2022 Benefits Options Guide

Atrium Health Floyd

We strive to provide high-quality, affordable, family-friendly benefit offerings to meet the needs of our diverse workforce. We are also committed to providing excellent customer service and resources to help employees and their families best utilize these valuable benefit programs. For information on how to call or visit us for assistance, go to **hr.floyd.org** or call **706.509.5770**.

Open Enrollment 2022

Open Enrollment runs from October 22 – November 1, 2021. For more information, go to **hr.floyd.org**.

Newly Hired Employees

If you are eligible for benefits, you must enroll during your first 30 days of employment with Floyd. For optional benefits if you do not enroll during your first 30 days of employment, you will not receive coverage.

Your next opportunity to enroll in optional benefits will be during the benefits annual open enrollment period, typically held in the fall of each year for the upcoming year.

Contact the **Floyd Benefits Support Team** at **800-414-6221 Monday through Friday, 8 a.m.** to **8 p.m. for benefits enrollment assistance.**

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Am I *Eligible?*

- You must be a regular full-time employee or part-time employee regularly scheduled to work at least 24 hours per week for medical benefits eligibility. Part-time employees are not eligible for life insurance and long term disability benefits.*
- Temporary (PRN) employees are not eligible for medical, dental, vision, life insurance, long-term disability or voluntary insurance benefits. Temporary employees may be eligible to participate in the 401(k) Savings Plan if you work 1,000 hours in the year.
- Auto payroll deduction authorization is required to enroll in Floyd benefits.

* *Employees who work on average 30 hours per week will be notified by Human Resources if they are eligible to enroll for medical plan coverage as a result of provisions in the Affordable Care Act (ACA).*

Covering Your Dependents

Covered dependents include your legally married spouse and your natural or adopted children, foster children, stepchildren or any child for whom you have court-ordered responsibility. Dependent children must be:

- For medical and dental coverage*, under age 26 (even if that child is married) or permanently and totally disabled, regardless of age and marital status
- For dependent life coverage, under age 19 (under age 24, if a full-time student) and unmarried; or permanently and totally disabled, regardless of age

* *Orthodontic benefit coverage ends at age 19.*

When Both Spouses Work at Floyd

For **Plan C** participants, if both spouses work for Floyd and have children, one employee should enroll as Employee and Family to cover everyone in the family. This allows the most cost effective deductible and out of pocket accumulations. Floyd will not provide more than $1000 in employer HSA contributions to any family. If no children are covered, each spouse should enroll as employee only.

For **Plan P** participants, if both spouses work at Floyd and want to cover children, one spouse may enroll for employee plus family and cover everyone, or one spouse can enroll as employee only and the other spouse with employee plus children. If no children are covered, each spouse should enroll as employee only.

Working Spouse Rule

If an employee's spouse can purchase group health coverage that meets ACA minimum requirements through an employer, but elects not to enroll in that coverage, the spouse is not eligible for coverage under Floyd medical plans. You may be asked to complete a working spouse affidavit once enrollment closes to certify there is no access to other medical care coverage if you enroll a spouse.

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When May I Change My Benefits Elections?

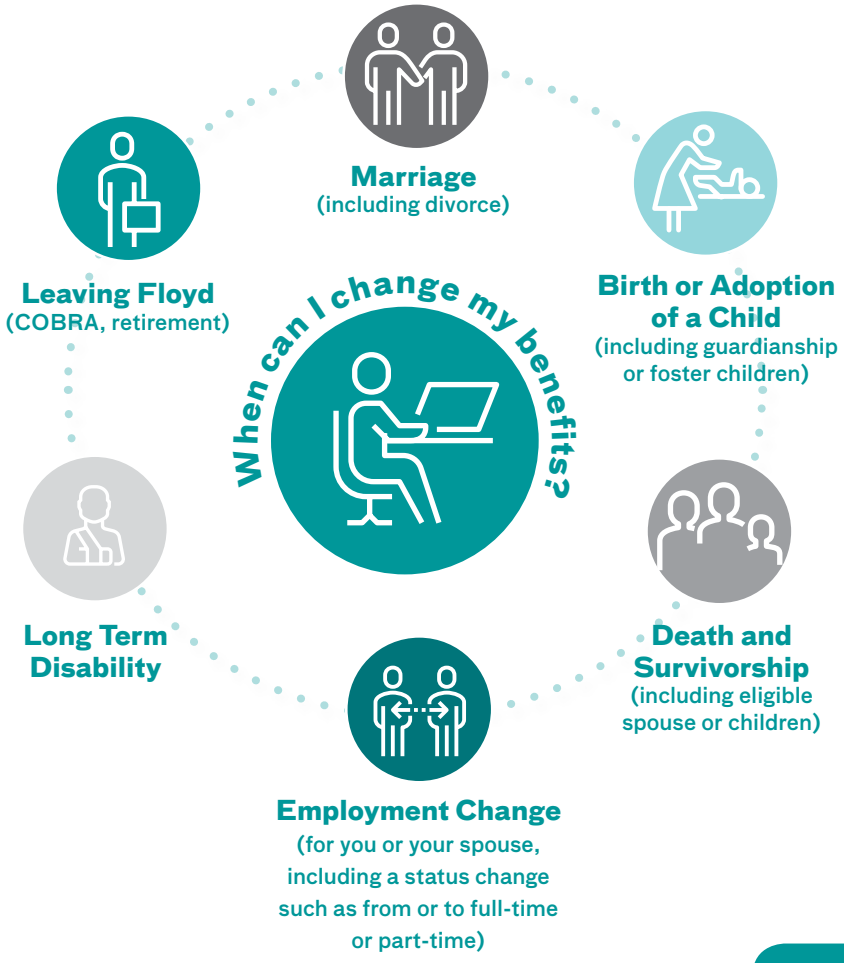
You may update or change your benefits:

1 During Open Enrollment

The annual Open Enrollment period is an opportunity for you to change your benefit elections and add or drop eligible dependents from coverages.

2 After a Life Event

Certain events in your life allow you to make election changes without the need to wait for Open Enrollment. Examples of a life event include the following:



31 DAYS to update benefits

You have 31 days from the date of the qualifying life event to make changes to your benefits. The change request cannot be made prior to the life event. If you miss the 31-day deadline, you will need to wait until the Open Enrollment period or experience another qualified life event to make changes.

You may change the number of dependents you cover but cannot change from one medical plan to another. Plan changes must be consistent with the family status event.

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30 DAYS to verify dependents

You have 30 days from the date you add your dependent to upload, fax or mail documentation to the Dependent Verification Center. Include your Floyd employee ID number on each document you submit.

Adding Dependents to Your Benefits

Floyd requires proof of dependent eligibility for the dependents you cover for the first time. View the ***Benefits*** tab page on the **my.adp.com** website for more information.

Why Must I Provide My Dependent's Social Security Number?

When you add a new dependent, you will be prompted to include his or her Social Security number. Centers for Medicare and Medicaid Services (CMS), the agency that monitors the claims collections from employers for Medicare, requires all employers to provide the Social Security number of any employee and dependent covered through an employer-sponsored medical plan. Note: If you are waiting for the Social Security number of a dependent you are newly adding to benefits, you must still initiate the life event within 31 days. Contact the Floyd Benefits Service Center at **1-800-414-6221** to update the Social Security number once it is received.

When Does Coverage Start and End?

Coverage for medical, vision and dental benefits starts on the first day of the month following 30 days from your start date and ends on the last day of your employment, known as your termination date. Dependents who reach age 26 have coverage to month end per federal requirements.

How to Enroll

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Enroll Online

Go to my.adp.com

My.adp.com, available 24/7 on hr.floyd.org, GreenLink or a mobile device is your starting point for enrollment. Once you have logged on to the Benefits tab you can follow the steps for Open Enrollment.

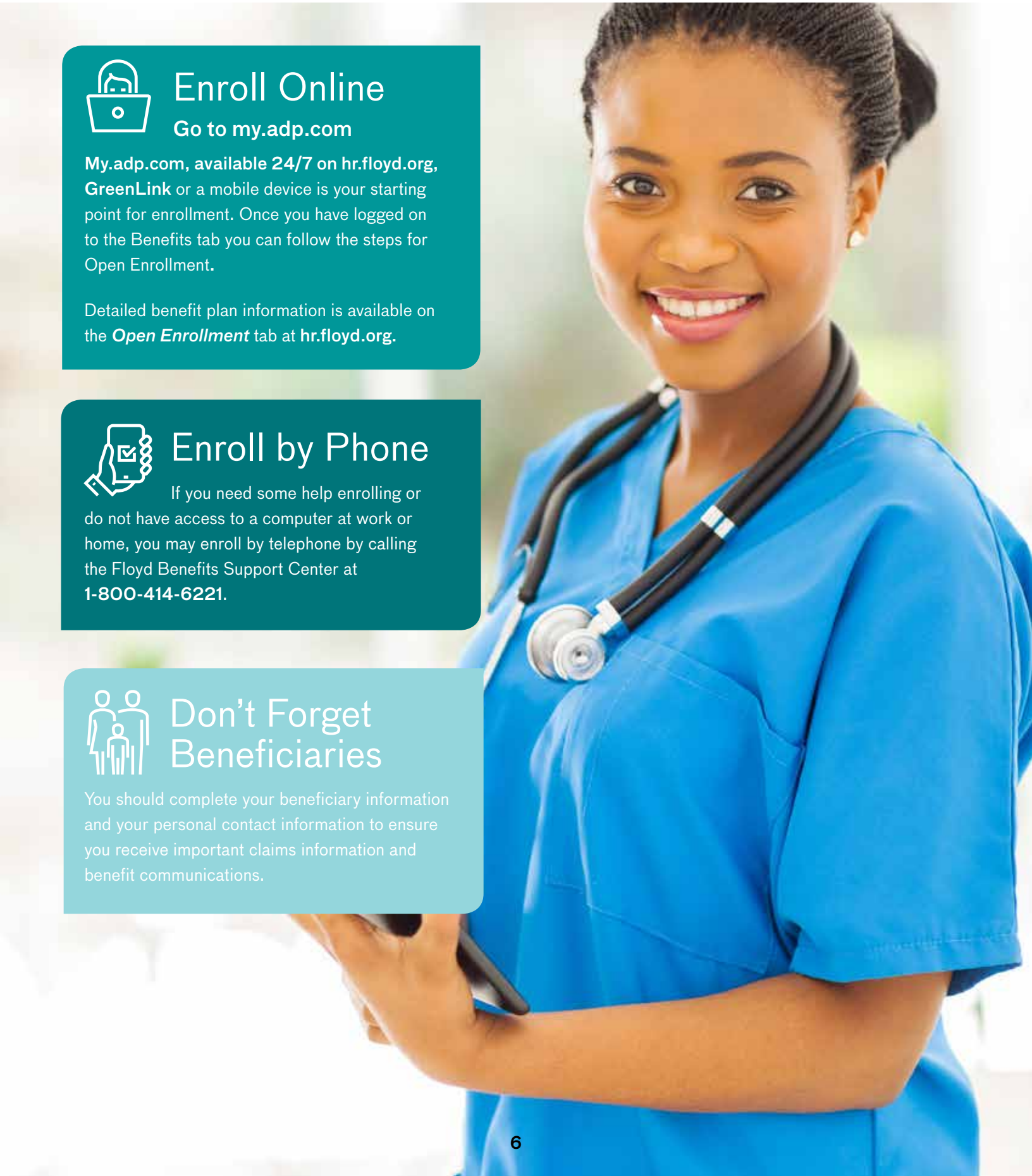
Detailed benefit plan information is available on the ***Open Enrollment*** tab at **hr.floyd.org.**

Enroll by Phone

If you need some help enrolling or do not have access to a computer at work or home, you may enroll by telephone by calling the Floyd Benefits Support Center at **1-800-414-6221**.

Don't Forget Beneficiaries

You should complete your beneficiary information and your personal contact information to ensure you receive important claims information and benefit communications.



Medical Plans

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Choosing the Right Medical Plan is Important

Becoming a good health care consumer means being actively involved in making choices about your health and wellness. Floyd offers eligible employees two medical plan options, an HSA plan, (Plan C) or a co-pay plan, (Plan P). Preventive Services are covered at 100% in both Plan C and Plan P.

Plan C: Choice Plan with HSA

- Plan C is a high deductible health plan and includes a Health Savings Account (HSA). This plan has the highest deductible amounts and the lowest premium cost. After the deductible is met, the plan pays 90 percent (at Floyd) or 70 percent (at Cigna In-Network providers) of the costs of medical care, and you pay the remaining costs.
- Consider this plan if you prefer to actively manage your health care dollars and you can afford to pay higher deductibles before any non-routine expenses are paid by the plan in the event you need care for an illness or injury

Plan P: Point of Service Copay Plan

- This plan has the highest premium costs but the lowest deductible amounts.
- Copays apply for office visits
- Consider this plan if you prefer to pay higher premiums in exchange for copays for physician office care

Medical Plan Providers

With the three-tier system of providers, you decide each time you receive care whether to visit a Tier 1 Floyd or Polk participating provider, a Tier 2 provider in the Cigna Open Access Plus network, or an out-of-network provider. **When you receive care from Floyd physicians or other Tier 1 providers you pay the lowest coinsurance possible.**

Tier 1 (In-Network) – FLOYD Providers

- Floyd Medical Center
- Polk Medical Center
- Cherokee Medical Center
- Floyd Primary Care Network
- Floyd Behavioral Health
- The Breast Center at Floyd
- Heyman HospiceCare at Floyd
- Floyd Physical Therapy & Rehab

Tier 2 (In-Network) – Cigna Open Access Plus Providers

This tier includes all providers in the Cigna Open Access Plus nationwide network. Hospital services are generally covered at a lower coinsurance than services received from a Tier 1 provider. Network directories are available on www.cigna.com, or you can call the Pre-Enrollment Information Line at 1-800-401-4041. For example, physicians at the Harbin Clinic are Tier 2 providers.

Tier 3 (Out-of-Network) – Providers

You always have the freedom to choose providers who are neither in the Cigna Open Access Plus network or part of the Floyd and Polk Tier 1 network. Generally, these services will be covered at the lowest coinsurance, and you will be required to meet an additional deductible before the plan starts paying benefits.

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Medical Plan Benefits At-a-Glance

Benefit Provision	PLAN P IN-NETWORK		PLAN C IN-NETWORK	
	TIER 1 FLOYD	TIER 2 CIGNA NATIONAL NETWORK	TIER 1 FLOYD	TIER 2 CIGNA NATIONAL NETWORK
Preventive Care	100%	100%	100%	100%
Deductible • Single • Family	$750 $1,500		Family Aggregate[1] $1,500 $3,000	
Hospital Services • Inpatient • Outpatient Surgery	85% 85%	75% 75%	90% 90%	70% 70%
Outpatient Labs	85% no deductible	75%	90%	70%
Outpatient Advanced Imaging (CT, MRI, PET)	85%	75%	90%	70%
Emergency Room Services	85%	85%	90%	70%
Urgent Care	$40 copay	$50 copay	90%	70%
Office Visits	$40 copay	$50 copay	90%	70%
Other Physician Services	85%	75%	90%	70%
Annual Out-of-Pocket Maximum (Includes deductible, coinsurance and copays)	$4,000 Single $8,000 Family		$3,500 Single $7,000 Family	

1 Family aggregate means that the entire amount of the family deductible must be met before any claims can be paid for any individual family member

Out-of-Network Care

If you use Tier 3 out-of-network providers, deductibles are doubled and coinsurance paid by Floyd decreases to 50 percent.

Benefit Coverage Information

For more complete benefit coverage information, please see the Plan Summaries for Plan C and Plan P and the federally required Summary of Benefits and Coverage (SBC) exhibits on **hr.floyd.org**.

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Prescription Drug Benefits

PRESCRIPTION DRUG COVERAGE	PLAN P RETAIL PHARMACIES	PLAN C RETAIL PHARMACIES
Generic	10% up to a max of $15 copay	90% coinsurance
Preferred Brand	20% up to a max of $50 copay	80% coinsurance
Non-Preferred Brand	30% up to a max of $90 copay	70% coinsurance
Specialty Pharmacy	10% up to a max of $125 copay	90% coinsurance

Some preventive and maintenance generic medicines are covered at 100% at all pharmacies. Check the list on **hr.floyd.org**. Read more at **mycigna.com**.

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Preventive Care

Preventive care services are covered at 100 percent in both medical plans. Below is a list of some of the most widely used preventive care services available to you and your family at no out-of-pocket cost to you.

GROUP	COMMON PREVENTIVE SERVICES
All Employees and Dependents	• Yearly preventive medicine visits (wellness visits) • All standard immunizations recommended by the Advisory Committee on Immunization Practices of the CDC (e.g., Tetanus, Influenza, MMR, Hepatitis A, Hepatitis B, Covid-19)
Employees and Dependents of Certain Ages or With Certain Health Risks	• Colorectal cancer screening/colonoscopy for age 50 and older • Elevated cholesterol and lipids screening • High blood pressure and diabetes screening
Women	• Cervical cancer screening, including Pap smears • Mammograms for age 40 and older (includes Clinical Breast Exam) • Reproductive health pharmacy expenses
Men	• Screening for prostate cancer (for men age 40 or older) • Screening for abdominal aortic aneurysm (beginning at age 65)
Newborns and Children	• Well-child care and immunizations • Screening for hearing problems, thyroid disease, phenylketonuria, sickle cell anemia • Counseling about fluoride for prevention of dental cavities • Screening for lead, tuberculosis, developmental/autism disorders • Counseling for obesity

EAP and Wellness

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Cigna offers a variety of free programs to help you and your family be healthier.

Employee Assistance Program (EAP)

The Cigna EAP offers free, confidential counseling any time, day or night, to help with personal problems and work-life balance issues. EAP counselors can confidentially discuss your situation and help you find resources and information on issues such as:

- Mental health
- Personal and professional relationships
- Substance abuse
- Family life
- Daily stress

You are automatically enrolled in this program, at no cost to you. The program also provides the following services to employees and their household family members:

EAP Assessment and Referral By Phone

You can call **888-371-1125** anytime, as often as you want, to talk with an EAP counselor. He or she will listen carefully and refer you to the best available resource for help.

In-Person Counseling

The program covers up to three free counseling visits each year for you and any family members.

3 visits at no charge for you and any family members.

Healthy Rewards® Discount Program

Includes special discounts on programs and services designed to help you enhance your health and wellness. The offers include programs and services such as Jenny Craig, Pearle Vision®, Curves, **drugstore.com**, acupuncture, massage and more. Good health is its own reward. So consider this a well-deserved bonus. Check **myCigna.com** for details.

Your Health First — Chronic Condition Management

This confidential outreach program gives you access to a dedicated health specialist to provide support, education, information and insight to help you manage your chronic condition and improve your health. This behavioral-based program provides comprehensive health management tailored to each individual and it is delivered through the continuous, personalized support of a dedicated health advocate. Focusing on each person's health needs, preferences and goals, the health advocate's one-on-one approach helps drive positive behavior changes.

Cigna's Healthy Pregnancies, Healthy Babies®

This program is designed to help you and your baby stay healthy during your pregnancy and in the days and weeks following your baby's birth. Just call the number on your Cigna ID card to talk to a nurse 24/7 who can help you with everything from tips on how to handle your discomfort during pregnancy to what foods to avoid, birthing classes and maternity benefits. Or, visit **myCigna.com** for tools to help you track your pregnancy week by week, prepare for delivery and care for your baby.

24-Hour Health Information Line

Get detailed answers to your health care questions, find directions to emergency care, and listen to recorded programs on health topics anywhere, any time. Dial the toll-free number on the back of your ID card **800-244-6224** and you'll be connected directly to a specialist who is ready to answer your health questions.

Visit MyCigna.com

Manage your health and wellness with tools specific to your needs: Find health care professionals, estimate out-of-pocket costs, check your HSA balance, reorder prescriptions and more.

My Health Assessment

My Health Assessment — your confidential online self-assessment for health and wellness is more fun than ever. Choose from one of several game pieces to begin. Answer questions and complete each step of your assessment journey. When you're finished, you'll receive a health score along with suggestions on how to improve your numbers or meet certain goals.

My Health Assistant Online Coaching Programs

Cigna offers coaching and education programs designed to utilize evidence-based behavior modification techniques to promote a healthier lifestyle. You have the option to self-enroll and can select a telephonic or online option, or both. Some examples include:

Healthy Steps to Weight Loss

Cigna helps you manage your weight using a non-diet approach. Get support to help build your confidence, become more active, eat healthier and change your habits.

Quit Today Tobacco Cessation

Our tobacco cessation program helps you get and stay tobacco free. Develop a personal "quit plan" that's right for you.

Strength and Resilience Stress Management

Our stress management program helps you understand the sources of your stress and learn coping techniques to manage.

Vision Plans

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Floyd offers Cigna and Davis vision care plans to help you manage the cost of eyeglasses and contact lenses as well as eye examinations. Both plans provide one vision exam and eyeglass lenses or contacts every year with frames every other year. If you purchase eye glasses or contacts at Walmart, the Davis plan might be the best choice for you. Full terms for both the Cigna Vision and Davis Vision plans can be found on **hr.floyd.org**.

Cigna Vision Benefits Summary

BENEFIT	IN-NETWORK COVERAGE	IN-NETWORK COPAY	FREQUENCY
WellVision Exam®	Focuses on your eyes and overall wellness	$5	Every calendar year
Prescription Glasses	Materials copay applies	$10	See Frame and Lenses
Frame	• $150 allowance for a wide selection of frames • 20% off amount over your allowance	Included in prescription glasses	Every other calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in prescription glasses	Every calendar year
Lens Options	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses	Included in Summary of Benefit	Every calendar year
Contacts (instead of glasses)	• Contact lens exam (fitting and evaluation) • $150 allowance for contacts; copay does not apply	Included in Summary of Benefit	Every calendar year

Davis Vision Benefits Summary

BENEFIT	IN-NETWORK COVERAGE	IN-NETWORK COPAY	FREQUENCY
Eye Examination	Covered in full. Includes dilation when professionally indicated.	$10	Once every year
Spectacle Lenses	Clear glass or plastic lenses in any single vision, bifocal, trifocal or lenticular prescription. Covered in full.	$25	Once every year
Frame Allowance	Any designer or fashion frame from Davis Vision collection or $130 towards any frame with conditions. See flyer for full terms at **hr.floyd.com**. No copay required.	$0	Once every other year
Contact Lens Evaluation, Fitting & Follow Up Care			
• Standard, Soft Contacts	After copay, covered in full.	$25	Once every year
• Specialty Contacts	$60 allowance. See flyer for full terms at **hr.floyd.com**.		
Contact Lenses (in lieu of eyeglasses)			
• Contact Lens Allowance	$130 allowance toward any contacts from provider's supply. See flyer for full terms at **hr.floyd.com**.	$0	Once every year

Dental Plan

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Because it's important to maintain dental health, dental plan coverage is available to you and your covered family members. Dental plan services include:

- **Preventive Care** — This care includes exams, cleanings, X-rays, sealants, fluoride treatment, preventive treatment and routine diagnostic procedures. Oral exams and cleanings are covered twice in any 12-month period. There are no copays for preventive care visits.
- **Minor Restorative Care** — This care includes extractions, fillings, drugs, periodontic treatment and emergency treatment. It is covered at 80 percent of reasonable and customary charges after your deductible.
- **Major Restorative Care** — This care includes bridges, crowns, dentures and repair
of prosthetic appliances. It is covered at 50 percent after your deductible.
- **Orthodontia Care** — This care includes initial diagnosis and ongoing treatment expenses for braces and is available only for dependent children up to age 19.

Pre-treatment Estimates for Dental Care

For certain high-cost dental services, your dentist may want to submit a pre-treatment estimate to Cigna. You and your dentist will be notified in advance of the amount the dental plan will pay for the treatment. This gives you an opportunity to discuss the charges and benefits with your dentist before you receive any treatment. No pre-treatment estimate is required for emergency care.

Dependent children up to age 26 are eligible for coverage in the dental plan, but **orthodontia services are available up to age 19 only.**

Your Dental Plan Benefits At-a-Glance

SERVICES	COVERAGE
Deductible (Does not apply to preventive care)	$50 per individual $150 per family
Preventive Care (No copay for 2022)	100%
Minor Restoration Care	80%
Major Restoration Care	50%
Annual Maximum for Preventive, Minor Restorative or Major Restorative Care	$2,000
Lifetime Deductible for Orthodontia	$50 for each dependent child
Lifetime Maximum for Orthodontia	$1,500 for each dependent child

Costs of Medical, Dental and Vision Plan Coverage

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Cost for Medical Coverage

You pay a portion of the cost of coverage for yourself and for covered family members on a pre-tax basis. To tailor your health care coverage to your individual needs, Floyd provides you with four coverage levels available in each plan.

Cost of Coverage for Full-time and Part-time Employees

(working between 24 – 40 hours per week)

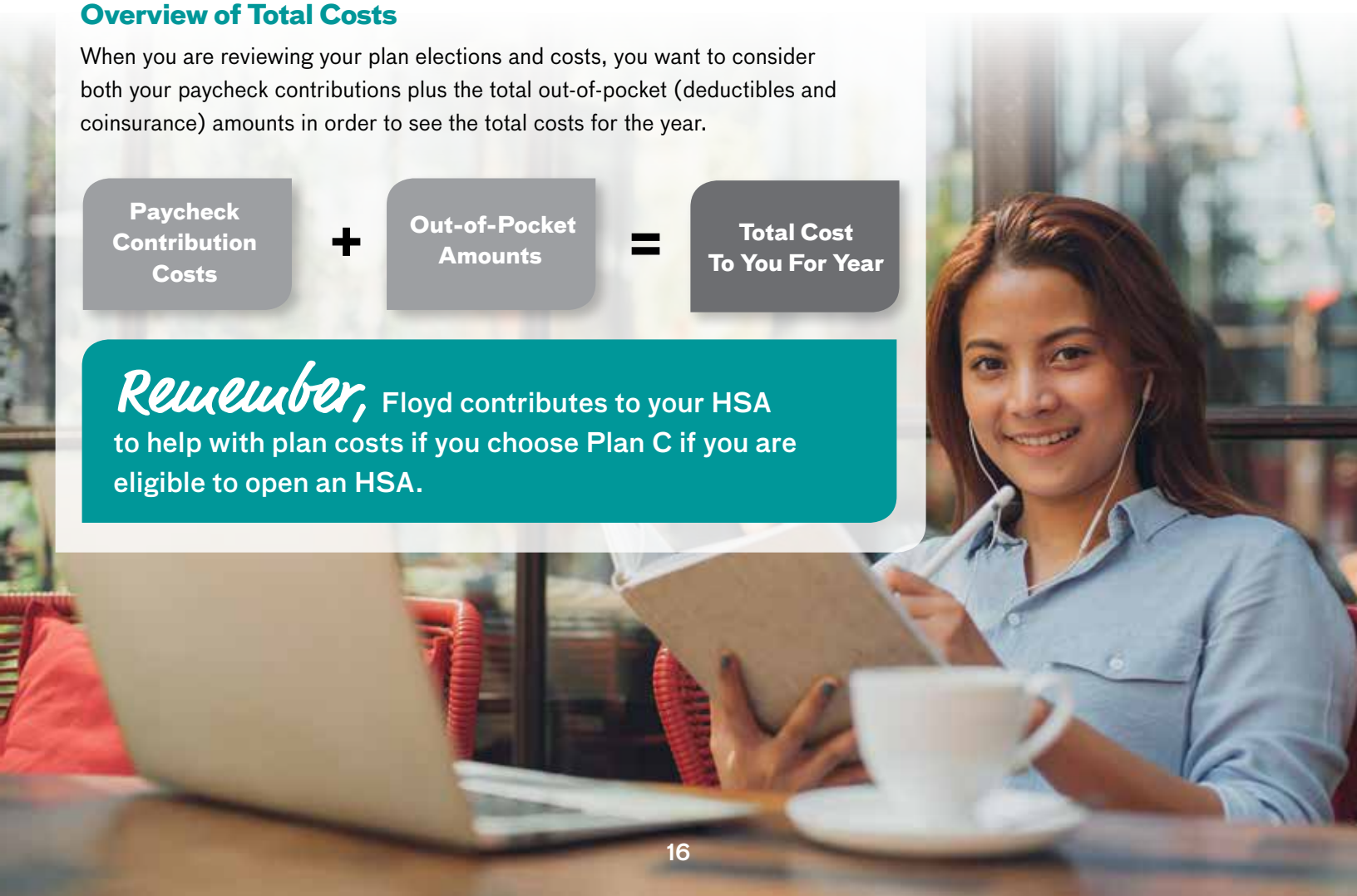
LEVELS OF COVERAGE	PLAN P Cost Each Pay Period	PLAN C Cost Each Pay Period
Employee Only	$57	$32
Employee & Child(ren)	$150	$95
Employee & Spouse	$206	$134
Employee & Family	$252	$165

Overview of Total Costs

When you are reviewing your plan elections and costs, you want to consider both your paycheck contributions plus the total out-of-pocket (deductibles and coinsurance) amounts in order to see the total costs for the year.

Paycheck Contribution Costs + **Out-of-Pocket Amounts** = **Total Cost To You For Year**

Remember, Floyd contributes to your HSA to help with plan costs if you choose Plan C if you are eligible to open an HSA.



Costs of Medical, Dental and Vision Plan Coverage continued

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Cost for Dental Coverage

Full-time and part-time employees have the same costs for this coverage.

LEVELS OF COVERAGE	DENTAL PLAN COST EACH PAY PERIOD
Employee Only	$18
Employee & Child(ren)	$36
Employee & Spouse	$36
Family	$46

You do not need to enroll for the same coverage levels in all plans. You can elect to cover yourself and/or any dependents in each benefit plan.

Cost for Vision Coverage

Full-time and part-time employees have the same costs for this coverage.

LEVELS OF COVERAGE	CIGNA VISION AND DAVIS VISION PLANS COST EACH PAY PERIOD
Employee Only	$3.20
Employee & Child(ren)	$6.10
Employee & Spouse	$5.80
Family	$9.60

Pre-tax contributions

Pre-tax contributions are allowed under Section 125 of the Internal Revenue Code. Your share of the medical and dental contributions is taken out of your pay before federal, Social Security and most state and local taxes are calculated. As a result, your take-home pay is higher because you pay less in taxes. You also may pay less into Social Security, and your Social Security benefit could be slightly reduced. Your pre-tax contributions do not appear as part of your taxable wages on your W-2 Form.

The pre-tax contributions do not affect other Floyd benefits that are based on your pay. Those benefits, such as life insurance and disability benefits, will continue to be based on your regular pay. Your contributions will automatically be made on a pre-tax basis unless you complete a form (available by calling Human Resources) stating that you choose not to take advantage of this tax-saving opportunity.

Spending Account for Dependent Day Care

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A Dependent Day Care Flexible Spending Account (FSA) helps any eligible employee with the costs of care so you can work.

How the Dependent Day Care FSA Works

- When you make contributions to a Dependent Day Care FSA, those dollars are deducted from your pay before taxes.
- This reduces your taxable income, thus saving you money. Depending on your tax bracket, this can mean savings of 15 percent to 40 percent.
- You can use the money you've contributed to reimburse yourself for eligible dependent care expenses that you normally incur.
- Use the money in your FSA account by year end. Keep in mind that funds do not roll over from year to year.

Dependent Day Care FSA

If you're single or married and filing a joint tax return, you can contribute up to $5,000 to the Dependent Day Care FSA. If you're married and file separately, you can each contribute up to $2,500. You can use contributions to pay for eligible, out-of-pocket, work-related dependent day care costs with pre-tax dollars.

DEPENDENT DAY CARE FSA	
How You Pay for Expenses	Pay out of pocket and submit a reimbursement claim form, along with an itemized bill from the service provider to WageWorks.

EXAMPLES OF ELIGIBLE DEPENDENT DAY CARE FSA EXPENSES

- Babysitting (in your own home or someone else's)
- Before and after school programs
- Child care, nursery school or preschool
- Payroll taxes for your care provider
- Sick child care
- Summer day camp
- Transportation to and from eligible care
- Adult day care center
- Elder care (in your home or someone else's)
- Senior day care

Eligible dependents include children under age 13 or a physically or mentally disabled parent or child.

WageWorks administers the Dependent Day Care FSA.

You must re-enroll every year for this account

Health Savings Account

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Health Savings Account (HSA)

Individuals enrolled in Plan C may participate in an HSA. You may make contributions to this interest-earning savings account (up to annual IRS limits) from your pay before taxes. You use the money in your account to pay for eligible health care-related expenses even after you retire.

How the HSA Works

- When you make contributions to an HSA, those dollars are deducted from your pay before taxes.
- This reduces your taxable income, saving you money. Depending on your tax bracket, this can mean savings of 10 percent to 30 percent.
- You can then use the money you've contributed to reimburse yourself for eligible health care expenses that you normally incur. You will be subject to income tax and penalties for any amount distributed or withdrawn from your HSA that is not used to pay for qualified medical expenses.

Contributions

For 2022, individuals electing single coverage or filing as single may choose to contribute up to $3,650 to an HSA. The contribution maximum for a family is $7,300. Individuals between the ages of 55 and 65 also may make a "catch-up" contribution up to $1,000 for 2022.

- IRS regulations also allow Floyd to contribute to your HSA. For 2022, Floyd will deposit employer dollars to your account as shown below.

Floyd will deposit a contribution to your HSA account shortly after you are eligible for health care benefits. You must have an open HSA account to receive the Floyd contribution. Information about opening an HSA account will be provided during your Enrollment.

HSA Bank administers Floyd Health Savings Accounts. More information is available on the my.adp.com portal and myCigna.com.

2022 Annual Contribution Maximum	**$3,650 Single* $7,300 Family***
Floyd's Contributions	**Plan C**** **$500 Single $1,000 Family**

* Your contributions plus Floyd's contributions cannot exceed the maximum allowable amount.

** Floyd will deposit a $500 single coverage contribution in January 2022.
Floyd will deposit a $1,000 family coverage contribution in two payments:

- $500 in January 2022
- $500 in July 2022

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Make Your Health Care Dollars Work for You with an HSA

- **You can take it with you —** If you leave Floyd, remember the HSA is your personal bank account, and any unused dollars remain yours. Your HSA dollars will be available to pay for qualified health care expenses in the future for you and your eligible dependents.
- **Get free money —** Floyd will contribute to your account if you elect single coverage or if you elect coverage for you and your dependent(s).
- **Save on other expenses** — Your HSA dollars can be used tax-free to pay for medical, dental, vision and other qualified health care services that are not covered under your medical and dental plans.
- **Earn interest —** You also have the option of paying claims out-of-pocket, allowing your HSA to earn interest and accrue so you'll have more savings to pay for future health care expenses for you and your qualified dependents.
- **Watch your account grow —** Any unused dollars in your HSA roll over from year-to-year.
- **Triple tax advantages —** The HSA is funded with before-tax contributions through payroll deduction. The dollars in your HSA grow and earn interest tax free. When you spend HSA dollars for qualified health care expenses, they are not taxed.

Are You Eligible for an HSA?

To be eligible for an HSA, you cannot be covered:

- Under any medical plan except another qualified high deductible health plan (HDHP) as an employee or as a spouse.
- If your spouse has a general purpose Healthcare FSA or HRA.
- Under TRICARE or Medicare coverage, including Parts A, B and/or D.

Employees Age 65 or Older

If you are actively working and have begun to receive your Social Security retirement, or if you are under age 65 and receive some form of Social Security benefits, you most likely are covered by Part A Medicare, and would not be eligible to open an HSA account. Please contact HR for assistance.

LTD Recipients, COBRA Participants and Certain Pre-65 Retirees

You are not eligible to receive or make contributions through Floyd to an HSA or receive a Floyd contribution. However you are eligible to contribute to an HSA on your own through an outside institution.

Life Insurance

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Life Insurance benefits are insured by New York Life and are available to full-time employees scheduled to work at least 35 hours per week. Coverage begins on the first day of the month after completing 90 days of service.
Three types of life insurance are available:

- **Basic Employee Life** — Insurance that is provided to you at no cost
- **Supplemental Life** — Additional insurance you may buy to supplement your basic coverage
- **Dependent Life** — Insurance you may buy for your dependents

Basic Employee Life Insurance

When you die, your beneficiary will receive a benefit equal to two times your annual base rate of pay, with a minimum amount of coverage of $35,000. For each plan year, your basic and supplemental life amounts will be calculated based upon your rate of pay on the date of your death. Benefits begin to reduce as shown below when you turn 65.

Supplemental Life Insurance

You can purchase additional life insurance coverage for yourself up to two times your annual base salary. You pay the full cost of this optional coverage with after-tax dollars. **If you enroll after your first opportunity when your employment begins, you will need to provide Evidence of Insurability before your new coverage amount is approved.**

AGE BASED LIFE INSURANCE REDUCTIONS

AGE	LIFE INSURANCE REDUCTION
65	65%
70	45%
75	30%
80	20%
85	15%
90	10%

Dependent Life Insurance

You may purchase life insurance coverage for your spouse and unmarried dependent children to age 19 (age 24 if student) with after-tax dollars as shown in the following chart:

YOU MAY PURCHASE COVERAGE FOR	IN THE AMOUNT OF
Your Spouse	$25,000
Per Child (Under Six Months)	$1,000
Per Child (Six Months – Age 23)	$5,000

Your costs for Supplemental and Dependent Life are shown in the Benefits tab in **my.adp.com** portal.

Naming a Beneficiary

The beneficiary you name for Basic Employee Life Insurance coverage will be the same for your Supplemental Life Insurance coverage, unless you choose someone else. You may change or add beneficiaries at any time online in the Benefits tab at **my.adp.com**. You are automatically the beneficiary for any Dependent Life Insurance coverage you elect.

Imputed Income
The IRS Code states that employer-provided basic and optional employee life insurance benefits in excess of $50,000 may result in taxable income for you. This is known as "imputed income." Imputed income must be reported on your W-2 Form; is included as earnings in your paycheck, and is subject to federal, state and FICA taxes each period.

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Enroll anytime for these benefits

Checkout *the next few pages for more about...*

- Long-Term Disability
- Retirement Saving
- Additional Benefits
- Additional Information
- Legal Notices

Long-Term Disability Insurance

Floyd provides Long-Term Disability (LTD) insurance to regular, full-time employees who are scheduled to work at least 35 hours each week. Coverage begins the first day of the month after completion of one year of service. You do not elect this coverage.

Qualifying for LTD Benefits

To receive LTD benefits, you must have a total disability defined as:

- During the first 24 months of disability, you are unable to perform the duties that are required for your job or similar type of work
- After 24 months of disability, you are unable to perform the duties of any occupation for which you are or may reasonably become qualified by education, training or experience.

IF YOUR DISABILITY BEGINS AT THIS AGE	YOUR MAXIMUM LTD BENEFITS PERIOD
Before age 60	To age 65, but no less than five years
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Long-Term Disability Benefit Amount

The LTD Plan is designed to provide 60 percent of your annual base pay, up to plan maximum limits. Long-term disability benefits are offset by other income you are eligible to receive such as Social Security and Workers' Compensation benefits.

Long-Term Disability Benefit Waiting Period is 150 Days

LTD benefits begin after you have been disabled for 150 days. How long benefits continue depends on your age when you first become disabled.

Long-term disability recipients are covered by a Floyd medical plan up to 30 months of disability. Once a LTD recipient begins to receive Social Security disability and becomes eligible for Medicare, medical coverage will no longer be available under a Floyd medical plan.

LTD insurance is provided through a fully insured plan from New York Life. Claims forms are available on GreenLink or hr.floyd.org.

Floyd 401(k) Retirement Savings Plan and 401(k) Roth Savings Plan

Eligibility

Floyd's 401(k) savings plan and 401(k) Roth savings plan provide a convenient way to save money for retirement. All employees who are at least 18 years old are eligible to defer compensation immediately. Employees who are at least 18 years old, have completed one year of service and have accumulated over 1,000 hours at work in a calendar year are eligible for Floyd's matching contribution beginning on the next Jan. 1 or July 1 of each year.

Contributions — You and Floyd

Employees may choose to make before-tax or after-tax contributions from one percent of eligible pay up to the annual federal limits. Employees decide a contribution percentage, and Floyd matches it according to these guidelines:

- Floyd matches 100 percent on the first three percent of the employee's contribution
- Floyd matches 50 percent on the next two percent of the employee's contribution
- Floyd matches a maximum of four percent of your contribution
- The 401(k) savings plan and the 401(k) Roth savings plan are subject to a combined Federal limit and Floyd matching contribution.

New co-workers may contribute immediately to the Floyd 401(k) plan. However, to receive a Floyd match, you must meet eligibility requirements.

Vesting

You are 100 percent vested in your retirement plans at the time of enrollment. You may borrow or take in-service withdrawals from the accounts, and you can take the accounts with you when you leave Floyd. This benefit also is provided to temporary (PRN) employees who meet eligibility requirements. Contact Human Resources if you have questions about your eligibility.

Administrator

The Floyd 401(k) savings plan and the 401(k) Roth savings plan are administered by TransAmerica Retirement Solutions (TRS). To learn more about Floyd's retirement savings plans contact TRS at **888-676-5512** or online at **www.trsretire.com**.

Enroll Any Time

You can enroll anytime during the year. Call TransAmerica Retirement Solutions (TRS) or go online at www.my.trsretire.com.

Voya Voluntary Benefits

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Voluntary Short Term Disability

Helps you pay your bills with disability income when an illness or injury keeps you out of work. If you do not enroll within 30 days of hire, your enrollment will be subject to evidence of insurability.

Voluntary Compass Accident Insurance

Helps you pay for out-of-pocket cost when you suffer an accident. Optional coverage for your spouse and children is available.

Voluntary Compass Critical Illness Insurance

Receive a lump-sum benefit that can help pay out-of-pocket costs if you are diagnosed with a covered critical illness or specified disease. Optional coverage for your spouse and dependent children is available.

Enrollment information is available at hr.floyd.org.

Important Information

Paying for Medical Expenses Owed to Tier 1 Providers

Employees are required to pay the medical expenses for which they are responsible. We use voluntary payroll deduction to collect medical expenses owed to Tier 1 providers unless the employee makes alternative arrangements.

When an employee or minor dependent child incurs medical expenses from a Tier 1 provider, the employee will receive a statement of account after the claims administrator has processed the claim and determined the amount of employee is responsibility.

PAYMENT SCHEDULE FOR PAYROLL DEDUCTED MEDICAL EXPENSES	
ACCOUNT BALANCE (RANGE)	**PAYROLL DEDUCTION AMOUNT (PER PAY PERIOD)**
$25 and under	Full amount due
$25.01 to $1,000	$25
$1,000.01 to $5,000	$50
$5,000.01 and up	$75

Notice of HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents, including your spouse, because of other health insurance coverage in the future, you may be able to enroll yourself or your dependents in the health care plans, provided you complete enrollment within 31 days after your coverage ends. In addition, if you have new dependents as a result of marriage, birth, or adoption, you may be able to enroll yourself and your dependents, provided you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, you and/or your dependents may be eligible to continue health care coverage (called "COBRA coverage") at group rates. This COBRA coverage is available in certain instances, called "qualifying events," where coverage under the Floyd health care plans would otherwise end. You may elect to continue coverage at your own expense on a post-tax basis when the coverage that you have through the Floyd health care plans ends due to one of these events.

Paying for COBRA Coverage

You will have to pay the entire cost of coverage — your share and the company's — plus a two percent administrative fee. Please contact Human Resources for complete COBRA information.

Floyd Retiree Medical Continuation Plan

Certain employees of Floyd can elect continuation of medical coverage upon retirement from Floyd. To be eligible for this coverage, employees must have attained the age of 62 and retired with a benefit from the FMC pension plan (the "Government Plan"). Coverage continues until the attainment of age 65. Premiums are required for the coverage, based on the elected plan and coverage level. Premiums are reviewed annually along with benefit coverage and other provisions of the plan. Monthly premium amounts are available from Floyd Human Resources. Special health benefits provided under this provision may cease to exist on or before Dec. 31, 2022. These employees are not eligible for Floyd employer contributions to Health Savings Accounts.

Legal Notices

HIPAA Privacy Notice

Floyd Healthcare Management Inc. — October 2015

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Floyd Healthcare Management Inc. Group Health Plan is required to provide you with a HIPAA Notice of Privacy Practices ("Notice") at the time of your enrollment in the plan and at certain other times. In addition, the plan is required to periodically notify you of the availability of the Notice and provide you with information on how to obtain a copy of the Notice.

You may request a copy of the plan's Notice at any time by calling the Human Resources, Monday through Friday between 8 a.m. and 5 p.m. ET at **706-509-5770**.

To the extent that the plan contains benefits other than those covered under the HIPAA's privacy rule, this reminder pertains only to those health care benefits that are covered under HIPAA's privacy rules.

Women's Health and Cancer Rights Act Annual Notice

On Oct. 21, 1998, the federal government passed the Women's Health and Cancer Rights Act of 1998. As part of our plan's compliance with this Act, we are required to provide you with this annual notice outlining the coverage that this law requires our plan to provide.

Our group health plan has always provided coverage for medically-necessary mastectomies. This coverage includes procedures to reconstruct the breast on which the mastectomy was performed, as well as the cost of necessary prostheses (implants, special bras, etc.) and treatment of any physical complications resulting from any stage of the mastectomy. However, as a result of this federal law, the plan now provides coverage for surgery and reconstruction of the other breast to achieve a symmetrical appearance and any complications that could result from that surgery.

The following benefits must be provided if benefits are provided for a mastectomy:

1. Coverage for reconstruction of the breast on which the mastectomy is performed.
2. Coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance with the breast on which the mastectomy is performed.
3. Coverage for prostheses and physical complications resulting from any stage of the mastectomy, including lymphedema.
4. These benefits are subject to the same deductible, copays and coinsurance that apply to mastectomy benefits under the plan.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can 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, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or go to **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan — as long as you and your dependents are eligible, but not already enrolled in the employer's plan.
This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

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, 2015. You should contact your State for further information on eligibility.

ALABAMA – Medicaid
Medicaid Website: www.medicaid.alabama.gov
Phone: 1-334-242-500

GEORGIA – Medicaid
Website: www.dch.georgia.gov/
Click on Programs, then Medicaid
Phone: 1-800-436-7442

To see if any more states have added a premium assistance program since July 31, 2011, or for more information on special enrollment rights, you can contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1.877.267.2323, Ext. 61565

Genetic Information Nondiscrimination Act

Congress passed the Genetic Information Nondiscrimination Act (GINA) establishing a national and uniform standard to protect workers from genetic discrimination. In addition to prohibitions on discrimination in employment practices, GINA prohibits group health insurers and group health plans from adjusting premiums or contributions based on genetic information. Also, GINA amended the HIPAA privacy rules to include genetic information in the definition of protected health information.

Summary of Benefits and Coverage

The Patient Protection and Affordable Care Act (also known as the Health Care Reform law) or ACA requires that you receive a Summary of Benefits and Coverage (SBC). The SBC is designed to help you understand and evaluate your health plan choices. To obtain copies of the SBC for each of the Floyd sponsored medical plans visit **GreenLink** and search SBC. Paper copies are also available, free of charge, from Human Resources.

Health Insurance Marketplace Notice

Effective January 1, 2014, the Affordable Care Act— also known as "health care reform"—requires most Americans to have health insurance. Individuals who don't have coverage by January 1, 2014, will be required to pay a penalty.

The Health Insurance Marketplace ("health insurance exchange") was created to ensure that everyone has access to affordable health insurance. The Marketplace is an option for someone who does not have employer-provided health coverage or for someone who chooses not to enroll in employer-provided health coverage. Because you have the option for employer-provided health coverage, it is unlikely that you will be eligible for federal subsidies.

Why am I receiving this notice?

This notice provides you with information about the Health Insurance Marketplace and where you can access more information about health plans offered to you by either your state or the U.S. Department of Health and Human Services.

Floyd is required to send the enclosed notice to every employee to comply with rules under the federal Affordable Care Act (ACA).

What do I need to do?

You're currently eligible to participate in a Floyd sponsored medical plan. If you participate in the medical plan, you and Floyd share in the cost of your coverage. Your share of the cost is paid with before tax dollars.

If you choose not to participate in a Floyd sponsored plan and you buy insurance in the Marketplace, you will be responsible for paying the entire premium yourself with after-tax dollars.

What this means for you

- Floyd has you and your family covered. As a benefits-eligible employee, you and your eligible dependents have access to health care coverage through Floyd.
- Our plans are affordable. You'll hear about new coverage options available in the Health Insurance Marketplace, but in most cases, Floyd's coverage will continue to provide the greatest value. And because our plans exceed the federally required "minimum value standards," it is unlikely that our employees will be eligible for federal subsidies.

This booklet explains the Employee Benefit Options and provides you with an overview of FHMI benefits programs. This booklet is intended to serve only as a general overview and is not a substitute for and does not alter or amend the Plan Documents that create and define the benefits for FHMI employees.

Employees can find more details about benefit options by visiting the "Benefits" section in the my.adp.com portal or under Human Resources on GreenLink, our intranet employee website. You may also visit www.floyd.org or contact Human Resources.

Receipt of the Employee Benefit Options booklet or network literature does not guarantee eligibility or benefit coverage. Eligibility is determined only by meeting the eligibility and coverage requirements of each plan. In addition, the benefit descriptions in the booklet are brief summaries of the benefits offered and are not intended to provide details regarding these benefits.

This booklet highlights the Floyd Healthcare Management Inc. benefits program. Details of each plan are contained in the Plan Documents and contracts with third-party administrators, which legally govern the operation of the program. If there is any conflict between this booklet and any of the Plan Documents, the Plan Documents will always govern. FHMI reserves the right to change, amend or terminate the program at any time. In some cases, Floyd may, by mutual agreement, modify the benefits program for certain employees. This communication does not constitute a contract of employment or a contract of any other nature between FHMI and any employee, nor do benefits provided herein create a property interest for an employee in continuous employment or otherwise.