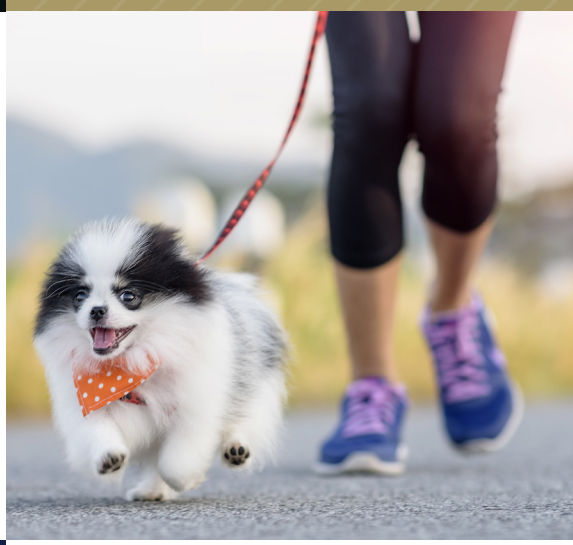


2024 EMPLOYEE BENEFITS

MARCH 1, 2024 - FEBRUARY 28, 2025

Important Contacts

COVERAGE	CONTACT	PHONE	WEBSITE
Medical #650-128 Member Advocate	Boon-Chapman	855-516-8531	www.boonchapman.com/ member-login Email: advocate@boonchapman.com
Prescription Drug Benefits	WellDyne	1-888-479-2000	www.WellView.WellDyne.com
Virtual Visits	Galileo	888-613-4254	www.galileo.health/beer
Dental	Guardian	888-600-1600	www.guardiananytime.com
Vision	Guardian	888-600-1600	www.guardiananytime.com
Life and AD&D	Guardian	888-600-1600	www.guardiananytime.com
Disability	Guardian	888-600-1600	www.guardiananytime.com
Employee Assistance Program	Aetna	Online Only	www.mylifevalues.com
	Guardian	800-386-7055	worklife.uprisehealth.com

Table of Contents

Welcome to Your Benefits!

We are pleased to provide you with a wide range of competitive benefits that are a vital part of your total compensation. You have the flexibility to select from a full range of benefits to keep you and your family healthy, and provide financial protection in the event of unforeseen circumstances. This guide was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this guide to make sure you understand the benefits that are available to you and your family, and be sure to take action before the enrollment deadline.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 37 for more details.

Eligibility

If you work at least 30 hours per week, you are eligible for benefits. Your benefits are effective on the 90th day following your date of hire. You may also enroll your eligible dependents for coverage. Eligible dependents could be:

- Your legal spouse
- Children under the age of 26, regardless of student, dependency or marital status
- Children who are past the age of 26 and are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return

CHANGING BENEFITS AFTER ENROLLMENT

During the year, you cannot make changes to your medical, dental, and vision unless you have a Qualified Life Event. If you do not contact Human Resources within 31 days of the Qualified Life Event, you will have to wait until the next annual Open Enrollment period to make changes (unless you experience another Qualified Life Event).

QUALIFIED LIFE EVENT		DOCUMENTATION NEEDED
Change in marital status	Marriage	Copy of marriage certificate
	Divorce/Legal Separation	Copy of divorce decree
	Death	Copy of death certificate
Change in number of dependents	Birth or adoption	Copy of birth certificate or copy of legal adoption papers
	Step-child	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
	Death	Copy of death certificate
Change in employment	Change in your eligibility status (i.e., full time to part time)	Notification of increase or reduction of hours that changes coverage status
	Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

How to Enroll

PAYCOM

1. Please gather the following information: dates of birth and Social Security numbers for yourself, spouse and all dependents (even if they are not being covered), and beneficiaries.
2. Log into the Paycom app. From the Notification Center or from the Benefits section, click the current year's Benefit Enrollment.
3. Review initial instructions and click "Start Enrollment." Then, enter your personal information and any dependents or beneficiaries.
4. After determining which plan will work for you, choose your coverage level, then select either to enroll or decline.
5. To complete enrollment, click "Finalize,"then "Sign and Submit."

Medical Plan

DAYTONA BEVERAGES OFFERS ONE MEDICAL PLAN, MANAGED BY BEVCAP MANAGEMENT AND ADMINISTERED BY BOON-CHAPMAN.

SAVE WHEN YOU USE IN-NETWORK PROVIDERS

The PPO medical plan allows access to both In-Network and Out-of-Network providers, but you will get better discounts and pay less money by remaining In-Network. When you use providers from within the Aetna Signature Providers network, you receive the benefits at the discounted network cost. If you use non-PPO providers, you will pay more for services. All Out-of-Network services are subject to the amount determined to be eligible by the health plan, and you are responsible for all charges over this allowance.

HEALTH CARE COVERAGE REMINDER

You may purchase insurance through the Marketplace only if you experience a Qualifying Life Event or during Open Enrollment. The federal Marketplace Open Enrollment dates are from November 1 through January 15. Refer to the Required Notices in this guide for additional details.

MEDICAL PLAN OVERVIEW

BOON CHAPMAN	PPO PLAN	
	IN-NETWORK	OUT-OF-NETWORK
BASIC INFORMATION		
Deductible (Single/Family)	$1,000/ $2,000	$3,000/ $6,000
Coinsurance (You Pay)	20%	50%
Out-of-Pocket Limit (Single/Family)	$4,000/ $8,000	$9,000/ $18,000
	YOU PAY	
ROUTINE SERVICES		
Virtual Care/Telehealth	$0	$0
Physician Office Visit	$20 copay	50%*
Specialist Office Visit	$45 copay	50%*
Preventive Services (Adults/Children)	$0	50%*
OTHER SERVICES		
Diagnostic Test	$0	50%*
Imaging	20%*	50%*
High Tech Radiology (CT, PET, MRI) performed at Preferred Advanced Imaging Provider (Preferred Provider)	$0 Through Direct Contract Provider; Otherwise Ded + Coinsurance (Must be coordinated through PrimeDx)	
Surgery Centers (Free Preferred Surgical Centers)	$0 Through Preferred Surgical Center; Otherwise Ded + Coinsurance (Must be coordinated through PrimeDx)	
HOSPITAL AND FACILITY SERVICES		
Inpatient Hospital	20%*	50%*
Outpatient Hospital	20%*	50%*
Emergency Room Visits	$500, then 20% after deductible (Copay waived if True Emergency)	
Urgent Care Visits	$50 copay	50%*
PRESCRIPTION DRUGS		
Tier 1/Tier 2/Tier 3	$15/ $40/ $60	N/A
Mail-Order Prescriptions	$30/ $80/ $120	
Specialty Preferred / Non-Preferred	20% max of $200 / $250	

*After Deductible

MEDICAL PLAN COSTS

MEDICAL (BIWEEKLY RATES)	WELLNESS	STANDARD
Employee	$30.00	$60.69
Employee + Spouse	$272.79	$371.27
Employee + Child(ren)	$212.05	$295.76
Employee + Family	$359.21	$477.11

*Please note that Wellness activities are required to be eligibile for the wellness rate. See Page 23.

Provider Network: Aetna

PROVIDER DETAILS

To visit the online directory, simply go to http://aetna.com/asa. Begin searching for a doctor using your location ZIP, city, county or state. You can use either the general or category search to see provider details that typically include:

- Board certification
- Hospital affiliation
- Medical school/year of graduation
- Gender

You can also see additional provider information that can include participation information, other office locations, whether they're accepting new patients, maps, driving directions and more.

HOW TO FIND A NETWORK PROVIDER

Looking for physicians who participate in your health insurance network? Use one of these easy ways to find out who's in-network and potentially save money:

- Contact the Boon-Chapman Member Advocate at 855-516-8531, or e-mail advocate@boonchapman.com
- Log on to www.bevcaphealth.com
- Visit http://aetna.com/asa

Quest Diagnostics and LabCorp are preferred national in-network providers of laboratory services for all Aetna members.

Prescription Drug Benefits

Prescription drug benefits are coordinated by WellDyne, our Pharmacy Benefit Manager (PBM). Through WellDyne, you can access a network of more than 55,000 national, regional and local pharmacies. Their mail-order pharmacy offers an affordable way to get the medications you regularly take shipped directly to your door. And if you are taking a specialty medication, WellDyne's Member Services team and pharmacists can provide added support and personalized clinical guidance 365 days a year.

- You can contact WellDyne via their member portal at WellView.WellDyne.com or at 1-888-479-2000.
- For mail order prescription benefits, contact WellDyne at 1-888-479-2000 or visit their website at WellView.WellDyne.com.
- Learn more about WellDyne at https://welldyne.com/health-fair/

Where to Seek Care

TELEMEDICINE		
Use Galileo to seek treatment for minor and easily diagnosable medical conditions. Speak/Text/message with a board-certified physician / pediatrician over the phone. Visit the website to enroll: http://galileohealth.com/welcome/bevcapbeer Use Access Code: bcbeer2023	» Colds & flu » Sore throats » Headaches » Stomach aches » Fever » Allergies & rashes » Pink Eye	» FREE! No cost to you! » Your insurance covers the cost of the consultation. » Registration takes 5–10 minutes. Consultation calls can take 10–15 minutes. No need to leave home or work.

PRIMARY CARE		
See a general practitioner or your primary care physician for routine or preventive care, to keep track of medications, health maintenance, or a referral to a see specialist.	» General health, immunizations, screenings » Preventive care » Routine check-ups	» Physician office visit copay is $20. » You usually need an appointment. » Wait times vary based on their appointment schedule.

URGENT CARE CLINIC		
Visit an urgent or convenience care clinic to seek treatment for minor medical conditions that may be more urgent or that should be diagnosed in-person.	» Colds & flu » Rashes or skin conditions » Sore throats, earaches, sinus pain » Minor cuts or burns » Pregnancy testing » Vaccinations » X-ray	» Urgent care copay is $50. » It ultimately depends on what codes the facility uses when submitting claims. » Some clinics take appointments, but walk-ins are most common.

EMERGENCY ROOM		
Only visit the ER for immediate treatment of critical or life-threatening injuries or illnesses. If truly life-threatening, call 911. Note: Free-standing ERs are growing in popularity. They look like urgent care clinics, but bill as ERs.	» Uncontrolled bleeding » Compound fractures » Sudden numbness or weakness » Seizure or loss of consciousness » Shortness of breath » Chest pain » Head injury or other major trauma » Blurry vision or loss of vision » Severe cuts or burns	» ER copay is $500, then 20% after deductible. » Depending on the extent of services provided, you may be balanced billed. » Wait times vary, but can often be extensive for ERs.

Virtual Visits: Galileo

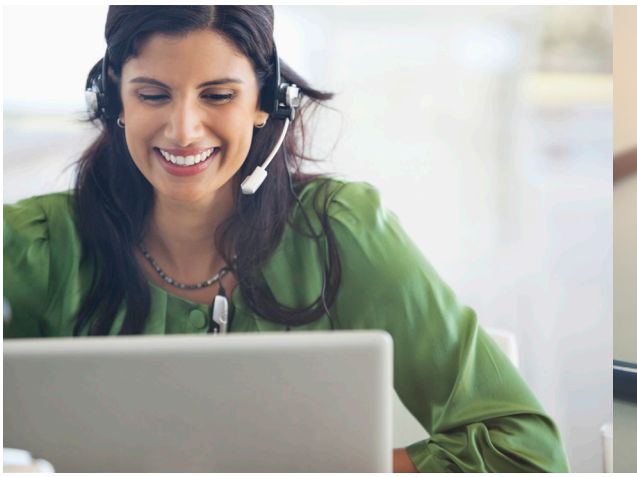
HOW IT WORKS

Galileo is your doctor's office — on your phone. With Galileo, you can:

- Consult with real doctors via chat or video anytime on the Galileo app — available in English and Spanish.
- Get access to primary care doctors and specialists: Galileo can diagnose most health care concerns, including acne, anxiety, diabetes, hypertension, cold and flu, and more.
- Have an annual wellness exam via video.

GET STARTED

Galileo is committed to medical care that thoughtfully and patiently listens to your questions and concerns. To get started, visit www.galileo.health/beer and use access code bcbeer2023. If you need registration help, call 888-613-4254.



Member Advocate

The Member Advocate delivers a higher level of customer service than you've ever experienced and is provided for your insurance needs. The Member Advocate is available to answer your health care questions and guide you through the complexities of your medical plan — at no cost to you.

HOW MEMBER ADVOCATE TAKES CARE OF YOU

UNDERSTAND INSURANCE BENEFITS

Receive guidance in understanding your benefits throughout the year.

GET HELP WITH MEDICAL BILLS

Have your medical bills reviewed to make sure you are not overcharged.

FIND A NETWORK PROVIDER

Find in network doctors in your area who meet your personal preferences and health care needs.

SAVE MONEY ON MEDICAL CARE

Get price comparisons before receiving care. Depending on the doctor, hospital or facility, costs can vary by hundreds or thousands of dollars — even in-network.

FREE MEDICAL CARE

If you require surgery or imaging, contact the Member Advocate to see if the services are eligible for one of the contracted surgery centers for a zero out-of-pocket* cost to you!

FOR QUESTIONS OR ADDITIONAL INFORMATION

Contact the Member Advocate advocate@boonchapman.com or call 855-516-8531.

Preferred Surgery Centers

Need surgery? No out-of-pocket costs? Contact your Member Advocate at 855-516-8531 or advocate@boonchapman.com. You can also contact the Nurse Advocate Team at 855-266-2093.

We are constantly evaluating and improving the benefits plans to provide you and your family with access to the highest quality care and the best patient experience available.

WHAT ARE THE BENEFITS TO USING A PREFERRED SURGERY CENTER?

- Receive high-quality post-op care from top-rated surgeons
- A superior patient experience and outstanding customer service
- Pay nothing out-of-pocket! Your health costs (deductible and coinsurance) are waived*
- Travel expenses for you and an adult caregiver are reimbursable

The following expenses for member and an adult caregiver who travel to the surgery center are covered: mileage, hotel, per diem food allowance during stay and first post-surgery prescription paid.

Member must elect to have surgical procedure performed at one of the plan's Preferred Surgical Centers. A wide range of procedures can be performed at our Preferred Surgical Centers.

BENEFITS

- Access top surgeons & anesthesiologists
- Beautiful, state-of-the-art facilities
- No copay/deductible
- Dedicated Nurse Advocate
- Care Coordination
- Travel Arrangements

PROCESS

- Outreach to members
- Obtain medical records
- Assist with diagnostic testing
- Coordinate surgery schedule
- Arrange travel (Flight, Hotel, Car Service)
- Facilitate post-op care (PT/Wound Care)

EMPLOYEE WILL RECEIVE AN INCENTIVE PAYMENT OF $1,000 WHEN A PREFERRED SURGICAL CENTER IS UTILIZED!

Preferred Advanced Imaging Providers

You have access to a concierge scheduling program for advanced radiology including MRI, CT and PET scans.

WHY USE A PREFERRED IMAGING PROVIDER?

Imaging costs are 100% covered* when you utilize a preferred advanced imaging provider by scheduling with a Nurse Advocate, at a time and place convenient to you. By utilizing an advanced imaging network, you have access to a national network with over thousands of facilities.

HOW IT WORKS

- Pre-certification is required so either you or your provider will contact the Member Advocate
- When the procedure has been pre-certified, PrimeDx will contact you to make sure you want to use Advanced Imaging
- An advanced imaging representative will call you to inform you of your authorized imaging and arrange for an appointment at a time and date convenient for you
- An advanced imaging representative can provide education about your test including quality and safety information
- An advanced imaging representative provides a written appointment confirmation and directions
- After your imaging has been completed, an advanced imaging representative sends a satisfaction survey to ensure an excellent level of service

FOR MORE INFORMATION ABOUT ADVANCED IMAGING PLEASE CONTACT:

Employees: Contact your Member Advocate at 855-516-8531 or advocate@boonchapman.com. You can also contact the Nurse Advocate Team at 855-266-2093.

Providers (for pre-certification): Nurse Advocate at 855-266-2093

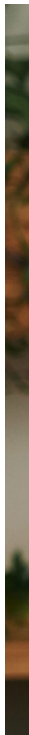
TESTIMONIALS

I was highly satisfied in all aspects of my first experience with U.S. Imaging Network and their referred MRI center.
– Lauren

The experience went very smoothly, from the conference call set-up throughout. Staff was professional and courteous.
– Juan

Everything went smoothly, no hassle or problem. I was in and out in twenty minutes and I had a disk to take to my surgeon.
– Ben

I didn't wait long. They were fantastic from the minute I walked in! Super, Super! Rick was great (the tech) I felt well taken care of. I felt refreshed when I left.
– Lindsay



Digital Physical Therapy

Digital Physical Therapy Network uses technology to provide quality, convenient and connected care to patients in the comfort of their own homes. No need to worry about transportation, traffic or the weather. You can safely recover from home, on your schedule, with your licensed physical therapist always available.

HOW IT WORKS

1. When you receive an order for physical therapy, your provider contacts the Nurse Advocate Team at 855-266-2093 to authorize therapy.
2. PrimeDx will submit authorization and referral to Digital Physical Therapy Network.
3. Digital Physical Therapy Network will contact you to schedule your initial evaluation.

Maternity Advocates

Even with health insurance and a good doctor, pregnancy is stressful, complicated and a unique experience every time. To make the pregnancy in your life easier, Daytona Beverages offers a benefit called the Maternity Advocates program. This unique benefit allows you to have on-demand access to Maternal Fetal Medicine specialists — physicians trained to deal with pregnancies of all kinds — and other pregnancy support services such as lactation consultants, behavioral health specialists, and nurse navigators.

The Maternity Advocates employee benefit is available to you free of charge. Book an appointment today by calling 800-477-4625.

WHAT IS INCLUDED?

- Unlimited On-Demand Visits – Meet with board-certified, U.S.-trained Maternal Fetal Medicine physicians on-demand, however much you want.
- Care Team Built for Pregnancies – Looking to meet with a lactation consultant, behavioral health specialist or nurse navigator? They're available too.
- Teleperinatal Mobile App – Track and learn about your pregnancy with our tracker and content library provided by Mayo Clinic.
- Personalized Pregnancy Roadmap – Following every visit, you'll receive a roadmap with everything to expect in your pregnancy, personalized to you.

Visit our site at www.maternityadvocates.com/bevcap for more information and FAQs.

ROADMAP TO A SUCCESSFUL PREGNANCY EXAMPLE

Here's a look at what a successful pregnancy utilizing the specialists in the Maternity Advocates program looks like:

4 WEEKS
Patient notifies provider she's pregnant
10 WEEKS
Patient visits with provider
14 WEEKS
Patient consults with MFM physician
20 WEEKS
Anatomy scan

28 WEEKS
Diabetic screen
36 WEEKS
Delivery planning meeting with MFM
40 WEEKS
Baby is born! Mother and baby go home

**** THE MATERNITY ADVOCATE PROGRAM IS EXTENDED TO EXPECTANT MOTHERS NOT COVERED ON THE PLAN.*

UPON COMPLETION OF THE PROGRAM, YOU WILL RECEIVE A 1-YEAR SUBSCRIPTION OF FREE DIAPERS!

Maternity Advocates Frequently Asked Questions

WHAT IS A MATERNAL FETAL MEDICINE (MFM) DOCTOR?

A Maternal Fetal Medicine specialist is a board-certified OB/GYN with three additional years of training in the management of high-risk pregnancies through the third trimester. MFM's are sub-sepcialists who care for mother and baby

HOW EFFECTIVE IS TELEMEDICINE FOR TREATING PREGNANCIES?

Given that there are so few MFM's, telemedicine has been used effectively for many years, making it one of the few specialties to widely adopt its use long before the pandemic.

I ALREADY HAVE AN OB/GYN. WHY DO I STILL NEED A MATERNITY ADVOCATE?

Maternity Advocates' MFM and nurses work directly with your Maternity Provider as a member of your care team. They provide support and guidance throughout your pregnancy to make sure you are getting the care you and your baby need when you need it.

WHAT IF MY OB/GYN RECOMMENDS ANOTHER MFM?

Some Obstetricians have well-established relationships with MFM's and that is fine. Maternity Advocates MFM's will still be there for you as an independent guide to make sure you and your baby follow the gold-standard in maternity care, the American College of Obstetricians and Gynecologists (ACOG) Guidelines.

THIS BENEFIT IS FREE OF CHARGE. WHAT'S THE CATCH?

There is no catch. Employers are regularly looking for unique employee benefits that they think will improve the quality of life of their employees and their families. Ensuring your family sustains a healthy, successful pregnancy is important to everyone, so your employer has subsidized the cost of this benefit for you.

PriceMDs Telemedicine Program

This treatment cost containment program is a regulatory compliant solution for providing high cost specialty pharmaceuticals at greatly reduced prices inclusive of all telehealth services and travel to PriceMDs' participating facilities.

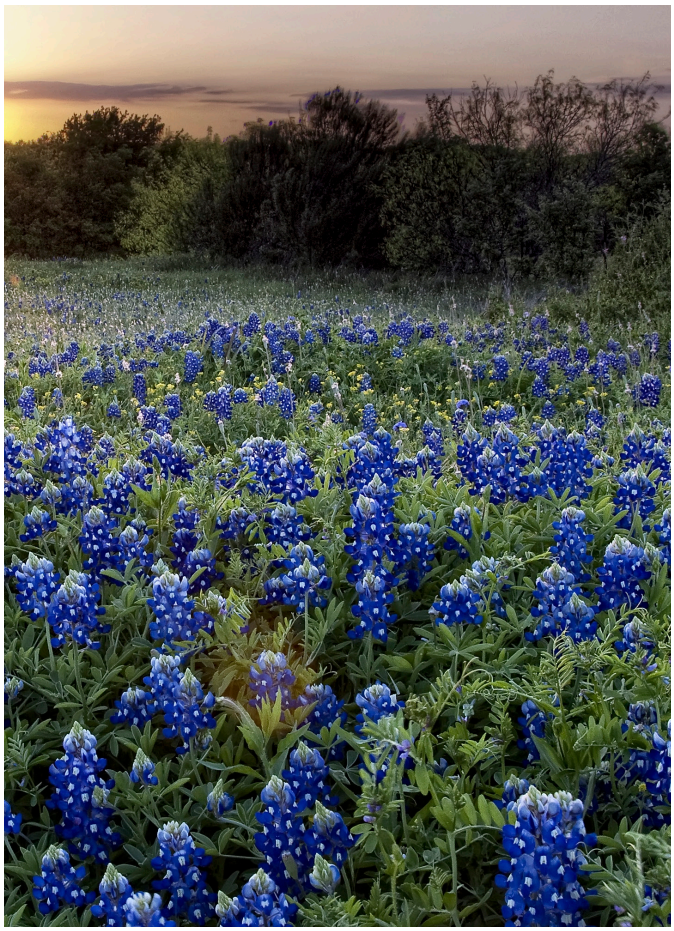
Receive your treatment and a 90-day supply of medication with two video Telemedicine consultations — NO TRAVEL required for treatment.

GUIDELINES FOR PATIENT ELIGIBILITY:

- Mandatory, initial telemedicine consultation with U.S. licensed/Board Certified Sub-Specialist, on-island doctor
- Next, a video telemedicine consultation with a U.S. licensed, state-registered PriceMDs Doctor
- Home delivery of medication after telemedicine consultation
- Cold chain medicines included (some subject to shipping eligibility)
- Strict limit of three-month supply per participant
- Passports required per FDA guidelines

INCENTIVES

When utilizing PriceMDs, members will receive an incentive of $1,000 for first fill. For each PriceMDs fill thereafter, members will receive an incentive of $250.



Disease Management

RETRO HEALTH

Retro Health Disease Management program assists members in managing chronic conditions with a goal of improving their clinical condition and reducing unnecessary health care costs while improving quality of life. Our program promotes participant self-care by providing patient education, coaching and monitoring, facilitates collaboration within the health care team (patient, physician and health plan), and coordinates services as appropriate across the health care continuum. You can contact the Retro Health Team at 844-573-3733 or info@retrohealth.com

MANAGED CHRONIC CONDITIONS INCLUDE:

- Diabetes
- Hyperlipidemia
- Hypertension

SERVICES

- Access to Registered Nurses
- Evidence-based Highly Personalized Care
- Member Engagement, Coaching and Monitoring
- Advanced Risk Scoring and Analytics
- Review of Reports, Lab Results, Screenings and Assessments
- Patient Education Tools and Resources

Case Management

PrimeDx Case Management services are designed to improve the quality of patient care while maximizing cost savings. Our team of nurses provide individuals a better understanding of specialized care needs, access to specialty care facilities, education on alternatives to costly inpatient care, and direction toward in-network discounts. We work with members to educate and assist them in making choices that contribute to a healthier lifestyle, thus reducing the incidence of complications and future medical costs. You can contact the PrimeDx Nurse Advocate Team at 855-266-2093 or pdx@primedx.com.

SERVICES

- Establish a Comprehensive Care Plan
- Care Coordination
- Pain Management Monitoring
- Facilitation of Social Services
- Review of Disease Process and Symptoms
- Monitoring Side Effects
- Educational Information

PRE-NOTIFICATION REQUIREMENT

In order to prevent unnecessary costs and to assist you in fully understanding your benefits, the pre-notification program fulfills the dual purpose of advising the participant of their benefits and protecting the financial integrity of the Plan. This benefit is available prior to any procedure.

Except in an urgent care situation, the participant must call the Nurse Advocate at 855-266-2093, at least three (3) business days before any/all procedures scheduled in advance including, but not limited to the following:

- In-patient procedures
- Out-patient procedures
- Imaging services; and
- Diagnostic testing

Cancer Advocacy Program Through ApricityCare

Each cancer patient is unique and responds differently to their anti-cancer treatment. Research shows frequent monitoring in between clinic visits results in early intervention, better treatment outcome, and improved patient satisfaction. Personalized prevention can also reduce treatment-related side effects helping patients get the most out of their anti-cancer treatment.

BevCap offers a cancer advocacy benefit through their partnership with ApricityCare. This unique benefit is an extension of your doctor allowing you to easily report cancer treatment related symptoms from your phone or computer – 24 hours a day, 7 days a week. Once your symptoms are reported, they will be promptly evaluated by an ApricityCare Oncology nurse who may reach out to you to provide guidance and support. After the evaluation, your doctor will be updated with the details to help them personalize your care and any necessary follow-up. You will also receive individualized fitness, nutrition, and wellness assessments to help you and your doctors take preventive measures to better prepare you for your anti-cancer treatment.

This benefit is available to you free of charge. Sign up today by contacting your Case Manager with PrimeDx or directly at the ApricityCare website: https://bevcap.apricitycare.com

WHAT IS INCLUDED?

- Extended Care Team – The ApricityCare nurses are trained to evaluate, assess, and manage your cancer symptoms and treatment related side effects. They function as an extension of your doctor and are available to you every day including holidays and weekends.
- The ApricityCare App – The application on your mobile phone or on the computer is an easy way to report symptoms to the ApricityCare nurses anytime from anywhere. Based on your symptoms, you'll be connected with one of the ApricityCare nurses for evaluation.[1]
- Personalized Care – The ApricityCare Team will assess your symptoms in the context of your cancer history and communicate your status to your doctor.
- Whole-Person Care – ApricityCare brings a holistic approach to help you maximize your treatment benefits with preventive measures based on personalized assessments and recommendations from the ApricityCare Cancer Advocacy partners[2] – Focusing on basic safety, balance and fitness, nutrition, and overall well-being for each patient regardless of their cancer diagnosis or treatment regimen.

The Cancer Advocacy Program is here to support you and your family by providing proactive symptom management and Whole-Person Care so you can live your life as comfortably as possible and have the best chance of a successful outcome.

Visit our site at https://bevcap.apricitycare.com for more information and FAQs.

[1] You can also reach the ApricityCare team by phone.

[2] Hope & Beauty for wellness, Galaxy Brain for physical therapy, and Savor Health for nutrition.

Roadmap to Your Journey with ApricityCare

Here's what a typical journey will look like using the Cancer Advocacy Program through ApricityCare during your cancer treatment:

CANCER DIAGNOSIS RECEIVED
» Sign Up for ApricityCare
» Connect with PrimeDX Case Manager
» Complete Medication Reconciliation prior to first/next visit with doctor
» Schedule Wellness Assessment
» Schedule PT/OT/SLP Assessment
» Sign Up for Nutrition Guidance
2-4 WEEKS POST DIAGNOSIS
» Complete Wellness Assessment
» Complete PT/OT/SLP Assessment

DURING TREATMENT
» Daily Check-Ins on ApricityCare app
» Regular Medication Reconciliation
» Regular Virtual Nutrition and Balance/Fitness Coaching
6 MONTHS ON TREATMENT
» Repeat Wellness Assessment
» Repeat PT/OT/SLP Assessments

FREQUENTLY ASKED QUESTIONS

HOW OFTEN SHOULD I CHECK IN AND REPORT MY SYMPTOMS?

We recommend checking-in daily to report your symptoms so side effects can be caught early and treated.

CAN I CONTACT A NURSE DIRECTLY IF I HAVE SYMPTOM-RELATED QUESTIONS?

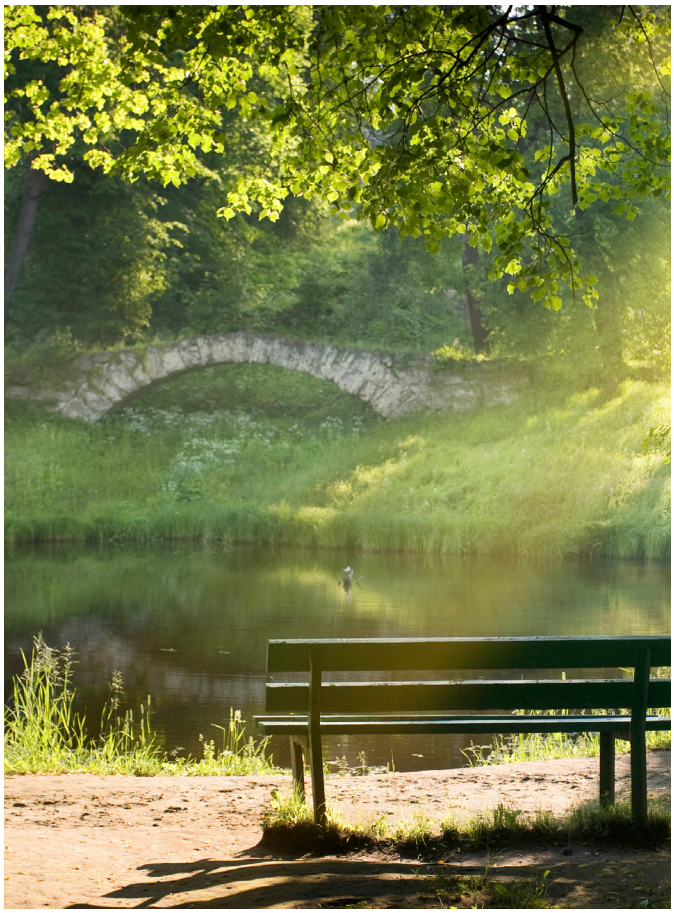
Absolutely. Our nurses are available via phone or you can use the app to message the Care Team directly.

I ALREADY HAVE AN ONCOLOGY DOCTOR. WHY DO I NEED THE CANCER ADVOCACY PROGRAM?

The ApricityCare team is an extension of your doctor allowing you to easily report symptoms right from the app, your computer, or your phone, 24/7. Once your symptoms are reported, they will be promptly evaluated by an ApricityCare Oncology nurse who may reach out to you to provide guidance or support. After the evaluation, your doctor will be updated with the details. This helps them personalize your care and any necessary follow-up.

THIS BENEFIT IS FREE OF CHARGE. WHAT'S THE CATCH?

There is no catch. Your employer has subsidized the cost of this benefit for you because ApricityCare is designed to help your doctors better manage your cancer symptoms and treatment side effects- so you are more likely to stay on and benefit from the treatment.



Wellness

We are committed to helping you prevent illnesses and achieve wellness. Did you know that your medical plans pay 100% of the cost for preventive care? This means you and your dependents receive recommended preventive services like immunizations and screenings at no cost to you.

WHAT IS PREVENTIVE CARE?

Preventive care includes services that help you stay healthy, including:

- Vaccines that protect your health by preventing diseases and other problems
- Screenings to check for diseases early when they may be easier to treat
- Education and counseling to help you make health decisions

TAKE ACTION!

Participating in our Wellness Program not only benefits you physically, mentally and emotionally. It also benefits you financially.

Employees and covered dependents (age 18+) must complete the required wellness activities to be eligible for the reduced medical plan Wellness rate:

- Annual physical exam and lab work
- Recommended preventative health screenings by age
- Remain tobacco free

* Note: If it is unreasonably difficult or medically inadvisable for you to attempt to achieve the requirements to earn the medical premium incentive or alternative standard, contact Human Resources and we will work with you to develop another way to qualify.

Dental

TAKING CARE OF YOUR ORAL HEALTH IS NOT A LUXURY — IT'S A NECESSITY TO LONG-TERM OPTIMAL HEALTH.

With a focus on prevention, early diagnosis and treatment, dental insurance can greatly reduce your costs when it comes to restorative, and emergency procedures. Preventive services are covered at no cost to you and include routine exams and cleanings. You will only pay a small deductible and coinsurance for basic and major services.

When you visit a dentist in the network, you will maximize your savings. These dentists have agreed to reduced fees, which means you won't get charged more than your expected share of the bill.

GUARDIAN	DENTAL PLAN	
	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE		
Individual	$50	$50
Family (3 per family)	$150	$150
CALENDAR YEAR PLAN MAXIMUM		
Per Individual	$2,000 + Maximum Rollover	
	YOU PAY	
PREVENTIVE CARE		
Exams, Cleanings, X-rays, Fluoride Treatments	$0	$0
BASIC SERVICES		
Fillings, Space Maintainers, Sealants, Extractions, Oral Surgery, Endodontics, Periodontics, Emergency Exams	20%	20%
MAJOR PROCEDURES		
Crowns, Inlays/Onlays, Dentures and Bridgework, Repairs	50%	50%
Orthodontics	50%* up to Lifetime Max of $1,000 per child	

DENTAL (BIWEEKLY RATES)	BASE
Employee	$2.43
Employee + Spouse	$17.17
Employee + Child(ren)	$21.54
Employee + Family	$30.15

Vision

HEALTHY EYES AND CLEAR VISION ARE AN IMPORTANT PART OF YOUR OVERALL HEALTH AND QUALITY OF LIFE.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

GUARDIAN	VISION PLAN
	PARTICIPATING PROVIDER
	YOU PAY
COST	
Exam	$10 copay
Materials	$25 copay
COVERED SERVICES – LENSES	
Single Lenses	$25 copay
Bifocals	
Trifocals	
Frames	$130 allowance + 20% off balance
COVERED SERVICES – CONTACTS IN LIEU OF FRAMES/LENSES	
Contacts – Medically Necessary	$130 allowance + 15% off balance
BENEFIT FREQUENCY	
Exams	Once every 12 months
Lenses	Once every 12 months
Frames	Once every 24 months
Contacts	Once every 12 months

VISION (BIWEEKLY RATES)	
Employee	$0.00
Employee + Spouse	$1.94
Employee + Child(ren)	$2.05
Employee + Family	$4.34

Life and Accidental Death & Dismemberment (AD&D) Insurance

Life insurance pays a lump-sum benefit to your beneficiary(ies) to help meet expenses in the event of your death. AD&D insurance pays a benefit if you die or suffer certain serious injuries as the result of a covered accident. In the case of a covered accidental injury (e.g., loss of sight, loss of a limb), the benefit you receive is a percentage of the total AD&D coverage you elected based on the severity of the accidental injury.

LIFE / AD&D INSURANCE – FOR YOU – GUARDIAN		
	LIFE AND AD&D	VOLUNTARY LIFE AND AD&D
Coverage Amount	$20,000 (employer paid benefit, election not required)	Increments of $10,000 not to exceed $400,000
Evidence of Insurability / Proof of Good Health	None	Required if electing coverage equal to or greater than $150,000 for ages under 65, $50,000 for ages 65-70 & $10,000 for ages 70+

DEPENDENT VOLUNTARY LIFE

Voluntary Life insurance for your dependents can help protect your family during difficult times.

LIFE / AD&D INSURANCE – FOR YOUR DEPENDENTS – GUARDIAN		
	SPOUSE	CHILD(REN)
Coverage Amount	Increments of $1,000 not to exceed 50% of Employee coverage	Increments of $1,000 to a maximum of $10,000 for children 14 days to 26 years of age
Evidence of Insurability / Proof of Good Health	Required for amounts equal to or greater than $30,000	None

GUARANTEED ISSUE (GI) AND EVIDENCE OF INSURABILITY (EOI)

Employees and spouses who elect coverage when first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). If the amount requested is more than GI, you will need to provide EOI before the amount over GI becomes effective.

IMPUTED INCOME

Under current tax laws, imputed income is the value of your Basic Life insurance that exceeds $50,000 and is subject to federal income, Social Security, and state income taxes, if applicable. This imputed income amount will be included in your paycheck and shown on your W-2 statement.

VOLUNTARY LIFE AND AD&D RATES (MONTHLY COST FOR EACH $1,000 OF COVERAGE)	
AGE	EMPLOYEE & SPOUSE
<20	$0.070
20-24	$0.070
25-29	$0.070
30-34	$0.080
35-39	$0.100
40-44	$0.160
45-49	$0.260
50-54	$0.500
55-59	$0.800
60-64	$0.930
65-69	$1.680
70+	$3.290
AD&D	$0.025
CHILD LIFE INSURANCE	
$1,000	$0.175
CHILD AD&D	$0.025

To calculate your cost, complete the following by selecting your coverage amount and rate (based on your insurance age).

	COVERAGE AMOUNT	INCREMENT	RATE	MONTHLY COST
Employee	$_____	÷ $ 1,000	x ($_____ + AD&D rate)	= $_____
Spouse	$_____	÷ $ 1,000	x ($_____ + AD&D rate)	= $_____
Children	$_____	÷ $ 1,000	x ($_____ + AD&D rate)	= $_____
TOTAL				= $_____

To determine the cost per paycheck, multiply the total monthly cost by 12 and then divide by 52, 26 or 24 pay periods per year, depending on your organization's pay schedule.

Disability Insurance

Disability insurance can keep you financially stable should you become disabled and unable to work. It can help provide a sense of security, knowing that if the unexpected should happen, you'll still receive a monthly income.

SHORT-TERM DISABILITY BENEFITS AT A GLANCE – GUARDIAN	
Coverage	60% of your weekly earnings to a $500 maximum for 24 weeks
When Benefits Begin	Benefit begins after 15 days of disability
Election Required	No - Employer Paid

LONG-TERM DISABILITY BENEFITS AT A GLANCE – GUARDIAN	
Coverage	60% of your pre-disability earnings, up to a maximum benefit of $2,500 per month until you recover or reach your Social Security Normal Retirement Age, whichever is sooner
When Benefits Begin	Benefit begins after 180 days of disability
Election Required	No - Employer Paid

HOW STD AND LTD WORK TOGETHER

Available PTO pays 100% of your pay until STD begins. → After 15 days of sickness or injury, approved STD pays a portion of your income. → After 24 weeks LTD begins if approved.

A qualifying disability is a sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training or experience.

Employee Assistance Program

Check out these Employee Assistance Program (EAP) web tools and get information and advice on the things that matter to you. Your member website is a single source for information on your career, health and personal life. With just a couple clicks you can:

- Search for child or elder care providers
- Learn about health conditions
- Take well-being assessments
- Access self-help tools and information
- Find discounts on over 3 million products and services, like computers and electronics, travel, fitness centers, restaurants and more.

AETNA RESOURCES FOR LIVING

www.mylifevalues.com

Username: peaceofmind
Password: solutions

GUARDIAN - WORKLIFE MATTERS

worklife.uprisehealth.com

Access Code: worklife
Phone: 800-386-7055

Health Benefit Glossary

Coinsurance. A percentage of a health care cost — such as 20 percent — that the covered employee pays after meeting the deductible.

Copayment. The fixed dollar amount — such as $25 for each doctor visit — that the covered employee pays for medical services.

Deductible. A fixed dollar amount that the covered employee must pay out of pocket each calendar year before the plan will begin reimbursing for non-preventive health expenses. Plans usually require separate limits per person and per family.

Formulary. A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Flexible Spending Account (FSA). An FSA is a type of savings account that allows employees to contribute a portion of their regular earnings to pay for qualified expenses. Funds contributed to the account are deducted from the employee's earnings before they are made subject to payroll taxes.

Preferred Provider Option Network (PPO). The PPO means your insurance company will have a network of care providers available to you at your discretion. The care provider will file the claim with your PPO carrier, and you pay the difference between the bill and the insurance payment.

In-network. Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.

Out-of-network. A health plan will cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-of-pocket limit. The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including co-payments and co-insurance.

Premium. The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

Required Notices

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Daytona Beveragess
Human Resources:
386-274-4005
2275 Mason Ave.
Daytona Beach, FL. 32117

NEWBORNS' ACT DISCLOSURE

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).

WHCRA ENROLLMENT 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. .

WHCRA ANNUAL NOTICE

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

MODEL NOTICES OF PRIVACY PRACTICES

The HIPAA Privacy Rule requires health plans and covered health care providers to develop and distribute a notice that provides a clear, user friendly explanation of individuals rights with respect to their personal health information and the privacy practices of health plans and health care providers. This page provides options for meeting the requirement to create notices of privacy practices (NPP).

HHS developed the model NPPs you see on this site to help improve patient experience and understanding. These models use plain language and approachable designs.

The options below are separated into two sets, for health plans and health care providers. Each set contains three formatted options and a text only option, in both English and Spanish. They are:

- Notice in the form of a booklet (preferred by consumers in focus testing);
- A layered notice that presents a summary of the information on the first page, followed by the full content on the following pages;
- A notice with the design elements found in the booklet, but formatted for full page presentation.
- A text only version of the notice.

The models reflect the regulatory changes of the Omnibus Rule (2013). In particular, the models highlight the new patient right to access their electronic information held in an electronic health record, if their provider has an EHR in their practice. Covered entities may use these models by entering their specific information. Please review Questions and Instructions documents before personalizing the notice.

For more information about the HIPAA Privacy Rule and the Notice requirements, see: http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/notice.html

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, 2023. Contact your State for more information on eligibility –

ALABAMA Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA 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

ARKANSAS Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA Medicaid

Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

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

FLORIDA Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA Medicaid

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)

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
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp

KANSAS Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY 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/agencies/dms

LOUISIANA 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)

MAINE Medicaid

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

MASSACHUSETTS Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and- amilies/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY Medicaid and CHIP

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

NEW YORK Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA Medicaid

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA Medicaid and CHIP

Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA Medicaid
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/ badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING Medicaid
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, 2021, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

BACKGROUND

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

HOW THE RULE WORKS

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information.

Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 164.500(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contracts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in plain language that describes:

- How the covered entity may use and disclose protected health information about an individual.
- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complain to the covered entity.
- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

PROVIDING THE NOTICE.

- A covered entity must make its notice available to any person who asks for it.
- A covered entity must prominently post and make available its notice on any web site it maintains that provides information about its customer services or benefits.
- Health Plans must also:
  - Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004, for small health plans) and to new enrollees at the time of enrollment.
  - Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
  - Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.
- Covered Direct Treatment Providers must also:
  - Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the Privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
  - When first service delivery to an individual is provided

over the Internet, through e-mail, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
  - In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
  - Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.
- A covered entity may e-mail the notice to an individual if the individual agrees to receive an electronic notice.

See 45 CFR 164.520(c) for the specific requirements for providing the notice.Organizational Options.

- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearinghouse) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.
- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individual, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

FREQUENTLY ASKED QUESTIONS

To see Privacy Rule FAQs, click the desired link below:

FAQs on Notice of Privacy Practices

FAQs on ALL Privacy Rule Topics

(You can also go to http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php, then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.)

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. 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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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 9.5% 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.

IMPORTANT NOTICE FROM DAYTONA BEVERAGESS ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer sponsored health plan about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your employer has determined that the prescription drug coverage offered by the your employer sponsored group health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, you will also be eligible for a two month Special Enrollment Period (SEP) to join a Medicare drug Plan.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with your employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by atleast 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage, your premium may consistently be a least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current employer sponsored group health plan coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current employer sponsored group health plan coverage, be aware that you and your dependents will not be able to get this coverage back until the plans next open enrollment.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through your employer sponsored group health plan coverage changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…

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

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

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

Daytona Beveragess
Human Resources:
386-274-4005
2275 Mason Ave.
Daytona Beach, FL. 32117

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. 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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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 9.5% 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 your plan administrator.

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.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.Continuation Coverage Rights Under COBRA

INTRODUCTION

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs.

Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other

than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child.

This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period1 to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

Daytona Beveragess
Human Resources:
386-274-4005
2275 Mason Ave.
Daytona Beach, FL. 32117

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Disclaimer: This brochure highlights the main features of Daytona Beverages Employee Benefits Program. It does not include all plan rules, details, limitations, and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Daytona Beverages reserves the right to change or discontinue its employee benefits plans at any time.