2025 – 2026

Open Enrollment Benefits Guide

May 8, 2025 through May 15, 2025

CAROLINA THERAPY SERVICES

Welcome

Your well-being is our priority, and we are committed to providing you with a benefits package that supports your overall health, happiness, and success. This guide has been designed to assist you in making informed decisions about your benefits.

Who is eligible for benefits?

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.

*Spousal Exclusion: If your spouse is eligible for group coverage through their employer, you may not cover them on a CTS Medical Plan. Those electing spousal coverage must sign an affidavit stating that their spouse isn't eligible for other group insurance.

When do I enroll?

If you are enrolling during the open enrollment period, this is an **active enrollment,** meaning you must make benefit elections in Employee Navigator to be enrolled in coverage this year. The annual open enrollment period is May 8, 2025 – May 15, 2025. The benefits you elect either during open enrollment or the new hire period will be effective through May 31, 2026.

How do I 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 ***Insurance Benefits 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.

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.

Have questions?

If you have any questions about benefit offerings or the enrollment process, you can contact Chastity Strickland, Human Resources Manager, at 1-910-892-0027.

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. CTS covers 85% of the employee-only coverage.

If you had an annual wellness check between 5/1/24 through 4/30/25, you've qualified for the wellness rate for the new 2025 – 2026 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.

Medical	Base PPO Plan Medcost	Buy-Up PPO Plan Medcost	CDHP / HSA Plan Medcost
Services	In-Network	In-Network	In-Network
Deductible Individual / Family	Embedded $6,000 / $12,000	Embedded $2,000 / $4,000	Embedded $3,300 / $6,600
Coinsurance Plan Pays / You Pay	70% / 30%	70% / 30%	80% / 20%
Out-of-Pocket Max Individual / Family	$9,450 / $18,900	$6,000 / $12,000	$6,000/ $12,000
Preventive Services	100% Covered	100% Covered	100% Covered
Primary Care	$30 Copay	$30 Copay	Deductible then 20%
Specialist Visit	$70 Copay	$70 Copay	Deductible then 20%
Teladoc Telemedicine	$30 Copay for mental health, $0 Copay otherwise	$30 Copay for mental health, $0 Copay otherwise	See Teladoc section on next page for explanation***
Urgent Care / Emergency Room	$75 Copay / Deductible then 30%	$75 Copay / Deductible then 30%	Deductible then 20% / Deductible then 20%
Inpatient Hospital	$250 per admission Copay / Deductible then 20%	$250 per admission Copay / Deductible then 20%	Deductible then 20%
Outpatient Facility	Deductible then 30%	Deductible then 30%	Deductible then 20%
Prescription			
Retail Tier 1 Generic	$10 Copay	$10 Copay	Deductible then 20%
Retail Tier 2 Preferred Brand	$85 Copay	$85 Copay	Deductible then 20%
Retail Tier 3 Non-Preferred Brand	$100 Copay	$100 Copay	Deductible then 20%

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.*

Note: All GLP-1s will have a cap of $3,000 for the plan year regardless of medical diagnosis.

Your Cost – Semi-Monthly Employee Deductions						
	Base PPO Plan		Buy-Up PPO Plan		CDHP / HSA Plan	
	Wellness Rates	Non-Wellness Rates	Wellness Rates	Non-Wellness Rates	Wellness Rates	Non-Wellness Rates
Employee Only	$10.41	$15.41	$66.45	$71.45	$58.33	$63.33
Employee + Spouse	$312.27	$317.27	$408.56	$413.56	$394.60	$399.60
Employee + Child(ren)	$270.24	$275.24	$360.92	$365.92	$347.78	$352.78
Employee + Family	$652.33	$657.33	$793.96	$798.96	$773.43	$778.43

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.

***If you are enrolled in the CDHP / HSA plan, you'll pay the full value of the visit:
$55 general medical visit
Behavioral Health - $220 initial psychiatry visit
$100 for ongoing visits
$90 for therapy visits
Once your deductible is satisfied then coinsurance will apply.

If you are enrolled in either the Base or Buy-Up PPO plans, this benefit is paid 100% by CTS with no employee fee for service with exception of behavioral health.

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: 855-549-2214

YOUR NEW PHARMACY BENEFIT PARTNER

SmithRx

Getting Started with SmithRx

Welcome to pharmacy benefits with SmithRx. At SmithRx, we're here to help reduce the cost and complexity of your prescription benefits.

Please look for an updated ID card in the mail. This will include your new SmithRx information, which you'll need to present to your pharmacist before filling prescriptions. In the meantime, please continue to use your current ID card until your new plan with SmithRx is in effect.

Our Pharmacy Network

With over 65,000 pharmacies in our network, chances are your current pharmacy will accept your SmithRx prescription drug plan. We partner with leading retail pharmacies such as CVS, Walgreens, RiteAid, Walmart, and Costco, as well as mail-order pharmacies like Amazon Pharmacy and Walmart Mail Order. For specialty medications, we work with trusted specialty pharmacies like Costco and Senderra to ensure comprehensive care.

amazon pharmacy

MARK CUBAN CostPlus DRUG COMPANY

COSTCO PHARMACY

CVS pharmacy

RITE AID

Walgreens

Walmart Pharmacy

YOUR NEW PHARMACY BENEFIT PARTNER

SmithRx

Getting Started with SmithRx

Once your plan is active, take these 3 simple steps to make the most of your benefits.

1: Register for the Member Portal

SmithRx's online Member Portal allows you to access benefit information and important forms, view your claims and prior authorization status, print or add your ID card to your digital wallet, and more. The Find My Meds tool will even help you find the lowest cost pharmacy near you.

To register for your account, go to smithrx.com/portal.

2: Update your Rx Insurance with your Pharmacy

Before refilling your medications, be sure to provide your new SmithRx prescription benefits card to your pharmacy and ask them to update your insurance profile. The pharmacy will need the BIN, PCN, Member ID, and RxGroup number to process any covered prescription(s)

3: Take Advantage of More Savings with SmithRx Connect 360

SmithRx's Connect 360 identifies cost savings programs that may apply to your medications. Many of these programs can help you obtain medications for little or no co-payment. If any of your prescriptions are eligible, the SmithRx Member Support Team will reach out via text message, email and a notification in the Member Portal.

We are here to help!

The SmithRx Member Support Team is dedicated to helping you understand your prescription benefits and connecting you with the tools and resources needed to lower your out of pocket costs for medications.

Chat

Chat live with a member service representative on our website or in the member portal

Portal

Find plan info, ID cards and documents at smithrx.com/portal

Email

Email our team at help@smithrx.com

Phone

Call us at 844-454-5201

SmithRx

OPEN ENROLLMENT INFORMATION

We make saving money simple

The SmithRx Connect 360 programs can help patients obtain medications for little or no co-payment. Our team will proactively reach out to you and help you navigate the process if any of these programs apply to your medications. Please ensure your contact information is updated with your human resources team and answer or return calls or emails from SmithRx to ensure you make the most of your benefits.

Access Plus

Navigating access to high-cost specialty medications through advocacy programs; assistance with applications is provided when these drugs are not covered under the pharmacy benefit.

Medical Pharmacy Management

Savings on high-cost infused specialty medications; assistance with qualification through advocacy programs and the facilitation of administration at home, local infusion centers, or doctors' offices for administration.

Access

Capturing manufacturer coupon savings on traditional and specialty medications. Members have a low or $0 copay on prescriptions while also helping groups save on pharmacy benefit costs.

Autoimmune

Through this program, SmithRx members can now access low cost, FDA-approved biosimilars such as Yusimry, a biosimilar for Humira, and Otulfi, a biosimilar for Stelara, through Cost Plus Drugs and Costco Specialty Pharmacy. FDA-approved biosimilars have no clinically meaningful differences in terms of safety and effectiveness from their brand-name counterparts, while offering a more affordable option for members with autoimmune conditions.

Diabetes Non-Insulin (DNI)

As diabetes spend increases, we transition members to the most affordable diabetes non-insulin medications. Our first low-cost solution is Brenzavvy, a SGTL2 inhibitor, at Cost Plus Drugs.

Low Cost Insulin The lowest cost insulin products on the market; typically a generic or biosimilar insulin, offering upfront savings to the health plan instead of having to wait for rebates.

Assist

Assist works in the background and automatically finds the lowest price discount card at the pharmacy for members, eliminating the need for members to pre-shop and print coupons.

Mark Cuban Cost Plus Drugs

This partnership expands access to more affordable prescription drugs. Like SmithRx, Cost Plus Drugs is transparent and offers cost plus a straightforward 15% markup and flat fee.

Third Party Sourcing

In the event that Third Party Sourcing is the lowest cost option, if requested by the group, SmithRx can connect members with an independent sourcing company for access to low cost medications.

Multiple Sclerosis (MS)

The lowest cost multiple sclerosis products on the market through Cost Plus Drugs; generic medications offer upfront savings to the health plan instead of having to wait for rebates.

340B Referral Program

In select geographic areas, SmithRx members can obtain expensive medications at a lower cost through the 340B Referral Program.

SURGERY. SIMPLIFIED.

To help you be healthy.

The KISx Card is a surgery & imaging program that your employer has made available to you for the most common surgical & imaging procedures. Some of the most typical procedures through The KISx Card include: Orthopedic, General Surgery, Colonoscopies, MRI, CT and PET Scans. If you utilize the program, you will receive your procedure at **NO COST** to you.

CALL

Call a KISx Card Nurse at 877-GET-KISX to find out more about your procedure and how the program works. We will assist you in finding the right facility nearby.

SCHEDULE

A KISx Card Nurse will help schedule your procedure. Upon scheduling, they will then provide you with a voucher to take to your initial consultation.

PROCESS

BE HEALTHY

After you have had your procedure through a KISx Card Provider, your KISx Card Nurse will follow up to make sure you are making a full recovery. We want to make sure you are getting better so you can live a healthy life!

SAVE

You will pay **$0** out of pocket for choosing a KISx Card provider. Every aspect of your procedure is covered through the KISx Card.

KISxCard™

Keep It Simple Surgery

HOW IT **WORKS?**

Before seeking In-Network Providers through your health plan, just call a KISx Card Nurse regarding your elective procedure. By choosing a KISx Card provider, you will always pay **$0**.

CALL, SCHEDULE, SAVE
BE HEALTHY

GET IN **TOUCH**

Phone: 877-GET-KISX

Email: info@getKISx.com

KISCard
Keep It Simple Surgery

Arthroscopy - General
- Knee - Diagnostic/OR meniscus repair, ACL, etc.
- Shoulder - includes Capsulorrhaphy/ Bankart
- Elbow
- Wrist
- Hip
- Ankle

Ear, Nose & Throat
- Inner Ear - Stapedectomy
- Mastoidectomy (Simple)
- Tympanoplasty and Mastoidectomy
- Myringoplasty
- Ossiculoplasty
- Bilateral Submucosal Resection of Turbinates
- Septoplasty
- Sinus/Turbinates Bilateral
- Parotidectomy
- Thyroidectomy- Total or Partial
- Thyroidectomy, Complex
- Adenoidectomy
- Adenoidectomy and BMT
- Tonsillectomy
- Frenulectomy
- Esophagoscopy With or Without Dilatation/Biopsy

Elbow
- Bursectomy (Elbow)
- Distal Biceps Re-attachment Ulnar Nerve Transposition / Epicondylectomy

Foot & Ankle
- Achilles Repair
- Tarsal Tunnel Release
- Brostrom Repair of ankle/ Reconstruction
- Bilateral Bunionectomy
- Unilateral Bunionectomy
- Hammertoe Reconstruction
- Arthrodesis of Great Toe/ Metatarsophalangeal Joint
- Plantar Fasciotomy
- Tarsal Tunnel Osteotomy
- Partial Excision of Gastrocnemius Recession
- Plantar Fasciotomy
- Morton's Neuroma Excision

General Surgery
- Hemorrhoidectomy
- Non-Urgent Laparoscopic or Open Cholecystectomy (Gall Bladder Removal)
- All Hernia Repairs
- Pilonidal Cyst Removal
- Non-Urgent Laparoscopic Appendectomy

GI
- Colonoscopy and EGD
- EGD
- Colonoscopy

GU
- Anterior Repair
- Epididymectomy /Partial Epididymectomy
- Total Hydrocelectomy
- Transurethral Resection of Prostate
- Mini-Arc Urethral Suspension
- Posterior Repair

Hardware Removal
- Complex
- Simple

Hip
- Hip Arthroscopy (Simple or Complex) With W/O Labral Repair
- Total or Partial Hip Arthroplasty (Repair)- Includes Implants

Imaging
- MRI
- CT Scans
- PET Scans
- Arthrograms
- X-ray in conjunction with MRI/ CT

Knee
- Anterior Cruciate Ligament Repair with Allograft OR Allograft Posterior Cruciate Ligament Repair Medial Collateral Ligament
- Tibial Tubercle Osteotomy
- Complete Synovectomy
- Chondroplasty
- Medial & Lateral Meniscectomy
- Total OR Partial Knee Arthroplasty (Knee Replacement

Shoulder
- Rotator Cuff Repair-Arthroscopic and Open
- Shoulder Manipulation (With or Without anesthesia)
- Repair Pectoralis Muscle Rupture
- Bankart Stabilization or Labral Repair
- Distal Clavicle Excision Extensive debridement
- Subacromial Decompression- Arthroscopic
- Total Shoulder Arthroplasty / Replacement

Spine
- Microdiscectomy
- Lumbar Laminectomy
- Anterior Cervical Discectomy with Fusion, 1 level (includes hardware)
- Anterior Cervical Discectomy with Fusion, 2 level (includes hardware

Women's Health Surgery
- Hysterectomy
- Hysteroscopy

Wrist & Hand
- Carpal Tunnel Release (Open or Laparoscopic)
- Dupuytrens Contracture
- Trigger Finger
- Excision of lesion of tendon sheath or joint capsule (ex. cyst, mucous cyst, or ganglion)
- Ganglion Excision
- Synovectomy/Tenosynovectomy

Other Specialties offered
- Bariatric Surgery- for weight loss
- Regenexx- Non-surgical treatment for orthopedic issues/injuries/pain

This list is meant as a summary of elective procedures available through the KISx program at the current time. Procedure availability can vary throughout the country, if we do not have a facility that is within a reasonable distance. Certain procedures may not be available until we are able to get facilities on board. New procedures may be added at any time without notice. Pediatric Surgeries are NOT covered through this program.
We also do not accommodate any urgent surgical procedures or those that need to be done in an acute hospital setting.

found

Comprehensive weight care driven by your biology

Welcome to Found–a comprehensive virtual weight loss program tailored to the factors that make you unique. We call this "weight care."

Found has served over 250,000 members in the U.S., helping them on their journey to safe, effective, lasting weight loss.

Feel like you've tried everything?

At Found, we connect you with a dedicated Care Team that delivers tailored treatment plans based on your body, not willpower.

Did you know
Only 1% of all doctors are actually trained to treat people with obesity and excess weight?[1]

Programs that fit your lifestyle

Medication-assisted weight care

This program is appropriate for individuals seeking support that combines medication, if clinically eligible, with lifestyle interventions and nutritional guidance.*

Wellness program

This program is appropriate for individuals seeking care without the use of medication, gaining support through 1:1 access to certified health coaches, lifestyle interventions, nutritional guidance.

*Program available to individuals who qualify for anti-obesity medications following FDA guidelines (BMI 30+ or BMI 27+ with comorbidities).

found

Results you can see, success you can feel

Julie W., lost 75 pounds**

"Everybody is different and we all respond differently to medications, diets, and other factors—which is why Found gives multiple weight loss options. This program works for so many people because it encourages you to do your part and work for it."

Xavier C., lost 23 pounds**

"One of the life-changing things I learned was about eating mindfully. Found changed my habits of how I see food and how I see myself interacting around it."

** Individual results may vary.
In 1 year, Found users lost an average of 12% body weight. Results based on data from 1,773 users who reported their weight at least 1 time/week on avg. for 1 year. Prescriptions are up to a medical provider's discretion.

Get started on your weight loss journey today!

Scan the QR or visit the dedicated landing page below to enroll.

business.joinfound.com/employers/pareto-health

Have questions? Contact our team at support@joinfound.com

ParetoHealth
CancerCARE+
Right Care. Right Place. Right Time.

What is CancerCARE?

The CancerCARE Program is a free, fully integrated cancer solution included in YOUR health plan that supports you from the first day of your diagnosis well into the stages of aftercare. CancerCARE coordinates care and benefits for patients with new or existing cancers. Our expert medical team advocates for the best possible care in your community or at a leading national Centers of Excellence location.

Day One Help

The day you receive a cancer diagnosis is overwhelming. Our CancerCARE professionals will answer questions about your diagnosis and help you evaluate your treatment options. They will also help maximize your health benefits and minimize your out-of-pocket expenses.

Register online or by phone promptly (within 72 hours) of diagnosis for the highest care impact.

Personalized Care

Today's cancer treatments vary by cancer type, stage of spread, and the patient's genetic makeup. The most effective care occurs when it is genetically personalized for you. Genetic testing is often not a covered benefit; however, it is fully covered when used for treatment planning with CancerCARE's recommendation.

National Resources

New treatments are developed and tested at leading cancer centers called Centers of Excellence. Treatment received from your local oncologist is often the best possible, but in some instances, we may suggest new treatments that are only offered at a Center of Excellence when those treatments could be more beneficial to you. Two examples would be Clinical Trials or proven new treatments that have not yet been written and given to community oncologists.

Expert Medical Team

During your Initial registration call, our highly trained Intake Coordinators will quickly gather your medical and health plan information. When a diagnosis permits, you will be assigned your own personal Oncology Nurse Expert who will answer any questions you have regarding your diagnosis as well as your care options. CancerCARE's entire team of Doctors, Nurses, and Medical Experts is dedicated to being with you throughout your treatment journey.

ParetoHealth CancerCARE+
Right Care. Right Place. Right Time.

Frequently Asked Questions

How do I use the Program?

To gain access to our services, register online at CancerCAREprogram.com, or call us at 1-877-640-9610. **Once you are registered in our system, a nurse will be assigned to your case and they will help you for the rest of your cancer journey.**

Do I have to pay for CancerCARE?

The CancerCARE Program is an additional service included in the health plan offered by your company. **Registration and program features are covered by your health plan. Contact your HR representative for more information.**

What if I am already being treated for cancer?

You can join CancerCARE at any point during your treatment. Once registered, **we are able to collaborate with your local oncologist** and give them access to resources they may not have at their facility. We will also review your treatment plan to ensure everything is evidence-based quality care.

I don't have cancer, do I still need to register?

Registration is only required if you have been diagnosed with cancer. If you had cancer in the past and are now cancer-free, you can still register as a survivor and we will help you deal with any long-term issues and concerns. **Covered dependents can also register for CancerCARE.**

SmartConnect POWERED BY SMARTMATCH

ParetoHealth.

(855) 248-1648 | TTY: 711
Mon - Fri, 7:30 a.m. - 5 p.m. CT

Introducing SmartConnect™

SmartConnect is an exclusive program created specifically for working or retiring adults (and family members) who are Medicare-eligible and may not have fully explored the benefits of Medicare coverage.

Staying on your employer's coverage may be easy, but it's not always the best option. In fact, Medicare plans could provide more coverage at a lower cost than your employer's plan.

SmartConnect puts your specific needs first and matches you with the education and the experienced advisor you need to make the best decision for you. SmartConnect gives you access to plans from national insurance carriers.

Whether you're planning to continue working or looking to retire, we are expert listeners who can guide you to a tailored solution. We know this is a big decision. Our mission is to inspire confidence and help you find your balance in Medicare.

About SmartMatch Insurance Agency

SmartMatch Insurance Agency is an independent Medicare insurance agency that helps consumers research, compare, and purchase Medicare insurance plans.

We provide an unfiltered view of the entire range of options and prices available to you. To get a head start, visit SmartConnect's Benefits GPS: **gps.smartmatch.com/pareto**

Comparing Medicare and employer health insurance offerings can be frustrating. We do the work for you, all you need to decide is how much you'd like to save.

SmartConnect POWERED BY SMARTMATCH

ParetoHealth.

(855) 248-1648 | TTY: 711
Mon - Fri, 7:30 a.m. - 5 p.m. CT

The SmartConnect Process

Here's what concierge service from SmartMatch looks like:

Educate
The first step is to understand the details that could impact your enrollment, costs, and coverage. To get started, visit SmartConnect's Benefits GPS: gps.smartmatch.com/pareto

Connect
Next, we get to know you. We'll ask you some questions about your health insurance needs and preferences so we can head down the right path.

Evaluate
Then, a licensed insurance agent will provide you with the plan and carrier options available to you

Enroll
While our services are obligation-free, if you find something you like and you're ready to take action, we can enroll you on the spot.

Support
We have a team who is dedicated to your Medicare experience. They're available to answer questions, conduct policy reviews, and even help you work with the carrier when necessary.

Whether you're familiar with Medicare or just starting out, we're here to guide you confidently through your options.

Explore your options: gps.smartmatch.com/pareto

Husk Marketplace

Achieving optimal health and wellness doesn't have to be complicated or expensive. Access exclusive best-in-class pricing with some of the biggest brands in fitness, nutrition, and wellness with HUSK Marketplace.

YOUR LANDING PAGE:

Marketplace.huskwellness.com/paretohealth

Click on Activate Benefit to register for the program and unlock your discounts and exclusive offers. Be sure to use you Eligibility ID: P16340 to register.

Have questions? Reach out to our Customer Support team at customerservices@huskwellness.com or call 800-294-1500

As part of the HUSK Marketplace program, you are eligible for exclusive discounts on:

GYMS & FITNESS CENTERS

HUSK Marketplace members can access exclusive savings and flexible membership options to a variety of facilities. From national chains to specialty studios, HUSK has something for every workout.

HUSK NUTRITION

HUSK Nutrition provides evidence-based virtual health and nutrition programs. You will meet with a Registered Dietitian who will implement a complete 1-on-1 nutrition program specifically designed to answer your nutrition related questions, meet your health goals, individual needs and busy lifestyle.

HOME EQUIPMENT & TECH

Whatever your fitness level is, HUSK has exclusive equipment and wearable technology to help support you on your wellness journey. Whether you want to monitor an everyday activity or start a new fitness routine, find the best products and deals here.

ON-DEMAND FITNESS

Take advantage of all the benefits of group exercise classes in the comfort of your own home. HUSK's streaming membership options will take your wellness and workouts to the next level.

MENTAL HEALTH

We all need help sometimes. We all go through difficulties and struggles. HUSK Mental Health connects you with licensed therapists through technology. Our therapists empower you through guidance and support using evidence-based practices.

Spending Accounts

Health Savings Account (HSA)

Flores & Associates | 800-532-3327 | www.flores247.com

An HSA is a tax-advantaged account that you and your employer can put money into to save for future eligible medical, dental and vision expenses. HSA funds can be used to pay for eligible medical, dental and vision expenses. Unused money grows tax-free and can be invested with a minimum balance.

Any adult can contribute to an HSA if they are covered under an HSA-qualified "consumer driven health plan" (CDHP), do not have any other first-dollar medical coverage (including spouse's Medical FSA), are *not* enrolled in Medicare and are *not* claimed as a dependent on someone else's tax return.

If either the Base or Buy-Up PPO plans are elected, employee is not eligible to participate in a Health Savings Account (HSA) for 2025 since these two plans are not an CDHP.

Your HSA is always yours, no matter what. Even if you leave the company, change health plans or retire. Unused money grows tax-free and can be invested with a minimum balance.

HSA Funding and Contributions:

Your employer helps fund your HSA by contributing the amounts below:

- ✓ $150 for employee only coverage monthly
- ✓ $267 for employee + family coverage monthly

For 2025, your IRS contribution limits are:

- $4,300 individual and $8,550 family
- For those 55 and older, you can contribute an additional $1,000

Qualified Medical Expenses:

The IRS maintains a list of all eligible expenses. Common qualified expenses include acupuncture, ambulance services, dental treatment, contact lenses, doctor's fees and hearing aids.

View the complete list of qualified expenses at https://www.irs.gov/publications/p502/index.html.

Flexible Spending Accounts (FSA)

Flores & Associates | 800-532-3327 | www.flores247.com

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. You must enroll in your FSA every year to contribute. **All Flexible Spending Account Plans require a six-month waiting period for new hires.**

Your FSA plan options are shown below.

Healthcare FSA

- Allows employees participating in the Base and Buy-Up plans to pay for certain IRS approved dental and vision 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, 2026 to incur services and use your funds, with a claims filing deadline of August 31, 2026.

Limited Purpose FSA

- Allows employees participating in the CDHP to pay for certain IRS-approved dental and vision care expenses with pre-tax dollars.
- **The annual maximum contribution of $1,200 can be used for eligible dental and vision expenses only.**
- The annual minimum contribution to participate is $100
- **Use it or lose it – any funds not used by end of the year will be forfeited**
- Expenses cannot be reimbursed by both HSA and Limited Purpose FSA.
- Limited Purpose FSA reimbursements must be filed by 8/31 for the prior plan year.

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, 2026 to incur services and use your funds, with a claims filing deadline of August 31, 2026.

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.

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. CTS pays 65% of the employee-only coverage.

Dental

Benefits	Dental Plan Guardian Preferred In-Network	Dental Plan Guardian Preferred Out-of-Network
Calendar Year Deductible Individual / Family	$50 / $150	$50 / $150
Calendar Year Benefit Maximum	Covered at 100%	Covered at 100%
Preventive Services Exams, Cleanings, X-rays, Fluoride	Covered at 80%	Covered at 80%
Basic Services Fillings, Sealants, Extractions	Covered at 50%	Covered at 50%
Major Services Crowns, Dentures, Bridges, Endodontics, Periodontics	$1,500 + Max Roll-over	$1,500 + Max Roll-over
Orthodontia *Dependent children up to age 19*	Covered at 50%	Covered at 50%
Orthodontia Lifetime Maximum	$1,000	$1,000

Your Cost – Semi-Monthly Employee Deductions				
	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
Dental Plan	$6.35	$22.70	$30.00	$46.38

Vision

Benefits	Vision Plan Insight In-Network*
Exam	$10 copay
Frames	$150 allowance + 20% off balance
Lenses	$25 copay
Contact Lenses (conventional)	$130 allowance
	Frequency of Services
Exams	Once every 12 months
Frames	Once every 12 months
Lenses or Contacts	Once every 12 months

**Using a provider that is out of the network shown above may result in higher costs.*

Your Cost – Semi-Monthly Employee Deductions				
	Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
Vision Plan	$3.41	$7.30	$5.90	$9.79

Life & Disability

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

Basic Life and AD&D Insurance

Reliance Standard | +1 800-351-4357 | **www.reliancestandard.com**

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 Insurance

Reliance Standard | +1 800-351-4357 | **www.reliancestandard.com**

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 previously waived this coverage when first eligible, you may be prompted to complete health questions to enroll during this open enrollment period.

	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 Monthly Benefits Duration	6 weeks vaginal delivery 8 weeks C-section	N/A
Benefits Begin	15th day accident/illness	After 90 days
Maximum Benefit	$1,500 weekly	$6,000 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) 0.60 x (VOLUME) / 10 = Monthly Premium	(RATE) 0.75 x Monthly Income / 100 = Monthly Premium
Monthly Premium x 12 / 24 = Payroll Deduction	Monthly Premium x 12 / 24 = Payroll Deduction

Additional Benefits

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

Voluntary Life and AD&D Insurance

Reliance Standard | +1 800-351-4357 | www.reliancestandard.com

Voluntary Life

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 previously waived this coverage as a new hire, or would like to increase your current coverage by any amount, you may be prompted to complete health questions to enroll during this open enrollment period.

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

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 previously waived this coverage as a new hire, or would like to increase your current coverage by any amount, you may be prompted to complete health questions to enroll during this open enrollment period.

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.

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 previously waived this coverage as a new hire, or would like to increase your current coverage by any amount, you may be prompted to complete health questions to enroll during this open enrollment period.

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**

Employee Discount Program

BenefitHub is your home to save on thousands of items all through an easy-to-use, exclusive discount marketplace. BenefitHub negotiates the best discounts on the market for you and many of the offers include additional cash back to make it the best overall value to you. Not only saving you money, but time and hassle, too.

Getting started is easy! Create your account at carolinatherapyservices.benfithub.com using referral code ZXHMGH.

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

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

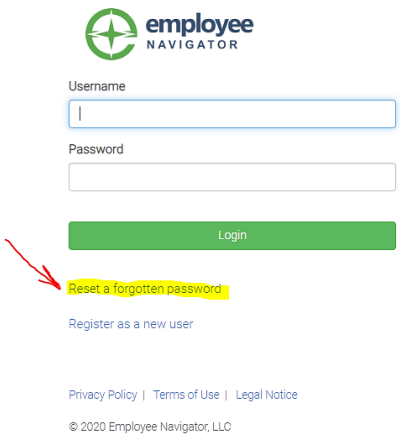
How to Enroll in your Benefits:

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 ***Insurance Benefits Online Enrollment Portal***

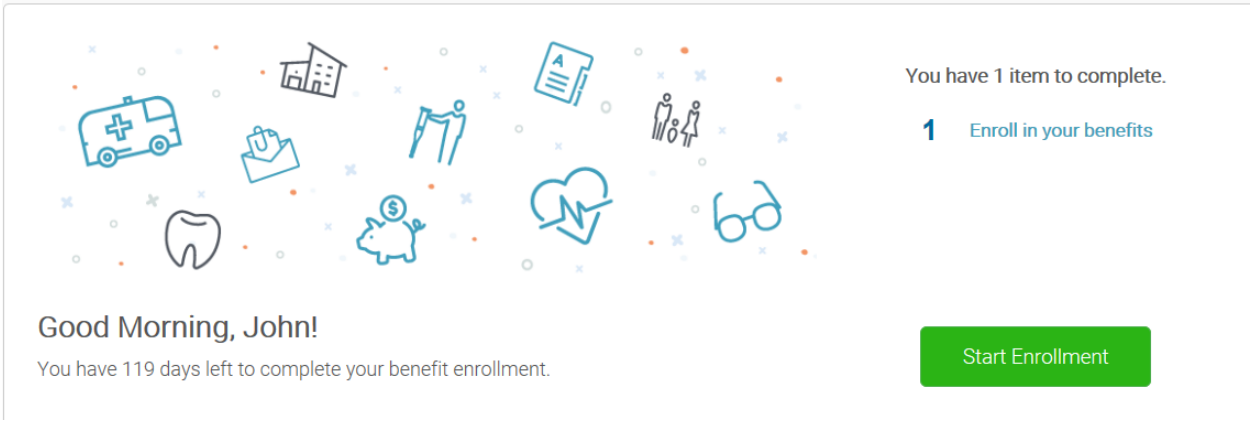
If you do not remember your login credentials, select "Forgot Username?" or "Forgot Password?" and follow the instructions in the email you receive.



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….

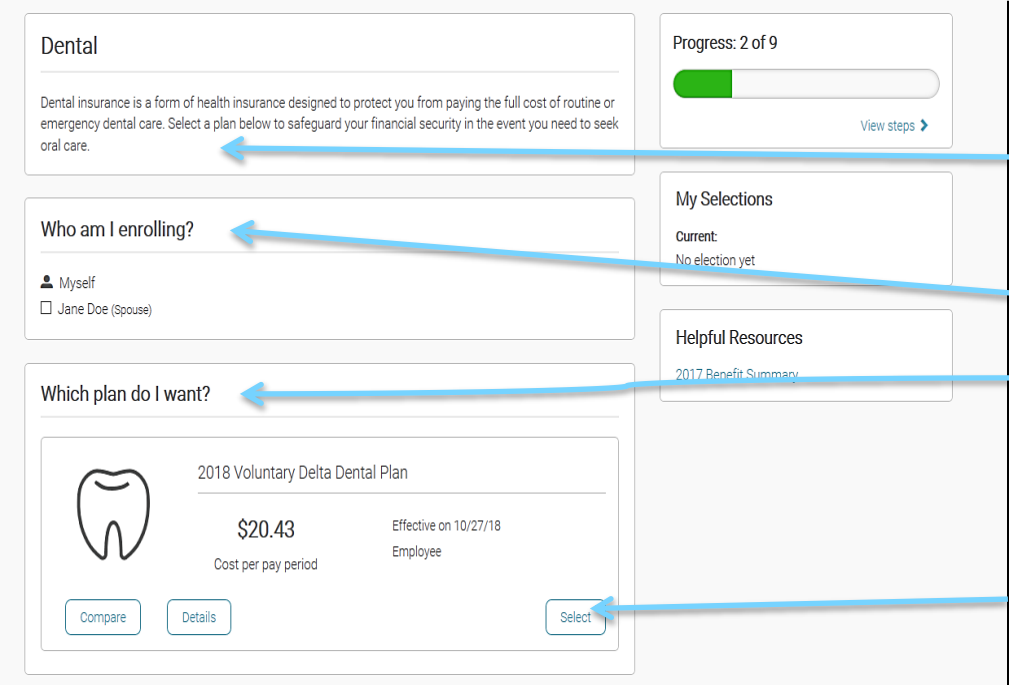
The first thing you will see is the welcome screen, example shown below. You will click the "Start Enrollment" Icon:



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

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).

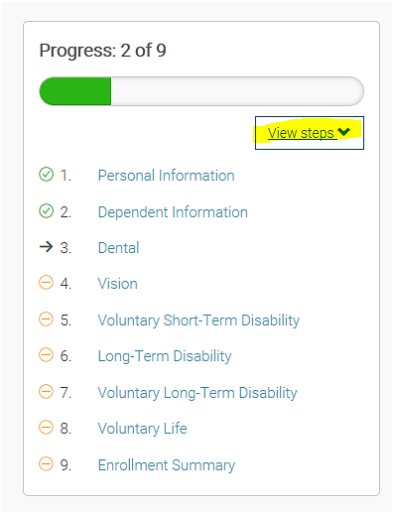
You can also click on the "compare" icon to show the plan(s) and cost for all tier levels… And the "details" icon to provide a brief benefits overview.

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

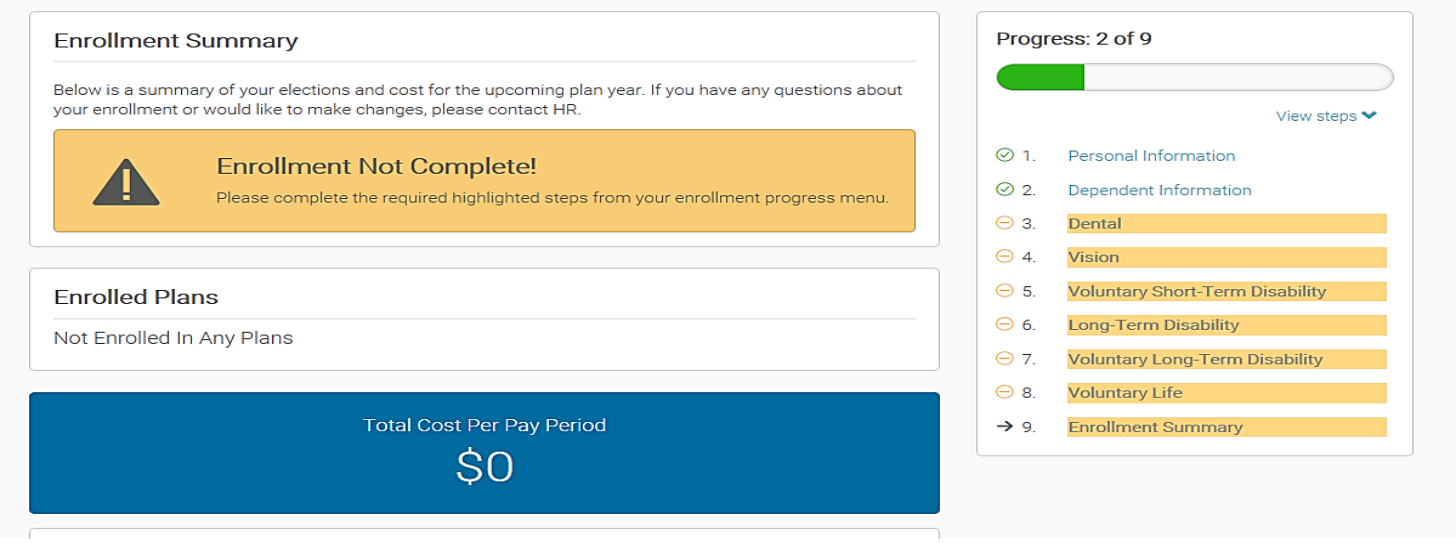
If you are not taking benefits, click "Don't want this benefit". It will ask you to provide a reason why you are not electing coverage.

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.

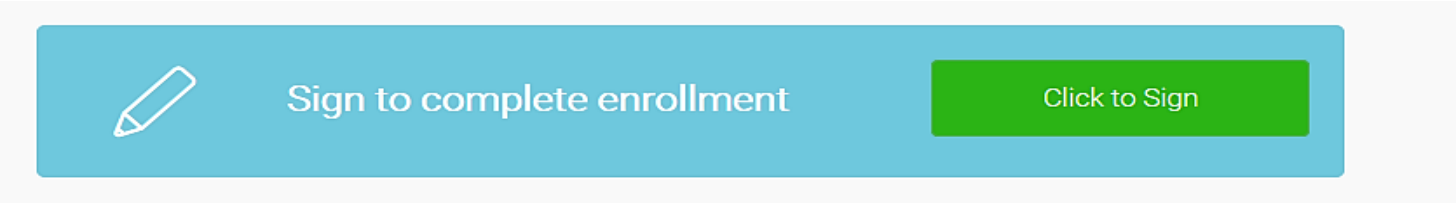


At the end, you will be able to view all elections and the cost for each line and you can print a copy for your records. If you have missed any steps, you will be notified which items need to be completed.



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.

Key Contacts

Benefit	Whom To Call	Phone Number	Email or Website
Medical	MedCost Network: MedCost	800-824-7406	www.medcost.com
Pharmacy	SmithRx	844-454-5201	member.mysmithrx.com
Telehealth	Teladoc	855-549-2214	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.guardiananytime.com Find a Provider: https://www.guardiananytime.com/fpapp/FPWeb/search
Vision	EyeMed Network: Insight	866-939-3633	Benefit Info: www.eyemed.com/member Find a Provider: https://eyedoclocator.eyemedvisioncare.com/member/en
Life, AD&D, Disability & Critical Illness	Reliance Standard	800-351-4357	www.reliancestandard.com
Flexible Spending Account (FSA / DCFSA / LPFSA)	Flores & Associates	800-532-3327	www.flores247.com
HSA	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

Carolina Therapy Services - Health and Welfare Benefits Annual Notices

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law for the 2025 - 2026 plan year.

Enclosures:

- Medicare Part D Creditable Coverage Notice
- Medicare Part D Non-Creditable Coverage Notice
- HIPAA Special Enrollment Rights Notice
- Women's Health Cancer Rights Act (WHCRA) Notice
- Newborns' Mothers Health Protection Act (NMHPA) Notice
- HIPAA Notice of Privacy Practices
- COBRA General Notice
- Your Rights and Protections Against Surprise Medical Bills
- Health Insurance Marketplace Coverage Options And Your Health Coverage – New Hires
- Children's Health Insurance Program (CHIP) Notice

Carolina Therapy Services, Inc. herein be referred to as "Employer"

MedCost will herein be referred to as "Medical Plan(s)"

Chastity Strickland, Human Resources Manager, will herein be referred to as "Plan Administrator"

You can contact your Plan Administrator at **+1 910-892-0027**

MEDICARE PART D CREDITABLE COVERAGE NOTICE

Important Notice From Your Employer About Your Prescription Drug Coverage And Medicare (Creditable Coverage Notice Delete Green Text If Applicable, Delete Whole Section If Not Applicable)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your Employer 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. Your employer has determined that the prescription drug coverage offered by the Medical Plan(or plans) 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 the Employer's coverage as an active employee, please note that your Employer 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 your Employer's coverage as a former employee.

You may also choose to drop your Employer's coverage. If you do decide to join a Medicare drug plan and drop your current Employer's 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 your Employer 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 your Employer 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 (+1800-633-4227). TTY users should call +1877-486-2048.

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 +1800-772-1213 (TTY +1800-325-0778).

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

Date:	6/1/2025
Name of Entity/Sender:	Carolina Therapy Services, Inc.
Contact--Position/Office:	Chastity Strickland
Address:	111 South Railroad Ave. Dunn, NC 28334
Phone Number:	+1 910-892-0027

MEDICARE PART D NON-CREDITABLE COVERAGE NOTICE

Important Notice From Your Employer About Your Prescription Drug Coverage And Medicare (NON-creditable coverage notice delete green text if applicable, delete whole section if not applicable)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your Employer 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. Your Employer has determined that the prescription drug coverage offered by the Medical Plan(or plans) 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 [Insert Name of 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 from your Employer. 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.

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 the Employer's coverage as an active employee, please note that your Employer 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 your Employer's coverage as a former employee.

You may also choose to drop your Employer's coverage. If you do decide to join a Medicare drug plan and drop your current Employer's 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?
Since the coverage under the Medical Plan (or plans) is not creditable you may pay a penalty to join a Medicare drug plan depending on how long you go without creditable prescription drug coverage. 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.

For More Information about This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. **NOTE:** You will 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 your Employer 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 (+1800-633-4227). TTY users should call +1877-486-2048.

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 +1800-772-1213 (TTY +1800-325-0778).

Date:	1/1/2025
Name of Entity/Sender:	Carolina Therapy Services, Inc.
Contact--Position/Office:	Chastity Strickland, Human Resources Manager
Address:	111 South Railroad Ave. Dunn, NC 28334
Phone Number:	+1 910-892-0027

HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE

If you are declining enrollment in your Employer's group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.
To request special enrollment or obtain more information, contact your plan administrator.

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.

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).

The Employer's Group Health 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 your Plan Administrator.

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.

The Employer sponsors 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 the Employer, 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 the Employer, 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 Employer's HIPAA Privacy Officer at:

Carolina Therapy Services, Inc.
Attention: HIPAA Privacy Officer
Chastity Strickland, Human Resources Manager
111 South Railroad Ave
Dunn, NC 28334
+1 910-892-0027

Effective Date

This Notice as revised is effective June 1, 2025.

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 ABC Company 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 +1877-696-6775, 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.

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 must pay for COBRA continuation coverage.

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

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

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

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

Your dependent children will become qualified 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: Chastity Strickland, Human Resources Manager.

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.

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.

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

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
Chastity 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.

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

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

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

You are protected from balance billing for:

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

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

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

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

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

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

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

If you believe you've been wrongly billed, 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 learn more about protections from surprise medical bills and for contact information for the state department of insurance or other similar agency/resource in your state to learn if you have any rights under applicable state law. Please click on your state in the map for contact information to appear.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE – NEW HIRE INFORMATION

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% 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.[2][3]

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.

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 +1800-318-2596. TTY users can call +1855-889-4325.

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.

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

[3] 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.

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:

Name of Entity/Sender:	Carolina Therapy Services, Inc.
Contact--Position/Office:	Chastity Strickland
Address:	111 South Railroad Ave. Dunn, NC 28334
Phone Number:	+1 910-892-0027

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 ordered to correspond to the Marketplace application.

**An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).*

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 **+1866-444-3272 (EBSA)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: +1855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: +1866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**

Website: http://myarhipp.com/ Phone: +1855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: +1916-445-8322 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: +1800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: +1800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: +1855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: +1877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: +1678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: +1678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: +1800-403-0864 Member Services Phone: +1800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: +1800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: +1800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: +1888-346-9562	Website: https://www.kancare.ks.gov/ Phone: +1800-792-4884 HIPP Phone: +1800-967-4660
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: +1855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: +1877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or +1855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: +1800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: +1800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: +1800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**

Website: https://mn.gov/dhs/health-care-coverage/ Phone: +1800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: +1573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: +1800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: +1855-632-7633 Lincoln: +1402-473-7000 Omaha: +1402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: +1800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: +1603-271-5218 Toll free number for the HIPP program: +1800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: +1800-356-1561 CHIP Premium Assistance Phone: +1609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: +1800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone:+1 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: +1844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: +1888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: +1800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: +1800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: +1855-697-4347, or +1401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: +1888-549-0820	Website: http://dss.sd.gov Phone: +1888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: +1800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: +1888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: +1800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs

	Medicaid/CHIP Phone: +1800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: +1800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: +1304-558-1700 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: +1800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: +1800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, 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