Term Disability, Supplemental Life Insurance	Reliance Standard	(866) 375-0775
Critical Illness, Accident, Hospital Indemnity, Chubb Lifetime Benefit Term Life Insurance	Chubb	(855) 241-9891
Auto Insurance	Farmers by MetLife	(800) 438-6381

Important Notice from Gulf Reserve, LLC About Your Prescription Drug Coverage under the Base, Premium, Premium Plus Plans and Medicare

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

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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. **Gulf Reserve, LLC has determined that the prescription drug coverage offered under the Base and Premium Plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Gulf Reserve, LLC coverage will not be affected. (e.g., you can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.). *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. For additional information on the plans offered by Gulf Reserve, LLC, please refer to the Benefit Summaries available for those plans.

If you do decide to join a Medicare drug plan and drop your current Gulf Reserve, LLC coverage, be aware that you and your dependents will *not* be able to get this coverage back.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% 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. **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 Gulf Reserve, LLC changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC **Updated April 1, 2011**

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).

Contact--Position/Office:	UHP Administrators
Address:	1662 61st Street Brooklyn, NY 11204
Phone Number:	718-686-7272

Important Notice from Gulf Reserve, LLC About Your Prescription Drug Coverage under the Essential Plan and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under Gulf Reserve, LLC's Essential Plan 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. **Gulf Reserve, LLC has determined that the prescription drug coverage offered by the Essential Plan medical plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Gulf Reserve, LLC Essential Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**

3. **You can keep your current coverage. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.**

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 decide to drop your current coverage with Gulf Reserve, LLC, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the current plan.

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

Since the coverage under the employer plan is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

See pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (http://www.cms.hhs.gov/CreditableCoverage) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. If you decide to join a Medicare drug plan, your current Gulf Reserve, LLC coverage may not be affected. However, if you decide to join a Medicare drug plan AND drop your current Gulf Reserve, LLC coverage, be aware that you and your dependents will not be able to get this coverage back.

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

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Gulf Reserve, LLC changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Contact: UHP Administrators
Address: 1662 61st Street Brooklyn, NY 11219
Phone Number: 718.686.7272

HIPAA Privacy Notice

When disclosing Personal Health Information (PHI), the Plan or Employer will only disclose the minimum amount of PHI which is required to accomplish the purpose for which the disclosure is made. For all disclosures that are made on a recurring and routine basis, the Plan or Employer will develop and implement policies and procedures that ensure that only the minimum amount of PHI necessary is disclosed. For all other disclosures, the Plan or Employer will develop and follow criteria designed to limit the disclosure of PHI to the minimum amount required to accomplish the purpose of the disclosure. Employee Designated as qualified to Release PHI (EDR) making any disclosure of PHI must follow the applicable policies and procedures.

NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS

A federal law called HIPAA requires that we notify you about an important provision in the Plan—your right to enroll in the Plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program) –
If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. You will be required to submit a signed statement that this other coverage is the reason for waiving enrollment originally. To be eligible for this special enrollment opportunity you must request enrollment within 30 days after your other coverage ends or after the employer stops contributing towards the other coverage.

Loss of Coverage for Medicaid or a State Children's Health Insurance Program –
If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption –
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/or your dependent(s). To be eligible for this special enrollment opportunity you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Medicaid Coverage: Gulf Reserve LLC group health plan will allow an employee or dependent who is eligible, but not enrolled for coverage, to enroll for coverage if either of the following events occur:

- TERMINATION OF MEDICAID OR CHIP COVERAGE- If the employee or dependent is covered under a Medicaid plan or under a State child health plan (SCHIP) and coverage of the team member or dependent under such a plan is terminated as a result of loss of eligibility.

- ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP- If the employee or dependent becomes eligible for premium assistance under Medicaid or CHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends.

To request special enrollment or obtain more information, please contact the JAS Solutions team at (718) 913-9000..

Women's Health and Cancer Rights Act Annual Notice

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

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. Please refer to the benefit summaries for the deductible and coinsurance for your plan.

Qualified Medical Child Support Order (QMCSO)

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Newborn Acts Disclosure

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).

Coverage Extension Rights under the Uniformed Services Employment & Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:
The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

Patient Protection Disclosure

Funding Reserve, LLC Health Plan generally allows 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 information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Human Resources Department.

You do not need prior authorization 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 the Human Resources Department.

Genetic Information Non-Discrimination Act (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual.
GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical

record, and may be disclosed to third parties only in very limited situations.

ACA Section 1557 Compliance

Funding Reserve, LLC ("Employer") complies with any applicable Federal and state civil rights laws regarding discrimination on the basis of race, color, national origin, age, disability or sex in respect of this medical plan, and shall administer, interpret, amend and construe the Plan benefits and exclusions to the extent such laws are deemed applicable, as determined by Funding Reserve, LLC in its sole discretion.

Funding Reserve, LLC:

- Provides free aids and services to people with disabilities to communicate effectively with the Plan, such as:
    - Qualified sign language interpreters.
    - Written information in other formats (large print, audio, accessible electronic formats, other formats).
    - Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters.
    - Information written in other languages

If you are in need of these services, please contact the Human Resources Department.

If you believe the Employer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, a grievance may be filed with: Funding Reserve, LLC HR Department. A grievance may be filed in person or by mail, fax, or email.

A civil rights complaint may also be filed with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

ALABAMA Medicaid	ALASKA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS Medicaid	**CALIFORNIA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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
COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA Medicaid	INDIANA 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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA Medicaid and CHIP (Hawki)	**KANSAS 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://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY Medicaid	**LOUISIANA 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: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE Medicaid	**MASSACHUSETTS Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA Medicaid	**MISSOURI Medicaid**
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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA Medicaid	**NEBRASKA Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA Medicaid	NEW HAMPSHIRE Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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
NEW JERSEY Medicaid and CHIP	**NEW YORK 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: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	**NORTH DAKOTA Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA Medicaid and CHIP	**OREGON Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA Medicaid and CHIP	**RHODE ISLAND Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA Medicaid	**SOUTH DAKOTA Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS Medicaid	**UTAH Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT Medicaid	**VIRGINIA Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid	**WEST VIRGINIA Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN Medicaid and CHIP	**WYOMING Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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 January 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact: 239-399-6252
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Orange Park Rehabilitation and Nursing Center	88-3183696
5. Employer address 2029 Professional Center	6. Employer phone number (904) 272-6194

7. City	8. State	9. ZIP code
Orange Park	FL	32073

10. Who can we contact about employee health coverage at this job?	
HUMAN RESOURCES	
11. Phone number (if different from above)	12. Email address

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☑ Some employees. Eligible employees are:

Employees classified as working 30 or more hours per week as a regular full-time Employee after completing 60 days of full-time employment.

Eligibility is first of month after satisfying the 60 day waiting period.

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

Your Spouse and your dependent children through age 26, including: natural, adopted and stepchildren regardless of other factors such as student status, marriage, residency, or support, and disabled children of any age.

☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.