FLORIDA CANCER SPECIALISTS

2021 Benefits Guide

rev.12/08/20

FLORIDA CANCER
SPECIALISTS

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Important Information

This document is only a summary of the Florida Cancer Specialists benefits available to employees and their eligible dependents beginning January 1, 2021. It does not contain all the information. For details, refer to the Summary Plan Description (SPD), certificates of coverage, and plan document. If any description in this document conflicts with descriptions in the official plan document, the plan document description will prevail. This document also serves as a Summary of Material Modifications to the Summary Plan Description for the Florida Cancer Specialists Plan. It is meant to supplement and/or replace certain information in the SPD. So, retain it for future reference along with your SPD. Please share these materials with your covered family members.

The benefits described in the document are subject to change at any time. This document is not a contract, guarantee of employment, or guarantee of benefits eligibility.

Your 2021 Benefits

Florida Cancer Specialists offers you comprehensive group benefits through best-in-class vendors. We have designed your benefits with the well-being of you and your dependents in mind.

The *2021 Benefits Guide* summarizes the benefits available to eligible employees and their dependents. Please review it carefully to prepare for your enrollment to ensure you have a thorough understanding of your Florida Cancer Specialists benefits and resources.

Benefits Eligibility

You are eligible if you are a full-time employee scheduled to work at least 30 hours a week or a part-time employee scheduled to work between 24 and 29 hours a week. *You become eligible on the first day of the month following 60 days of continuous employment*.

Eligible Classes

Seasonal employees: If you are a seasonal employee, you are eligible to enroll in medical, dental, and vision plans beginning on the first day of the month following 30 days of continuous employment.

PRN employees: If you are a PRN employee you will only be eligible to participate in the FCS 401(k) plan after meeting the plan's eligibility requirement.

Other eligible employees: Eligibility for any other classes will be defined in company policies, and/or plan details as applicable.

Please contact FCS at **FCSBenefits@FLcancer.com** for details.

Questions?

Please email:

FCSBenefits@FLcancer.com

Dependent Eligibility

If you enroll, you may also add your legal spouse or qualifying domestic partner, and eligible dependent children to your medical, dental, vision, and other benefits.

Your dependent child(ren) are eligible if they are under age 26 and:

- Natural-born or legally adopted child(ren)
- Foster or stepchild(ren)
- Child(ren) for whom you are the court-appointed legal guardian or custodian
- Child(ren) for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMSCO)

Eligibility also applies to children of any age if they are mentally or physically disabled before reaching age 26 and for whom you have proof of disability from a physician certifying that the child was disabled before age 26 and incapable of self-sustaining employment.

When Dependent Eligibility Ends

Coverage for dependents ends when they reach age 26, as follows:

- Medical, dental, and vision at the end of the month in which they turn age 26
- Voluntary life and AD&D coverage on their 26th birthday

For any other benefit covering a dependent, coverage ends at the end of the month in which they turn age 26. Please contact FCSBenefits@FLcancer.com, or the plans insurance carriers to confirm the benefits eligibility end terms.

Dependent Eligibility Audit

FCS's mission is to offer benefits programs to our employees that are competitive, comprehensive and affordable. Part of that initiative is to ensure that those who are enrolled in our benefits meet the definitions of eligibility for employees and dependents.

Across the US, employers regularly conduct dependent verification audits to ensure that eligibility information is accurate for the appropriate payment of medical claims and other tax reporting and obligations for the company, and also to ensure that premium dollars are being spent on you and your eligible family members. Therefore, FCS is targeted to conduct a comprehensive audit for all enrolled dependents in the first quarter of 2021.

In line with the above, you will be asked to provide certification for your dependents at that time. Such certification will include, but not be limited to, two of the following documents: marriage license, Federal 1040 or state income tax return (where applicable), utility bill, bank statement or insurance documents that includes the name of you and your dependent, birth certificates, adoption or affidavit of parentage.

We are partnering with a third party to conduct this audit on our behalf, and none of your personal information will be shared with FCS. Details will be available in the coming months. FCS reserves the right to determine changes applicable to conducting the dependent audit, and the process that will take place.

If you currently cover any persons who do not meet the definition of eligibility, it is suggested that you drop them from coverage during a Benefits Annual Open Enrollment period.

Medical and Prescription Drug Benefits

You have three options for medical benefits: The Core Plan, Prime Plan, and High Deductible Health Plan with Health Savings Account (HDHP with HSA). All three plans are offered through Blue Cross Blue Shield. Your pharmacy benefits are managed through CVS Caremark and administered by Rx Benefits.

The following table compares the medical plan options. See the next page for a summary of prescription drug benefits.

Comparing Medical Plan Options (In-Network)			
Feature	**Core**	**Prime**	**HDHP with HSA**
Financials			
Deductible (single/ family)	$2,500/$5,000	$1,500/$3,000	$2,800/$5,600
Coinsurance (carrier/ member)	30% after deductible	20% after deductible	10% after deductible
Maximum Out-of-Pocket (single/family)	$8,000/$16,000 includes deductible, coinsurance, and copays	$4,500/$9,000 includes deductible, coinsurance, and copays	$6,500/$13,000
Lifetime Maximum (per person)	Unlimited	Unlimited	Unlimited
Physician Services	Preventive Care is Covered at 100%		
Primary Care	$30 copay (does not apply to deductible; applies to MOOP)	$25 copay (does not apply to deductible; applies to MOOP)	10% after deductible
Specialist	$50 copay	$45 copay	10% after deductible
Teladoc (see page 12 for rates)			
Hearing Aids	Subject to a deductible and $1,000 in-network coinsurance every 3 years		10% after deductible
Hospitalization			
Inpatient Hospitalization	30% after deductible	20% after deductible	10% after deductible
Outpatient Surgery	30% after deductible	20% after deductible	10% after deductible
Physician Services at Hospital and ER	30% after deductible	20% after deductible	10% after deductible
Urgent Care	$30 copay	$25 copay	10% after deductible
Emergency Room	30% after deductible	20% after deductible	10% after deductible
Outpatient Diagnostics	Lab services–Quest Diagnostics		
Routine Diagnostics (lab and x-ray)	30% after deductible	20% after deductible	10% after deductible
Major Diagnostics (MRI, CAT, PET scans, etc.)	30% after deductible	20% after deductible	10% after deductible
Outpatient Therapies	(60 visits combined)		
Physical Therapy	30% after deductible	20% after deductible	10% after deductible
Speech Therapy	30% after deductible	20% after deductible	10% after deductible
Occupational Therapy	30% after deductible	20% after deductible	10% after deductible
Out-of-Network			
Deductible (single/ family)	$7,500/$15,000	$4,500/$9,000	$8,400/$16,800
Coinsurance	50% after deductible	50% after deductible	50% after deductible
Maximum Out-of- Pocket (single/family)	$24,000/$48,000 includes deductible, coinsurance, and copays	$13,500/$27,000 includes deductible, coinsurance, and copays	$19,500/$39,000
Lifetime Maximum (per person)	Unlimited	Unlimited	Unlimited

Note: Physicians may be subject to full premium amount (Employer Bi-Weekly rates) for their elected medical plan.

Always confirm the medical procedure is covered under the plan before beginning. For example gastric bypass/lap band, ABA Therapy, and breast reduction procedures are not covered.

Medical Providers

To research medical providers please go to **myhealthtoolkitfl.com** and click "Find a Provider", enter in ZIP code and click "Save", select "Show me Only Doctors and Hospitals in my Plan", enter in the first 3 letters from the ID card "FGG", then enter in any search information (name, location, and/ or specialty.)

Chemotherapy Services

When receiving chemotherapy services, if the provider or service facility is in- network, covered services will be paid and no referral or requirement involving an FCS provider/facility applies.

FCS Provider/facility (In Network): If you do choose to go to an FCS provider/facility, it will be free after the deductible, and coinsurance will be waived after the deductible is met.

Important Plan Features

- Labwork: in Florida you must use Quest Diagnostics; for lab work outside of Florida you must call Blue Cross Blue Shield customer service (800.830.1501) to locate a contracted lab
- Durable medical equipment: pre-authorization is required for any claims over $1,000
- Gastric bypass and/or lapband is not covered, but treatment leading up to it is. Contact BCBS for details.
- Prior authorizations are required, but not limited to surgery, advanced imaging, etc.; please call Blue Cross Blue Shield customer service for prior authorization requirements

Medical Plan Bi-Weekly Contribution Rates						
Coverage Level	Core		Prime		HDHP with HSA	
	Employee	Employer	Employee	Employer	Employee	Employer
Full-Time Wellness Benefit Costs						
Employee	$11.54	$239.71	$54.27	$222.48	$27.69	$232.52
Employee/Spouse	$129.67	$382.88	$174.38	$390.19	$134.29	$396.54
Employee/Child(ren)	$112.69	$352.12	$151.11	$360.88	$116.59	$364.80
Family	$229.22	$554.67	$292.10	$571.37	$237.23	$574.62
Part-time (24-29 Hours) Wellness Benefit Costs						
Employee	$129.12	$122.13	$156.04	$120.71	$131.91	$128.30
Employee/Spouse	$263.15	$249.40	$340.46	$224.11	$269.10	$261.72
Employee/Child(ren)	$239.25	$225.56	$278.63	$233.36	$244.04	$237.35
Family	$403.12	$380.77	$469.90	$393.56	$411.56	$400.29
Full-Time Non-Wellness Benefit Costs						
Employee	$64.42	$186.63	$107.35	$169.40	$80.77	$179.44
Employee/Spouse	$235.83	$276.72	$280.54	$284.03	$187.37	$343.45
Employee/Child(ren)	$165.77	$299.04	$204.19	$307.80	$169.67	$311.71
Family	$335.38	$448.51	$398.26	$465.20	$290.30	$521.55
Part-Time (24-29 Hours) Non-Wellness Benefit Costs						
Employee	$182.20	$69.05	$209.11	$67.64	$184.99	$75.22
Employee/Spouse	$369.30	$143.25	$446.61	$117.96	$322.18	$202.61
Employee/Child(ren)	$292.32	$172.49	$331.71	$180.28	$297.12	$184.26
Family	$509.28	$274.61	$576.06	$287.40	$464.64	$346.75

Note: The FCS employee premium rates remain the same for 2021. Changes apply to the employer premium rates, these are reflected above. Physicians may be subject to full premium cost sharing (employee and employer premium).

Spousal Coverage: If you are enrolling your spouse or domestic partner as a dependent in an FCS medical plan, the enrollment system will require you to complete an affidavit certifying if your spouse is eligible for a medical plan elsewhere (including his or her employer.) If so, a $150 surcharge will be added to your medical plan's bi-weekly rate.

Non-Wellness: A biweekly additional rate is added to your premium when the employee or the employee's spouse/ domestic partner do not complete the wellness requirements. If both the employee and the employee's spouse/ domestic partner do not complete the wellness requirements then a biweekly additional rate is added.

Wellness: If you have met your wellness goals in 2020, the wellness contribution rate that applies to your medical plan will continue into 2021. We will announce new wellness goals for 2021. Stay tuned!

Prescription Drug Benefits

The medical and Rx out-of-pocket maximums are combined. See medical grid for total out-of-pocket max.

Your pharmacy benefit is through ***CVS Caremark*** and is administered by Rx Benefits. CVS Caremark includes all CVS pharmacies, Walmart, Publix, Walgreens, and Target locations, plus various grocers and independent pharmacies. Visit **caremark.com** to get a list of in- network pharmacies. You will receive a separate ID card for Rx Benefits. On or after your effective date, you can register online at **caremark.com**. It is designed to help you explore ways to save, track your prescription benefits, and manage your own alerts. You can even give family members permission to manage prescriptions online, if they are on your benefit plan. We put the power in your hands so you can maximize your prescription benefits.

Members can use any of the more than 60,000 pharmacies in the network for all prescriptions except those considered maintenance medications. Maintenance medications must be filled at CVS or mail order with CVS Caremark. After the first 2 fills, you will be ***required*** to either set-up the prescription for a 90-day fill via Rx Benefits—CVS Caremark system or fill these medications at a CVS retail pharmacy in accordance with the directions on the following page.

CVS Caremark Administered by RxBenefits

- Fill at a CVS pharmacy—ask your physician for a 90-day prescription; then have your doctor send it to the CVS/ pharmacy of your choice
- Mail order service—you can enroll easily online by visiting ca**remark.com/mailservice** and sign in or register to request a new prescription, or call CVS Caremark at 800.875.0867

The following are examples of how Rx deductible and copay are applied—a 30-day fill and a 90-day fill for maintenance medications.

- **30-day example:** Bob fills his first Rx in 2020 and the cost of the medication is $38.50; Bob will pay the full $38.50; next month Bob fills his second Rx and the cost is $150; Bob will pay the balance of the $100 deducible ($61.50), then the $50 copay because this is a non-preferred brand Rx; any prescriptions after this will simply be the applicable copay

	Core and Prime		HDHP with HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Retail (Non-Maintenance) (30-Day Supply)				
Deductible	$50 Rx deductible—applied per member capped at $200 per family		Generic maintenance medication covered 100%—no deductible	
Generic	$10 copay	Not covered	10% after deductible	Not covered
Preferred Brand	$40 copay	Not covered	10% after deductible	Not covered
Non-Preferred Brand	20% to a maximum of $200	Not covered	10% after deductible	Not covered
Specialty Medications	10% to a max of $400	Not covered	10% after deductible	Not covered
Mail Order (90-Day Supply)				
Generic	$25 copay	Not covered	10% after deductible	Not covered
Preferred Brand	$100 Copay	Not covered	10% after deductible	Not covered
Non-Preferred Brand	20% to a maximum of $400	Not covered	10% after deductible	Not covered

- **90-day example:** Bob fills his first Rx in 2020 and it is 90-day maintenance medication; the cost for a 90-day supply of the medication is $300; Bob will pay the first $100 and will satisfy his deducible for the year; then, Bob will pay the $100 mail order copay because this is a preferred brand medication he is filling at CVS and the plan will pay the remaining $100; any prescriptions after this will simply be the applicable copay

If either you or your doctor request a brand-name medication when a generic equivalent is available, you will pay the brand copay plus the difference in cost between the brand-name and the generic medication.

- Brand—30-day supply
  - Total cost: $253
  - Total copay: $40
- Generic—30-day supply
  - Total cost: $63.07
  - Total copay: $10
- Cost to member under "Dispense As Written" penalty
  - Brand copay: $40
  - Difference in drug cost: ($253–$63.07) $189.93
  - Total cost to member: $229.93

Dispense As Written (Generics Policy)

If you choose to buy the brand name drug when a generic equivalent is available, you will be required to pay the brand copay plus the difference in cost between the generic and brand name drug.

Health Savings Accounts

A Health Savings Account (HSA) is a tax-favored account that works in conjunction with your health plan for paying eligible healthcare expenses.

If you enroll in the High Deductible Health Plan (HDHP) with HSA, you can open an HSA and contribute pre-tax earnings, if you are eligible. See the *HSA Eligibility* box below for eligibility highlights.

Major Advantages to an HSA

- The money in your HSA is yours to keep even if you change medical plans or leave employment
- Account balances roll over from year to year
- Your tax-free contributions lower your taxable income (and may increase your tax refund)
- Contributions help reduce deductibles

Triple-tax Advantage

Health Savings Accounts offer three tax advantages for all tax brackets:

1. Contributions by you and Florida Cancer Specialists are tax-free to you
2. You can invest your account after it reaches a certain amount and any earnings are tax-free
3. Any eligible expenses you pay from your HSA are tax-free

Funding Health Savings Accounts

Florida Cancer Specialists will contribute up to $500 (individual) and up to $1,000 (family) annually, regardless of how much you contribute to your HSA account.

Contributions will be made on a bi-weekly payroll basis (monthly payroll may apply).

The IRS limits the amount both Florida Cancer Specialists and you can contribute annually as shown in the following table.

HSA Annual Maximum Contribution Amounts			
Coverage Level	**2021 IRS Limit**	**FCS Contribution**	**Your Maximum Contribution**
Individual Coverage	$3,600	$500	$3,100
Employee + Dependents	$7,200	$1,000	$6,200
If you are age 55 or older, you can contribute up to an additional $1,000 annually as a catch-up contribution.			
FCS contributions are subject to change or discontinuance in future years.			

HSA Eligibility

You are able to open and contribute pre-tax earnings to an HSA if you meet these requirements:

- Enrolled in an IRS qualified HDHP
- Cannot be enrolled in a medical plan through your spouse or other employer sponsored plan options
- Cannot be enrolled in a Government sponsored program (Medicare, Medicaid, Tricare, etc.)
- Cannot have received Veterans Administration benefits within the last three months (unless receiving benefits for a service-related disability)
- Cannot be claimed as a dependent on someone else's tax return (except your spouse's)
- Cannot have an HSA and healthcare FSA; your spouse cannot have a healthcare FSA through his/her own employer

Debit Card

If you are a new participant in the HDHP with HSA, you will receive a debit card to use in paying expenses from your HSA. If you are continuing to participate in the HDHP with HSA and already have an HSA debit card, you can continue using your card as your funds will be loaded on the card for the new year.

Opening an HSA

We partner with Flores & Associates, powered by Avidia Bank, for our HSA program. You may open and manage your HSA at **flores247.com**. After your HSA is set up, you will receive a welcome email with login instructions and more information. You will receive a debit card within 10 business days after the date your HSA becomes effective. If you already have an HSA debit card, your funds will be added to your existing account.

Paying Expenses from an HSA

After you set up your HSA, the administrator will send you a welcome kit containing a debit card and additional information on managing your HSA. Also, please be aware that you:

- Can only pay expenses up to the balance in your account
- Must use the money to pay qualifying expenses or you will need to pay taxes and possibly a penalty
- Can pay your tax dependents' expenses from an HSA even if they are not covered in the HDHP with HSA
- However, you cannot pay expenses for a dependent who is not your tax dependent, even if that person is enrolled in the HDHP with HSA

You may use an HSA to pay for:

- Medical plan deductibles, coinsurance, and copayments
- Expenses not covered by a health plan
- Many over-the-counter (OTC) medications with or without a prescription (see the "Paying for OTC Medications and Products from an HSA or FSA" on this page). A list of qualifying expenses is also available in IRS publication 502 and on the Flores & Associates website at flores247.com.

Calculating How Much to Contribute

The calculator at **flores247.com** can help you estimate how much to contribute to an HSA.

Paying for OTC Medications and Products from an HSA or FSA

You can pay for many popular OTC drugs and medicines from your Health Savings Account or Healthcare Flexible Spending Account without a prescription. These include medications and products for pain relief, flu and cold, allergies, heartburn, and menstrual care (including tampons, pads, and menstrual sponges).

Teladoc

Teladoc gives you affordable 24/7/365 access to a doctor through the convenience of phone or video consults. You can speak to a licensed doctor by web, phone, or mobile app generally within 10 minutes.

When Can I Use Teladoc?

- In place of your doctor or when you need a doctor for primacy care
- If your doctor is unavailable
- For short-term prescriptions
- If you're considering the ER or urgent care center for a non-emergency issue
- On vacation, on a business trip, or away from home

Get The Care You Need

Teladoc doctors can treat many medical conditions, including the following:

- Cold and flu symptoms
- Allergies
- Bronchitis
- Skin problems
- Respiratory infection
- Sinus problems
- And more!

Corrected rates as of 11/17/20 effective 1/1/21

Teladoc Features	Your Copay Per Visit		
	Core	Prime	HDHP with HSA
PCP visit	$10	$10	$55, then 10% after deductible
Dermatology	$35	$30	$85, then 10% after deductible
Behavioral			
Psychologist, Licensed Clinical Social Worker, Counselor, or Therapist	$35	$35	$90, then 10% after deductible
Psychiatrist (initial visit)	$50	$45	$220, then 10% after deductible
Psychiatrist (ongoing visit)	$40	$40	$100, then 10% after deductible

Teladoc is available based on participation in an FCS medical plan.

Share With Your PCP

With your consent, Teladoc will provide information about your Teladoc consult to your primary care physician.

Teladoc

Teladoc.com
800.Teladoc (835.2362)
Facebook.com/Teladoc
Teladoc.com/mobile

Enhanced Coverage: Diabetes Testing Supplies

The FCS health plan offers the following enhanced coverage for diabetes testing supplies, which are provided as part of the preferred diabetes treatment plan.

1. Diabetes Supplies through the LivingConnected from CCS Medical Diabetes Wellness Program will be part of the treatment plan for those plan participants who are diagnosed with diabetes.
2. All diabetes supplies provided by the FCS plan as part of the Preferred Diabetes Treatment Plan through LivingConnected Diabetes Program will be provided to covered employees and their covered dependents, at no cost.
   The supplies provided at no cost include the following.
   - One glucose meter
   - Control solution
   - Lancets
   - Lancing devices
   - Diabetes testing strips
3. Participation in the Preferred Diabetes Treatment Plan is voluntary. Should you or your dependents who are diagnosed with diabetes choose not to participate, you must opt out by calling LivingConnected at 800.966.2046. Those participants who opt out of the treatment plan will be responsible for diabetes supply purchases at the standard copays, just as they were prior to the LivingConnected Diabetes Program.
4. As part of the Preferred Diabetes Treatment Plan, members will have access to their personal health information collected by LivingConnected for the Diabetes Wellness Program. This access will be provided via a HIPAA compliant web portal, requiring an individual specific user ID and password.

If you or your covered dependent(s) have been diagnosed with diabetes by a physician or you are purchasing diabetes supplies through our drug card, you will receive a letter mailed to your home address advising you of the specifics of the new Preferred Diabetes Treatment Plan. If you do not receive this letter and you have diabetes, please advise LivingConnected at 800.966.2046 as soon as possible to assure you receive your supplies.

Blue365 (BCBS)

We partner with BCBS to offer health and wellness product deals and discounts through Blue365 to employees enrolled in an FCS health plan.

- Offers health and wellness products and services that members can purchase from independent vendors
- Provides access to an online destination featuring healthy deals and discounts exclusively for members
- Using your BCBS Member ID card you can register for the program for access to great deals from gym memberships, to a variety of health & wellness vendors.
- Register at: **blue365deals.com**

Case Management and Health Coaching

Included in Your Plan at No Additional Cost

Case management and health coaching is included in your plan at no additional cost.

When you're dealing with difficult health issues, you face some tough decisions. It can help to have your own personal case manager. Through BCBS you can work with a registered nurse who can help you get the answers and services you need.

Case management can be especially helpful for members who experience the following.

- Frequent hospitalization
- Long-term illness
- Extensive home healthcare
- Life-threatening illness
- Effects of traumatic injury

This is a voluntary program. You can choose whether or not to have a case manager and you can withdraw from the program any time.

Health Coaching

With health coaching through BCBS, you'll have a personal coach to support, guide and motivate you to make healthy lifestyle changes at your own pace. Your coach can:

- Help identify barriers to reaching and maintaining your health goals
- Personalize your plan for better health
- Help you find a physician if you don't have one
- Help you get the most out of your health benefits

Some examples of Health Coaching programs through BCBS of Florida are as follows:

- Back care
- Maternity management (preconception, maternity, and postpartum care)
- Pre-hypertension
- Stress management
- Tobacco-free living
- Weight management (pediatric and adult)
- Anxiety
- Attention deficit hyperactivity disorder (ADHD)
- Asthma (pediatric and adult)
- Bipolar disorder
- Coronary artery disease (CAD)
- Chronic heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Diabetes (adult and pediatric)
- Hypertension (high blood pressure)
- Hyperlipidemia (high cholesterol)
- Migraine
- Recovery support

Signing Up

If you would like to try case management, just call the customer service number on the back of your insurance card and ask to speak to a case manager. You may opt out of the program at any time by notifying your case manager.

Your Choices for Care

Your medical benefits through FCS offer several options for treatment. Each option provides different levels of care based on your situation and needs. Making the right choice can save you time and money! Use the following table to learn about the different service options available and the right choice for different situations. The cost ranges from the least expensive (top row) to the most expensive (bottom row). Plans vary in how they cover these services.

	Service	Estimated Wait
	**24-Hour NurseLine** Talk to a nurse 24/7 about common illnesses and types of care	**36 seconds** for calls to be answered
	**Teladoc** Consults by phone or online video for routine ailments	**17 minutes** for doctor to respond
	**Retail clinic** Clinics located in retail stores, supermarkets, and pharmacies	**15 minutes** or less
	**Urgent Care / Walk-in clinic** Daytime and weekend treatment for illnesses or injuries	**20 to 30 minutes**
	**Clinical care (doctor's office)** See your primary care provider for preventive and ongoing care	**1 week** or longer for an appointment
	**Emergency Room** Serious injuries or illnesses. Non-emergency visits may not be covered.	**3 to 12 hours** for non-critical cases

The information is for illustration purposes to show some of the different types of care. For specific plan options, and cost, please refer to your employer's benefits plan design, and overall benefits details.

Frequent Questions – Healthcare Benefits

How will I enroll in benefits or make changes?

If you are enrolling for the first time, you will use SyncHR to elect your benefits. You will receive separate instructions on how to enroll in your FCS benefits. If you need to make changes you will need to contact Benefits at FCSBenefits@FLcancer.com

When does my health coverage begin?

New hires are eligible the first of the month following 60 days of continuous employment. Other classes may be subject to different eligibility rules. See page 3 for further information or contact Benefits at FCSBenefits@FLcancer.com.

When will I receive my medical insurance cards?

All cards are received around the 10th of the month following the effective date of coverage. Newly enrolled subscribers will receive an EyeMed ID card. Cigna does not send dental ID cards; go to **mycigna.com** to register.

What is a "Deductible"?

A deductible is the amount you pay for covered healthcare services before your insurance plan starts to pay. With a $2,500 deductible, for example, you pay the first $2,500 of covered services yourself. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services.

What is a "Copayment"?

Copayment (or "copay") is a charge that the health insurance plan requires you to pay in order to receive a specific medical service or supply. For example, your health insurance plan may require a $30 copayment for an office visit that costs $180 with the plan paying $150.

What is "Coinsurance"?

Coinsurance is the percentage of costs of a covered healthcare service you pay (20%, for example) after you've paid your deductible. Let's say your health insurance plan's allowed amount for an office visit is $100 and your coinsurance is 20%. If you've paid your deductible: You pay 20% of $100, or $20.

What is an "Out-of-Pocket Maximum"?

Out-of-pocket maximum is the most you have to pay for covered services in a plan year. After you spend this amount on deductible and coinsurance, your health plan pays 100% of the costs of covered benefits. The out-of-pocket limit doesn't include your monthly premiums.

Example: the Smith family has an out-of-pocket maximum of 9,000; they have a $3,000 deductible and will pay that first, then pay coinsurance up to $6,000 for the total out-of-pocket maximum amount of $9,000. After the out-of-pocket maximum is met, the health plan pays 100% of the cost of covered benefits for the remainder of the plan year.

What is the difference between "In-Network" and "Out-of- Network"?

"In-network" healthcare providers have contracted with the insurance plan to accept certain negotiated (i.e., discounted) rates for cost of services. You will typically pay less with an in-network provider. "Out-of-network" providers have not agreed to the discounted rates. If you go out of network, you will pay a higher percentage of your coinsurance, plus there is no control on what an out-of-network provider charges for services.

When will my medical costs be paid at 100%?

Eligible medical costs will be covered at 100% for the remainder of the plan year after you fully satisfy your deductible and meet your out-of-pocket maximum.

What does it mean that paycheck contributions are made on a "pre-tax basis"?

This means your premium deduction is taken from your earnings before any taxes are deducted. This pre-tax deduction reduces your total tax obligation. For example, if your premium payment is $150 and your tax bracket is 20%, you will pay $30 less in taxes ($150 × 20% = $30).

Can I make changes to my insurance elections during the calendar year?

Generally, no. In order to change your elections after an Open Enrollment, you must have a qualifying event. These are events such as marriage, divorce, birth/adoption of a child, death of a dependent or spouse, etc. Contact Benefits at FCSBenefits@FLcancer.com for further information.

If my employment terminates with Florida Cancer Specialists when will my insurance coverage end?

Medical and voluntary plan coverages end effective with the last day of your termination of employment with Florida Cancer Specialists.

Note: This section has been updated as of November 25, 2020

I plan to contribute to a Healthcare FSA. When will those funds be available?

Even though you will not have contributed the entire amount until the end of the calendar year, the total "planned" amount is made available to you on January 1 of the year.

Dental Benefits

Maintaining healthy teeth and gums, and seeking professional treatment for dental care is important to your overall health.

You can choose to enroll in one of two dental plan options through Cigna or waive coverage. In both plans, you pay significantly less when using in-network providers.

Dentists listed in the Cigna DPPO Advantage network have agreed to charge discounted rates. To obtain a detailed summry of your coverage and to find an Advantage network dentist, go to **mycigna.com** and click *Find a Doctor, Dentist, or Facility*. Then, select *DPPO/EPO* and *Cigna DPPO* Advantage for the list of network dentists. You can also call Cigna at 800-244-6224. Cigna does not send out Dental Plan ID cards.

More information is available on SyncHR or FCS Intranet (as applicable).

Cigna DPPO Advantage Benefits (in-network)		
	Base Plan	**Buy Up Plan**
Preventive Expenses Benefit	100%	100%
Basic Expenses Benefit	80%	80%
Major Expenses Benefit	50%	50%
Deductible (single/family)	$75/$225	$50/$150
Calendar Year Maximum	$1,500	$2,500
Orthodontia	Not covered	100%—eligible to age 19
Orthodontia Lifetime Maximum	Not available	$1,500

*Composite filings are covered under basic benefit

Note: For either plan, when you use out-of-network providers, you will pay for any charges over the plan's maximum amount for that service billed by the provider (referred to as balance billing). See the Cigna materials for both in-network and out-of-network DPPO/EPO benefits and coverage.

Dental Plan Contribution Rates		
	Bi-Weekly	
	Base Plan	**Buy Up Plan**
Employee Only	$12.32	$14.41
Employee and Spouse/DP	$25.89	$30.28
Employee and Child(ren)	$23.42	$27.39
Family Coverage	$36.98	$43.25

Vision Benefits

The group vision plan is offered through EyeMed. The plan offers a comprehensive package of vision benefits designed to promote eye health. EyeMed will send ID cards to new enrollees.

Vision Plan Features	In-Network	Out-of-Network (reimbursement)
Vision Exam – Once Every 12 Months		
Routine Eye Exam	$10 copay	Up to $30
Lens Benefit – Once Every 12 Months		
Single Vision Lenses (pair)	$15 copay	Up to $25
Bifocal Lenses (pair)	$15 copay	Up to $40
Trifocal Lenses (pair)	$15 copay	Up to $60
Lenticular Lenses (pair)	$15 copay	Up to $60
Frame Benefit – Once Every 12 Months		
Frame	No copay, $130 allowance plus 20% off amount over allowance	Up to $65
Contact Lenses* (in lieu of frame and spectacle lenses) – Once Every 12 Months		
Medically Necessary	No copay, covered at 100%	Up to $210
Elective Contact Lenses		
Conventional	No copay, $130 allowance plus 15% off balance	Up to $104
Disposable	No copay, $130 allowance	

*An additional $20 off the cost of contacts and free shipping is available if you order contacts at contactsdirect.com.

Vision Plan Contribution Rates	Bi-Weekly
Employee Only	$3.18
Employee and Spouse/DP	$6.04
Employee and Child(ren)	$6.36
Family Coverage	$9.35

For more information and a complete listing of network providers, visit: **eyemed.com**.

Retinal Imaging

- The high-resolution images of the inside of your eye can help your doctor identify the early signs of common eye conditions
- They also provide a historical baseline of your eye health, allowing your doctor to compare images year over year, and identify any changes
- Retinal images also enable you to see what the doctor sees when looking inside the eye
- You'll be able to review images with your doctor to better understand your eye health
- Retinal imaging is also referred to as fundus photography
- Each member pays no more than $39 and is eligible for one imaging per year

Additional Plan Features

- **Contacts Direct:** get an additional $20 off member purchase and free shipping at **contactsdirect.com**
- **Sun Perks:** $20 off any purchase; or, $50 off a purchase of $200 or more from Sunglass Hut or **sunglasshut.com**
- **Hearing Health Discount:** Receive a 40% discount off of hearing exams and a low price guarantee on set, discounted pricing of hearing aids.

Flexible Spending Accounts

Healthcare Flexible Spending Accounts (FSA)

An FSA allows you to set aside a portion of your earnings to pay for qualified healthcare expenses as established by the IRS. You do not have to be enrolled in the medical, dental, or vision plans to enroll in a healthcare FSA. Money deducted from your paycheck into the FSA account is not subject to payroll taxes, resulting in a payroll tax savings to you. For 2021, you may contribute up to $2,750.

Once you begin contributing, you may not change or stop your contribution or change elections during the year unless you have a qualifying family status/life event change.

Paying Expenses

Flores & Associates administers our FSAs. If you enroll, you will receive a Flores & Associates Mastercard to use in paying eligible expenses, including:

- Medical, dental, and vision care expenses not covered by a health plan
- Deductibles, coinsurance, and copayments
- Other qualified expenses which are allowable for a medical tax deduction
- Certain over-the-counter medications and products (see the "Paying for OTC Medications and Products from an HSA or FSA" box on page 11.

Note: the FSA healthcare plan does not allow reimbursement for claims of domestic partners or their children.

If you already have an FSA debit card, your funds will be added to your existing account for the new year.

Expenses must be incurred in 2021 while you are a covered participant in the plan. You may roll over up to a maximum of $550 of any unused money in your healthcare FSA at the end of the year to be used in your healthcare FSA. Any additional balance will be forfeited to comply with IRS regulations. Please note any amount you roll over does not affect your $2,750 annual election.

Healthcare Flexible Spending Account

The Healthcare FSA is designed for you if you enroll in the PPO Plan or you do not elect an FCS medical plan. You can contribute pre-tax earnings to your account and use the money to pay eligible medical, dental, and vision care expenses.

Carryover Unused Funds

If you enroll in the HDHP with HSA for next year and you have a healthcare FSA with a balance at the end of this year, you will not receive any contributions to the HSA unless you can dispose of the balance in your healthcare FSA by the end of this year.

Calculating How Much to Contribute

Use the calculator at **flores247.com** to help you estimate how much to contribute to your FSA.

Enrolling Mid-Year

If you are enrolling mid-year, an FSA cannot be used for expenses incurred before you are eligible for benefits.

Estimate Your Healthcare Expenses

When calculating expenses for 2021, estimate carefully! The IRS allows a maximum contribution amount to healthcare FSA, and a rollover of up to $550 to the next plan year. Any remaining balance at the end of the plan year above $550 is not refundable.

Estimated Monthly Healthcare Expenses		x12
Deductibles (medical, dental, Rx)	$	$
Coinsurance	$	$
Prescriptions	$	$
Total	$	$

Decide on Your Contribution

Annual total $_____ divided by 26 pay periods* $_____

Dependent Care Flexible Spending Accounts

Florida Cancer Specialists also makes available a flexible spending account for dependent child care and eldercare expenses (per IRS regulations). You can contribute up to $5,000 per year.

Expenses must be incurred in 2021 while you are a covered participant in the plan and elections cannot be stopped or changed during the year unless you have a qualified family status change (as defined by the IRS).

You cannot use both a child care tax credit and a flex dependent care account. You cannot use your Dependent Care FSA for healthcare-related expenses. The flexible spending account for dependent care is administered by Flores & Associates.

Note: the FSA dependent care plan does not allow reimbursement for claims for the children of domestic partners unless the child is claimed as a dependent on your taxes or if you file your taxes jointly.

You cannot use your Flores Mastercard with your dependent care account.

Reminder: unused money in your dependent care account at the end of the year will not be allowed to be used in the following plan year, nor will it be refunded, so plan ahead before electing this benefit! However, you can submit a claim form signed by your care provider to Flores to be reimbursed each pay period.

To help estimate your contribution amount, use this worksheet.

Estimate Your Dependent Care Expenses

Plan carefully! The IRS does not allow rollover or refund of unused dependent care funds.

Estimated Monthly Healthcare Expenses		x12
Monthly Daycare Expenses	$	$
Total	$	$

Decide on Your Contribution

Annual total $_____ divided by 26 pay periods* $_____

*Note: The amount deducted from your paycheck will be based on the number of pay periods during the calendar year (12, 24, 26, 27) and subject to rounding. For the above calculations you should use the applicable number of pay periods to estimate your expenses.

Life and AD&D Insurance

Employer-Paid Life and AD&D

FCS provides an employer-paid life and AD&D benefit at no cost to you. The benefit amount equals one times your annual compensation with a minimum of $25,000, not to exceed $50,000, rounded up to the next higher $1,000. An amount equal to your life insurance benefit is paid if your death is due to an accident. A portion of your benefit is paid following a covered injury. The benefits amount is based on the injury.

Imputed Income

For your employer-paid life insurance, any coverage amount exceeding $50,000 will be subject to imputed income. Imputed income can be explained as follows: Life insurance is a tax-free benefit in amounts up to $50,000. The Internal Revenue Service requires you to pay income tax on the value of any amount exceeding $50,000. The IRS-determined value is called "imputed income" and is calculated from the government's "Uniform Premium Table I." This Table can be found in the **irs.gov** website.

Employee-Paid Life and AD&D Insurance

To supplement your company-paid Basic Life and Accidental Death and Dismemberment (AD&D) Insurance, you can elect coverage for yourself and dependents through Cigna Voluntary Life Insurance. Please be aware of the following requirements before enrolling.

During Open Enrollment

- **For You:** If currently insured under the Cigna Voluntary Life and AD&D insurance plan, you may increase your life insurance coverage by up to one unit of $10,000 if the total benefit amount does not exceed the Guarantee Issue Amount of $350,000. For any other amount, up to the maximum of $500,000, you must provide evidence of insurability.
- **For Your Eligible Spouse or Domestic Partner:** If you elect coverage for yourself, you may also elect coverage for your eligible spouse or domestic partner. If your spouse/domestic partner is currently insured under the Cigna Voluntary Life and AD&D insurance plan, you may increase life insurance coverage by up to one unit of $5,000 if the total benefit amount does not exceed the Guarantee Issue Amount of $50,000. For any other amount, up to the maximum of $250,000, you must provide evidence of insurability.
- **For Your Dependent Children:** You can elect $10,000 in coverage for children from age six months to 26 years or $250 for children under six months. Evidence of insurability is not required.

For Newly Hired or Newly Eligible Employees

- **For You:** You can elect up to the $350,000 Guarantee Issue in $10,000 increments without evidence of insurability. You can elect up to the maximum benefit of $500,000, not to exceed five times your annual salary, if you provide evidence of insurability. Highlighted below.
- **For Your Eligible Spouse or Domestic Partner:** If your spouse or domestic partner was not previously enrolled, you may elect up to the Guarantee Issue amount of $50,000 in $5,000 increments without evidence of insurability. For any other amount, up to the $250,000 maximum, you must provide evidence of insurability.
- **For Your Dependent Children:** You can elect $10,000 in coverage for children from age six months to 26 years or $250 for children under six months. Evidence of insurability is not required.

What Is Evidence of Insurability?

If you elect a coverage amount requiring evidence of insurability for yourself and/or your spouse/domestic partner, Cigna will require you to complete and submit a medical questionnaire for the carrier to review and approve or deny before any coverage amount requiring evidence of insurability can begin. For more information, and to obtain (as applicable) the medical questionnaire form, you may contact Cigna at 800.244.6224.

Voluntary Life and AD&D Coverage During Open Enrollment (if you already have coverage)		
Coverage	**Without Evidence of Insurability**	**With Evidence of Insurability**
For you	If you are currently insured in this plan, you may increase your coverage by one $10,000 unit up the Guarantee Issue total amount of $350,000.	For any other amount, up to $500,000, not to exceed 5× salary.
For your spouse	If you purchase coverage for yourself and your spouse/domestic partner is currently insured in this plan, you may increase coverage by one $5,000 unit up to the Guarantee Issue amount of $50,000.	For any other amount, up to $250,000.
For your dependent child(ren)	If you purchase coverage for yourself, you may purchase $10,000 in coverage for your eligible dependent children from six months of age up to 26 years. For children under age six months, you can elect a $250 benefit. Evidence of insurability is not required.	

Rates are available via SyncHR and/or SharePoint (as applicable).

Electing Voluntary Life Insurance as a Newly Hired Employee		
Coverage	**Without Evidence of Insurability**	**With Evidence of Insurability**
For you	Elect up to the $350,000 Guarantee Issue in $10,000 increments.	For any other amount up to the maximum benefit of $500,000, not to exceed 5× salary.
For your spouse	Elect up to the Guarantee Issue amount of $50,000 in $5,000 increments.	For any other amount, up to the $250,000 maximum.
For your dependent child(ren)	If you purchase coverage for yourself, you may purchase $10,000 in coverage for your eligible dependent children from six months of age up to 26 years. For children under age six months, you can elect a $250 benefit. Evidence of insurability is not required.	

Rates are available via SyncHR and/or SharePoint (as applicable).

Benefit Reductions Begin at Age 65

Benefits are reduced when reaching these ages for Basic Life and Voluntary Life Insurance for you and your enrolled spouse/domestic partner:

- 65% at age 65
- 40% at age 70
- 20% beginning at age 75.

Contribution Rates

The contribution rates can be accessed via SyncHR and/or Sharepoint (as applicable).

Accidental Death and Dismemberment Insurance

An amount equal to your life insurance election is paid if your death is from an accident. A portion of your life insurance benefit is paid to you for a covered injury. The amount is based on the injury.

Beneficiary

For both the employer-paid and voluntary life insurance coverage and AD&D coverage, be sure to elect at least one beneficiary. You are the beneficiary for your dependents' coverage.

Cigna Resources

You have additional resources through Cigna, including services at no cost to you. More details are available in SyncHR and/or SharePoint (as applicable) or by contacting Cigna at the phone number or website listed below.

Life Assistance and Life Work Support Program

You or a household member can call at any time for a phone consultation or referral to meet face-to-face with a local behavioral counselor or to set up a free 30-minute consultation with a network attorney or financial counselor for help with tax planning and preparation.

My Secure Advantage

Financial issues are a major cause of stress for many people. Through My Secure Advantage, you can have full-service financial counseling available. Take advantage of a free 30-minute consultation with a certified financial expert; then connect with a Money Coach at no cost to you for 30 days. After the first 30 days, you may continue working with your Money Coach for $39.95 a month.

Cigna Secure Travel

Emergencies can happen while traveling, but help is just a phone call away with Cigna Secure Travel. You can get help with pre-trip planning and assistance while traveling. This includes emergency medical transportation benefits for covered persons when traveling 100 or more miles from your home domestically or internationally, 24-hour multilinguistic and translation services, medical care referrals, assistance with lost or stolen items, and access to up to $1,500 in emergency cash. Many more services are available.

Cignassurance for Beneficiaries

This free service is available to the beneficiaries you have designated for your Cigna life insurance benefits.

Services include: a free, interest-bearing account for claim payments of $5,000 or more, bereavement counseling, financial and legal assistance, will preparation, identify theft recovery, and more.

Life Assistance Program
800.538.3543
cignalap.com

My Secure Advantage
888.724.2262
cigna.mysecureadvantage.com

Cigna Secure Travel
888.226.4567
Email: Cigna@gga-usa.com

Cignassurance
Available 24/7
Cignassurance.com

Cigna Short Term Disability

Prepare for the Unexpected with Short Term Disability (STD) Insurance

Eligible employees are able to purchase voluntary STD insurance (100% employee paid) which provides benefits if you become disabled because of a non-occupational illness or injury and cannot work in your own job. Payment begins on the 8th day for accident and for illness with a benefit of up to 60% of your basic weekly earnings with a maximum benefit of $1,000 per week.

Evidence of Insurability

If you elect coverage when you are first eligible to enroll in FCS benefits, you do not need to provide evidence of insurability. However, if you elect coverage at a later date, such as during an Open Enrollment, you will need to complete and submit a medical questionnaire to the carrier to review before your election is approved. For more information or to obtain a copy of the medical questionnaire (as applicable) you can contact Cigna at 800.244.6224.

Pre-existing Conditions

Pre-existing conditions will not be covered if you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed medications, or for which a reasonable person would have consulted a physician within three months before the effective date of insurance. This pre-existing requirement will be satisfied after six months of continuous enrollment.

Employee STD Calculation

To calculate your STD bi-weekly payroll deduction, use the formula indicated below. Round all numbers to the nearest whole number.

Calculate Your STD Bi-weekly Payroll Deduction		
	Enter your annual salary*, not to exceed $86,667	
1	If you work part-time, to calculate your annual salary: Hourly rate × # scheduled hours per week = weekly salary Weekly salary × 52 = annual salary	$
2	Divide your annual earnings (line 1) by 52	$
3	Multiply the amount on line 2 by 0.60	$
4	Multiply the amount on line 3 by 0.061 to get the monthly cost	$
5	Multiply the amount on line 4 by 12 to get your annual cost	$
6	Divide the annual cost by 26 to get your bi-weekly cost	$

*To determine your annual salary, multiply your hourly rate by 2,080 hours

Note: The amount deducted from your paycheck will be based on the number of pay periods during the calendar year (12, 24, 26, 27) and subject to rounding. For the above calculations you should use the applicable number of pay periods to estimate your expenses.

Effective January 1, 2021, once you have met the eligibility 1st of the month following 12 months of continuous employment, FCS will offer a 4-week paid parental leave for eligible employees. Please refer to the FCS leave policy and/or contact HR@FLcancer.com for any questions regarding leaves.

For employees participating in the Short Term Disability (STD) plan, the parental leave will run concurrent with the STD plan as applicable. For further information regarding STD, you may contact Cigna at 888-842-4462.

Continuing Benefits while on Leave

In the event you have a status change or a leave of absence that is unpaid, any continued benefits and premiums for existing elections will continue to apply to maintain coverage(s). Given that you may not be receiving your regular paycheck or a reduced paycheck, the benefits premiums will accrue from the date of the missed payroll deduction--this is referred to as "Arrears." You will be responsible for paying any Arrears upon your return from leave or start of your payroll checks. Prior to your return, you will receive correspondence from Human Resources which will include the details of your Arrears balance, and the deductions that will apply from your paychecks.

If you have a Qualified Life Event during your unpaid leave that may change your benefits coverage, please contact the HR Benefits team.

If you separate employment, the Arrears will be considered monies owed to the company and will require repayment. The company reserves the right to take further action.

This information serves as a summary of the process with further details outlined within other internal company policies. Under the company's discretion these programs and any related process are subject to change.

Effects of Other Income Benefits

Your FCS Short Term Disability benefits will be reduced by any Social Security or other disability benefits paid to you or your dependents as a result of your disability.

Examples of other income sources which may reduce your benefits include, but are not limited to Social Security disability or retirement benefits, Railroad Retirement Act, company sponsored sick leave, and workers' compensation.

Cigna Long Term Disability

Partner Physicians and Associate Physicians

You are eligible to participate in an LTD plan through Cigna. You may elect a monthly benefit equal to 50% of your covered earnings with a maximum benefit of $10,000 for Associate Physicians and Partner Associates. There is a maximum of $20,000 for Partner Physicians.

Note: A different percentage and maximum benefit amount may be applicable to your practice. Please contact FCSBenefits@FLcancer.com for further information.

Effects of Other Income Benefits

Your FCS Long Term Disability benefits will be reduced by any Social Security or other disability benefits paid to you or your dependents as a result of your disability.

Prepare for the Unexpected with Long Term Disability (LTD) Insurance

Eligible employees are able to purchase voluntary LTD insurance (100% employee paid) which provides benefits should you become disabled because of a non-occupational illness or injury and cannot work in your own job, you would qualify for LTD. This benefit would begin paying on the 91st day of the illness or injury, but may continue until retirement. You would receive 60% of your monthly earnings to a maximum of $10,000 per month.

Evidence of Insurability

If you elect coverage when you are first eligible to enroll in FCS benefits, you do not need to provide evidence of insurability. However, if you elect coverage at a later date, such as during an Open Enrollment, you will need to complete and submit a medical questionnaire to the carrier to review before you election is approved. For more information, and an to obtain (as applicable) the medical questionnaire form, you may contact Cigna at 800.244.6224.

Pre-existing Conditions

Pre-existing conditions will not be covered if you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed medications, or for which a reasonable person would have consulted a physician within three months before the effective date of insurance. This pre-existing requirement will be satisfied after six months of continuous enrollment.

Employee LTD Calculation

To calculate your LTD bi-weekly payroll deduction, use the formula indicated below. Round all numbers to the nearest whole number.

Calculate Your LTD Bi-weekly Payroll Deduction		
	Enter your annual salary*	
1	If you work part-time, to calculate your annual salary: Hourly rate × # scheduled hours per week = weekly salary; Weekly salary × 52 = annual salary	$
2	Divide your annual earnings by 12 (monthly income); average monthly income cannot exceed $16,666	$
3	Multiply the amount on line 2 by 0.60	$
4	Divide the amount on line 3 by 100 and enter the amount on line 4 to get your monthly cost	$
5	Multiply the amount on line 4 by 12 to get your annual cost	$
6	Divide the annual cost by 26 to get your bi-weekly cost	$

*To determine your annual salary, multiply your hourly rate by 2,080 hours

Note: Executive, and certain Physician classes may be eligible for supplemental income protection with Guardian Life, and additional disability insurance protection through Lloyds of London. Details are available through SyncHR.

Cigna Voluntary Benefits

Voluntary Critical Illness Insurance

Critical Illness insurance provides a cash benefit when a covered person is diagnosed with a covered critical illness or event after coverage is in effect.

Available Coverage

The benefit amounts shown will be paid regardless of the actual expenses incurred. The benefit descriptions are a summary only. There are terms, conditions, state variations, exclusions, and limitations applicable to these benefits. Please read all of the information in this summary and your certificate of insurance for more information. All covered critical illness conditions must be due to disease or sickness.

	Benefit Amount	Guaranteed Issue Amount
Employee	$20,000, $10,000, $5,000	Up to $20,000
Spouse	50% of employee amount	Up to $10,000
Children	25% of employee amount	All guaranteed issue

Covered Cancer Conditions	Benefit Amount
Skin Cancer*	$250—1× per lifetime
Second Opinion Cancer	$500—1× per lifetime

*For Childhood Conditions, the Initial Benefit Amount % listed above refers to the Employee's percentage amount. Please refer to the beginning of the Available Coverage section above for details on how much coverage is available for covered children.

Covered Conditions	Initial Benefit Amount %	Recurrence % of Initial Benefit Amount
Invasive Cancer	100%	100%
Carcinoma In Situ	25%	25%
Vascular Conditions		
Heart Attack	100%	100%
Stroke	100%	100%
Coronary Artery Disease	25%	25%
Nervous System Conditions		
Advanced Alzheimer's Disease	25%	Not available
Amyotrophic Lateral Sclerosis (ALS)	25%	Not available
Parkinson's Disease	25%	Not available
Multiple Sclerosis	25%	Not available
Infectious Conditions		
Bacterial Meningitis	25%	25%
Malaria	25%	25%
Tuberculosis	25%	25%
Necrotizing Fasciitis	25%	25%
Osteomyelitis	25%	25%
Childhood Conditions*		
Cerebral Palsy	100%	Not available
Cystic Fibrosis	100%	100%
Muscular Dystrophy	100%	100%
Poliomyelitis	100%	Not available
Other Specified Conditions		
Benign Brain Tumor	100%	100%
Blindness	100%	Not available
Coma	25%	25%
End-Stage Renal (Kidney) Disease	100%	100%
Major Organ Failure	100%	100%
Paralysis	100%	100%
Occupational Conditions		
Occupational Hepatitis-B	100%	100%
Occupational Hepatitis-C	100%	100%
Occupational HIV*	100%	100%

*For Childhood Conditions, the Initial Benefit Amount % listed above refers to the Employee's percentage amount. Please refer to the beginning of the Available Coverage section above for details on how much coverage is available for covered children.

Wellness Treatment, Health Screening Test, or Preventive Care Benefit*	Benefit Amount
Examples includes (but are not limited to) routine gynecological exams, general health exams, mammography, and certain blood tests. A 30-day benefit waiting period applies, during which benefits will not be paid.	$100 per day, limited to 1 per year

* For Childhood Conditions, the Initial Benefit Amount % listed above refers to the Employee's percentage amount. Please refer to the beginning of the Available Coverage section above for details on how much coverage is available for covered children.

Benefits	
Initial Critical Illness Benefit	Benefit for a diagnosis made after the effective date of coverage for each covered condition shown above. The amount payable per covered condition is the initial benefit amount multiplied by the applicable percentage shown. Each covered condition will be payable one time per covered person, subject to the maximum lifetime limit. A 180 days separation period between the dates of diagnosis is required.*
Recurrence Benefit	Benefit for the diagnosis of a subsequent and same covered condition for which an Initial critical illness benefit has been paid, payable after a 12-month separation period from diagnosis of a previous covered condition, subject to the maximum lifetime limit.
Skin Cancer Benefit and Second Opinion	Pays benefit stated above.
Maximum Lifetime Limit	The maximum benefit payable per covered person is the lesser of 5 times the elected benefit amount or $100,000. The following benefits are not subject to this limit: skin cancer, second opinion, and additional benefits.

Portability Feature: You can continue 100% of coverage for all covered persons at the time your coverage ends. You must be covered under the policy and be under the age of 70 in order to continue your coverage. Rates may change and all coverage ends at age 100. Applies to United States Citizens and Permanent Resident Aliens residing in the United States.

Voluntary Critical Illness Bi-Weekly Contribution Rates

Benefit Amount: $5,000

	Employee		Employee + Spouse		Employee + Children		Employee + Family	
Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
<25	$2.93	$3.02	$4.45	$4.60	$2.93	$3.02	$4.45	$4.60
25 to 29	$3.02	$3.18	$4.55	$4.81	$3.02	$3.18	$4.55	$4.81
30 to 34	$3.25	$3.59	$4.85	$5.34	$3.25	$3.59	$4.85	$5.34
35 to 39	$3.58	$4.28	$5.31	$6.34	$3.58	$4.28	$5.31	$6.34
40 to 44	$3.88	$4.92	$5.77	$7.29	$3.88	$4.92	$5.77	$7.29
45 to 49	$4.45	$6.14	$6.65	$9.20	$4.45	$6.14	$6.65	$9.20
50 to 54	$5.07	$7.41	$7.81	$11.40	$5.07	$7.41	$7.81	$11.40
55 to 59	$5.85	$8.79	$9.33	$14.80	$5.85	$8.79	$9.33	$14.80
60 to 64	$6.71	$10.13	$10.85	$16.42	$6.71	$10.13	$10.85	$16.42
65 to 69	$7.77	$11.79	$12.52	$18.60	$7.77	$11.79	$12.52	$18.60
70 to 74	$10.17	$14.99	$16.11	$23.56	$10.17	$14.99	$16.11	$23.56
75 to 79	$13.14	$17.80	$20.43	$27.87	$13.14	$17.80	$20.43	$27.87
80 to 84	$15.59	$21.20	$24.24	$33.22	$15.59	$21.20	$24.24	$33.22
85 to 89	$21.08	$25.01	$32.80	$39.03	$21.08	$25.01	$32.80	$39.03
90 to 94	$21.08	$25.01	$32.80	$39.03	$21.08	$25.01	$32.80	$39.03
95+	$21.08	$25.01	$32.80	$39.03	$21.08	$25.01	$32.80	$39.03

Voluntary Critical Illness Bi-Weekly Contribution Rates Benefit Amount: $10,000								
	Employee		Employee + Spouse		Employee + Children		Employee + Family	
Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
<25	$3.75	$3.93	$5.51	$5.81	$3.75	$3.93	$5.51	$5.81
25 to 29	$3.92	$4.26	$5.72	$6.23	$3.92	$4.26	$5.72	$6.23
30 to 34	$4.39	$5.06	$6.32	$7.29	$4.39	$5.06	$6.32	$7.29
35 to 39	$5.04	$6.46	$7.23	$9.29	$5.04	$6.46	$7.32	$9.29
40 to 44	$5.65	$7.72	$8.15	$11.20	$5.65	$7.72	$8.15	$11.20
45 to 49	$6.80	$10.18	$9.91	$15.00	$6.80	$10.18	$9.91	$15.00
50 to 54	$8.02	$12.70	$12.23	$19.42	$8.02	$12.70	$12.23	$19.42
55 to 59	$9.58	$15.47	$15.27	$24.77	$9.58	$15.47	$15.27	$24.77
60 to 64	$11.30	$18.14	$18.31	$29.46	$11.30	$18.14	$18.31	$29.46
65 to 69	$13.44	$21.47	$21.65	$33.82	$13.44	$21.47	$21.65	$33.82
70 to 74	$18.23	$27.86	$28.83	$43.73	$18.23	$27.86	$28.83	$43.73
75 to 79	$24.17	$33.50	$37.47	$52.35	$24.17	$33.50	$37.47	$52.35
80 to 84	$29.07	$40.28	$45.10	$63.04	$29.07	$40.28	$45.10	$63.04
85 to 89	$40.05	$47.91	$62.21	$74.67	$40.05	$47.91	$62.21	$74.67
90 to 94	$40.05	$47.91	$62.21	$74.67	$40.05	$47.91	$62.21	$74.67
95+	$40.05	$47.91	$62.21	$74.67	$40.05	$47.91	$62.21	$74.67

Voluntary Critical Illness Bi-Weekly Contribution Rates Benefit Amount: $20,000								
	Employee		Employee + Spouse		Employee + Children		Employee + Family	
Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
<25	$5.39	$5.76	$7.64	$8.23	$5.39	$5.76	$7.64	$8.23
25 to 29	$5.73	$6.40	$8.05	$9.08	$5.73	$6.40	$8.05	$9.08
30 to 34	$6.68	$8.01	$9.25	$11.20	$6.68	$8.01	$9.25	$11.20
35 to 39	$7.97	$10.80	$11.08	$15.20	$7.97	$10.80	$11.08	$15.20
40 to 44	$9.18	$13.33	$12.92	$19.01	$9.18	$13.33	$12.92	$19.01
45 to 49	$11.48	$18.24	$16.43	$26.62	$11.48	$18.24	$16.43	$26.62
50 to 54	$13.93	$23.29	$21.07	$35.45	$13.93	$23.29	$21.07	$35.45
55 to 59	$17.05	$28.83	$27.16	$46.16	$17.05	$28.83	$27.16	$46.16
60 to 64	$20.49	$34.17	$33.24	$55.52	$20.49	$34.17	$33.24	$55.52
65 to 69	$24.76	$40.83	$39.92	$64.25	$24.76	$40.83	$39.92	$64.25
70 to 74	$34.35	$53.61	$54.26	$84.07	$34.35	$53.61	$54.26	$84.07
75 to 79	$46.22	$64.88	$71.55	$101.32	$46.22	$64.88	$71.55	$101.32
80 to 84	$56.04	$78.45	$86.80	$122.70	$56.04	$78.45	$86.60	$122.70
85 to 89	$77.98	$93.70	$121.03	$145.95	$77.98	$93.70	$121.03	$145.95
90 to 94	$77.98	$93.70	$121.03	$145.95	$77.98	$93.70	$121.03	$145.95
95+	$77.98	$93.70	$121.03	$145.95	$77.98	$93.70	$121.03	$145.95

Rates are subject to change. Actual per pay period premiums may differ slightly due to rounding.

Voluntary Accident Insurance

Accidental injury coverage provides a benefit according to the schedule below when a covered person suffers covered injuries or undergoes a broad range of medical treatments or care resulting from a covered accident.

Available Coverage

This accidental injury plan provides 24-hour coverage. The benefit amounts shown in this summary will be paid regardless of the actual expenses incurred. Benefits are only payable when all policy terms and conditions are met. Please read all the information in this summary to understand terms, conditions, state variations, exclusions and limitations applicable to these benefits. See your certificate of insurance for more information.

Voluntary Accident Insurance Features	Benefit Amount
Initial and Emergency Care	
Ground Ambulance/Air Ambulance	$400/$1,200
Emergency Care Treatment	$400
Diagnostic Exam (x-ray or lab)	$50
Physician Office Visit	$200
Hospitalization Benefits	
Hospital Admission	$2,000
Hospital Stay (per day)	$400
Intensive Care Unit Stay (per day)	$800
Fractures and Dislocations	
Per Covered Surgically-Repaired Fracture	$300-$10,000
Per Covered Non-Surgically-Repaired Fracture	$150-$5,000
Chip Fracture (percent of fracture benefit)	25%
Per Covered Surgically-Repaired Dislocation	$300-$6,000
Per Covered Non-Surgically-Repaired Dislocation	$150-$3,000
Follow-Up Care	
Follow-Up Visit To The Doctor	$200
Follow-Up Physical Therapy Visits	$75
Enhanced Accident Benefits Examples	
Small Lacerations (less than or equal to 6 inches long and requires 2 or more sutures)	$150
Large Lacerations (more than 6 inches long and requires 2 or more sutures)	$800
Coma (lasting 7 days with no response)	$40,000
Concussion	$200
Plus up to 22 additional benefits. See certificate for details, including limitations and exclusions.	
Wellness, Health Screening Test, or Preventive Care Benefit	
Examples include (but are not limited to) routine gynecological exams, general health exams, mammography, and certain blood tests. A 30-day benefit waiting period applies during which benefits will not be paid.	$100 per year

Accidental death and dismemberment rider: Pays benefits for accidental death and dismemberment. Examples of benefits include (but are not limited to) payment for death from automobile accident or total and permanent loss of speech or hearing in both ears. Actual benefit amount paid depends on the type of covered loss. To receive benefits, the death or loss must occur within 365 days of the covered accident.

Benefit-Specific Conditions, Exclusions, Limitation, and Reductions: The exclusions which apply to this benefit are in the common exclusions section. If a covered person dies as a result of an automobile accident or common carrier accident other loss of life benefits will not be paid.

To receive the auto accident death benefit, the persons must be wearing and properly using a seatbelt and auto equipped with the manufacturer's originally air bag system, and if the driver, hold a valid license. Common carrier benefit, the person cannot be the operator. If more than one benefit is payable for the same accident, the largest available benefit is payable and death benefits will be reduced by payable dismemberment benefits.

If total and permanent loss of speech or hearing in both ears is payable, no benefits will be paid under the dismemberment benefit and total benefits will not exceed the loss of life death benefit. Benefit amounts for the covered person's will reduce to 50% at age 100, but child benefits if applicable, will not reduce. This is not a complete list. See certificate for complete details, including limitations and exclusions that apply to this benefit.

Portability Feature: You, your spouse, and child(ren) can continue 100% of your coverage at the time your coverage ends. You must be under the age of 70 in order to continue your coverage. Rates may change and all coverage ends at age 100. Applies to United States Citizens and Permanent Resident Aliens residing in the United States.

Voluntary Accident Insurance Contribution Rates	Bi-Weekly
Employee	$7.02
Employee and Spouse	$16.04
Employee and Child(ren)	$19.64
Family	$25.74

Rates are subject to change. Actual per pay period premiums may differ slightly due to rounding.

For More Information

Additional coverage, benefits, common exclusions, and limitations are described in the Cigna summary located on the enrollment site. Please direct any questions directly to Cigna at 800.754.3207.

Voluntary Hospital Indemnity Insurance

Hospital Indemnity Insurance through Cigna is designed to help you with medical expenses if you or a covered family member are hospitalized. As you review your medical plan enrollment options, consider the expenses you may face if hospitalized. How much would you potentially pay out-of-pocket?

Available Coverage

Hospital Indemnity Insurance provides 24-hour coverage. The benefit amounts shown in the summary will be paid regardless of the actual expenses incurred. Benefits are only payable when all policy terms and conditions are met. Please read all the information in this summary and the Cigna certificate of insurance to understand terms, conditions, state variations, exclusions and limitations applicable to these benefits. See the certificate of insurance for more information.

Benefits are paid directly to the policyholder as a lump-sum amount based on the following schedule.

Voluntary Hospital Indemnity Benefit Features		
Benefit Type	**Summary**	**Benefit Amount**
Hospital Admission	Limited to 1 day, 1 benefit every 365 days	$1,000 per day
Hospital Chronic Condition Admission	Limited to 1 day, 1 benefit every 90 days.	$50 per day
Hospital Stay	Limited to 30 days, 1 benefit every 90 days.	$100 per day
Hospital Intensive Care Unit Stay	Limited to 1 day, 1 benefit every 90 days.	$200 per day
Hospital Observation Stay	24-hour elimination period Limited to 72 hours.	$100 per day
Newborn Nursery Care Admission	Limited to 1 day, 1 benefit per newborn child and paid to employee even if child coverage is not elected.	$500 per day

Portability Feature: You, your spouse, and child(ren) can continue 100% of your coverage at the time your coverage through FCS ends. You must be under the age of 100 to continue coverage. Rates may change and all coverage ends at age 100. Applies to United States citizens and Permanent Resident Allies residing in the United States.

Costs are subject to change. Actual per pay period premium may differ slightly due to rounding.

Voluntary Hospital Indemnity Insurance Contributions Rates	
	Bi-Weekly
Employee	$8.66
Employee and Spouse	$14.79
Employee and Child(ren)	$13.89
Family	$20.01

Employee Assistance Program

Our Employee Assistance Program is provided by ComPsych GuidanceResources. ComPsych GuidanceResources offers confidential access to a trained professional and resources to and resources to consult whenever and wherever you need them. This program provides 24/7 support, resources, and information for the following:

- Emotional Support
- Work-Life Solutions
- Legal Guidance
- Financial Resources
- Online Support

Contact Information

There are two ways to access your GuidanceResources benefits:

1. Call the toll-free number. You'll speak to a counseling professional who can listen to your concerns and guide you to the appropriate services you require.
2. Visit GuidanceResources Online at **guidanceresources.com** and enter your employee ID.

Remember, your GuidanceResources benefits are strictly confidential.

GuidanceResources

guidanceresources.com
Web ID" EAP4FCS
877.809.3056
TTY: 800.697.0353
App: GuidanceNow

401(k) Plan

Employee Contributions

Employees may contribute up to $19,500 pre-tax and/or Roth after tax dollars (per IRS regulations). If you are 50 or older, the IRS allows you to contribute even more pre-tax dollars to your retirement account to help offset smaller contributions from earlier in your working years. If you qualify for these "catch-up" contributions, you can contribute an additional $6,500 to the 401(k). How do you qualify? Simply by being 50 or over. You do not have to be "behind" in your retirement saving goals or below a certain threshold.

401(k) Savings and Retirement Plan

Florida Cancer Specialists's 401(k) profit sharing plan provides an excellent opportunity for employees to enhance their long term financial well-being and plan for their retirement. The 401(k) Plan is administered through Vanguard. More details on Roth and vesting for discretionary profit sharing will be coming soon.

Employees are eligible on the first day of the month after completing six months of continuous employment and if age 18 or older.

Florida Cancer Specialists provides a match of 100% on the first 3% of employee contributions and a 50% match on the next 2% of employee contributions. Employees are 100% vested in their contributions and 100% vested in the Florida Cancer Specialists match. Any profit-sharing contributions apply to a cliff vesting schedule with less than 3 years 0%, and 3 years 100%.

Example

John's annual compensation is $45,000/$1,730 per pay period. He contributes 5% each pay period into the 401(k) plan. John's contribution and the Florida Cancer Specialists match is calculated as follows.

	John	Florida Cancer Specialists
$1,730 × 3%	$51.90	$51.90
$1,730 × 2%	$34.60	$17.30
Totals	$86.50	$69.20

Total per pay period contribution and match = $155.70

Paid Time Off

Paid time off (PTO) for vacation, sick, and personal time off is accrued from your date of hire. You must be in an eligible classification to accrue/earn PTO. Eligible classes are:

- Regular full-time (regularly scheduled 30 to 40 hours per week)
- Regular part-time (regularly scheduled 24 to 29 hours per week)
- Other part-time (regularly scheduled 20 to 23 hours per week)

Although you begin accruing from date of hire, PTO may not be used for any reason until after your 3-month anniversary date. The amount of PTO accrued is based on your years of service and the number of hours you are paid in a work week up to a maximum of 40 hours paid, not including overtime.*

Eligible employees accrue PTO based on the following schedule.

Time Period – Tier	Per Hour Paid Amount Accrued	Maximum Number of Hours Eligible to Accrue per Week and Pay Period Based on Maximum of 40 Hours Paid per Week	Maximum Number of Days/Hours Eligible to Accrue per Year Based on Maximum of 40 Hours Paid per Week
Tier 1: Date of Hire to Completion of 5th Anniversary	0.0693 hours accrued per hour paid	2.77 hours per week max 5.54 hours per pay period max	18.01 days max 144.04 hours max
Tier 2: Beginning of 6th Year through Completion of 10th Anniversary**	0.0885 hours accrued per hour paid	3.54 hours per week max 7.08 hours per pay period max	23.01 days max 184.08 hours max
Tier 3: Beginning of 11th Year and Thereafter**	0.1078 hours accrued per hour paid	4.31 hours per week max 8.62 hours per pay period max	28.02 days max 224.12 hours max

*Paid hours include: work hours, PTO (all paid types), jury duty, paid holiday (see Florida Cancer Specialists Personnel Policy #302 Holidays), bereavement, and education (aka CEU). Actual accruals will not exceed the maximum weekly accrual amount of 40 hours as indicated in the PTO accrual chart above (see Florida Cancer Specialists Personnel Policy #309 Paid Time Off).

**Staff members will also receive at the completion of their 5th year and at the completion of their 10th year, an additional one time upload of PTO hours. The PTO hours are equal to 1 week of your regularly scheduled work hours. If regularly scheduled to work 30 hours per week, the additional PTO hours given will be equal to 30 hours.

Note: Other rules as applicable will be provided.

Changes to Paid Time Off eligibility for certain classes may be subject to change in 2021.

To receive holiday pay, you must work your scheduled day before and day after a holiday (unless on approved PTO).

Holidays

There are 6 paid holidays each year, in addition to a paid floater day.

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day
- Floating Day (employee determines the day) - cannot be rolled over or cashed out. Employees must submit their request in advance for approval similar to PTO request.

Hourly employees are eligible for holiday pay after 30 days of employment. If the holiday falls on a Saturday it is observed on the Friday before, and if it falls on a Sunday it is observed on the Monday immediately following.

Eligible classes are below.

- Regular full-time (regularly scheduled 30 to 40 hours per week)
- Regular part-time (regularly scheduled 24 to 29 hours per week)
- Seasonal full-time (regularly scheduled 30 to 40 hours per week)
- Seasonal part-time (regularly scheduled 24 to 29 hours per week)
- Directors & Above—upon date of hire the PTO eligibility starts with the number of days currently reflected under Tier 2 (23 days)

Education

Tuition Reimbursement and Continuing Education

The FCS tuition reimbursement policy includes undergraduate and graduate degree programs related to a staff member's current position or a position which would be available at FCS.

- Tuition reimbursement is up to $5,250 per calendar year for full-time employees and up to $2,625 per calendar year for part-time employees
- Staff members must remain employed in either a full-time or part- time status for at least 12 months after receiving reimbursement or repayment is required
- A grade of B or better (pass for pass/fail courses) is required for reimbursement

Please contact Human Resources for the tuition reimbursement request form and tuition reimbursement agreement. All tuition reimbursement requests must be approved prior to the start date of the class.

In addition, FCS will provide up to 8 hours of paid CEU time for individuals who are required to have a professional license as part of their job.

Note: Reimbursement amounts are subject to change. Programs and courses are subject to prior approval by Facility Manager, or Operations Director and HR Manager.

Provista – Employee Discount Program

The *Employee Discount Program* is offered through PROVISTA at NO COST TO YOU!

The Employee Discount Program is a unique discount program designed to provide you and your family with pure savings and a one-stop shop for exclusive discounts at many of your favorite national and local merchants! As a member of this great program, you have access to more than 300,000 discount offers. The program is also optimized for use on any device: desktops, tables, and mobile access.

Start Saving: Take advantage of online offers and special pricing on Wireless Phone Service, Movie Tickets, Theme Parks, Sporting Events, Free Legal Services, Discounted Real Estate, Insurance, Lending Services and much more. You can discover discounts in your neighborhood by keying in your zip code onto the local map within the Provista website.

Filter your map results by categories like restaurant, health & wellness, retail, and more!

Getting Started: To register follow the instructions below! Attached you will find further information on the program, including instructions and access details.

Web Access

- Employees can register at **provistaco.com/savings**.
- When registering, you will need to use your work email address.
- We encourage you to visit **provistaco.com/savings** regularly to view the latest offers.

Note: When accessing the AT&T mobile discounts, you will be asked for the AT&T FAN# 03068418. After registering for AT&T, you will need to select att.com/wireless/vizient8 on the drop-down menu.

Mobile Access

For easy mobile access download the app. Search "Employee Discounts by Vizient" in the app store or Google play.

Support: Employees having any issues with the website can click the support button on the site. For more information or questions related to the Exclusive Offers section should be emailed to **vizientsupport@vizientinc.com**.

Should you have any further questions please contact your FCS Benefits Team at **FCSBenefits@FLcancer.com**.

TicketsatWork – Employee Discount Program

TicketsatWork, a unique discount benefits program, is offered exclusively to companies and their employees at NO COST TO YOU!

Who is TicketsatWork?

TicketsatWork is a leading travel and entertainment corporate benefits program that offers exclusive discounts to theme parks, hotels, shows, sporting events, movie tickets, and much more.

Start Saving

The Employee Benefits discount program provides access to many discounts available to you and your family with savings with special pricing to Movie Tickets, Theme Parks, Sporting Events, and much more.

Web Access

You can visit **ticketsatwork.com**, and click Become a Member.

Use the code ***FLCAN*** for access to the program.

TicketsatWork provides bulletin newsletters and information related to monthly savings on their website, and as applicable, information may also be referenced in the various internal company sites (including, but not limited to SyncHR and Sharepoint as applicable).

For more information or questions related to the TicketsatWork, email **customerservice@ticketsatwork.com** or call 800.331.6483.

Benefits Directory

For questions or additional information regarding your benefits, below are the phone numbers and websites for each line of coverage. In addition, the Florida Cancer Specialists Benefit Assistance information is listed should you need further assistance. Please keep in mind, your carrier will be the fastest way to get assistance on any claim issues, locate an in-network doctor, how to register online, and many other services.

Benefit	Vendor	Website	Phone	Note
Medical	Florida Blue	floridablue.com	800.FLA.BLUE (352.2583)	
Prescription Drugs	CVS Caremark / Rx Benefits	caremark.com	800.334.8134	
Diabetic Wellness	LivingConnected		800.966.2046	
Health Savings Account	Flores & Associates	flores247.com	800.532.3327	
Flexible Spending Account	Flores & Associates	flores247.com	800.532.3327	
Dental	Cigna	mycigna.com	800.CIGNA24 (800.244.6224)	
Vision	EyeMed	eyemed.com	866.723.0514	
Employee Assistance Program	ComPsych Guidance Resources	guidanceresources.com Web ID: EAP4FCS App: GuidanceNow	877.809.3056 TTY: 800.697.0353	
Short-Term Disability	Cigna	mycigna.com	888.842.4462	
Long-Term Disability	Cigna	mycigna.com	888.842.4462	
Family Medical Leave	Cigna	mycigna.com	888.842.4462	
Accident Insurance	Cigna	mycigna.com	800.754.3207	Mail documents to: Cigna Phoenix Claims Services P.O. Box 55290 Phoenix, AZ 85078
Hospital Indemnity	Cigna	mycigna.com	800.754.3207	
Critical Illness Insurance	Cigna	mycigna.com	800.754.3207	
Life and AD&D Insurance	Cigna	mycigna.com	800.CIGNA24 (800.244.6224)	
Life Assistance Program	Cigna	cignalap.com	800.538.3543	
My Secure Advantage	Cigna	cigna.mysecureadvantage.com	888.724.2262	
Cigna Secure Travel	Cigna	Email: cigna@gg-usa.com	888.226.4567	
Cignassurance	Cigna	cignassurance.com		Available 24/7
Benefits Administration	FCS Benefits	Email: FCSBenefits@FLcancer.com		
401(k)	Vanguard	vanguard.com/retirement	800.523.1188	Plan Number: 092936
Enrollment	SyncHR	clients.synchr.com Email: FCSbenefits@FLcancer.com		
Human Resources	HR	HR@FLcancer.com		

Legal Notices

IMPORTANT NOTICE FROM FLORIDA CANCER SPECIALISTS & RESEARCH INSTITUTE ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage under the Florida Cancer Specialists & Research Institute medical plans are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2021. This is known as "creditable coverage."

Why this is important: if you or your covered dependent(s) are enrolled in any prescription drug coverage during 2021 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty — as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't not currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Florida Cancer Specialists & Research Institute and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

NOTICE OF CREDITABLE COVERAGE

You may have heard about Medicare's prescription drug coverage (called Part D) and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage, or experiencing another life event, may be eligible to enroll outside of these timeframes if the individual qualifies for a Medicare Special Enrollment Period. Events that will qualify an individual to enroll outside of the dates of October 15 through December 7 may be found here: https://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/special-circumstances-special-enrollment-periods

If you are covered by one of the Florida Cancer Specialists & Research Institute prescription drug plans, you'll be interested to know that the prescription drug coverage under the plan is, on average, at least as good as standard Medicare prescription drug coverage for 2021. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Florida Cancer Specialists & Research Institute plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Florida Cancer Specialists & Research Institute coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the Florida Cancer Specialists & Research Institute plan, assuming you remain eligible.

You should know that if you waive or leave coverage with Florida Cancer Specialists & Research Institute and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future — such as before the next period you can enroll in Medicare prescription drug coverage, if this Florida Cancer Specialists & Research Institute coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Date: October 12, 2020
Name of Entity/Sender: Florida Cancer Specialists & Research Institute
Contact--Position/Office: Human Resources, Benefits Department
Address: 4371 Veronica S. Shoemaker Blvd., Ft. Myers, FL 33916
Phone Number: 239-274-8200
Email: FCSBenefits@FLcancer.com

Notice of Special Enrollment Rights for Health Plan Coverage

As you know, if you have declined enrollment in Florida Cancer Specialists & Research Institute's healthplan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plans without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. 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 eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Florida Cancer Specialists & Research Institute will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Florida Cancer Specialists & Research Institute group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Women's Health and Cancer Rights Act Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 239-274-8200.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at 239-274-8200.

Florida Cancer Specialists & Research Institute HIPAA Privacy Notice

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Florida Cancer Specialists & Research Institute health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: Florida Cancer Specialists, P.L. Employee Welfare Benefits Plan. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Florida Cancer Specialists & Research Institute as an employer — that's the way the HIPAA rules work. Different policies may apply to other Florida Cancer Specialists & Research Institute programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- Payment includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- Health care operations include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with Florida Cancer Specialists & Research Institute

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Florida Cancer Specialists & Research Institute for plan administration purposes. Florida Cancer Specialists & Research Institute may need your health information to administer benefits under the Plan. Florida Cancer Specialists & Research Institute agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. HR and payroll staff are the only Florida Cancer Specialists & Research Institute employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Florida Cancer Specialists & Research Institute, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Florida Cancer Specialists & Research Institute , if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to Florida Cancer Specialists & Research Institute information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Florida Cancer Specialists & Research Institute cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Florida Cancer Specialists & Research Institute from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects

Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request

in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect immediately. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact your plan administrator.

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact your plan administrator 239-274-8200.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.78% (for 2020) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Benefits Service Center at (866) 962-6368.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name: Florida Cancer Specialists & Research Institute	4. Employer Identification Number (EIN): 65-0825133	
5. Employer address: 4371 Veronica S. Shoemaker Blvd	6. Employer phone number: 239-274-8200	
7. City Ft. Myers	8. State: FL	9. Zip code: 33916
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	12. Email address: FCSBenefits@FLcancer.com	

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

- As your employer, we offer a health plan to:
  - ❒ All employees. Eligible employees are:
  - ✓ Some employees. Eligible employees are: All active full-time employee working a minimum of 30 hours a week and all active part-time employees working 24-29 hours a week
- With respect to dependents:
  - ✓ We do offer coverage. Eligible dependents are: Dependents may include your spouse, domestic partner (same or opposite sex) and children as defined by each specific Benefit Program
  - ❒ We do not offer coverage.
  - ✓ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

HIPAA Notice of Reasonable Alternative Standards (for Health-Contingent Wellness Programs)

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program may be available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 239-274-8200 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

NOTICE REGARDING WELLNESS PROGRAM

Any Florida Cancer Specialists & Research Institute Wellness Incentive Programs that are implemented are voluntary wellness programs available to all employees. These programs are administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in a wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in any wellness programs may receive an incentive. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources at 239-274-8200 .

The information from your HRA and the results from your biometric screening may be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although any wellness programs and Florida Cancer Specialists & Research Institute may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at 239-274-8200.

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, 2020. Contact your State for more information on eligibility:

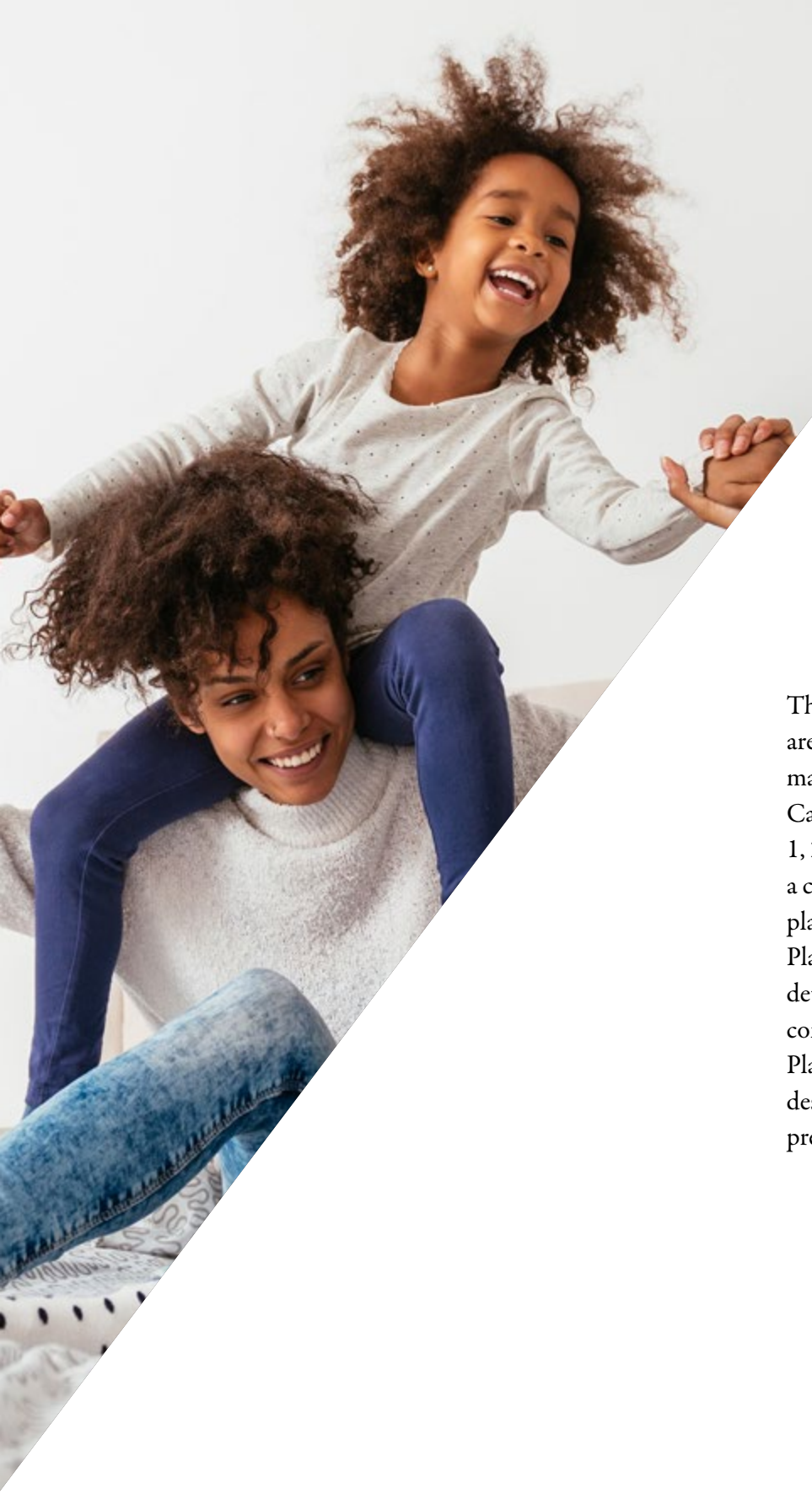
Alabama – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	NEBRASKA – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	NEVADA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp. htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	VERMONT– Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	WASHINGTON – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, 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 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565



The benefits described in this document are only intended to highlight some of the major benefit provisions of the Florida Cancer Specialists plan effective January 1, 2021 and should not be relied upon as a complete detailed representation of the plan. Please refer to the plan's Summary Plan Description (as applicable) for further detail. If any description in this document conflict with descriptions in the Summary Plan Description or plan document, the description in the plan document will prevail.