CAROLINA THERAPY SERVICES

2023 Open Enrollment Benefits Guide

May 10, 2023 through May 19, 2023

Prepared by Marsh & McLennan Agency

Eligibility & Enrollment

Who is Eligible

If you are a full-time employee working 30 or more hours per week, you are eligible to enroll in the benefits described in this guide following first of the month following 30 days of service. Eligible dependents include your legally married spouse who does not have access to other employer coverage and dependent children. Dependent children are eligible for medical, dental, and vision coverage up to age 26. For child voluntary life coverage, children who are between 19 and 26 must be enrolled as a full-time student.

New Hires

If you are enrolling as a new hire, outside of the open enrollment period, benefits are effective first of the month after 30 days after your date of hire.

How to Enroll

Each person must login to Employee Navigator to confirm their Open Enrollment elections. Even if you do not make any changes for the upcoming year, you must login to confirm your enrollment. Go to http://www.carolinatherapy.net click ***Employee*** tab, select ***Employee Links*** then select ***2023 Open Enrollment Online Enrollment Portal***. Once in Employee Navigator click the ***Benefits Login*** link. You will then be prompted to go through each step of the enrollment process. Additional instructions can be found at the end of this booklet.

When to Enroll

The open enrollment period is May 10, 2023 at 3pm through 10am on May 19, 2023. The benefits you elect during open enrollment will be effective from June 1, 2023 through May 31, 2024.

How to Make Changes

Unless you have a qualified change in status, you cannot make changes to your benefit elections until next year's open enrollment period. Life events such as marriage, divorce, birth or adoption of a child, change in child's dependent status, death of qualified dependent, change in employment status or change in coverage under another employer-sponsored plan may qualify you for a special enrollment period. Please notify Chastity Strickland within 30 days of your qualifying event.

SBC & Summary Annual Report

The Summary of Benefits and Coverage (SBC) for the medical plans offered to full-time employees of your company has been prepared by MedCost in accordance with the requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively referred to as "PPACA"). When group health plans are offered your employer is required to provide access to certain notices annually to meet compliance guidelines. These documents can be found at http://www.carolinatherapy.net. If, however, you would like a printed copy of the notices please reach out to Human Resources.

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have questions about your benefits, contact Human Resources.

Medical Plans – MedCost

The chart below provides an overview of your available medical plans through MedCost. Please refer to your plan document for specific details. Networks frequently change, so it is always a good idea to confirm your provider's participation is in-network to avoid additional costs.

New for 2023! If you had an annual wellness check during the 2022 – 2023 plan year, you've qualified for the wellness rate for the new 2023 – 2024 plan year. This discount is a $5.00 per pay period deduction on your medical coverage to reward you for making your health a priority! If you didn't qualify, be sure to get an annual wellness check this year and you'll be on your way to earning the wellness rate next year.

	PPO Plan	
Semi - Monthly Payroll Deductions	**Wellness Rates**	**Non-Wellness Rates**
Employee Only	**$49.37**	**$54.37**
Employee + Spouse	**$309.68**	**$314.68**
Employee + Child(ren)	**$273.43**	**$278.43**
Employee + Family	**$602.93**	**$607.93**
Services	**In-Network***	
Deductible • Individual • Family	**Embedded** $2,000 $4,000	
Coinsurance • Plan Pays • You Pay	 70% 30%	
Out-of-Pocket Max (including deductible, copay & coinsurance) • Individual • Family	 $6,000 $12,000	
Preventive Services	100% No Deductible	
Primary Care	$30 copay	
Specialist Visit	$70 copay	
Physical, Occupational & Speech Therapy	$30 copay	
Telemedicine	$30 copay for mental health, $0 copay otherwise	
Emergency Room	Deductible then 30%	
Urgent Care	$75 copay	
Inpatient / Outpatient	$250 per admission copay, Deductible then 20% / Deductible then 30%	

Embedded Deductible/Out-of-Pocket: *All individual deductible and/or out-of-pocket amounts will count towards meeting the family deductible and/or out-of-pocket, but an individual will not have to pay more than the individual deductible and/or out-of-pocket amount.*

Telemedicine – Teladoc

Get quick care from anywhere with Teladoc telemedicine visits! A telemedicine visit lets you see and talk to a doctor from your laptop or mobile device.

Telemedicine doctors can treat cold and flu symptoms, bronchitis and other respiratory infections, sinus and ear infections, pinkeye, allergies, migraines, rashes and other skin irritations, urinary tract infections and much more! This benefit is available to all full time employees and their families enrolled. This benefit is paid 100% by CTS with no employee fee for service with exception of behavioral health.

New for 2023! You now have the added ability to use Teladoc for behavioral health visits for a $30 copay. There's a limit to 20 of these visits allowed per plan year, but be sure to take advantage of remotely handling your mental health and wellness as well!

How to Get Started

Create your account so that when you need care, you can get it quickly.

Online: www.teladoc.com

Phone: 800-835-2362

Pharmacy Information

Enrolling in medical coverage provides prescription drug coverage through MedCost. Below highlights information about the prescription drug plan offered!

	PPO Plan
	Retail
Tier 1 Generic	$10 copay
Tier 2 Preferred Brand	$85 copay
Tier 3 Non-Preferred Brand	$100 copay

877-GET-KISX

SCHEDULE

SAVE

KISx Card is the first program to ever exist that directly rewards YOU for taking action!

KISx Card covers over 400 different procedures

- Orthopedic Surgery
- General Surgery
- Colonoscopies
- MRI, CT & PET Scans

Just call, text, or email your personal nurse concierge who is waiting to schedule your procedure today!

www.getkisx.com

Please make sure to sign-up for push notifications and download the Spruce Health App: https://spruce.care/KISXCARD so we can stay in touch!

*HSA Plans require first dollar coverage from patient before procedure up to IRS Minimum, before program incentives are received.

Flexible Spending Accounts (FSA) – Flores & Associates

FSAs provide you with an important tax advantage that can help you pay for expenses on a pre-tax basis. By anticipating your family's costs for the next year, you can actually lower your taxable income. **Both Flexible Spending Account Plans require a six-month waiting period for new hires.**

You must enroll in your FSA every year to contribute. Your FSA plan options are shown below.

Dependent Care FSA

- Allows employees to use pre-tax dollars toward qualified dependent care such as caring for children under age 13 or caring for elders.
- **The annual contribution maximum is $5,000** (or $2,500 if married and filing separately).
- This benefit has a 75 day grace period to use up funds in your account, but no funds will roll over to the next plan year. You have until August 15, 2024 to incur services and use your funds, with a claims filing deadline of August 31, 2024.

Healthcare FSA

- Allows employees who are not enrolled in an HDHP or contributing to an HSA to pay for certain IRS-approved medical care expenses with pre-tax dollars.
- **The annual maximum contribution of $1,200 can be used for eligible health care related expenses, including medical, dental and vision expenses.**
- **You will have access to the total amount you have elected for the plan year after your first Health Care FSA contribution to the plan.**
- This benefit has a 75 day grace period to use up funds in your account, but no funds will roll over to the next plan year. You have until August 15, 2024 to incur services and use your funds, with a claims filing deadline of August 31, 2024.

How to File a Claim

Claims may be uploaded to your account via web portal (www.flores247.com), or using the Flores mobile app. You may also submit your reimbursement via fax (800.726.9982 or 704.335.0818) or mail (Flores & Associates, LLC, PO Box 31397, Charlotte, NC 28231), if you prefer. Please note that all claims must be received by the filing deadline for the applicable plan year in which your expenses were incurred.

All receipts for reimbursement must include the following information: Date of Service, Description of Service, Out-of-Pocket cost, Provider Name, and Patient Name.

Regardless of who is covered on your medical insurance, the Health Care FSA may reimburse expenses for your spouse or any qualifying tax or adult dependent.

A comprehensive list of allowable expenses and an expense worksheet can be found at www.flores247.com.

Dental Plans – Guardian

The chart below outlines your plan options through Guardian. Please refer to your plan document for specific details. Using an in-network provider will offer you the lowest service pricing.

	Dental Plan	
Benefits	**In-Network**	**Out of Network**
Annual Deductible • Individual • Family Applies to basic & major services ONLY	Calendar Year $50 $150	Calendar Year $50 $150
Preventive Services Exams, routine cleanings, x-ray, emergency room services.	Covered at 100%	Covered at 100%
Basic Services Fillings, simple extractions	Covered at 80%	Covered at 80%
Major Services Oral surgery, crowns, periodontics.	Covered at 50%	Covered at 50%
Annual Maximum Calendar Year	$1,500 + Max Roll-over	$1,500 + Max Roll-over
Orthodontia Children up to age 19	Covered at 50%	Covered at 50%
Orthodontia Lifetime Maximum	$1,000	$1,000

Your Cost

Your payroll deductions are shown below.

Semi-Monthly Employee Deductions				
	Employee Only	**Employee & Spouse**	**Employee & Child(ren)**	**Employee & Family**
Dental Plan	$7.09	$24.52	$32.29	$49.73

Vision Plan – Guardian

The chart below outlines your plan options through Guardian. Please refer to your plan document for specific details. Using an in-network provider will offer you the lowest service pricing.

	Vision Plan
Benefits	**In-Network***
Exam	$10 copay
Frames	$130 allowance + 20% off balance
Lenses	$25 copay
Contacts Lenses (Conventional)	$130 allowance
Frequency of Services Exams / Frames / Lenses OR Contacts	12 / 24 / 12 months

** Using a provider that is out of the network shown above, you may experience higher costs.*

Your Cost

Your payroll deductions are shown below.

Semi-Monthly Employee Deductions				
	Employee Only	**Employee & Spouse**	**Employee & Child(ren)**	**Employee & Family**
Vision Plan	$4.03	$8.62	$6.97	$11.57

Voluntary Life Insurance – Reliance Standard

Employees may elect to purchase additional life insurance on themselves or their dependents through the convenience of payroll deduction. If you elect when first eligible, you may elect coverage up to the Guaranteed Issue amount without having to answer any medical questions. Employee and spouse benefits reduce by 50% at employee age 70; employee and spouse rates are based on employee age. To be eligible for coverage you must be actively at work. If you have previously elected this coverage, it will continue into this plan year. If you would like to add this benefit as a late entrant, or a make a change to your current coverage, please contact HR so they can provide you with any necessary paperwork.

Voluntary Life Insurance			
Guaranteed Issue	Employee $180,000	Spouse $20,000	Dependent Child $10,000
Employee Coverage	You may elect coverage in $10,000 increments up to a maximum of 5x your base annual earnings or $500,000.		
Spouse Coverage	You may elect coverage for your spouse in $10,000 increments up to $250,000, not to exceed 100% of employee's amount.		
Child Coverage	You may elect coverage for your dependent child(ren) up to a maximum of $10,000. ($500 – 14 Days to 6 Months)		

Voluntary AD&D Insurance – Reliance Standard

Voluntary Accidental Death & Dismemberment benefit with Reliance Standard provides additional protection for policyholder or beneficiaries in the event of an accidental death or dismemberment of the policyholder. Employee and spouse benefits reduce by 50% at employee age 75 and an additional 25% at age 80; employee and spouse rates are based on employee age. To be eligible for coverage you must be actively at work. If you have previously elected this coverage, it will continue into this plan year. If you would like to add this benefit as a late entrant, or a make a change to your current coverage, please contact HR so they can provide you with any necessary paperwork.

Voluntary AD&D Insurance	
Employee Coverage	You may elect coverage in $10,000 increments up to a maximum of 10x your annual earnings or $500,000.
Spouse Coverage	You may elect coverage up to 50% of employee amount with no child(ren) covered. If child(ren) are also to be covered you may election up 40% of employee amount
Child Coverage	You may elect up to 10% of employee amount if spouse is covered. If the coverage is employee and child(ren) only you can elect up to 15% of employee amount.

Basic Life Insurance – Reliance Standard

Your company provides full-time employees with group life and accidental death and dismemberment (AD&D) insurance according to your class status and pays the full cost of this benefit. Benefits begin reducing at age 70. Contact Human Resources to update your beneficiary information.

Disability – Reliance Standard

Employees may elect to purchase short and long-term disability coverage through the convenience of payroll deduction. If you experience an illness or injury (non-work related for STD) that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation. If you have previously elected this coverage it will continue into this plan year. If you have previously elected this coverage it will continue into this plan year. If you would like to add this benefit as a late entrant, or a make a change to your current coverage, please contact HR so they can provide you with any necessary paperwork.

	Short Term Disability	Long Term Disability
Percentage of Income Replaced	60% of weekly income	60% of monthly income
Benefits Duration	11 weeks	Social Security Normal Retirement Age (SSNRA)
Standard Maternity Benefits Duration	6 weeks vaginal delivery 8 weeks c-section	N/A
Benefits Begin	15th day accident/illness	After 90 days
Maximum Benefit	$1,000 weekly	$5,000 monthly

*Benefits duration includes the waiting period and is subject to medical necessity.

Short Term Disability Premium Calculation	Long Term Disability Premium Calculations
60% x Weekly Earnings = Volume	Annual Income / 12 = Monthly Income
(RATE) 0.65 x (VOLUME) / 10 = Monthly Premium	(RATE) 0.80 x Monthly Income / 100 = Monthly Premium
Monthly Premium x 12 / 24 = Payroll Deduction	Monthly Premium x 12 / 24 = Payroll Deduction

Supplemental Health Benefits – Reliance Standard

The additional health benefit options below can be used to customize your coverage to complement your medical plan options. If you elect any other the voluntary options below, you will be responsible for the cost of the benefit.

Voluntary Critical Illness Insurance

CTS offers group critical illness insurance that can help protect your finances from the expense of a serious health problem, such as cancer, stroke or heart attack. If you elect, you will have a flat lump-sum benefit that is paid directly to you at the first diagnosis of a covered condition. You can use the benefit any way you choose. If you elect coverage on yourself, you can also buy coverage for your spouse in amounts up to 100% of employee's coverage. In addition, children are allowed to elect up to 25% of the employee's election. **There is also a $50 wellness incentive per year for each insured person for having your annual physical.** See the Schedule of Benefits for a full list of covered conditions. If you have previously elected this coverage it will continue into this plan year. If you would like to add this benefit as a late entrant, or a make a change to your current coverage, please contact HR so they can provide you with any necessary paperwork.

Guaranteed Issue	Employee $30,000	Spouse $30,000	Dependent Child $12,500
Employee Coverage	You may elect coverage in $1,000 increments from $5,000 up to a maximum of $50,000		
Spouse Coverage	You may elect coverage in $1,000 increments from $5,000 up to a maximum of $50,000; spouse election cannot exceed 100% of employee election.		
Child Coverage	You may elect coverage for your dependent child(ren) in increments of $1,000 not to exceed 25% of employee election up to a maximum of $12,500.		

Benefit Amount	Age 0-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70-74	Age 75-79
$5,000	$1.08	$1.60	$2.05	$3.08	$4.75	$6.98	$9.28	$12.90	$18.43	$23.53	$31.65
$10,000	$2.15	$3.20	$4.10	$6.15	$9.50	$13.95	$18.55	$25.80	$36.85	$47.05	$63.30
$15,000	$3.23	$4.80	$6.15	$9.23	$14.25	$20.93	$27.83	$38.70	$55.28	$70.58	$94.95
$20,000	$4.30	$6.40	$8.20	$12.30	$19.00	$27.90	$37.10	$51.60	$73.70	$94.10	$126.60
$25,000	$5.38	$8.00	$10.25	$15.38	$23.75	$34.88	$46.38	$64.50	$92.13	$117.63	$158.25
$30,000	$6.45	$9.60	$12.30	$18.45	$28.50	$41.85	$55.65	$77.40	$110.55	$141.15	$189.90
$35,000	$7.53	$11.20	$14.35	$21.53	$33.25	$48.83	$64.93	$90.30	$128.98	$164.68	$221.55
$40,000	$8.60	$12.80	$16.40	$24.60	$38.00	$55.80	$74.20	$103.20	$147.40	$188.20	$253.20
$45,000	$9.68	$14.40	$18.45	$27.68	$42.75	$62.78	$83.48	$116.10	$165.83	$211.73	$284.85
$50,000	$10.75	$16.00	$20.50	$30.75	$47.50	$69.75	$92.75	$129.00	$184.25	$235.25	$316.50

iNGAGED Benefits Mobile App

There is a new and improved mobile app called iNGAGED Benefits for you to use! It is available on iOS and Android mobile devices as well as desktop format. iNGAGED makes accessing your benefits information easier than ever!

With iNGAGED Benefits you can:

- View your benefit plan options, resources, and documentation 24/7
- Access carrier policy information and group numbers
- Quickly contact a benefit carrier using the "tap to call" feature in the app
- Keep up to date with important company announcements via app push notifications
- Store an image of your ID card in your app

Download the iNGAGED Benefits app to get started! Use your company code to login:
CarolinaTherapyServices

Benefit Hub – Employee Discount Marketplace

Enjoy discounts, rewards and perks on thousands of the brands you love in a variety of categories:

- Travel
- Auto
- Electronics
- Apparel
- Local Deals
- Education
- Entertainment
- Restaurants
- Health and Wellness
- Beauty and Spa
- Tickets
- Sports & Outdoors

1.) Go to: carolinatherapyservices.benfithub.com
2.) Create an Account Using Referral Code: **ZXHMGH**
3.) Complete Registration

Questions? Call 1-866-664-4621 or email customercare@benefithub.com

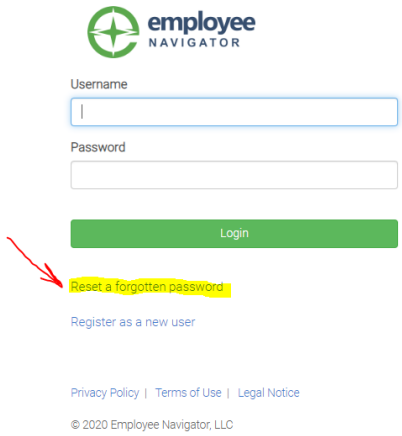
How to Enroll in your Benefits:

Employee Navigator Login Instructions

IF YOU HAVE ALREADY REGISTERED ON EMPLOYEE NAVIGATOR, GO TO:

http://www.carolinatherapy.net; click ***Employee tab***, select ***Employee Links*** then select ***2023 Open Enrollment Online Enrollment Portal***

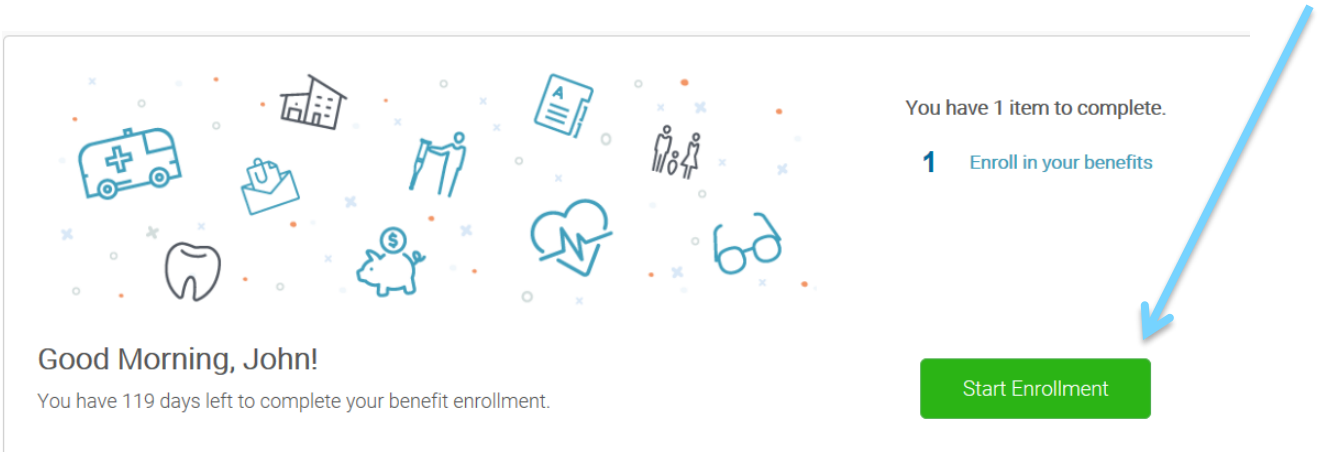
If you do not remember your login credentials, select "Forgot Username?" or "Forgot Password?" and follow the instructions in the email you receive.



Once you have successfully logged in, you will be taken through a wizard that will help navigate you through the enrollment process.

So let's begin….

The first thing you will see is the welcome screen, example shown below. You will click the "Start Enrollment" Icon:

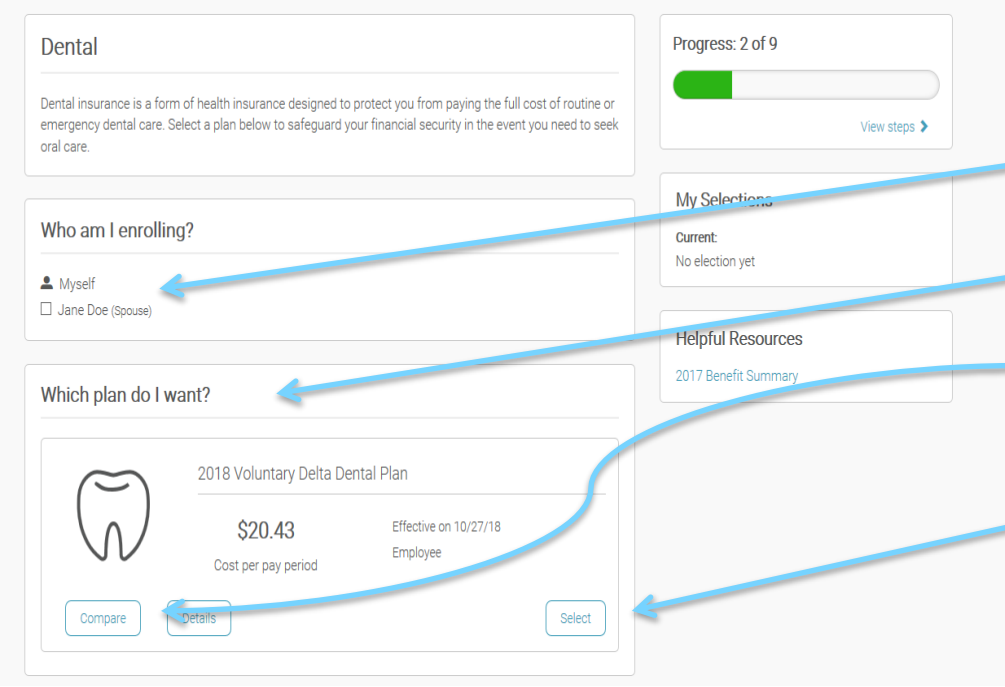


Next you will see a page to welcome you to your enrollment process. Click "Get Started".

Complete any missing data on the first page where you will see your employee information. Be sure to click this button at the bottom of the screen if you have made any changes:

Save & Continue

If you do not have any changes, click Save to go to the next screen which is “Dependent Information” and add your dependents there. Be sure to click the “Save & Continue” button once you are done adding dependents. If you do not have dependents to add, click “Save”.



This is the next page you will see. Simply complete the information to enroll or waive coverage you wish to elect for you and your dependents.

Who am I enrolling? *You will need to select your dependents on each line of coverage you are enrolling them on.*

Which plan do I want (if you have more than one to choose from).

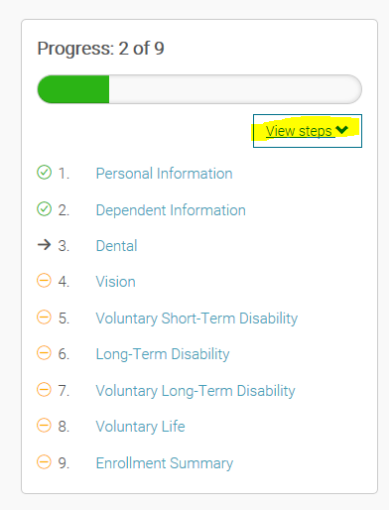
You can also click on the “compare” icon to show the plan(s) and cost for all tier levels…
And the “details” icon to provide a brief benefits overview.

Click on the “Select Plan” button which will elect your option. Then “Save & Continue” to go to the next benefit available.

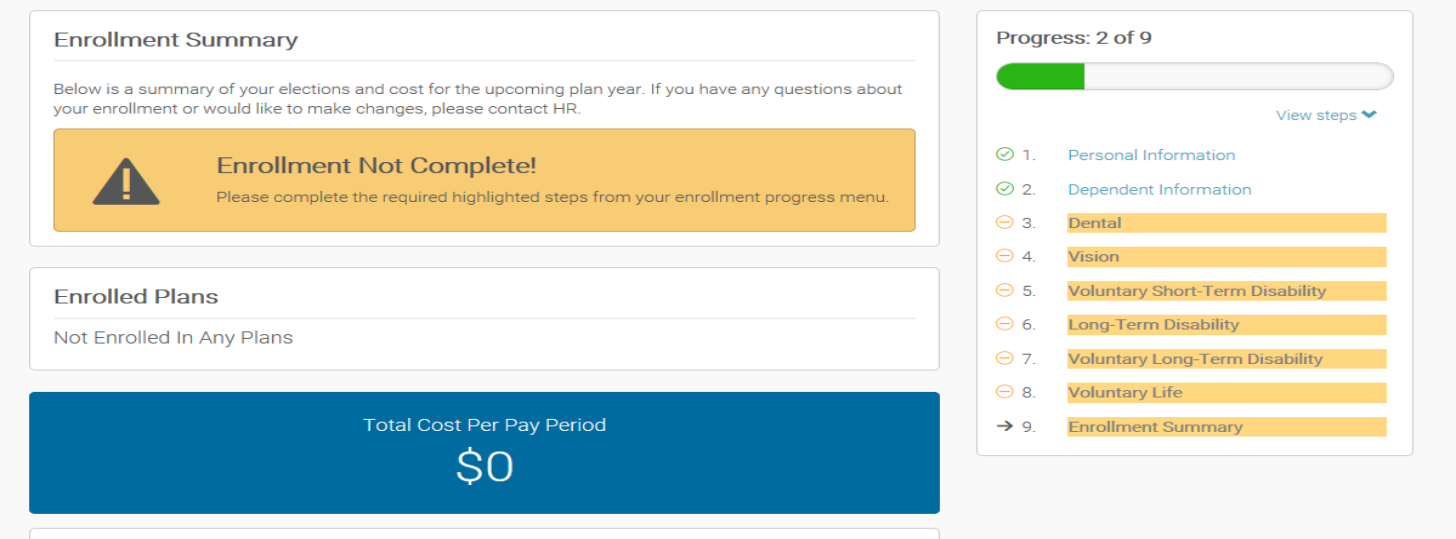
If you are not taking benefits, click “Don’t want this benefit”. It will ask you to provide a reason why you are not electing coverage.

You will do this the same for each line of coverage available to you during this enrollment process.

If you need to go back during any step of the enrollment process, click on the “View Steps” under the Progress Bar and a drop down will appear. Simply click on that benefit to go that screen.

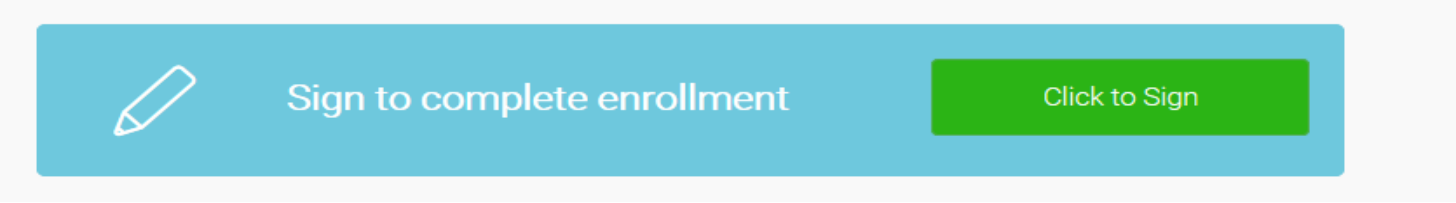


At the end, you will be able to view all elections and the cost for each line and you can print a copy for your records. If you have missed any steps, you will be notified which items need to be completed:



Be sure to always select "SAVE & CONTINUE" for any modifications that you make.

Once you have made elections for all benefits, you will ask to electronically sign and you will click the green "Click here to sign" button which will complete your enrollment process!



If you have any questions, please call Marsh & McLennan's Employee Benefit Services at 855-313-1075 or via email at ebservices@marshmma.com.

Refer to this list when you need to contact one of your benefit vendors. For general information contact Human Resources or Employee Benefits Service Team.

Benefit	Carrier Name	Phone Number	Website
Medical	MedCost Network: MedCost	800-824-7406	www.medcost.com
Pharmacy	Southern Scripts	800-710-9341	www.southernscripts.net
Telehealth	Teladoc	800-835-2362	www.teladoc.com
Medical Procedures at no cost	KISx Card	877-438-5479	www.getkisx.com
Dental	Guardian Network: Guardian Preferred	800-541-7846	Benefit Info: www.guardianantytime.com Find a Provider: https://www.guardianantytime.com/fpapp/FPWeb/search
Vision	Guardian Network: VSP Choice	800-627-4200	Benefit Info: www.guardianantytime.com Find a Provider: www.vsp.com/eye-doctor
Life, AD&D, Disability & Critical Illness	Reliance Standard	800-351-4357	www.reliancestandard.com
Flexible Spending Account (FSA)	Flores & Associates	800-532-3327	www.flores247.com
ingaged App & Web Portal	iNGAGED	-	Company Login Code: **CTS2022** www.ingagedbenefits.com Search “iNGAGED Benefits” in your smart phone App Store

Employee Benefits Service Team

Your dedicated Employee Benefits Services Team is your benefits resource throughout the year. You can contact the Employee Benefits Services Team when you need personal assistance with our group benefit plans. Their dedicated client support specialists can help with inquiries about your medical, dental, vision, disability and voluntary benefits plans.

Call when you have questions about:

- Concerns or issues with claims
- How to obtain ID cards
- General benefit coverage

The Employee Benefits Services team is available Monday through Friday 8am to 5pm EST.

Contact by phone or email:

- Toll Free: 855-313-1075
- EBServices@marshmma.com

Notes

Carolina Therapy Services Health and Welfare Benefits Annual Notice Packet

For the 2023-2024 Plan Year

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- ☐ Medicare Part D Creditable Coverage Notice
- ☐ HIPAA Special Enrollment Rights Notice
- ☐ HIPAA Notice of Privacy Practices
- ☐ Children's Health Insurance Program (CHIP) Notice
- ☐ Women's Health and Cancer Rights Act (WHCRA) Notice
- ☐ Newborns' Mothers Health Protection Act (NMHPA) Notice
- ☐ General Notice of COBRA Continuation Rights

Should you have any questions regarding the content of the notices, please contact us at 910-892-0027

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).

Medicare Part D
Creditable Coverage Notice

Important Notice from Carolina Therapy Services
About Your Prescription Drug Coverage 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 Carolina Therapy Services 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. **Carolina Therapy Services has determined that the prescription drug coverage offered by the MedCost is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan while enrolled in Carolina Therapy Services coverage as an active employee, please note that your Carolina Therapy Services coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Carolina Therapy Services coverage as a former employee.

You may also choose to drop your Carolina Therapy Services coverage. If you do decide to join a Medicare drug plan and drop your current Carolina Therapy Services coverage, be aware that you and your dependents may 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 Carolina Therapy Services 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 at 910-892-0027. **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 Carolina Therapy Services 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).

Date: June 1, 2023
Name of Entity/Sender: CAROLINA THERAPY SERVICES, INC.
Contact--Position/Office: CHASTITY STRICKLAND, HUMAN RESOURCES MANAGER
Address: 111 South Railroad Avenue Dunn, NC 28334
Phone Number: 910-892-0027

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Carolina Therapy Services, certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Carolina Therapy Services, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Carolina Therapy Services, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the CAROLINA THERAPY SERVICES, INC. HIPAA Privacy Officer:

CAROLINA THERAPY SERVICES, INC.
Attention: HIPAA Privacy Officer
Chastity Strickland, Human Resources Manager
111 South Railroad Avenue
Dunn, NC 28334

Effective Date

This Notice as revised is effective June 1, 2023

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with

conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or

- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period Carolina Therapy Services has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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 –

NORTH CAROLINA – Medicaid	SOUTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
CALIFORNIA – Medicaid	**CALIFORNIA – Medicaid**
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	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
SOUTH DAKOTA - Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
GEORGIA – Medic GEORGIA – 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	

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

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), 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?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at 910-892-0027.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

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

Model General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Chasity Strickland 910-892-0027.

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

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

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to

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

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

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease (ESRD).

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
Chasity Strickland, Human Resources Mananager.

HIPAA Notice of Availability of Notice of Privacy Practices

The Carolina Therapy Services (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Chasity Strickland, Human Resources Manager.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

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

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

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

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

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to earn more about protections from surprise medical bills.


MarshMcLennan
Agency