2025

Atlantic Care
Services

EMPLOYEE BENEFITS GUIDE

JANUARY 1, 2025 - DECEMBER 31, 2025

Introduction

Atlantic Care Services is committed to employee health and welfare. This commitment involves offering a comprehensive benefits program to help prepare you and your family for planned as well as unplanned life events. This guide provides a summary of the benefit options available to you.

Eligibility and Enrollment

All regularly scheduled employees working at least 30 hours per week are eligible for benefits. Coverage may also be elected for dependents, including your legal spouse and dependent children (up to age 26 or age 30) in certain situations. New employees are eligible for benefits the 1st of the month following 30 days from your hire date.

Once elections are made, they can only be changed annually during the Open Enrollment Period or if you experience an IRS recognized event. Examples include marriage, divorce, birth or adoption, change in spouse's employment status and change in eligibility. Should you or your family member experience an IRS recognized event, be sure to notify Human Resources within 30 days, so your coverage changes can be made.

Atlantic Care Services

Retirement Plan

401k video link to your enrollment materials, found here: [Atlantic Care Services (venrollment. com)]

Atlantic Care Services LLC

ATLANTIC CARE SERVICES 401K
025854

Your Plan's Highlights

READY TO ENROLL?

Text Enroll 401k to 72408

Eligibility

Invest in yourself and take advantage of your retirement savings plan benefit.

- You will be automatically enrolled into the Plan. A voluntary elective contribution of 3% will be deducted from your pay before-taxes and deposited in your retirement account in the Plan's default fund. For more information, including important dates, please refer to your Welcome Letter.

  If you decide now is not the right time to start saving, you can decline enrollment through My.ADP.com, Voice-Response System or ADP Mobile Solutions App. You can always change your mind and enroll later.
- 21 years of age on the next plan entry date
- You must have completed 3 month(s) of service by the next plan entry date

Contributions

You can take an active part in your financial wellness by contributing as much as you can to your retirement account. Your contribution option(s) are listed below:

- **Before-tax:** 1% to 90%
- **Roth:** 1% to 90%
- The total maximum amount you may contribute to the Plan is 90%.
- You have the option of electing a flat dollar amount to contribute each pay period.
- If you are considered a Highly Compensated Employee, the total maximum amount you may contribute to the Plan may be limited.
- The total dollar amount you may contribute to the Plan is $23,000.
- **Catch-up Contributions:** If you're 50 years of age or older, you may also make a catch-up contribution in excess of Internal Revenue Code or Plan Limits. This year, you can save an additional $7,500.

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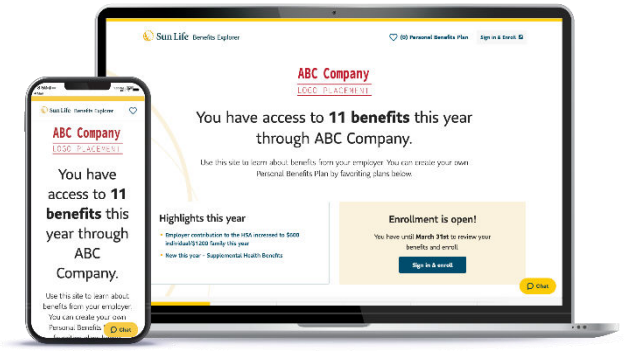
As we review your available benefit options, use the checklist to mark which benefits best suit your needs. You can review plan details and learn how to enroll in benefits by visiting the Benefits Explorer site.

- ☐ **Medical**
- ☐ **Dental**
- ☐ **Vision**
- ☐ **Accident**
- ☐ **Critical Illness**
- ☐ **Hospital Indemnity**



Visit Benefits Explorer today!

https://sunlife.co/AtlanticCareServicesLLC

Benefits Explorer is your digital benefit counselor

You can:

- Learn about the benefits your employer is offering
- Create your personal benefits plan
- Chat with a live benefits counselor or schedule an appointment for a virtual call

Read important plan provisions in your benefit highlighter

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York. Prepaid dental products are provided and administered by Sun Life Assurance Company of Canada (SLOC), and are provided by prepaid dental companies, affiliated with SLOC in all states, except New York. Prepaid dental companies are Denticare of Alabama, Inc., United Dental Care of Arizona, Inc., UDC Dental California, Inc., United Dental Care of Colorado, Inc., Union Security DentalCare of Georgia, Inc., United Dental Care of Missouri, Inc., Union Security DentalCare of New Jersey, Inc., United Dental Care of New Mexico, Inc., UDC Ohio, Inc., United Dental Care of Texas, Inc., and United Dental Care of Utah, Inc. In New York, group insurance policies are underwritten by Sun Life and Health Insurance Company (U.S.) (Lansing, MI). In New York, prepaid dental products are provided and administered by Sun Life and Health Insurance Company (U.S.) (SLHIC) (Lansing, MI). Product offerings may not be available in all states and may vary depending on state laws and regulations.

 MPFL-1934-a #1194288052 08/23 (exp. 08/25)

As you know, your benefits are an important part of your overall compensation. Employee Navigator provides a simple and convenient online benefits enrollment system that will make enrollment fast and easy! After completing your enrollment, you may access Employee Navigator throughout the year to find important information such as benefit summaries, coverage selected and contribution amounts.

Getting Started

Using your computer, tablet or phone
go to the benefits website:

https://www.employeenavigator.com/benefits/Account/Login

- You will then need to enter the following information:
    - First Name and Last Name
    - Company Identifier: **AtlCar2023**
    - PIN (Last 4 digits of your Social Security Number)
    - Birth Date (MM/DD/YYYY)
    - Click “Next” and create a Username (email recommended) and Password
    - If you have already registered, simply click “Login”. If you are registered and have forgotten your login, please click on the “forgot username / forgot password” option on the screen and follow the instructions.

Enrollment

Once logged in, you will go through a series of screens – each screen takes only a few moments to complete. All of your benefit elections will be displayed on a cost “per paycheck” basis based on your specific benefit options.

Important: Be prepared to enter birth dates and social security numbers for yourself and all dependents. Emergency contacts and life insurance beneficiary information are also needed.

Step 1:

Review and update your personal information

- Click “Profile” which will take you to Profile Overview. Review the first 2 sections, Personal Information and Dependents. It is important that all the fields be competed. If the information needs updating or is incomplete, click on “Edit” and enter necessary revisions.

Step 2:

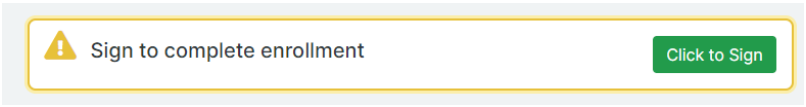
Start your benefits enrollment

- From the Profile page, select the “Home” icon next to your name at the top of the screen. On the Home page click on “Start Enrollment”.

Step 3:

Complete your benefits enrollment

- The next few screens will present benefit selections by type (Medical, Dental, Vision, Life Insurance, etc.). Each page will show you the benefits you are eligible for along with a cost “Per Paycheck”. You will need to select or decline each benefit type, then save and continue to the next benefit. If you are covered under a separate medical plan please indicate what type under your decline reason.
- When asked for beneficiary information, it is important that you complete this section by selecting a dependent(s) or adding a designated person and indicating a benefit percentage for each.
- The last section shows your benefit choices and costs for your review. If you wish to make changes, click the “Edit” button to update your selections. Click “Continue” and you will be given an opportunity to print a Benefits Confirmation Statement. You may also access your enrollment and plan information at any time by logging into Employee Navigator.
- Last step is selecting “Click to Sign” to submit



When Can I Enroll?

New Hires

You must enroll within 30 days of your eligibility date. If you fail to enroll within your 30-day window, you will be required to wait until Open Enrollment to enroll or make changes. Please complete your online enrollment prior to your effective date.

Enrollment Changes

If you experience a recognized event during the plan year, please reach out to Human Resources and then log into Employee Navigator and request the change within 30 days of the event. If you fail to do so, you will be required to wait until Open Enrollment to enroll or make changes.

Scan to view the Employee Navigator How-To video

If you need assistance with your enrollment, please contact your Human Resources Department.

MEDICAL BENEFITS

Curative	EPO	PPO		PPO Max	
	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network
Network	First Health	First Health	N/A	First Health	N/A
Deductible (Ded.) Individual / Family	Baseline: $0 / $0 Non-Baseline: $5,000 / $10,000	Baseline: $0 / $0 Non-Baseline: $5,000 / $10,000	Non-Baseline: $10,000 / $20,000	Baseline: $0 / $0 Non-Baseline: $5,000 / $10,000	Baseline: $0 / $0
Coinsurance Carrier / Member	Baseline: 100% / 0% Non-Baseline: 80% / 20%	Baseline: 100% / 0% Non-Baseline: 80% / 20%	Non-Baseline: 50% / 50%	Baseline: 100% / 0% Non-Baseline: 80% / 20%	Baseline: 100% / 0%
Virtual Visit / Telehealth	$0 Copay	$0 Copay	Non-Baseline: Ded. + 50% Coins.	$0 Copay	Baseline: Ded. + 20% Coins.
Primary Physician Service	Baseline: $0 Copay Non-Baseline: Ded. + $25 Copay	Baseline: $0 Copay Non-Baseline: Ded. + $25 Copay	Non-Baseline: Ded. + $50 Copay	Baseline: $0 Copay Non-Baseline: Ded. + $25 Copay	Baseline: Ded. + $50 Copay
Specialist Physician Service	Baseline: $0 Copay Non-Baseline: Ded. + $50 Copay	Baseline: $0 Copay Non-Baseline: Ded. + $50 Copay	Non-Baseline: Ded. + $100 Copay	Baseline: $0 Copay Non-Baseline: Ded. + $50 Copay	Baseline: Ded. + $100 Copay
Preventive Care	$0 Copay	$0 Copay	Non-Baseline: Ded. + $50 Copay	$0 Copay	Baseline: Ded. + $50 Copay
Inpatient Hospitalization	Baseline: $0 Copay Non-Baseline: Ded. + 20% Coins.	Baseline: $0 Copay Non-Baseline: Ded. + 20% Coins.	Non-Baseline: Ded. + 50% Coins.	Baseline: $0 Copay Non-Baseline: Ded. + 20% Coins.	Baseline: Ded. + 20% Coins.
Outpatient Surgery	Baseline: $0 Copay Non-Baseline: Ded. + 20% Coins.	Baseline: $0 Copay Non-Baseline: Ded. + 20% Coins.	Non-Baseline: Ded. + 50% Coins.	Baseline: $0 Copay Non-Baseline: Ded. + 20% Coins.	Baseline: Ded. + 20% Coins.
Emergency Room	Baseline: $0 Copay Non-Baseline: Ded. + 20% Coins.	Baseline: $0 Copay Non-Baseline: Ded. + 20% Coins.	Non-Baseline: Ded. + 20% Coins.	Baseline: $0 Copay Non-Baseline: Ded. + 20% Coins.	Baseline: Ded. + 20% Coins.
Urgent Care Services	Baseline: $0 Copay Non-Baseline: Ded. + 20% Coins.	Baseline: $0 Copay Non-Baseline: Ded. + 20% Coins.	Non-Baseline: Ded. + 50% Coins.	Baseline: $0 Copay Non-Baseline: Ded. + 20% Coins.	Baseline: Ded. + 20% Coins.
Diagnostic Lab & X-Ray	Baseline: $0 Copay Non-Baseline: Ded. + 20% Coins.	Baseline: $0 Copay Non-Baseline: Ded. + 20% Coins.	Non-Baseline: Ded. + 50% Coins.	Baseline: $0 Copay Non-Baseline: Ded. + 20% Coins.	Baseline: Ded. + 20% Coins.
Advanced Imaging	Baseline: $0 Copay Non-Baseline: Ded. + 20% Coins.	Baseline: $0 Copay Non-Baseline: Ded. + 20% Coins.	Non-Baseline: Ded. + 50% Coins.	Baseline: $0 Copay Non-Baseline: Ded. + 20% Coins.	Baseline: Ded. + 20% Coins.
Prescription Medications	Publix Rx Only Tier 1 (Preferred): Baseline: $0 Copay Non-Baseline: Ded. + $50 Copay Tier 2 (Non-Preferred): Baseline: $50 or $250 Copay Non-Baseline: Ded. + $100 Copay	Publix Rx Only Tier 1 (Preferred): Baseline: $0 Copay Non-Baseline: Ded. + $50 Copay Tier 2 (Non-Preferred): Baseline: $50 or $250 Copay Non-Baseline: Ded. + $100 Copay	Non-Baseline: Ded. + 50% Coins.	Any Pharmacy Tier 1 (Preferred): Baseline: $0 Copay Non-Baseline: Ded. + $50 Copay Tier 2 (Non-Preferred): Baseline: $50 or $250 Copay Non-Baseline: Ded. + $100 Copay	Baseline: Ded. + 20% Coins.
Mail-Order (90 Day Supply)	3 X Retail Copay	3 X Retail Copay	N/A	3 X Retail Copay	N.A
Out-of-Pocket Max Individual / Family	Baseline: $0 / $0 Non-Baseline: $7,500 / $15,000	Baseline: $0 / $0 Non-Baseline: $7,500 / $15,000	Non-Baseline: $15,000 / $30,000	Baseline: $0 / $0 Non-Baseline: $7,500 / $15,000	Baseline: $7,500 / $15,000

*Extra costs could arise for services after admittance to the Emergency Room.

MEDICAL DEDUCTIONS Weekly	EPO	PPO	PPO Max
Employee	$72.62	$95.15	$128.13
Employee + Spouse	$287.79	$339.16	$414.36
Employee + Child(ren)	$246.78	$291.84	$357.81
Employee + Family	$422.54	$494.64	$600.19

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Jumpstart your health with a Baseline Visit

At Curative, we're committed to helping our members get the most out of their health plan from day one. Curative members are invited to participate in a Baseline Visit to help take the guesswork out of their health. By completing a visit in the first 120 days of plan effective date, members continue with $0 out-of-pocket costs for in-network care and preferred prescriptions.

It is completely confidential and won't impact your premiums or costs in any way.
98% of health plan participants complete the Baseline Visit.

Here's what you get with your virtual visit:

Say hello to your Care Navigator

- Learn all about your new plan and benefits
- Get support on finding in-network care and 24/7/365 telemedicine
- Transfer prescriptions to an in-network pharmacy
- Get connected to programs to help reach your health goals

Meet with a clinician

Members who meet with a clinician can discuss any healthcare goals or needs.

Unlock $0 in-network care

After your Baseline Visit, continue to get $0 deductibles and copays for all in-network care and preferred prescriptions.

Care Navigator

Each Curative plan member is paired with a Care Navigator who will be their first point of contact to the plan and follow-up post-Baseline Visit. They provide resources and guidance on maximizing Curative benefits, find in-network care, and help navigate an often complex health system.

Members can reach them by phone, text or email. Plus there's 24/7/365 member services support.

Your Baseline Visit is our investment in you. Enroll in Curative today and experience a health plan you'll love to use. More information: curative.com/faq/prospective-members.

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You're now a Curative member. Congrats!

We've made it official. So, what happens next?

1. Register your account

To get started, you'll receive a Curative welcome email where you can register for the member portal. Keep an eye out for this email to arrive in your inbox 1-2 days before your effective date.

Once your effective date begins, your digital member ID card will be ready for immediate use through the member portal. You can expect your physical member ID card to arrive within two weeks of your effective date.

Through the Member Portal, you can:

- Download, print, and request a replacement ID card
- View your pharmacy and care benefits
- Update personal information
- Register and connect to virtual urgent care

Visit the member portal at **health.curative.com**.

2. Sign-up for Virtual Urgent Care

When you register for the member portal, you'll also receive a sign-up email for virtual urgent care. Members in Texas will have access to **NormanMD**, and if you're outside Texas, you'll be able to use **Teladoc**. Through both partnerships, you can access virtual urgent care **24/7/365**.

- Access family doctors and pediatricians
- Messaging, audio, or video chat
- Prescriptions available to your door
- $0 copay

Learn more at **curative.com/virtual-urgent-care**.

3. Schedule your Baseline Visit

As a Curative member, you and your dependents over the age of 18 year-old, will get the most out of your health plan by completing a Baseline Visit (mobile/in-person visits available in select locations). Think of a Baseline Visit as an individualized appointment that focuses on your complete well-being. By completing your visit within 120 days of your plan effective date, you'll also keep your $0 copays and $0 deductible for in-network care and preferred prescriptions. For more info on the Baseline Visit, go to **curative.com/baseline**.

Questions? We're here for you. Contact Member Services at 855-4-CURATIVE (855-428-7284)

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Get care when you need it with Curative

Find a provider near you

Use our network search tool to find your go-to care providers and pharmacies near you at curative.com/providers

Provider search tips

- Search using the provider, facility, or pharmacy name.
- Use filters to select a care type to get the most accurate results.
- Enable location services or add your location in the search box to populate providers or pharmacies near you.

Traveling? Simply enter your travel location to find in-network providers in that area (only within the U.S.)

- **When filtering**, be sure to select your language preference and check the box reading "Accepting new patients" when looking for a new provider.
- **When searching** for a primary care provider, note that providers may be found under "family medicine" or "internal medicine."

Don't see a retailer?

*If you are out-of-area for our preferred in-network pharmacies, go to the provider search tool at curative.com/providers or contact Member Services at 855-428-7284.

Free delivery from Curative Pharmacy — no more waiting in line. Overnight and same-day delivery options are available in select locations. Check your local pharmacy retailers for delivery options.

Questions?
Call Member Services at 855-428-7284

Meds made simple.

Transferring prescriptions? Follow these simple steps below or go to health.curative.com/pharmacy

Step 1

Get your Baseline Visit within 120 days of your plan's effective date to unlock $0 coverage for in-network care and preferred prescriptions.

Step 2

Visit an in-network provider who prescribes a preferred medication.

Step 3

Use the preferred in-network pharmacies.

Our in-network pharmacies include all locations across the United States and include: Curative, H-E-B, ACME, Albertsons, Amigos, Carrs, Haggen, Jewel-Osco, Market Street, MedCart, Pavillions, Randalls, Safeway, Sav-on, Tom Thumb, United, Vons, Publix, Brookshire Brothers.

For more information on what's covered, prescription transfers, and updates on Curative Pharmacy's Expansion, visit curative.com/pharmacy

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Pharmacy Operational Overview

No Copays for Preferred Prescriptions. No... Really.

Optimize the pharmacy benefit of $0 copay on preferred medications. **In fact, 97% of conditions are covered on our preferred list.**

1. Get your Baseline Visit within 120 days of your start date.

2. Visit an in-network provider who prescribes a preferred medication.

3. Use our preferred in-network pharmacies.

Preferred
Consists of generic, biosimilars, select brand and specialty medications.

$0 Copay*

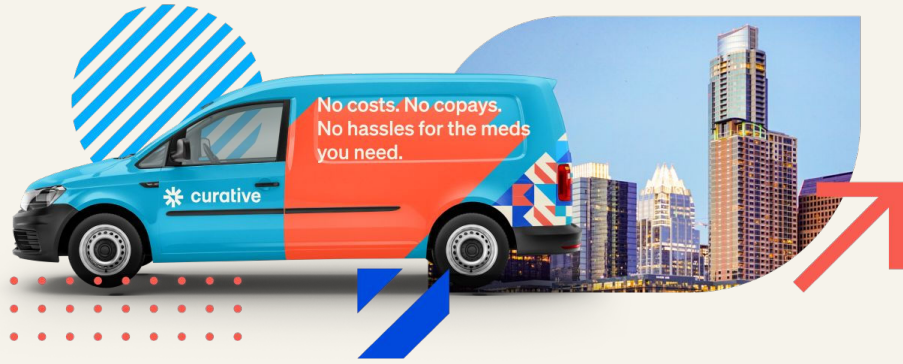
$50/$250 Copay*

Non-Preferred
Consists of lower value generics, brands, and specialty medications.

Affordability = Adherence

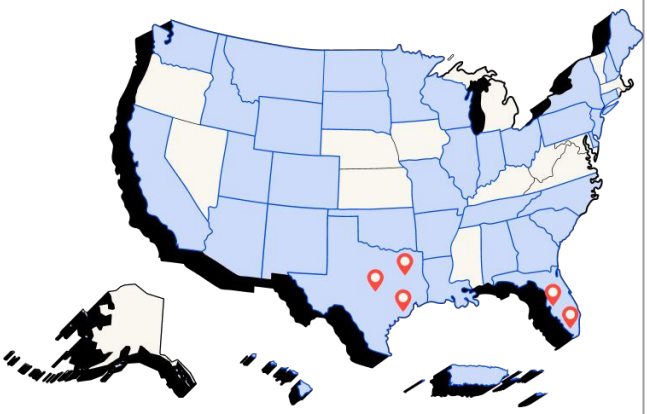
	Curative Adherence	Average PBM Adherence
Hypertension - CCB	93.2%	76.5%
Hypertension - RASA	91.5%	79.4%
Diabetes	94.9%	75.7%
Cholesterol - STATIN	94.3%	75.7%
COPD - LABA	92.2%	41.2%

Your Pharmacy Choice:
From Exclusive to Everywhere



Pharmacy Network

Our in-network pharmacies include all locations across the United States.

Curative Pharmacy	National Pharmacy Options
	**Albertsons Pharmacy Companies:** Acme Pharmacy, Albertsons Pharmacy, Albertsons Market Pharmacy, Amigos Pharmacy, Carrs Pharmacy, Haggen Pharmacy, Jewel-Osco Pharmacy, Market Street Pharmacy, Pavilions Pharmacy, Randalls Pharmacy, Safeway Pharmacy, Say-On Pharmacy, Star Market Pharmacy, Shaws Pharmacy, Tom Thumb Pharmacy, United Coalition Pharmacy, United Pharmacy, Vons Pharmacy Publix Pharmacy H-E-B Pharmacy ***Out of standard service area: CapRx Wrap Network* includes major partners, such as Walgreens, CVS, RiteAid, and Walmart***

Don't see a retailer? Never fear. If a member is not near an in-network retail pharmacy and not in range of the Curative Pharmacy, Curative will use find an alternative custom option using the CapRx network to each person that is convenient.

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Redefining Pharmacy, the Curative Way

We made our own Curative Pharmacy simple. Serving only Curative members, we're the overly attentive partner in health members never knew you needed.

Next Day Delivery
Next-day delivery available in most states and actively working to add the remaining.

Flexible Delivery Points:
Home, workplace, or wherever a member might be.

Two-Way Text Capabilities:
Members can communicate directly with our pharmacy about new medications, or refills.

Making it Simple
Curative Pharmacy will work with doctors, previous pharmacies and anyone in between to make sure members are covered every step of the way.

Regular Check-ins:
We stay in touch and make sure medications are going well.

One-Stop-Shop
Members with multiple medications can be serviced by one easy-to-use pharmacy.

Trusted Tips
We know the cost-effective choices to help members make the most of their benefits.

Members can sign-up 24/7/365 for the Curative Pharmacy through member services: 855-4-CURATIVE.

**Every Curative member can qualify for the $0 deductible or copay for in-network care. Just complete a Baseline Visit in your first 120 days. See curative.com to learn more. Curative Insurance Company PPO.BR230921-1*

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Virtual Urgent Care and Therapy for $0 with Teladoc

Access on-demand virtual urgent care and therapy from the comfort of home with **Teladoc**. Say goodbye to long wait times.

24/7 Virtual Care

Access doctors anytime, anywhere, through phone or video.

Expert Medical Guidance

Receive accurate diagnoses and treatment options from healthcare professionals, not the internet.

Virtual Mental Health Support

Connect with licensed psychologists, psychiatrists, and therapists to address your mental health and emotional well-being.

Prescriptions and Lab Tests

Get the medications and tests you need without leaving your home.

$0 Copay

Enjoy virtual urgent care and therapy visits without out-of-pocket expenses.

Get treated for conditions and symptoms including:

- Flu
- Cold
- Sore throat
- Bronchitis
- Cough
- Pink eye
- Arthritis
- Back ache
- Rash
- Allergies
- Sinus problems
- Skin conditions

Access remote mental health support to help with:

- Anxiety, stress, feeling overwhelmed
- Negative thought patterns
- Depression
- Not feeling like yourself
- Not wanting to get out of bed
- Relationship conflicts
- Marriage and relationship issues
- Trauma and PTSD
- Mood swings
- Medication management (Psychiatry only)

To sign up, **visit teladoc.com**, and select **register now.** (No code needed)

Questions on Teladoc? Contact 1-800-835-2362

**Teladoc is available to Curative members residing outside of Texas. Members in Texas can access virtual urgent care through NormanMD.*

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Curative Guide to $0 Care*

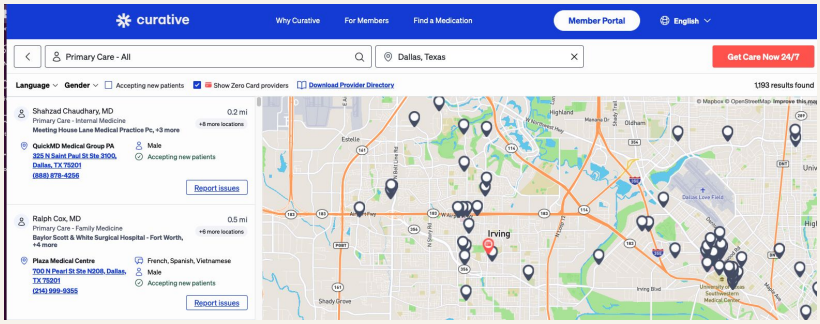
Two cards. One goal. Zero dollars.

We guarantee $0 copays and deductibles for covered services provided by any doctor in our search.* There are two options to provide payment covered by Curative: 1) insurance billing using the Curative Member ID Card and 2) cash pay using our unique Curative Zero Card.

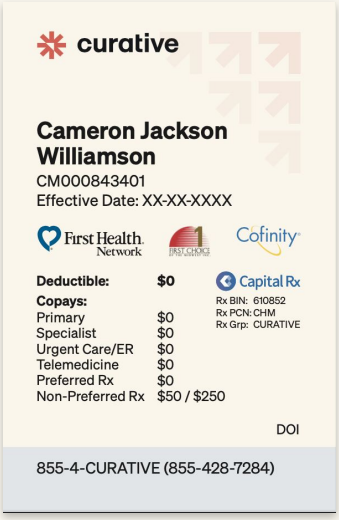
Either way, you don't pay. Here is a quick and easy guide to $0 care.

Start here
Provider Search

All clinicians shown at curative.com/providers have $0 out-of-pocket costs for covered services.

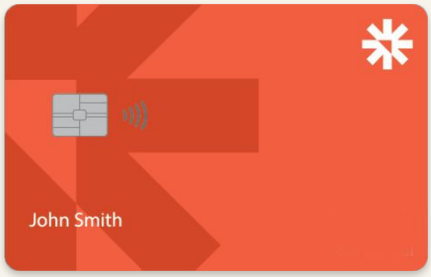


Option 1
Member ID Card



Use the Curative Member ID Card first if the provider shows in our search.

Option 2
Curative Zero Card



Use the Curative Zero Card for any provider that shows as Zero Card in our search. Tell the front desk you will **pay the cash price** and hand over your Zero Card. Think of it as a payment card with no impact on credit. It can be used for office visits, urgent care, behavioral health, and certain services without hospital stays. It does not include medications, labs and non-covered benefits.

More $0 Providers: It's easy to nominate a provider for the Zero Card. Fill out a quick form cur.tv/nominate or call Member Services 855-428-7284.

Backup: If a provider appears in our search but does not take your Member ID Card for any reason or tries to charge a copay, say you'll pay cash instead and hand over your Curative Zero Card.

Members must be 18 years and older to use the Curative Zero Card and complete their Baseline Visit in the first 120 days of their plan start date to maintain $0 out-of-pocket costs. Curative Zero Card Visa® Commercial Credit cards are issued by Celtic Bank. Additional Terms & Conditions can be found in your Member Portal Account at health.curative.com.

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Broker and Employer

Commonly Asked Questions

Why does Curative have two different cards?
Our dual-card system allows more provider choice and less friction with no out-of-pocket costs for members who complete a Baseline Visit within the first 120 days. Providers will either bill later through insurance or take cash pay at the point of service. Either way, members pay $0 copays, $0 deductibles and Curative foots the bill.

- **The Curative Member ID Card** is the traditional route – providers bill through claims and Curative pays those claims.
- **The Curative Zero Card** is on-the-spot payment – it allows members to see providers that don't take the Member ID Card for any reason. They may not take insurance at all, like many mental health providers, or they may not recognize Curative as contracted but do appear in the provider search. Some providers are designated as Zero Card only and you should show the Zero Card first.

Why do you guarantee your provider search?
Provider searches are known throughout the industry to be inaccurate and outdated, but we believe members shouldn't have to pay the price. If the provider is in the directory and it is for a covered service, we will cover it with one card or the other.

What if a member has a favorite doctor and doesn't see them in the provider search?
Members can easily nominate providers for the Curative Zero Card. All they need to do is fill out a quick form at cur.tv/nominate or call Member Services. Members will hear back within five business days, and, if approved, can see that provider immediately using the Zero Card. Curative will then consider adding that provider to the network, but that can take a much longer time.

What do providers think of Curative Zero Card?
Many providers accept cash pay as an option and appreciate the ease and ability to get paid on the spot instead of dealing with insurance billing. The cash price is set by the provider.

Who is eligible to use the Curative Zero Card?
In the first 120 days, Zero Card is available to all members 18 and over. For the remainder of the year, Zero Card is only available to members 18 and over who completed their Baseline. Cardholders can use it for themselves or their covered dependent.

Are the cardholders responsible for any expenses? Does it impact credit?
Members will not owe anything as long as the provider is Zero Card approved, as marked in the provider search, and it is used for a covered service. Curative pays for all approved charges and member credit is not impacted.

What services does the Zero Card cover? Does it include prescriptions or labs?
The Curative Zero Card covers office visits, urgent care, and services without hospital stays. The Curative Zero card can also be used for behavioral health sessions where many clinicians don't accept insurance. Expenses for prescriptions, lab work, and non-covered plan benefits cannot be charged to the Curative Zero Card. Prior authorization requirements still apply.

*Members must complete Baseline in the first 120 days of plan start date to continue with $0 copays and deductibles.
The Member ID Card and Curative Zero Card can only be used for services outlined in the benefit booklet. Prior authorizations still apply.
PPO Max can go out-of-network for $0 deductible but may receive a balance bill.

curative

Elevate Your Workforce with Curative Member Services:

At Curative, we've **revolutionized** the way our member services interact, providing a **simple**, **in-house and interactive experience** that puts **employees' health in their own hands.**

A High-Touch, Personalized Approach:	Enhanced Provider & Pharmacy Selection:	Empowering Employees with Online Tools:	24/7 Member Services at Your Fingertips:	Streamlined Prescription Management:
Say goodbye to impersonal interactions and hello to a designated Care Navigator for each member, providing personalized support every step of the way.	Whether it's finding an in-network specialist or locating a nearby participating pharmacy, we can make the process simple and stress-free	From log-in access to helping update contact information and scheduling appointments, we provide assistance navigating our user-friendly member portal	Health concerns can arise at any time. That's why we are available 24/7/365 to help members with coverage questions. **If you are experiencing a medical emergency dial 911 or go to your nearest emergency center*	Transferring prescriptions and verifying coverage can be a hassle; we are here to alleviate that burden, whether it's checking if a specific medication is covered or understanding tier levels.

Care Navigators vs Member Services

Care Navigators
At the Baseline Visit, members receive a Care Navigator, their go-to source for all things Curative, and the direct point of contact if there are questions or concerns about coverage.

Member Services
Members can access our Member Services 24/7/365 for assistance. Our Member Services team is an excellent resource for any questions that may arise.

Member Services are available to assist with:

- Finding and verifying in-network providers
- Locating a participating pharmacy
- Transferring prescriptions
- Medication coverages & tiers
- Member Portal access and logging in
- Scheduling a Baseline Visit
- Updating member contact information
- Prior Authorizations
- Claims Processing and denial resolution

Say goodbye to frustrations and hello to a better healthcare experience, where employees are at the center of their own healthcare journey.

Available 24/7/365 | 855-428-7284 | health@curative.com

KNOW WHERE TO GO

71%

of Emergency Room visits are unnecessary or could have been avoided

Emergency Room

- Chest Pain
- Abdominal Pain
- Stroke
- Severe Head Injury
- Major Trauma
- Compound Fractures
- Knife or Gunshot Wounds
- Moderate/Severe Burns
- Poisoning
- Seizures or Loss of Consciousness
- Head, Neck or Back Injuries
- Uncontrollable Bleeding

AVERAGE WAIT TIME IS 2 HOURS

OPEN 24/7

Virtual Visits

- Cold, Flu or Fever
- Cough
- Rashes
- Bronchitis
- Sore Throat
- Headache/Migraine
- Pink Eye
- Poison Ivy/Oak
- Sprains & Strains
- Sinusitis
- Allergies
- Urinary Tract Infections

FROM THE COMFORT OF YOUR HOME

OPEN 24/7

Walk-In Clinic

- Allergies
- Bladder Infections
- Cold Sores
- Ear Infections
- Eye Infections
- Immunizations
- Sinus Infections
- Strep Throat
- Colds
- Head Lice
- Diabetes
- Blood Pressure Management

WALK-IN OR SCHEDULE APPOINTMENT

WEEKEND HOURS AVAILABLE

Urgent Care

- Strains, Sprains, or Breaks
- Infections
- Mild Burns
- Diagnostic Services (X-Rays, Lab tests)
- Minor Broken Bones (Toes, Fingers)
- Severe Sore Throat or Cough
- Skin Rashes or Infections
- Vomiting, Diarrhea or Dehydration
- Controlled bleeding, cuts that require stitches

TYPICALLY A 30 MINUTE WAIT

EXTENDED HOURS ON WEEKENDS

5 WAYS TO CUT DOWN YOUR HEALTHCARE COSTS

1 ALWAYS USE IN-NETWORK PROVIDERS, WHENEVER POSSIBLE

An In-Network provider is a provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates. In general, if you visit an In-Network provider, you will get your healthcare at a lower price.

2 ASK THE RIGHT QUESTIONS

- Why is this treatment necessary?
- How much will my treatment cost?
- Can I be treated another way that is equally effective but less costly?

3 KEEP PRESCRIPTION COSTS DOWN

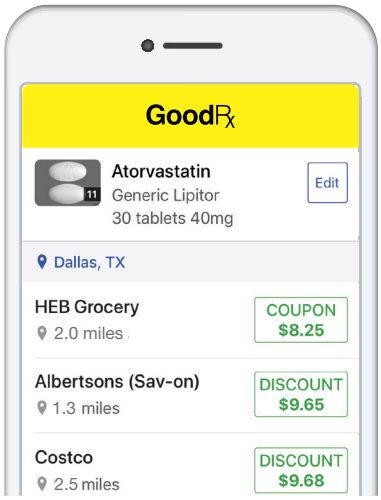
- Shop around at local pharmacies to find the best price on your prescription.
- Ask your doctor about generic or over-the-counter drug alternatives to brand name prescriptions.
- Look into discount prescription programs.

4 PRACTICE PREVENTION

In its broadest definition, prevention includes a healthy lifestyle, exercise, diet and other similar efforts. When preventive care services like physical examination, screenings and immunizations are combined with a lifestyle that is focused on wellness,significant savings can be achieved.

5 TAKE CONTROL OF YOUR HEALTHCARE

Learn to shop for value when it comes to healthcare. Ask your doctor the right questions, conduct price comparisons, read reviews, and review all the medical bills carefully. With a little effort, you can ensure that you are getting the best value for your healthcare dollars.



Save up to 80% on your prescriptions.

GoodRx

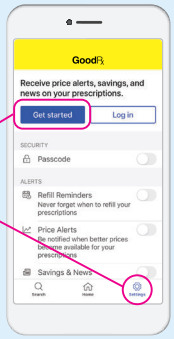
Search, compare and save with the **FREE** GoodRx app.

Download on the App Store

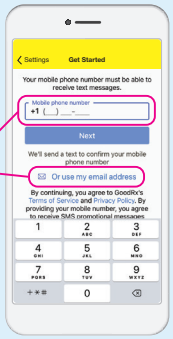
GET IT ON Google Play

It's easy to create your free GoodRx account:

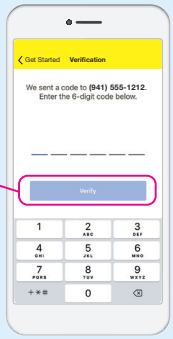
Step 1
Download the GoodRx app, go to Settings and select ***"Get started."***



Step 2
Enter your mobile phone number or email address.



Step 3
You will receive a code via email or text. Enter it in the area provided and select ***"Verify."***



Scan this QR code or visit **goodrx.com/mobile** to download the **FREE** GoodRx app.

Accepted at 70,000+ U.S. pharmacies, including:

CVS pharmacy · Walmart · Walgreens · Kroger · RITE AID

The FREE GoodRx app allows you to:

Search and compare to find the lowest prices for your prescriptions at local pharmacies.

Get free coupons — save up to 80% on your prescriptions.

Save your prescriptions to track prices and get notified with savings alerts.

DENTAL BENEFITS

Sun Life	Basic		Enhanced	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Individual / Family	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Maximum Annual Benefit Calendar Year	$1,000	$1,000	$1,500	$1,500
Preventive Care	100%	100%	100%	100%
Basic Services	80%	80%	80%	80%
Major Services	50%	50%	50%	50%
Implants	50%	50%	50%	50%
Orthodontia Services	50% Up to Age 26 Lifetime Maximum: $1,000	50% Up to Age 26 Lifetime Maximum: $1,000	50% Up to Age 26 Lifetime Maximum: $1,000	50% Up to Age 26 Lifetime Maximum: $1,000

*Plans with Out-of-Network benefits may require greater cost share (Deductible/Coinsurance) and charges may exceed the carrier's "reasonable and customary" rate or "maximum allowable charge", this may result in leaving the member paying the balance. Some plans do not cover claims from Out-of-Network providers. Please refer to the summary of benefits or contact **Sun Life** to better understand Out-of-Network coverage.

DENTAL DEDUCTIONS Weekly	Basic	Enhanced
Employee	$4.22	$7.25
Employee + Spouse	$8.44	$14.50
Employee + Child(ren)	$10.44	$17.47
Employee + Family	$15.49	$26.08

Tips for using your dental plan

Your dentist office will want to know that you are a Sun Life plan member at your next visit. Simply share a copy of your new dental ID card with them. You can access a copy of your dental ID card through your Sun Life account. Quick references to register and access your account are included on this page. Please note that printed dental ID cards are not provided and/or mailed to your home.

Check out our short video for step-by-step instructions on downloading your dental ID card at sunlife.com/dentalIDCard.

Online services

Your mobile-responsive Sun Life account gives you access to everything you need to know about your dental plan, including your dental ID card, benefit schedule and more. To complete your registration, you will need your Social Security number or member ID, and date of birth. Register today at sunlife.com/account.

24/7 virtual dental visits

Sun Life PPO dental members[1] have access to dental visits through teledentistry.com/sunlife.[2]

Find a dentist

If your plan leverages one of our networks, you can easily search for a dentist online. Your network is listed on the back of your dental ID card. To find a participating dentist, visit sunlife.com/findadentist.

Is your dentist not in our network? Nominate your dentist at sunlife.com/findadentist!

Dental Health Center

Get the most from your dental plan by visiting our Dental Health Center. Learn more about dental treatments, average costs, and you can even pose questions through ask-a-dentist. Take control of your dental health at sunlife.com/dentalhealthcenter.

We look forward to providing you and your family with dental benefits and great service!

Frequently asked questions

How does a Prepaid plan work?

This plan gives you and your family access to a range of dental services from in-network providers at fixed copayment amounts. A copayment is the set fee that you pay to the plan dentist at the time of treatment for covered services that are being performed. To receive services at these fixed rates, you must use a network provider.

How do I find a dentist?

Simply visit www.sunlife.com/findadentist. Follow the prompts to find a dentist in your area who participates in the DHMO network. You can also call 800-443-2995 for help finding a dentist.

Do I have to choose a dentist in the network?

Yes. To receive the fixed copayment amounts you must visit a dentist in the network and you must select the dentist in advance. Each family member may choose a different plan dentist.

Are my dependents eligible for coverage?

Yes. Your plan offers coverage for your spouse[3] and dependent children. An eligible child is defined as a child to age 26.[4]

What features does my plan include?

- No annual dollar maximums for plan dentists and plan specialty dentists
- No deductibles
- No waiting periods
- Benefits are payable for pre-existing dental conditions within the copayment schedule
- Extensive provider network updated regularly
- Copayments and discounts for specialty care including orthodontics

How will the plan dentist know I am a patient?

The plan dentist receives a patient listing, called a roster, from Sun Life each month that includes all members who have chosen those individuals as their dentist. Please confirm at the time of making your appointment with the plan dentist that you are on their roster.

Do I have to file the claim?

No. You will not need to file a claim for a plan dentist or plan specialty dentist.

If I have a dental emergency, do I need to see my plan dentist?

First, contact your plan dentist to make an appointment. If your plan dentist is unable to see you, you may seek treatment from any licensed dentist in the United States. Please be informed that the emergency benefit of your plan is limited to the temporary relief of pain and has limited benefits.

How can I get more information about my coverage, change my assigned dentist or find my dental ID card?

After the effective date of your coverage, you can view benefit information online at your convenience through your Sun Life account. To create an account go to www.sunlife.com/account and register. You can also access this information from our mobile app – *Benefit Tools*, which is available for Apple and Android devices. Or you can call Sun Life's Dental Customer Service at 800-443-2995. You can also call any time, day or night, to access our automated system and get answers to common questions when it's convenient for you.

PLAN SPECIALTY DENTISTS

You will find a list of plan specialty dentists by looking in the plan network directory, visiting www.sunlife.com/findadentist or calling 800-443-2995 for assistance. No referrals are necessary from your plan dentist to seek treatment from a plan specialty dentist.

1. https://www.perio.org/consumer/gum-disease-and-other-diseases (accessed 07/21)
2. https://www.perio.org/newsroom/periodontal-disease-fact-sheet (accessed 07/21)
3. If permitted by the Employer's employee benefit plan and not prohibited by state law, the term "spouse" in this benefit includes any individual who is either recognized as a spouse, a registered domestic partner, or a partner in a civil union, or otherwise accorded the same rights as a spouse.
4. Please see your employer for more specific information.

Read the *Important information* section for more details including limitations and exclusions.

Important information

For the prepaid dental plan, you must meet the eligibility requirements set forth by your employer. Your effective date will be determined by your Group Dental Service Agreement and Evidence of Coverage. Refer to these plan documents for details.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see the Evidence of Coverage or ask your benefits administrator for details.

Prepaid Dental

We will not pay a benefit for any Dental procedure or service not specifically mentioned in the Copayment Schedule (including any hospital or outpatient care facility cost associated with any dental procedures). Any dental service listed in the Copayment Schedule incurred prior to Member's Effective Date or after the Member's termination is not covered, except as provided in the Orthodontia Services Section of the Copayment Schedule. Services provided by non-Plan Providers are not covered unless for Emergency Services specifically provided in the EMERGENCY SERVICES Article of the Evidence of Coverage. Fixed or removable prosthetics are subject to a 5 year replacement limitation. Extractions for Orthodontic purposes only are at a 25% discount off of the Plan Provider's normal retail charge. Implants and implant related procedures are not covered. Orthodontic treatment involving therapy for myofunctional problems, TMJ (temporomandibular joint) dysfunctions, micrognathia, macroglossia, cleft palate or other growth and developmental abnormalities are not covered. Limitations and exclusions apply with respect to the Member's oral conditions without regard to whether or not such conditions existed before the effective date of the Member's enrollment.

The prepaid dental Overview is preliminary to the issuance of your plan documents. Refer to your Evidence of Coverage for details. Receipt of this Overview does not constitute approval of coverage. In the event of a discrepancy between this Overview and the Evidence of Coverage, the terms of the Evidence of Coverage will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

This plan does not provide coverage for pediatric oral health services that satisfies the requirements for "minimum essential coverage" as defined by The Patient Protection and Affordable Care Act (PPACA).

Sun Life companies include Sun Life and Health Insurance Company (U.S.) and Sun Life Assurance Company of Canada (collectively, "Sun Life").

Prepaid dental products are provided by Sun Life Assurance Company of Canada (SLOC) (Wellesley Hills, MA), under Form Series BDC-GDSA.

GDBH-EE-8731 SLPC 29579

VISION BENEFITS

Sun Life	VSP – Plan 3		
	In-Network	Out-of-Network	Frequency of Benefits
Eye Examination	$10 Copay	Reimbursed up to $45	Once Every 12 Months
Eyeglass Lenses	$10 Copay	Reimbursed up to: Single: $30 Bifocal: $50 Trifocal: $60 Lenticular: $100	Once Every 12 Months
Eyeglass Frames	$150 Allowance + 20% off Balance Costco: $80 Allowance	Reimbursed up to $70	Once Every 24 Months
Contact Lenses In Lieu of Eyeglasses	Elective: $150 Allowance Medically Necessary: Covered in Full after Copay	Reimbursed up to: Elective: $105 Medically Necessary: $210	Once Every 12 Months
Laser Vision Correction	Discounts Available	N/A	N/A

*Visit an In-Network provider to access benefits for annual eye exams, prescription contacts, or lenses and frames. If you visit an Out-of-Network provider, you may be required to submit a claim form to the carrier to access your benefits. For complete benefits information, please refer to the carrier's plan documents.

VISION DEDUCTIONS Weekly	VSP – Plan 3
Employee	$1.41
Employee + Spouse	$2.55
Employee + Child(ren)	$2.69
Employee + Family	$4.25

BENEFIT TOOLS

Let Sun Life help you discover the true benefit of benefits—anytime, anywhere.

With the Benefit Tools app, you can easily view your dental and vision coverage, find a dentist, access your electronic dental ID card, and more.

Use this app to quickly access:

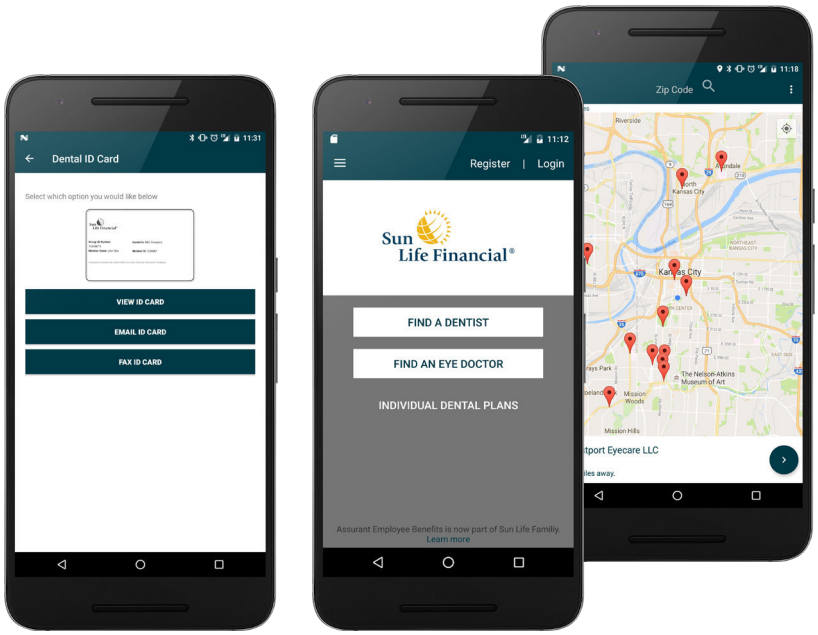
- **My Benefits**—An overview of dental and vision plan details
- **Dental ID Card**—Your electronic dental ID card
- **Find a Dentist**—Uses your location to find a dentist nearby
- **Find an Eye Doctor**—Uses your location to find an eye doctor nearby
- **Contact Us**—To connect with us to ask questions
- **Individual dental plans**—To learn about the products we sell in your area

Available for iPhone and Android devices.
Download now:

Download on the App Store

ANDROID APP ON Google play

The Benefit Tools app is available for iPad and Android Tablets.
For more information, please visit www.sunlife.com/mobileapps



Dental ID Card

Find a Dentist/
Find a Doctor

Sun Life Financial®

One Sun Life Executive Park
Wellesley Hills, MA 02481

www.sunlife.com/us

GGFL-ALG-6292d

SLPC 27854 10/16 (exp. 10/18)

VOLUNTARY LIFE AND DISABILITY BENEFITS

VOLUNTARY LIFE AND AD&D INSURANCE

Additional Life insurance is available for purchase on yourself, your spouse, and your child(ren) on a voluntary basis. Premiums are based on your age and the coverage amount selected and is paid through payroll deductions. Refer to your plan documents for complete benefit information and rates.

Sun Life			
Insured	**Available Increments**	**Maximum Benefit**	**Guarantee Issue***
Employee	$10,000	$100,000	$100,000
Spouse	$10,000	50% of Employee Amount, up to $20,000	$20,000
Child(ren)	$5,000	50% of Employee Amount, Up to $10,000	$10,000

*An Evidence of Insurability form (health history questionnaire) may be required if you are electing coverage after your initial enrollment period and/or over the Guarantee Issue amount.

VOLUNTARY SHORT-TERM & VOLUNTARY LONG-TERM DISABILITY

Disability insurance provides income protection, should you become disabled due to a non-work-related illness or injury. Premiums are based on your age and salary and will be payroll deducted. Refer to **UnitedHealthcare's** carrier plan documents for complete benefits information and rates.

UnitedHealthcare		
Coverage	**Voluntary Short-Term Disability***	**Voluntary Long-Term Disability***
Benefit Pays	60% Base Salary	60% Base Salary
Maximum Benefit	$1,500	$5,000
Elimination Period	14 Days	90 Days
Benefits Begin	15th Day	91st Day
Maximum Benefit Period	13 Weeks	2 Years
Pre-Existing Limitation	12 months look back / 12 months insured	3 months look back / 12 months insured

*An Evidence of Insurability form (health history questionnaire) may be required if you are electing coverage after your initial enrollment period.

VOLUNTARY WORKSITE BENEFITS

Accident insurance provides you and your family with hospital, doctor, and catastrophic accident benefits. These benefits can help with unexpected Out-of-Pocket medical and non-medical expenses associated with an accident. Please refer to the **Sun Life** plan documents for all benefits and information.

Weekly Deduction	Standard Plan	Enhanced Plan
Employee	$2.52	$3.84
Employee + Spouse	$4.14	$6.71
Employee + Child(ren)	$4.98	$8.13
Employee + Family	$6.61	$11.00

Critical Illness insurance pays you a lump sum benefit if you are diagnosed with a covered specified critical illness such as a heart attack, stroke or specified disease. This coverage is available to you and your covered dependents. Please refer to the **Sun Life** plan documents for all benefits and information.

Sun Life			
Insured	**Available Increments**	**Maximum Benefit**	**Guarantee Issue***
Employee	$10,000	$40,000	$40,000
Spouse	$10,000	100% of Employee's Amount up to $40,000	$40,000
Child(ren)	$5,000	50% of Employee's Amount up to $20,000	$20,000

Hospital Indemnity insurance provides you with direct cash payments in the event of a hospitalization, regardless of treatment costs or other insurance coverage. This coverage is available to you and your covered dependents. Please refer to the **Sun Life** plan documents for all benefits and information.

Sun Life	Low	High
Confinement	$100 / Day	$200 / Day
Covered days per confinement	Up to 30 Days	Up to 30 days
Maintenance Screening	$50 / Day	$50 / Day
Pre-Existing Limitation	N/A	N/A

Weekly Deduction	Low	High
Employee	$3.70	$6.24
Employee + Spouse	$7.25	$12.65
Employee + Child(ren)	$5.95	$10.19
Employee + Family	$9.50	$16.60

Accident Insurance

Sun Life

You can purchase this coverage for you and your family. Child coverage is available to age 26.

HELPS YOUR FINANCES AFTER A MISHAP.

When you, your spouse or child has a covered accident, like a fall from a bicycle that requires medical attention, you can receive cash benefits to help cover the unexpected costs.

HELPS COVER RELATED EXPENSES.

While health plans may cover direct costs associated with an accident, you can use accident benefits to help cover related expenses like lost income, child care, deductibles and co-pays.

PAYS CASH BENEFITS DIRECTLY TO YOU.

Accident Insurance can be used however you want, and it pays in addition to any other coverage you may already have. Benefits are payable directly to you. And get this – there are no health questions or pre-existing conditions limitations.

What's more, all family members on your plan are eligible for a wellness-screening benefit, also paid directly to you once each year per covered person.

ACCIDENT FAST FACTS

Falls *are the leading cause of injuries treated in emergency rooms every year, for people of all ages.*[1]

This coverage pays benefits whether your covered accident happens at work, at home, or away (also known as 24-hour coverage).

ATLANTIC CARE SERVICES

All Eligible Employees

POLICY # 964378

Sun Life Assurance Company of Canada

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Once your coverage goes into effect, you can file a claim for covered accidents that occur after your insurance plan's effective date. Unless otherwise specified, benefits are payable only once for each covered accident, as applicable. The full list of benefits is listed here. Choose the plan that best meets your needs and your budget.

	STANDARD PLAN		ENHANCED PLAN	
DISLOCATIONS	**OPEN (SURGERY)**	**CLOSED (NO SURGERY)**	**OPEN (SURGERY)**	**CLOSED (NO SURGERY)**
Hip	$4,000	$2,000	$8,000	$4,000
Knee, ankle, or bones of the foot	$2,000	$1,000	$3,000	$1,500
Elbow, wrist or Lower jaw	$800	$400	$2,000	$1,000
Shoulder	$1,000	$500	$2,000	$1,000
Collarbone or bones of the hand	$1,600	$800	$2,000	$1,000
Finger(s) or toe(s)	$200	$100	$400	$200
FRACTURES	**OPEN (SURGERY)**	**CLOSED (NO SURGERY)**	**OPEN (SURGERY)**	**CLOSED (NO SURGERY)**
Hip or thigh	$4,000	$2,000	$6,000	$3,000
Skull-depressed	$6,000	$3,000	$7,500	$3,750
Skull-simple	$3,000	$1,500	$4,000	$2,000
Vertebral processes, Bones of the face, Nose, Lower jaw, Collarbone, Shoulder, Forearm, Hand, Wrist, Foot, Ankle, Kneecap, Elbow or Heel	$700	$350	$1,500	$750
Leg	$2,000	$1,000	$3,000	$1,500
Vertebrae, Sternum or Pelvis	$1,600	$800	$2,400	$1,200
Upper jaw or upper arm	$800	$400	$1,500	$750
Rib, Finger, Toe or Coccyx	$400	$200	$600	$300
Multiple ribs	$1,000	$500	$1,500	$750
ADDITIONAL INJURIES				
Eye Injury - surgical repair		$200		$300
Eye Injury - object remove		$200		$300
Brain injury		$500		$500
Paralysis—paraplegia		$5,000		$12,500
Paralysis—quadriplegia		$10,000		$20,000
Coma		$5,000		$10,000
Concussion		$250		$250
BURNS	**2ND DEGREE**	**3RD DEGREE**	**2ND DEGREE**	**3RD DEGREE**
20-40 square centimeters	$200	$500	$300	$750
41-65 square centimeters	$400	$1,000	$600	$1,500
66-160 square centimeters	$600	$3,000	$800	$4,500
161-225 square centimeters	$800	$7,000	$1,200	$10,000
More than 225 square centimeters	$1,000	$10,000	$1,500	$15,000
Skin graft	50% of the applicable Burn Benefit		50% of the applicable Burn Benefit	
LACERATIONS				
No sutures and treated by doctor		$20		$35
Single laceration under 5 cm with sutures		$35		$65
5-15 cm with sutures (total of all lacerations)		$125		$250
Greater than 15 cm with sutures (total of all lacerations)		$500		$700

MEDICAL SERVICES		
Diagnostic Exam - Arteriogram, Angiogram, CT, CAT, EKG, EEG, or MRI (1 time per benefit year)	$100	$200
Diagnostic Exam - X-ray (1 time per covered accident)	$50	$100
Accident Emergency Treatment, non-emergency room (once per covered accident)	$100	$200
Physician's Follow-up Treatment office visit (per visit, up to 6 times per covered accident)	$50	$100
Physical Therapy (per visit up to 10 visits per covered accident)	$25	$50
Medical Devices	$200	$400
Epidural Pain Management (up to 2 times per covered accident)	$50	$100
Prescription drug	$15	$35
Prosthesis (one)	$500	$750
Prosthesis (two)	$1,000	$1,500
Blood, Plasma, or Platelet Transfusion	$100	$200
HOSPITAL		
Hospital Admission (once per benefit year)	$1,000	$1,500
Hospital Confinement (per day up to 365 days per covered accident)	$200	$300
Intensive Care Unit Admission (once per Benefit Year; payable instead of Hospital Admission benefit if Confined immediately to ICU)	$1,500	$2,000
Intensive Care Unit Confinement (per day up to 14 days, payable in addition to any Hospital Confinement benefit)	$200	$300
Ambulance (Ground)	$300	$400
Ambulance (Air)	$1,000	$1,500
Emergency Room Admission	$100	$200
Family Lodging (per day up to 30 days per benefit year)	$50	$100
Transportation (100 or more miles up to 3 times per covered accident)	$250	$500
Rehabilitation Unit (per day up to 30 days per covered accident)	$50	$100
SURGERY		
Miscellaneous Surgery requiring general anesthesia (not covered by any other benefit)	$300	$750
Open Surgery	$1,000	$1,500
Exploratory Surgery or Debridement	$250	$500
Tendon/Ligament/Rotator Cuff Tear	$500	$750
Torn Knee Cartilage	$500	$750
Ruptured/Herniated Disc	$500	$750
EMERGENCY DENTAL		
Emergency Dental extraction	$30	$65
Emergency Dental crown	$100	$200
WELLNESS		
Wellness Screening Benefit (once per benefit year)	$50	$50

LIFE AND DISMEMBERMENT LOSSES*		
Accidental Death	$15,000	$25,000
Accidental Death Common Carrier (pays an additional benefit if accidental death occurs while traveling as a fare-paying passenger on a public conveyance)	$30,000	$100,000
Catastrophic Loss: Both arms or both hands, both legs or both feet, one hand and one foot or one arm and one leg, or irrecoverable loss of sight of both eyes	$15,000	$25,000
Loss of one hand, foot, leg, or arm	$7,500	$15,000
Loss of sight of one eye or loss of one eye	$7,500	$15,000
Two or more fingers or toes	$1,500	$3,000
One finger or one toe	$750	$1,500
Loss of hearing of one ear or loss of one ear	$2,500	$5,000

Critical Illness Insurance

Sun Life

HELPS PROTECT YOUR FINANCES FROM AN ILLNESS.

When you, your spouse or child is diagnosed with a covered condition, you can receive a cash benefit to help pay unexpected costs not covered by your health plan.

HELPS COVER RELATED EXPENSES.

While health plans may cover direct costs associated with a critical illness, you can use your benefit to help with related expenses like lost income, child care, travel to and from treatment, deductibles and co-pays.

PAYS A CASH BENEFIT DIRECTLY TO YOU.

Critical Illness insurance can be used however you want, and it pays in addition to any other coverage you may already have.

What's more, all family members on your plan are eligible for a wellness-screening benefit, also paid directly to you once each year per covered person.

With Critical Illness Insurance, you also get access to health care support services. You can talk with medical and claims experts about your medical coverage, benefits, diagnosis and treatment options.

BENEFITS *(You can purchase this coverage at a group rate.)*	
For you	You can choose between **$10,000** and **$40,000** of coverage, in increments of $10,000. No medical questions asked.
For your spouse	If you elect coverage for yourself, you can choose between **$10,000** and **$40,000** of coverage, in increments of $10,000. No medical questions asked. Not to exceed 100% of your coverage amount.
For your child(ren)	If you elect coverage for yourself, you can choose between **$5,000** and **$20,000** of coverage, in increments of $5,000. No medical questions asked. Not to exceed 50% of your coverage amount. An eligible child is defined as your child from birth to age 26.

ATLANTIC CARE SERVICES

All Eligible Employees

POLICY #: 964378

What's covered

Once your coverage goes into effect, you can file a claim for covered conditions diagnosed after your insurance plan's effective date. Below is the full list of conditions.

COVERED CONDITIONS – *The plan pays 100% of the benefit amount unless stated otherwise.*		
Core Conditions	Heart Attack[R] End-Stage Kidney Disease[R] Occupational HIV/Hepatitis B, C, or D Major Organ Failure[R]	Stroke[R] Coronary Artery Bypass Graft[R] (Pays 25%) Angioplasty[R] (Pays 5%)
Cancer Conditions	Invasive Cancer[R] Noninvasive Cancer[R] (Pays 25%) Skin Cancer[R] (Pays 5%)	
Other Conditions	Complete Blindness Complete Loss of Hearing Loss of Speech Benign Brain Tumor Coma	Severe Burns Advanced ALS/Lou Gehrig's Disease Advanced Parkinson's Disease (Pays 25%) Advanced Alzheimer's Disease (Pays 25%) Paralysis
Childhood Conditions *Applies to dependent children only*	Down Syndrome Cystic Fibrosis Type 1 Diabetes Mellitus Complex Congenital Heart Disease	Cerebral Palsy Cleft Lip/Palate Muscular Dystrophy Spina Bifida
Wellness Screening Benefit	Payable to any covered person on your plan one time each year, once you provide proof of an eligible health screening.	Employee $50 Spouse $50 Child $50

[R] = *Recurrence Benefit available*

When would I need the Recurrence Benefit?

Sometimes people are diagnosed with the same condition twice. If this happens to you, and 12 consecutive months have passed between the first and second diagnoses, we'll pay you an additional benefit (the amount of which is noted in your Certificate). Only the conditions marked (R) in the table above are eligible for the Recurrence Benefit. Once a Recurrence Benefit has been paid, no additional benefit will be paid for that critical illness.

Hospital Indemnity Insurance

Sun Life

HELPS PROTECT YOUR FINANCES.
When you, your spouse or child are facing a hospital stay, you can receive a benefit to help pay unexpected expenses not covered by your plan.

HELPS COVER RELATED EXPENSES.
While health plans may cover direct costs associated with an illness or injury, you can use your hospital indemnity benefits to help cover related expenses like lost income, child care, deductibles and copays.

PAYS CASH BENEFITS DIRECTLY TO YOU.
Hospital Indemnity insurance payments can be used however you want, and it pays in addition to any other coverage you may already have. Benefits are payable directly to you.

You can purchase this coverage for you and your family. Child coverage is available to age 26.

BENEFITS	
Benefits are payable for hospital stays due to:	• Sickness • Accidents* • Routine pregnancy • Complications of pregnancy • Newborn complications • Mental and nervous disorders • Substance abuse
Additional reasons to sign up:	• No medical questions to answer - guaranteed issue coverage

Your employer is offering you a choice of two plans. Please review the information for both plans. Then, choose the one plan that best fits your needs.

*Confinements due to an accident must be within 365 days of the accident.

ATLANTIC CARE SERVICES

All Eligible Employees

POLICY # 964378

Sun Life Assurance Company of Canada

2319866 SEQ18 CL1 11/29/2023 08:17:10

What's covered – LOW

This plan provides benefits due to hospital stays for covered accidents or sickness. Once your Hospital Indemnity coverage goes into effect, you can file a claim for covered hospital stays occurring after your plan's effective date.

The benefits shown in the schedule are payable for each person covered by the plan unless otherwise stated.

BENEFIT SCHEDULE – LOW

FIRST DAY BENEFITS Payable per benefit year	**LOW**
First day hospital confinement – This benefit pays the first day you stay in a regular hospital bed.	$500 per day 1 day
First day ICU confinement – This benefit pays the first day you stay in an ICU bed.	$1,000 per day 1 day
CONFINEMENT BENEFITS Payable per benefit year	**LOW**
Hospital confinement – This benefit pays for a hospital stay in a standard room.	$100 per day Up to 30 days
Intensive Care Unit (ICU) confinement – This benefit pays for a hospital ICU stay.	$100 per day Up to 15 days
ADDITIONAL AND ENHANCED BENEFITS Payable per benefit year	**LOW**
Wellness screening benefit – This benefit pays for a covered wellness test or exam even without a hospital stay.	$50 per day 1 day per insured per benefit year

What's covered – HIGH

This plan provides benefits due to hospital stays for covered accidents or sickness. Once your Hospital Indemnity coverage goes into effect, you can file a claim for covered hospital stays occurring after your plan's effective date.

The benefits shown in the schedule are payable for each person covered by the plan unless otherwise stated.

BENEFIT SCHEDULE – HIGH

FIRST DAY BENEFITS Payable per benefit year	**HIGH**
First day hospital confinement – This benefit pays the first day you stay in a regular hospital bed.	$1,000 per day 1 day
First day ICU confinement – This benefit pays the first day you stay in an ICU bed.	$2,000 per day 1 day
CONFINEMENT BENEFITS Payable per benefit year	**HIGH**
Hospital confinement – This benefit pays for a hospital stay in a standard room.	$200 per day Up to 30 days
Intensive Care Unit (ICU) confinement – This benefit pays for a hospital ICU stay.	$200 per day Up to 15 days
ADDITIONAL AND ENHANCED BENEFITS Payable per benefit year	**HIGH**
Wellness screening benefit – This benefit pays for a covered wellness test or exam even without a hospital stay.	$50 per day 1 day per insured per benefit year

Hospital Indemnity Policy Notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Always Designing for People®

We have tools and support to make your life easier

LifeCare®

Enjoy more, worry less

Through your company's suite of ADP's Comprehensive HR products, you and your family have access to LifeCare, a Work-Life Employee Assistance Program (EAP).

LifeCare is here for you and offers an abundance of resources and guidance for your personal needs including parenting, senior care, wellness, home services, and legal and financial services. All of this is available 24 hours a day, 7 days a week! Here are just a few of the helpful services you can access through LifeCare:

Child care & Parenting

- Adoption
- Before-and after-school
- Child development
- Breast feeding resources
- Child care (centers,in-home, family & day care)
- Prenatal care
- Special needs education

Senior care & aging

- Care options
- Caregiving
- Medicare/Medicaid/ Social Security
- Health/safety
- Hospice services
- Meal delivery
- Respite care
- Transportation services
- In-home services

Emotional health

- Stress
- Domestic abuse
- Anxiety
- Divorce
- Substance abuse
- Family counseling
- Grief
- Depression

Health & Wellness

- Smoking cessation
- Safety
- Diet & nutrition
- Fitness
- Preventative care
- Sleep health

Legal & Financial

- Personal finance
- Real estate & loans
- Credit & debt
- Retirement planning
- Insurance

With ADP and LifeCare, you will also have access to thousands of FREE discounts:

- Computers and electronics
- Theme parks
- Flights, cruises, car rentals and hotels
- Gifts and retail shopping
- Work and family
- Audio books & magazines
- Child and elder care products
- Movie tickets
- Concerts
- And much more!

For more information for you and your employees, download these helpful materials:

- Overview/flyer
- Employer Frequently Asked Questions
- Manager Frequently Asked Questions
- LifeCare wallet card

Call toll-free, 24 hours a day

1-800-697-7315 (1-800-873-1322 TTY).

Please mention your affiliation with ADP.
Sign into LifeCare by visiting the My Tools Page and select LifeCare-Work/ Life, EAP, Discounts link.

Get the most out of life

We have personalized support, tips & tools to help

Emotional health guidance

Focusing on self-improvement and making yourself a priority is important for everyone. Specialists are available 24/7 to provide the tools and support that will help you reach your goals and live your best life. You and your household members can contact us for access to 3 free confidential counseling sessions either face-to-face or on the phone.

What can you do to improve yourself?

- Start your week off with optimism
- Build your self-esteem
- Increase your happiness
- Take care of yourself everyday
- Turn your goals into reality
- Change your negative thoughts

Coping with loss

It is difficult to cope with a loss. During this time, our collection of resources and compassionate guidance can help you through one of life's most challenging transitions. You and your household members can contact us for access to 3 free confidential counseling sessions either face-to-face or on the phone.

Access resources to help you cope, heal and move forward:

- Visit our grief & loss library for content with an informed perspective
- Read about how to support others through grief
- Explore tips for talking to someone who is hurting
- Learn the facts about coping with grief
- Get strategies to help understand and manage stress
- Consider techniques to become an effective listener

As you face a loss, we're here to help.

When faced with a loss, the details of planning a funeral can be overwhelming. We're here to provide personalized research, guidance and resources you need to arrange transportation for family and friends; order flowers; cater a lunch; or find caregivers for the children. In addition, we can help locate grief support such as local support groups and counseling.

Atlantic Care Services

Coming Soon:

New Benefit Options for You!

Atlantic Care Discount Marketplace

We are excited to announce the launch of **Atlantic Care Discount Marketplace**! This exclusive marketplace provides access to benefits as well as thousands of amazing discounts!

With Atlantic Care Discount Marketplace, you have access to a variety of benefits coverage in the following categories:

♥	**Health and well-being**	$	**Financial well-being**
🚗🏠	**Auto and home**	✓	**Rewards**
☂	**Voluntary benefits**	%	**Discounts and perks**

The mobile-friendly marketplace makes shopping for benefits as easy as any other online purchase.

Register in Two Simple Steps!

1. Go to: https://AtlanticCare.benefithub.com
2. Register with your name and email a address and start saving today!

Medicare Part D
Creditable Coverage Notice

Important Notice from Atlantic Care Services, LLC Group Health Plan About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Atlantic Care Services, LLC Group Health Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. 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. **Atlantic Care Services, LLC Group Health Plan has determined that the prescription drug coverage offered by the Curative EPO, PPO, and PPO Max plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan while enrolled in Atlantic Care Services, LLC Group Health Plan coverage as an active employee, please note that your Atlantic Care Services, LLC Group Health Plan 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 Atlantic Care Services, LLC Group Health Plan coverage as a former employee.

You may also choose to drop your Atlantic Care Services, LLC Group Health Plan coverage. If you do decide to join a Medicare drug plan and drop your current Atlantic Care Services, LLC Group Health Plan 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 Atlantic Care Services, LLC Group Health Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact 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 Atlantic Care Services, LLC Group Health Plan changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Name of Entity/Sender: Atlantic Care Services, LLC Group Health Plan
Contact-Position/Office: Bonnie Bennett, VP of HR
Address: 163 E Morse Blvd. Suite 210, Winter Park, Florida 32789
Phone Number: 407-270-5501

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in Atlantic Care Services, LLC 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 Bonnie Bennett, VP of HR 407-270-5501.

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

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

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

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

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

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

FLORIDA – Medicaid	TEXAS – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Website: Health Insurance Premium Payment (HIPP) Program| Texas Health and Human Services Phone: 1-800-440-0493

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

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at 407-270-5501.

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

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Model General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

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

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace.

By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage 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."
- Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- 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 after the qualifying event occurs. You must provide this notice to: Bonnie Bennett, VP of HR.

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. You must provide a copy of the notice from Social Security regarding their disability determination within 60 days of the date of the notice in order to receive the additional extension.

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**.

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

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

Bonnie Bennett, VP of HR
163 E Morse Blvd, Suite 210
Winter Park, Florida 32789
407-270-5501

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

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

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

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

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to 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.

CONTACT INFORMATION

Coverage	Partner	Contact
Medical	Curative	www.curative.com 855-428-7284
Dental	Sun Life Financial®	www.sunlife.com 800-786-5433
Vision		
Voluntary Life		
Voluntary STD	UnitedHealthcare	www.unitedhealthcarespecialtybenefits.com 888-299-2070
Voluntary LTD		
Accident, Hospital Indemnity & Critical Illness	Sun Life Financial®	www.sunlife.com 800-786-5433
ADP EAP	ADP Always Designing for People®	1-800-697-7315

This brochure contains the highlights of the benefit options available through Atlantic Care Services. This is intended to only be an overview to assist in your understanding the options that are available to you and some of the important terms that you need to consider. The charts are not intended to reflect all plan provisions. For complete details, be sure to read all individual insurance option booklets and materials. That information is important to help you decide what choices are right for you. The charts in the booklet are for illustrative purposes only. In the event of a discrepancy, the carrier plan documents will prevail. The Human Resources Department will have all plan documents and summary plan descriptions available for your review. Remember to reach out to Human Resources if you have any questions.

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