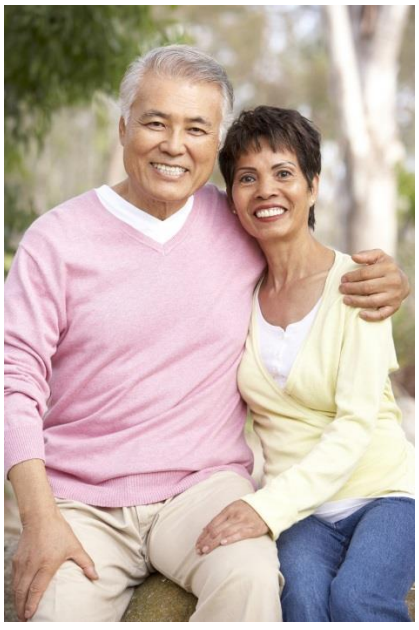
SARASOTA MEMORIAL

HEALTH CARE SYSTEM



2020 - 2021

Benefits Guide

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Welcome Letter

Sarasota Memorial Health Care System (SMHCS) offers an inclusive, flexible compensation and benefits package to help you take care of yourself and your family. We are committed to providing relevant and comprehensive benefits, at costs that are reasonable for you, as well as our health system.

SMHCS wants to ensure you have all the resources to understand what is available to you and how to make the most of it. This guide highlights the plans offered to you and the resources available, so that you may make informed choices.

There are a few changes to the plan offerings for 2021. We have incorporated a "What's New" page for a quick overview of those changes.

Please set aside time to read these materials, share them with your family and choose the combination of benefits that's right for you.

Detailed information regarding our health plans is available in the "Sarasota Memorial Health Care System Health and Wellness Plan Summary Plan Description" and in our "Summary of Benefit Coverage".

These documents can be found on the **Sarasota Memorial Mobile Wallet Card** (www.mymobilewalletcard.com/smh) as well as on the HR benefits page on Pulse, the SMHCS intranet site.

The benefits reviewed in this guide are effective

October 1, 2020 through September 30, 2021.

The benefits in this guide apply to most employees, but the benefits available to Per Diem and temporary employees, as well as residents and physicians may differ.

Please refer to the Summary Plan Description, your contract or your department for further details.

Benefit Basics

Sarasota Memorial Health Care System (SMHCS) offers a comprehensive suite of benefits to promote health and financial security for you and your family. This booklet provides a summary of these benefits. Please review it carefully so you can choose the coverage that is right for you.

Benefit Basics

You are eligible for benefits if you are a regular full-time employee, working thirty-five (35) or more hours per week; or a part-time employee, working at least twenty (20) hours per week or forty (40) hours per pay period or; a Temporary or Per Diem Employee who works, on average, over a year's time, thirty (30) hours or more per week, as determined using the measurement period selected by SMH that is compliant with the Affordable Care Act.

Most of your benefits are effective on the first day of the month following your date of hire. You may also enroll your eligible dependents. Eligible dependents include:

- Your legal spouse
- Your children up to age 26
  - *Per Diem employees enrolled in medical coverage may only cover dependent children*

Once your benefit elections become effective, they remain in effect through the end of the plan year, **September 30, 2021**. You may only make changes to your coverage if you experience a "Qualifying Life Event".

Qualifying Life Events – 31-Day Window

Generally, you may only change your benefit elections during the annual open enrollment period. However, you may change your elections during the year if you experience a Qualified Life Event such as:

- Marriage
- Divorce
- Birth, Adoption or placement of a child
- Death of your spouse or dependent child
- Change in employment status of yourself, your spouse or your dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage (QMSCO)
- Entitlement to Medicare or Medicaid

You must notify Human Resources within 31 days of a qualifying life event.

You may notify HR through employee self-service (ESS) on My HR or via email to **HR-ServiceCenter@smh.com.**

Depending on the type of event, you will need to provide proof of the event, such as a marriage license, birth certificate or divorce decree. If you do not contact Human Resources within 31 days after the qualified event, you will have to wait until the next open enrollment period to make changes (unless you experience another, separate qualifying life event).

Proof of Relationship is Required to Enroll All Dependents.

Acceptable Proof of Relationship documents are:

- First page of your most recent Federal Tax Return, Form 1040 (All dependents)
  - Must list full name and social security number of all participants in the SMHCS healthcare plan (**please black out or redact all financial data**)
- Marriage Certificate and two additional documents proving joint ownership. (Spouse)
- Birth Certificate (Dependent Children under age 26)
- Birth Certificate and copy of current full- or part-time School Schedule (for qualified overage dependent children)
- Physician's Certifications for disabled children (Unmarried, disabled dependent children age 26 and older)

The full list of acceptable documents can be found in the SPD and SMHCS reserves the right to request this documentation at any time.

Benefit Costs

SMHCS pays the full cost of many of your benefits; you share the cost for some others. In addition, you pay the full cost for any voluntary benefits you elect.

Benefit	Who Pays	Tax Treatment
Medical	SMHCS & You	Pretax
Dental	SMHCS & You	Pretax
Vision	You	Pretax
Basic Life and Accidental Death and Dismemberment (AD&D) Insurance	SMHCS	Pretax*
Voluntary Life and AD&D Insurance	You	After-tax
Dependent Life Insurance	You	After-tax
Short Term Disability	You	After-tax
Basic Long Term Disability	SMHCS	Pretax
Long Term Disability Buy Up	You	Pretax
Flexible Spending Accounts	You	Pretax
Employee Assistance Plan	SMHCS	N/A
403(b) Retirement Savings Plan	SMHCS & You	Pretax
**Pretax up to $50,000 per IRS guidelines*		

Medical Coverage

SMHCS offers three medical plan options:

- Comprehensive Medical (SMHCS most popular plan)
- Basic Medical
- Extended Medical

Each medical plan has varying features: in network coverage; individual and family deductibles; copays; coinsurance; and out-of-pocket maximums.

Comprehensive Medical Plan
The comprehensive medical plan generally offers access to an SMHCS-only network. This plan has the most robust plan design, with no deductible, and very low copays and coinsurance. It also offers the lowest coinsurance out of pocket maximum of the three plans.

Basic Medical Plan*
The basic medical plan also offers access to an SMHCS-only network. This plan has a $250 individual deductible and a $1,500 family deductible, as well as a higher coinsurance for some services. Additionally, the coinsurance out of pocket maximum for the Basic Medical Plan is higher.

Extended Medical Plan
The extended medical plan offers access to a broader network, as well as some out of network coverage. This plan has the highest deductible, copays and coinsurance.

In/Out-of-Network Coverage
Although the Extended Medical Plan does allow you to use in- or out-of-network providers, you will always pay less if you see a doctor and/or receive services within the SMHCS provider network.

**Per Diem/Temporary employees, who meet the eligibility criteria for medical coverage per ACA guidelines, are only eligible to enroll in the Basic Medical Plan with Basic Rx plan, and can only cover themselves and any eligible dependent children.*

Prescription Drug Coverage

A prescription drug benefit **must** be selected with your medical plan. Three prescription drug plans are structured similarly to the medical options, and are described in the Prescription Drug Comparison Chart on page 8.

If you have elected a Medical Plan, you must choose a Prescription Drug Plan. Prescription plans are not available without enrollment in a Medical Plan.

The three prescription plan options are:

- **Rx C (Comprehensive)**
- **Rx B (Basic)**
- **Rx E (Extended)**

While the prescription plans are structured like the medical plans, you may combine any prescription plan with any medical plan

(**Additional details outlined on page 8**)

Not sure what plan to choose?

Ask ALEX®, our NEW benefit plan decision support counselor, he can help you pick the best plan for you and your family. Get started at **myalex.com/smh**.

Medical Plans

SMHCS medical plan options:

Plan Provision	Comprehensive Plan	Basic Plan	Extended Plan		
	SMHCS	SMHCS	SMHCS	In-Network	Out-of-Network
Annual Deductible (Individual/Family)	$0/$0	$250/$1,500	$0/$0	$1,500/ $4,500	$2,500/ $8,500
Additional Hospital Deductible	N/A	N/A	N/A	N/A	$1,000
Out-of-Area Child Additional Deductible	$1,000	$1,000	$1,500	$2,500	$2,500
Out-of-Pocket Maximum (Co-insurance limit)	$1,500/$4,500 (Coinsurance limit) $6,600/$13,200 (Essential Health Benefits; Med and Rx Combined)	$2,500/$7,500 (Coinsurance limit) $6,600/$13,200 (Essential Health Benefits; Med and Rx Combined)	$6,350/ $12,700	$6,350/ $12,700	Unlimited
Lifetime Maximum	Unlimited	Unlimited	Unlimited		
Preventive Care *In accordance with ACA requirements*	No charge	No charge	No charge	No charge	N/A
Primary Physician Office Visit	$25	$25	$25	$25	$25*
Specialist Office Visit	$50	$50	$50	$50	$50*
X-Ray and Lab	15%	20%*	15%	40%*	60%*
Inpatient Hospital Services	15%	20%*	15%	40%*	60%*
Outpatient Hospital Services	15%	20%*	15%	40%*	60%*
Urgent Care**	$30	$30	$30*	$30*	$30*
Emergency Room Care	$200 copay Waived if admitted	$200 copay Waived if admitted	$200 copay Waived if admitted		
Prescription Drug Deductible (Individual/Family)	N/A	$100/$200 Waived for generic drugs		N/A	

^ Eligibility rules and plan choices may differ for Per Diem/Temporary employees
***After deductible is met**

****Urgent Care: $30 copay for services at SMH Urgent Care Centers for employees living in Sarasota or Manatee Counties; or services provided at an Urgent Care outside of SMH, if living or traveling outside Sarasota or Manatee counties.**

Special Allowance for Out-of-Area Children: Children who live outside of the Gulf Coast Provider Select network area have access to services provided through the nationwide First Health provider network. You are responsible for 20% of the cost after the applicable deductible, for out-of-area services for children.

Note: This is a summary only of your coverage. In-network services are based on negotiated charges; out-of-network services are based on reasonable and customary (R&C) charges.

Medical Coverage

Wellness & Preventive Care

Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Medical Benefits. Certain additional preventive care services will be covered without a copayment or coinsurance regardless of the deductible, as long as the services are provided by an in-network provider, and are provided in accordance with guidelines from Gulf Coast Medical Management.

A current listing of ACA Preventive Care services provided (in-network) at no cost to you can be accessed at: **https://www.healthcare.gov/coverage/preventive-care-benefits/**

Chronic Disease Case Management

Chronic Disease Case Management is a free program offered to plan members living with chronic diseases or conditions.

Case managers can help participants get the care they need, provide education about the disease/condition, help make a treatment plan, arrange doctor visits and assist with referrals and treatment.

If you or a covered dependent is living with a chronic disease/condition and is actively participating in the Chronic Disease Case Management program, you may be eligible for a reduction in your Specialist office visit copay.

For more information, visit:
www.gulfcoastmemberservices.org or call **941-917- 2956**.

Pre-Authorizations

All of the medical plans require pre-authorizations for the following procedures:

- Non-emergency hospital admission
- Non-emergency inpatient or outpatient surgery
- Invasive outpatient procedures
- EGD's, ERCP, Cardiac Cath and office procedures and diagnostics over $1,000 except for Dermatology procedures.
- PET scans
- Hospital admissions due to emergencies within 48 hours (72 hours on weekends and holidays) or as soon as reasonably possible.
- Mental Health services must be authorized by Gulf Coast Medical Management.
- Radiation Oncology

The Comprehensive Plan requires a referral from your Primary Care Physician after two visits to the same type of specialist, with the exception of gynecology and podiatry.

The Basic Plan requires a referral from your Primary Care Physician for all visits to a specialist.

Change for 2021

Sarasota Memorial now offers in-network radiation oncology services at the SMHCS Radiation Center. No referrals or pre-authorizations are needed.

Effective October 1, 2020, all other radiation oncology services/providers will require pre-authorization. To obtain pre- authorization, you must work with your provider to place the request at **www.gulfcoastmemberservices.org**.

Prescription Drug Coverage

Prescription Drug Benefit

A prescription drug benefit **must** be selected with your medical plan. Three prescription drug plans are available and these are described in the following Prescription Drug Comparison Chart.

If you have elected a Medical Plan, you must choose a Prescription Drug Plan. A Prescription Drug Plan is not available without enrollment in a Medical Plan. While the prescription plans are structured similarly to the medical plans, any prescription plan can be paired with any medical plan.

The Prescription Drug Plans are administered by Navitus Health Solutions. Here's how it works.

- **Retail Pharmacies**
  - You may have your prescription filled at any of the retail pharmacies that participate in the Navitus network. You will pay the appropriate copayment for up to a 30-day or 90-day supply of the drug.
- **Mail Order Program** (For longer-term prescriptions):
  - This feature enables you to receive up to a 90-day supply at a reduced cost compared to retail.

Drug Formulary

All the medical plan options available include a drug formulary, which limits the drugs that are available under the plan. Many times there are several brands of the same drug that are identical in chemical composition but have different costs. The formulary might only contain one or two brands of that drug that have proven to be the most effective and least costly.

Generic vs. Brand Drugs

Prescriptions typically must be filled with a generic drug when a generic is available. Brand name medications will always be a more expensive option.

Generic step therapy requires that a cost effective generic alternative is tried first before moving to a targeted single source brand medication.

See more details at **www.gulfcoastmemberservices.org** under Pharmacy Case Management.

Pharmacy Case Management

A pharmacy case manager is available to work with you to understand your prescription benefit.

By working with the pharmacy case manager, you may receive a up to a $1,500 increase to your pharmacy cap for each covered family member who participates. You may also want to take this benefit into consideration while calculating your plan choice for the upcoming plan year.

You must go online and complete a submission form for each covered member in order to apply for the additional $1,500.

The pharmacy case manager can be reached through **www.gulfcoastmemberservices.org** or at 941-917-1473.

Prescription Plan	Rx C	Rx B	Rx E
Prescription Drug Limitations			
Base Benefit	$3,000	$2,000	$7,000
Coverage gap Per Participant	$1,000	$1,000	$1,000
Umbrella Coverage	50%	50%	50%
Retail (30-day supply)			
Tier 1 (preferred generics)	$9	$9	$9
Tier 2 (preferred brand)	40%, $25 minimum	40%, $25 minimum	40%, $25 minimum
Tier 3 (non-preferred brand)	60%, $35 minimum	60%, $35 minimum	60%, $35 minimum
Maximum Copay	$75 per script	$75 per script	$100 per script
Specialty Drugs	$100	$100	$100
Retail & Mail Order (90-day supply)			
Tier 1 (preferred generics)	$20	$20	$20
Tier 2 (preferred brand)	40%, $50 minimum	40%, $50 minimum	40%, $50 minimum
Tier 3 (non-preferred brand)	60%, $75 minimum	60%, $75 minimum	60%, $75 minimum
Maximum Copay	$75 per script	$75 per script	$100 per script
Compound Drugs	Follows Tier 3 copays up to a max of $400 limit per 30-day supply. If total cost is >$400, then Prior Authorization is required.		

Dental Plan

Your Dental Coverage

Quality dental care is a part of healthy living. Regular dental exams can help you and your dentist detect problems in the early stages when treatment is more basic and costs are much lower. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease and is an important part of maintaining your medical health.

SMHCS offers you a choice of two dental plans:

- Aetna Premium Plan
- Aetna Standard Plan

The plans pay a percentage of the Usual and Customer Rates (UCR).

Effective October 1, 2020, SMH has made several enhancements to your dental plan offerings:

- 100% Coverage for Preventive Services
- Preventive Services no longer count against your annual per person maximum
- Coverage for composite fillings in all teeth
- **Aetna Dental Care Reward**- Up to $200 Annual Max Rollover when a member completes their preventative care and exams and has not utilized all of their benefit

Provision	Aetna Premium Plan	Aetna Standard Plan
Annual deductible (Individual/Family)	$0/$0	$50 applies to major services only
Annual Maximum per person	$2,000	$1,000
Diagnostic and Preventive	100% UCR	100% UCR
Basic Services	90% UCR	80% UCR
Major Services to include crowns, bridges, full and partial dentures	60% UCR	$50 deductible then 50% UCR
Orthodontia	50%; $1,000 lifetime maximum	None

You will always save money when you use an in-network provider.

If you elect the Premium or Standard plan, you may go to any dentist you wish.

However, if you select a dentist from the Aetna PPO Network, you will not be balance billed for charges above the network fee.

A list of providers in Aetna's PPO network is available at www.aetnanavigator.com.

Vision Plan

Your Vision Coverage

Quality vision care is important at all ages and helps ensure not only eye wellness and proper vision but overall health as well.

Your vision plan is provided through Aetna. It provides coverage for routine eye exams and also pays for all or a portion of the cost of glasses or contact lenses if you need them.

You can see in-network or out-of-network providers; however, keep in mind that you always save more money if you stay in-network.

SMH has made several enhancements to your vision plan which will become effective October 1, 2020. These changes include:

- An increase in your frames/contact lenses allowance to $160 a year
- Coverage of new frames every 12 months
- Coverage of prescription sunglasses in lieu of glasses

Benefit	In-Network	Out-of-Network
Exam	$10 copay	Up to $30
Hardware	$15 copay	N/A
Frequency • Exam • Lenses • Frames	 Every 12 months Every 12 months Every 12 months	 Every 12 months Every 12 months Every 12 months
Frames	$160 allowance + 20% off balance	Up to $65
Lenses • Single vision • Bifocal • Trifocal	 Covered in full after the hardware copay	 Up to $25 Up to $40 Up to $60
Contact lenses • Medically necessary	$0	Up to $200
Contact lenses • Elective • Conventional • Disposable	$160 allowance + 15% off balance $160 allowance	Up to $104 UP to $104

Flexible Spending Accounts

(Open Enrollment in late Fall 2020 for 2021 calendar year)

A Flexible Spending Account (FSA) is a program that helps you pay for health care and dependent care costs using tax-free dollars.

You decide how much money you would like to contribute to one or both accounts on an annual basis. Your contribution is deducted from your paycheck on a pretax basis over the number of pay periods (remaining) in the year and is put into a Health Care FSA, a Dependent Care FSA, or both, depending upon enrollment. When you incur eligible expenses, you can access the funds in your account to pay for those qualified health care or dependent care expenses with pretax dollars.

The chart below shows the eligible expenses for each FSA; how much you can contribute to each FSA each year, and how you benefit by using an FSA.

Account Type And Eligible Expenses	Annual Contribution Limits	Benefit
Health Care FSA Most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses and doctor-prescribed over the counter medications)	Maximum contribution is $2,750* per year	Saves on eligible expenses not covered by insurance; reduces your taxable income
Dependent Care FSA Dependent care expenses (such as daycare, after school programs or qualified eldercare programs such as adult day care centers) so you and your spouse can work or attend school full-time	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns)	Reduces your taxable income

**Based on the 2020 IRS limit for HCFSAs. The IRS usually releases guidance each October, so this amount may increase for 2021.*

Important Information about FSAs

FSA enrollment is generally held in the late Fall each year and FSA elections are effective from January 1 through December 31.

Claims for reimbursement must be submitted by February 28 of the following year.

You may elect to contribute up to the IRS limits each year, which are usually announced in October for the following calendar year. Please plan your contributions carefully. If you have funds remaining at the end of the plan year, you may be able to carry over up to $550 to the next calendar year. Any money remaining in your account over $550 will be forfeited. This is known as the "use it or lose it" rule and it is governed by Internal Revenue Service regulations.

Note: FSA elections do not automatically continue from year to year; you must actively enroll each year. Enrollment for the 2021 plan year will be in the Fall of 2020.

This program is administered through the P & A Group and you will be issued a debit card.
For more information, please contact P&A at 1-800-688-2611 or visit their website at www.padmin.com.

If you are a highly compensated individual as defined by the Internal Revenue Code ("the Code"), it may become necessary to reduce your salary reductions (and increase your taxable income) to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law. If this becomes necessary, you will be contacted by the Plan administrator.

Life, AD&D and Disability Insurance

What would your family do if your income was lost due to death or disability? Life and disability insurance are important for your financial security.

Life Insurance

Life insurance is an important part of your financial security, especially if you support a family.

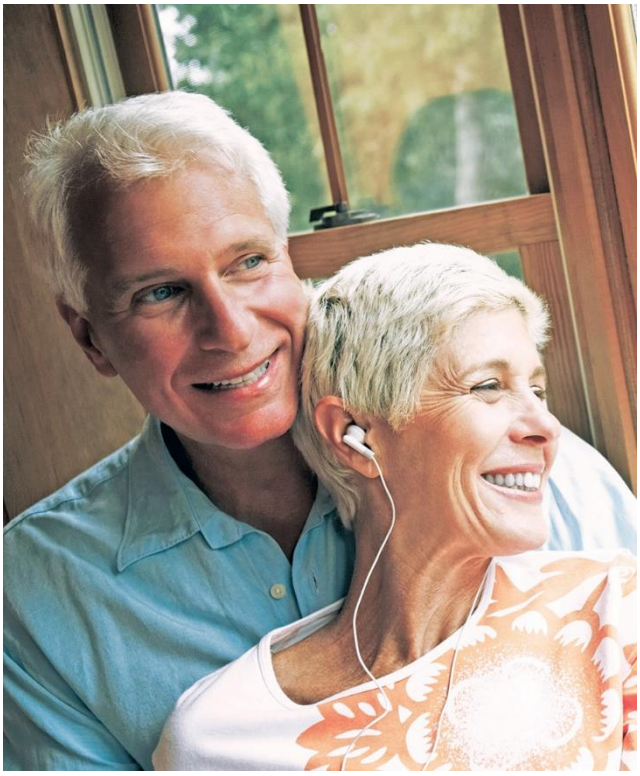
SMHCS provides basic Life and Accidental Death and Dismemberment (AD&D) insurance to all eligible employees at no cost. Enrollment is not necessary.

Account Type	Benefit
Employer-provided basic life insurance	• $10,000
Employer-provided AD&D insurance	• $10,000

Supplemental Life and AD&D Insurance

In addition to the basic coverage provided by SMHCS, full time employees have the option to purchase Supplemental Life and AD&D insurance. Under the plan, you may purchase:

Account Type	Benefit
Employee-paid Group Term Life Insurance (Supplemental Life or Dependent Life)	**Employee** • 1 to 5 times your annual base salary **Spouse** • $5,000. $10,000, or $25,000; Not to exceed 50% of the amount of the Employee Supplemental Life Insurance **Child** • Option of $2,500, $5,000 or $10,000; Not to exceed 50% of the amount of the Employee Supplemental Life Insurance
Employee- paid Term AD&D Insurance	• 1 to 6 times your annual base salary - This coverage can be chosen as Employee Only or as Employee + Family *(The payout for dependent AD&D is a portion of the employee coverage)*



Disability Insurance Coverage

Disability insurance provides income replacement should you become disabled and unable to work due to a non-work-related illness or injury. SMHCS provides eligible employees with long-term disability income benefits at no cost, as shown below.

Basic long-term disability coverage is automatic. You do not need to enroll.

Coverage and Benefits
Short-Term Disability (STD)* • Employee-paid voluntary option • 60% of your annual base salary up to a weekly maximum of $2,500 • Benefits begin after 7 consecutive calendar days and depletion of Bank B, for continuous disability due to an accident or an illness. Benefits are payable up to 25 weeks, less any Bank B time
Long-Term Disability (LTD)* • Company paid (Basic) LTD at 50% (company paid of your annual base salary, up to a monthly maximum of $8,000 • Buy Up LTD at 66 2/3%, up to a monthly maximum of $8,000 • Benefits begin after 180 calendar days of disability and require medical documentation

**FPG Physicians Disability coverage differs. Please refer to your contract, department head, or HR.*

Employee Assistance Program (EAP)

Your Health Advocate Employee Assistance Program

If you find yourself in need of some professional support to deal with personal, work, financial or family issues, your Employee Assistance Program (EAP) can help.

You and your immediate family (spouse, dependent children, parents and parents-in-law) can use the EAP for help with:

- Marriage and family problems
- Job-related issues
- Stress, anxiety and depression
- Parent and child relationships
- Legal and financial counseling
- Identity theft counseling
- Financial planning
- Various other related issues

If you need help or guidance, you can connect with a Health Advocate counselor 24/7 by calling 877-240-6863 or visiting **www.HealthAdvocate.com/members**.

Additional Benefits

HealthFit Wellness and Fitness Program

HealthFit offers discounts to employees, including the employee gym on the 4th floor of the main hospital. For details please call 941-917-7000.

SMHCS Child Care Services

SMHCS has two child care centers. Both centers are licensed and participate in the Look for the Stars Quality Improvement System of Sarasota County. For information regarding the Child Care Centers please call 941-917-1477 or 941-917-2535.

SMHCS Employee Discount Program

SMHCS offers an Employee Discount Program through PerkSpot. Gain discounts on your favorite restaurants, travel clubs and hotels, and retail vendors. Log on at **https://smh.perkspot.com**.

Paid Time Off

PTO Bank A

SMHCS provides paid time off (PTO) so that you can recharge, and find balance in your life by spending time away from work. PTO can be used for a combination of:

Vacation time,

Holidays,

Personal business that you need to take care of during working hours, and

Time off for illness.

You are provided with 2 "banks" of PTO.

Bank A hours accrue each pay period based upon your hours worked. The accrual schedule is shown below. Your PTO Bank A may accumulate up to a maximum of 320 hours.

Service	Accrual per Hours Worked	Annual Accrual (based on 1.0 FTE)	Per Pay Period Accrual (based on 80 Hour pay period)
0 to less than 2 years*	0.09231 hours	24 days	7.38 hours
2 years but less than 5 years	0.1 hours	26 days	8.00 hours
5 years but less than 10 years	0.11538 hours	30 days	9.23 hours
10 or more years	0.12688 hours	33 days	10.15 hours

**Employees of Sarasota Memorial Nursing and Rehab Center accrue PTO A at the 24 days per year level until 5 years of service. FPG Physicians need to check their specific contracts for vacation details PTO accrual rates are based on benefitted service time.*

PTO Bank B

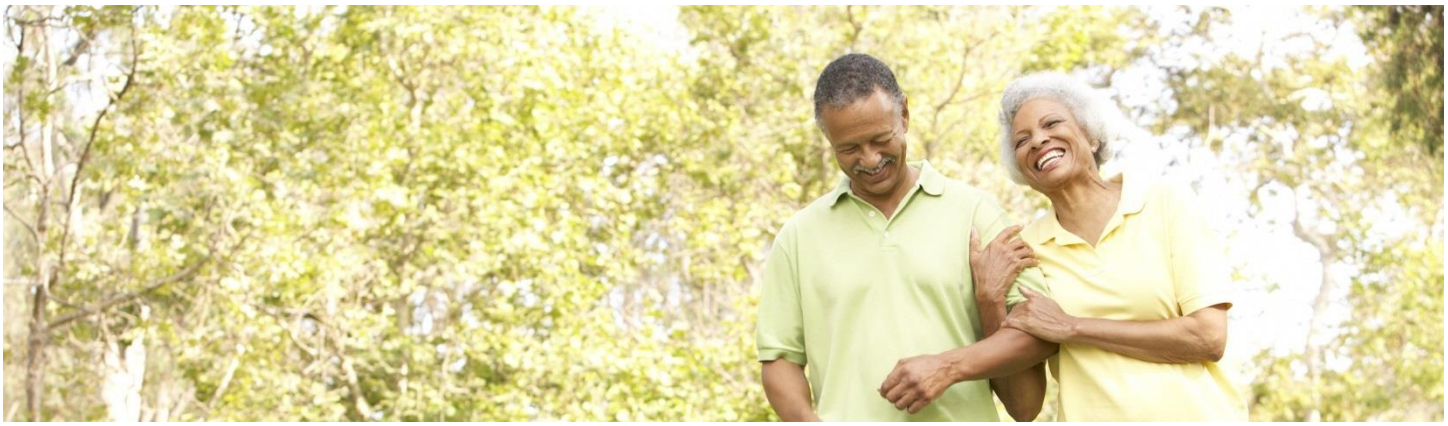
PTO Bank B is provided to regular employees for extended illnesses. The purpose of Bank B is to protect your income in case of a short-term disability. Bank B hours accrue each pay period based upon your hours worked. The accrual schedule is shown below. Your PTO Bank B may accumulate up to a maximum of 800 hours.

All Bank B hours must be depleted before voluntary STD would pay benefits.

Employees of Sarasota Nursing and Rehab Center are not eligible for PTO B.

Accrual per hour worked	Annual Accrual (based on 1.0 FTE)	Per Pay Period Accrual (based on 80 hour pay period)
0.03075 hours	8 days	2.46 hours

403(b) Retirement Savings Plan



The SMHCS 403(b) plan gives you the opportunity to save up to an annual maximum of $19,500 on a tax deferred basis, based on the 2020 IRS limits. If you are 50 years old or over, there is a special catch-up provision that allows you to defer up to $6,500 additional, based on the 2020 IRS limits.

The value of these plans is that you not only save money for retirement but you also decrease the amount of federal income tax you have to pay. You have control over how your money is invested and there are many investment options from which you can choose.

Employees hired on or after October 1, 2009 are offered the 403(b) plan through Lincoln Financial.

Your contributions will be set up as pre-tax payroll deductions. You will be auto enrolled at 3% unless you make a different contribution election, or opt out. You may change your contribution amount at any time via Employee Self Service through myHR.

Employees hired before October 1, 2009 may be enrolled in a different plan(s). Please email **HRBenefits-Retirement@smh.com** with any questions.

More Information

For additional details about the 403(b) Retirement Savings Plan or to change investment elections, please refer to:

Lincoln Financial
800-234-500

www.lfg.com

The Effects of Contributing to the 403(b) Plan

This example is based upon an annual salary of $40,000 and the participant being in the 28% tax bracket.

	Contributes to 403(b)	Does Not Contribute to 403(b)
Gross Pay per Pay Period	$1,538.46	$1,538.46
403(b) Contribution	$150.00	$0.00
Federal Income Tax	$388.76	$430.76

Although the person who contributed to the 403(b) contributed $150.00 per pay period, their take home pay was only reduced by $108.00 due to the reduction in gross earnings.

Glossary

Brand Name Drugs: Drugs that have trade names and are protected by patents. Brand name drugs are generally the more expensive choice.

Coinsurance: Coinsurance is both the percentage of covered expenses that the medical plan in which you are enrolled pays, and the percentage of covered expenses that you pay.

Copayment (Copay): A flat dollar amount you pay for medical or prescription drug services regardless of the actual amount charged by your doctor or health care provider.

Deductible: The annual amount you and your family must pay each year before the plan pays benefits.

Dependent Care Flexible Spending Account (DCFSA): A DCFSA allows you to pay for eligible dependent care expenses using tax-free dollars. This account is "use it or lose it" which means any funds remaining in the account at the end of the calendar year will be forfeited.

Generic Drugs: Generic drugs are less expensive versions of brand name drugs that have the same intended use, dosage, effects, risks, safety and strength. The strength and purity of generic medications are strictly regulated by the Federal Food and Drug Administration.

Health Care Flexible Spending Account (HCFSA): A HCFSA allows you to pay for eligible health care expenses using tax-free dollars. Up to $500 per year may be rolled into the next year, but any additional funds in the account will be forfeited.

In-Network: Use of a health care provider that participates in the plan's network. When you use providers in the network, you lower your out-of-pocket expenses because the plan pays a higher percentage of covered expenses.

Inpatient: Services provided to an individual during an overnight hospital stay.

Mail Order Pharmacy: Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.

Out-of-Network: Use of a health care provider that does not participate in a plan's network.

Outpatient: Services provided to an individual at a hospital facility without an overnight hospital stay.

Out-of-Pocket Maximum: The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the plan year. This applies to health coverage only, not prescriptions.

Preventive care: Includes services such as routine check-ups, screening tests, an immunizations intended to prevent illness or detect problems before you notice any symptoms.

Primary Care Physician (PCP): Physician (generally a family practitioner, internist or pediatrician) who provides and also coordinates ongoing medical care. A primary care physician treats a wide variety of health-related conditions and refers patients to specialists as necessary.

Specialist: A physician who has specialized training in a particular branch of medicine (e.g., a surgeon, gastroenterologist or neurologist).

Contacts and Additional Support

Not sure what plan(s) to enroll in?
Do you need help making a decision?

ALEX can help!

Ask ALEX is a NEW online decision support tool that will help you pick the best medical plan for you and your family.

Get started at https://www.myalex.com/smh.

RESOURCE	PHONE NUMBER	WEBSITE/EMAIL
Aetna Dental Plans (Group number 842874)	(877) 238-6200	www.aetnanavigator.com
Aetna Vision Plan (Group number 842874)	(877) 973-3238	www.aetnavision.com
Employee Assistance Program (EAP) Health Advocate	(877) 240-6863	www.HealthAdvocate.com/members
Employee Health Services (EHS)	(941) 917-7320	
FMLA And Other Leaves of Absence	(941) 917-8754	HRBenefits-Leave@smh.com
P&A Group HCFSA and DCFSA	(800) 688-2611	www.padmin.com
Gulf Coast Medical Management/Member Services	(866) 260-0305	www.gulfcoastmemberservices.org
Gulf Coast Provider Network	(866) 260-0305	www.gulfcoastprovider.net
HealthFit	(941) 917-7000	www.smhfit.com
HR Service Center	(941) 917-6177	HRServiceCenter@smh.com
Life & AD&D Insurance Group: SA3-890-461036-01 Lincoln Financial	(888) 787-2129	www.MyLincolnportal.com
Lincoln [403(b)]	(800) 234-3500	www.MyLincolnportal.com/customer
Lincoln GVA	(800) 341-0441	www.MyLincolnportal.com
Short Term Disability Group: GD3-890-461036-01 Long-Term Disability Group: GF3-890-461036-01 Disability Claim Intake Line (24/7/365) Lincoln Financial	(800) 291-0112	www.Mylincolnportal.com
Medical Plans (WebTPA)	(877) 697-2299	www.webtpa.com
Navitus Health Solutions	(866) 333-2757	Accessed through: www.webtpa.com
NoviXus (Mail Order Rx)	(888) 240-2211	www.novixus.com
Employee Discounts PerkSpot		https://smh.perkspot.com
Pension and Other Retirement Plans	(941) 917-8755	HRBenefits-Retirement@smh.com
SMHCS Chronic Disease Case Manager	(941) 917-2956	www.gulfcoastmemberservices.org
SMHCS Child Care Center	(941) 917-1477 or (941) 917-2535	
Voya [403(b)]	(866) 818-5899	www.voya.com

Annual Notices

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020.

Contact your State for more information on eligibility –

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

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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HIPAA Special Enrollment Rights

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 or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents other coverage). However, you must request enrollment within 30 days after your or your dependents other coverage ends (or after the employer stops contributing toward the other coverage).

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

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applies to most special enrollments.

The Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits 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
- Treatment of physical complications of the mastectomy, including lymphedema

Our plan complies with these requirements. Benefits for these items generally are comparable to those provided under our plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by the patient and her physician. Our plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements. If you would like more information about WHCRA required coverage, you can contact the HR Service Center.

Notice of Availability SMHCS Plan Notice of Privacy Practices

SMHCS (the "Plan") provides health benefits to eligible employees of SMHCS (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information. To receive a copy of the Plan's Notice of Privacy Practices you should contact the HR Service Center.

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Patient Protection Disclosure

SMHCS generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Gulf Coast Medical Management at (866) 260-0305 or visit **www.gulfcoastprovider.net**.

Medicare Part D Creditable Coverage Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with SMHCS and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.
Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

When Can You Join a Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current plan coverage will be affected. You can keep your coverage through SMHCS; however, the prescription drug coverage available through SMHCS plan will not coordinate with Medicare Part D.

If you decide to join a Medicare drug plan and drop your coverage through SMHCS, be aware that you and your dependents may not be eligible to enroll back into the SMHCS medical/prescription drug plan. This determination depends on your specific circumstances and is subject to the terms of the group health insurance policies in effect under the SMHCS Plan. Please contact the HR Service Center for further information.

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Below is a description of the current prescription drug coverage offered through the SMHCS medical plan:

Prescription Plan	Rx C	Rx B	Rx E
Prescription Drug Limitations Base Benefit Coverage gap Per Participant Umbrella Coverage	$3,000* $1,000 50%	$2,000* $1,000 50%	$7,000* $1,000 50%
Retail (30-day supply) Tier 1 (preferred generics) Tier 2 (preferred brand) Tier 3 (non-preferred brand) Maximum Copay Specialty Drugs	$9 40%, $25 minimum 60%, $35 minimum $75 per script $100	$9 40%, $25 minimum 60%, $35 minimum $75 per script $100	$9 40%, $25 minimum 60%, $35 minimum $100 per script $100
Retail & Mail Order (90-day supply) Tier 1 (preferred generics) Tier 2 (preferred brand) Tier 3 (non-preferred brand) Maximum Copay	$20 40%, $50 minimum 60%, $75 minimum $75 per script	$20 40%, $50 minimum 60%, $75 minimum $75 per script	$20 40%, $50 minimum 60%, $75 minimum $100 per script
Compound Drugs	Follows Tier 3 copays up to a max of $400 limit per 30-day supply. If total cost is >$400, then Prior Authorization is required.		

**By working with the pharmacy case manager, you will receive an additional $1,500 to your pharmacy cap*

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 SMHCS and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the HR Service Center 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 SMHCS 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** OR call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help. Call 1-800- MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1- 800-325-0778).

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

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GINA Warning against Providing Genetic Information

The Genetic Information Nondiscrimination Act (GINA) prohibits collection of genetic information by both employers and health plans, and defines genetic information very broadly. Asking an individual to provide family medical history is considered collection of genetic information, even if there is no reward for responding (or penalty for failure to respond). In addition, a question about an individual's current health status is considered to be a request for genetic information if it is made in a way likely to result in obtaining genetic information (e.g., family medical history). Wellness programs that require completion of health risk assessments or other forms that request health information may violate the collection prohibition unless they fit within an exception to the prohibition for inadvertent acquisition of such information. This exception applies if the request does not violate any laws, does not ask for genetic information and includes a warning against providing genetic information in any responses. An employer administering a wellness program might include on the relevant forms a warning such as the one set out below.

Your Protections Under the Newborns' and Mothers' Health Protection Act (Newborns' Act)

If a group health plan, health insurance company, or health maintenance organization (HMO) provides maternity benefits, it may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

You cannot be required to obtain preauthorization from your plan in order for your 48-hour or 96-hour stay to be covered. (However, certain requirements that you give notice to the plan of the pregnancy or the childbirth may apply.)

The law allows you and your baby to be released earlier than these time periods only if the attending provider decides, after consulting with you, that you or your baby can be discharged earlier.

In any case, the attending provider cannot receive incentives or disincentives to discharge you or your child earlier than 48 hours (or 96 hours).

If your state has a law that provides similar hospital stay protections and your plan offers coverage through an insurance policy or HMO, then you may be protected under state law rather than under the Newborns' and Mothers' Health Protection Act.

General Notice of COBRA Continuation Coverage Rights Introduction

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.

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What is COBRA continuation coverage?

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

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

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

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

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to SMHCS, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

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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, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

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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

SMHCS Benefits Department, 1700 S. Tamiami Trail, HR – Second Floor, Sarasota, FL 34239 or HR-ServiceCenter@smh.com or (941-917-6177).

Notice of Extended Coverage to Participants Covered Under a Group Health Plan

Federal legislation known as "Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year.

The Sarasota Memorial Health Care System Medical (the "Plan") currently permits an employee to continue a child's coverage to the end of the month in which that child turns 30 if that child is enrolled at an accredited institution of learning on a full-time basis, with full-time defined by the accredited institution's registration and/or attendance policies. Michelle's Law requires the Plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for Plan coverage due to loss of full-time student status.

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There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- *Dependent child* means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his or her student status and who was enrolled at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.
- *Medically necessary leave of absence* means a leave of absence or any other change in enrollment: of a dependent child from a post-secondary educational institution that begins while the child is
    - Suffering from a serious injury;
    - Which is medically necessary; and
    - Which causes the dependent child which is medically necessary; and to lose student status under the terms of the Plan

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility). If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- One year after the first day of the leave of absence; or
- The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student).

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

SMHCS RETIREMENT SAVINGS PLAN UNIVERSAL AVAILABILITY NOTICE

This notice provides important information regarding the 403(b) plan in which you are eligible to participate (the "plan").

You may want to take this opportunity to either (1) begin making pre-tax 403(b) elective deferral contributions or (2) review your current elections and decide if you want to make changes. Before making any initial elections or changes, be sure to consult the written plan and any other materials provided to you that explain the terms of the plan.

When can I enroll?

You are eligible to enroll immediately upon your date of hire.

If you were hired between 10/1/2009 and 12/31/2011, and did not enter an election amount, including an election amount of 0%, you were automatically enrolled at 1%. This percentage of automatic enrollment increased to 3% for employees hired since 1/1/2012.

You may choose your elective deferral rate by completing the appropriate application in Self Service on MyHR. Or, if the online option is not available to you, the form is available on the HR Home Page on Pulse, or by contacting HR Retirement Benefits at 941- 917-8755. Follow your plan's normal process to obtain either a Salary Reduction Agreement or an Enrollment Form so that you may choose your elective deferral rate.

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Can I change or stop my elective deferral contributions?

You may change your elective deferral contributions any time during the plan year. You are permitted to stop your elective deferral contributions to the plan at any time during the plan year. Salary deferral elections that will result in less than $200 annually will not be honored.

When are my elective deferral contributions effective?

After completing the enrollment requirements, your elective deferral contributions will begin as soon as administratively possible.

What is the maximum amount that I can contribute?

The Internal Revenue Service (IRS) limits the annual contributions you can make to a 403(b) plan and the limits are adjusted each year. The IRS 2020 calendar year limits are as follows:

Elective Deferral Limit	$19,500
Age 50 Catch-Up	$ 6,500
Special 15 Years of Service Catch-Up	$ 3,000

NOTE: The 15 years of service catch-up contribution applies before the age 50 catch-up contribution and is based on a formula that takes into account all past contributions to the plan and the employee's total years of service to the employer. The maximum allowable for the 15 years of service catch-up is $3,000 per year up to a $15,000 lifetime benefit, but an employee's actual catch- up may be lower than this maximum.

Will my employer make additional contributions?

In addition to pre-tax 403(b) elective deferral contributions, the plan allows for additional employer contributions, including a contribution of up to 4% of your eligible compensation annually, for those eligible employees employed on the last day of the plan year. Please see your written plan for more detailed information about the employer contributions that may be available to you under the plan.

Whom do I contact for additional information?

To learn more about 403(b) plans, please visit **http://www.irs.gov** and search for Publication 571. If you have any questions about how the plan works or your rights and obligations under the plan, please contact HR Retirement at 941-917-8755 or HR-Benefits-Retirement@smh.com

Annual Notices

Automatic Deferral Notice (2020 Plan Year)
SMHCS Retirement Savings Plan

If you are an eligible participant in the SMHCS 403(b) Retirement Savings Plan (the "Plan"), you may make contributions (called "Salary Deferrals") directly from your paycheck into the Plan. The ability to make Salary Deferrals provides you with an easy method to save for retirement on a tax-deferred basis. If you make Salary Deferrals to the Plan, you generally will not be taxed on those deferrals or on any earnings on those contributions until you withdraw those amounts from the Plan.

If you have any questions regarding your eligibility to make Salary Deferrals under the Plan or any other questions regarding the Plan that are not addressed in this Notice, please review your Summary Plan Description. For example, Article 5 of the Summary Plan Description contains a discussion of the eligibility conditions applicable to Salary Deferrals. In addition, from time to time we may make changes to the Plan and/or Summary Plan Description, which are described in a Summary of Material Modifications supplementing the Summary Plan Description. Any reference to the Summary Plan Description in this Notice includes any Summary of Material Modifications we may have issued with respect to the Plan. If you do not have a copy of the Summary Plan Description or any Summary of Material Modifications, if applicable, please contact the Plan Administrator named below.

Automatic Deferral Feature

To assist you in your decision whether to make Salary Deferrals, we have established an automatic deferral feature under the Plan. Under this automatic deferral feature, if you do not specifically elect to make Salary Deferrals into the Plan, we will automatically withhold a designated percentage of your compensation from each paycheck and deposit such amount into the Plan in your name as a Salary Deferral. If you wish to defer a greater or lesser amount (including no deferral), you must complete a Salary Deferral election designating a different percentage of deferral.

This Notice provides important information regarding the Plan's automatic enrollment feature and describes:

- your right to make Salary Deferrals under the Plan;
- what amounts you may contribute to the Plan;
- how the automatic deferral feature applies to you;
- when you can change your Salary Deferral election;
- how your account will be invested; and
- other valuable information regarding your rights under the Plan.

For a full discussion of your benefits under the Plan, please review your Summary Plan Description.

Procedures for making Salary Deferrals under the Plan -- automatic deferral feature. If you do not specifically elect an alternative deferral amount (including zero), we will automatically withhold 3% from your paycheck each pay period and deposit that amount into the Plan in your name as a Salary Deferral. This is called your **automatic contribution rate**. If you wish to defer a greater or lesser amount (including no deferral), you must specifically elect to defer a different amount. If you have any questions about how to change your automatic contribution rate, you should contact the Plan Administrator.

Application of automatic deferral feature. The current automatic deferral feature under the Plan applies to all eligible participants who become a participant on or after the effective date of the automatic deferral provisions or a Participant who was previously automatically enrolled as set forth under a prior Plan document maintained by the Employer and who do not complete a Salary Deferral election designating an alternate deferral percentage (including an election not to defer).

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Special rules for applying automatic deferral provisions. The following provision(s) apply in determining eligible participants under the automatic deferral feature: The automatic deferral provisions of this section 6A-8 do not apply to employees classified as "temporary." The prior automatic enrollment percentage of 1% applies to employees hired between 10/1/2009 and 1/1/2012.

Special withdrawal rule. If amounts are automatically withheld from your paycheck, you may withdraw those amounts within 90 days after the first amounts are withheld from your pay, regardless of any other withdrawal restrictions under the Plan. If you withdraw automatic deferrals under this special withdrawal rule, you will lose any matching contributions associated with those deferrals. Such withdrawal also will not be subject to the 10% penalty for early withdrawal. If you withdraw the automatic deferrals, no additional deferrals will be withheld from your paycheck unless you enter into a subsequent election to defer into the Plan.

Taxation of Salary Deferrals. The amount that you defer into the Plan reduces your taxable income, meaning you do not pay income taxes on those amounts until you withdraw your deferrals from the Plan. Any gains or earnings made from the investment of these contributions within the Plan are also not subject to income tax until they are withdrawn from the Plan.

Change in deferral amount. You may increase or decrease the amount of your current Salary Deferrals or stop making Salary Deferrals altogether, as of any designated election date. For this purpose, the designated election date(s) for changing or modifying your Salary Deferrals will be set forth in the Salary Deferral election or other written procedures describing the time period for changing Salary Deferral elections. However, regardless of the Plan's normal deferral procedures, you will have a reasonable time after receipt of this notice and before the first amount is withheld from your paycheck under the automatic deferral feature to modify the automatic contribution rate. In addition, unless provided otherwise under the Plan, you may revoke an existing deferral election at any time. Any change you make to your Salary Deferrals will become effective as of the next designated election date, and will remain in effect until modified or canceled during a subsequent election period.

Other contributions. In addition to the Salary Deferrals you may make to the Plan, the Plan provides for the following contributions:

- Employer contributions
- Matching contributions

For more information about the type of contributions permitted under the Plan, how the amount of such contributions is determined, any limits that might apply to such amounts and the eligibility conditions for receiving such contributions, see the Summary Plan Description.

Vesting of contributions. You are always 100% vested in any Salary Deferrals you make to the Plan. This means that you have an immediate ownership right to such contributions and you will not lose that right if you should terminate from employment.

As mentioned above, the Plan also provides for regular matching contributions and employer contributions. These matching contributions and employer contributions will become vested based on your years of service, as described in the following table:

Years of service	Vested percentage
1	0%
2	0%
3	0%
4	0%
5	100%
6 or more	100%

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You will not have any ownership rights to such matching contributions or employer contributions to the extent you have not vested in those amounts. If you should terminate employment with a non-vested benefit, you will forfeit the non-vested portion of those contributions.

Withdrawal restrictions. Generally, you may withdraw amounts held on your behalf under the Plan upon death, disability or termination of employment. In addition, the following withdrawal options apply while you are still employed.

- **Salary Deferrals.** You may withdraw amounts attributable to Salary Deferrals from the Plan while you are still employed under the following circumstances:
  - You have reached age 59-1/2.
  - You have reached Normal Retirement Age under the Plan.
  - You experience a hardship (as defined in the Plan). See the Summary Plan Description (or other communication) for a list of permissible hardship events.

  Note: *No in-service distribution of Salary Deferrals will be permitted on account of an age earlier than 59½ except for a distribution on account of a hardship, to the extent allowed under the Plan.*

- **Rollover contributions.** You may withdraw any rollover contributions you make to the Plan at any time.

- **Other contributions.** As described above, the Plan also provides for employer contributions and matching contributions. You may withdraw amounts attributable to such contributions while you are still employed if:
  - You have attained age 59-1/2.
  - You experience a hardship (as defined in the Plan). See your Summary Plan Description (or other communication) for a list of permissible hardship events.
  - You have reached Normal Retirement Age under the Plan. See your Summary Plan Description for the definition of Normal Retirement Age.

Note: The Bipartisan Budget Act of 2018 and subsequent IRS regulations changed the rules applicable to hardship withdrawals. For example, the Plan no longer will suspend your ability to make Salary Deferrals if you take a hardship withdrawal. The new rules may or may not have an impact on you. If necessary, the Plan Administrator will provide you with relevant information relating to these rules.

Special distribution rules. In applying the withdrawal provisions under the Plan, the following special rules apply:

- Unless otherwise provided within a specific annuity investment product, no more than 2 hardship distributions are permitted in a single plan year

Plan investments. The amounts contributed to the Plan on your behalf will be invested in accordance with the Plan's investment procedures. Any earnings on the investment of your contributions under the Plan will be allocated to your Plan account. The Plan allows you to direct the investment of your Plan account within the available investment options under the Plan. If you do not elect to invest your Plan account, such amounts will automatically be invested in the Plan's default investment fund. Even if your Plan account is invested in the Plan's default investment fund, you have the continuing right to change your default investment and elect to have your Plan account invested in any other available investment options under the Plan. To learn more about the available investments under the Plan, you may contact the Plan Administrator.

Additional information. Please refer to the Summary Plan Description for additional information regarding Plan contributions, withdrawal restrictions, and other Plan features. You also may contact the Plan Administrator for more information. The following is the name, address and phone number of the Plan Administrator.

SMH Health Care, Inc.
1700 South Tamiami Trail
HR Benefits – Second Floor
Sarasota, FL 34239
941-917-9000

Annual Notices

ANNUAL 403(b) PLAN NOTICE
2020 PLAN YEAR

The **SMHCS 403(b) Retirement Savings Plan** ("Plan") has been adopted to help our employees save for retirement. As an employee, you may make Salary Deferrals if you are eligible to participate under the Plan. (Please refer to the Summary Plan Description (SPD) or other Plan information materials to determine whether you are eligible to participate in this Plan.) This Annual 403(b) Plan Notice provides important information relevant to your participation in the Plan.

Notice of Universal Availability

This *Annual Notice of Universal Availability* describes your right to make Salary Deferrals (if you are eligible for the Plan), the procedures for electing to make Salary Deferrals Reduction Contributions and the tax advantages of making contributions to the Plan.

Eligibility to Participate. The Plan is a special type of retirement plan described under Section 403(b) of the Internal Revenue Code. A "403(b) Plan" is subject to the universal availability requirement which requires that all employees (with certain exceptions) are eligible to make voluntary contributions to the Plan. These contributions are called Salary Deferrals. To make Salary Deferrals, you must complete a Salary Reduction Agreement designating the amount you want to have withheld from your paycheck and deposited into the Plan. You will also need to complete additional enrollment forms provided by the approved investment provider that you elect to have hold and invest your contributions. Please contact the Plan Administrator to request a copy of the Salary Reduction Agreement and/or to receive a list of approved investment arrangements.

Salary Deferral Limits. You may make Salary Deferrals up to $19,500 in 2020 (unless otherwise limited under the Plan). *This annual Salary Deferral limit is subject to change each year, depending on Social Security Administration Cost of Living adjustments and IRS guidance, if any*. In addition, this limit may be increased if you are eligible to make "catch-up" contributions under the Plan. Please see the SPD or other Plan information materials or contact your Plan Administrator for more information concerning the availability of catch-up contributions under the Plan.

Tax Advantages. If you elect to make Salary Deferrals to the Plan, you may make these contributions on a pre-tax basis.

- If you elect to make Salary Deferrals to the Plan, the amounts deferred (and any earnings on those amounts) generally will not be subject to income taxes until the amounts are distributed from the Plan. Upon distribution, such amounts are taxed as ordinary income.

Notice of Required Contribution Aggregation If You Are "In Control" of Another Business

Under IRS rules, in certain situations, Plan participants must aggregate Salary Deferrals and other amounts contributed to this Plan and other "qualified retirement plans" to determine whether they are within the maximum annual contribution limits under the law. If you meet all of the conditions below, the Internal Revenue Service requires that you contact the Plan Administrator to review whether or not you have exceeded your maximum annual contribution limit.

Failure to provide the Plan Administrator with certain necessary and correct information may result in adverse tax consequences, including your inability to exclude the amounts contributed to this Plan from your taxable income.

You must notify the Plan Administrator if you meet all the following conditions:

- You make contributions to this Plan,
- You are "in control" of another company, and
- The other company maintains a "qualified retirement plan" and makes contributions to your account.

Annual Notices

What does it mean to be "in control" of another company?

For you to be considered "in control" of another business, you generally must have a significant ownership interest in the other business. For example, you own 100% of a business that is separate from SMH Health Care, Inc. Determining whether you are 'in control" of another business is complicated. Your tax advisor can assist you in making this determination.

Example: You are a doctor or professor that participates in this Plan and you also own more than 50% of a private practice or consulting business. You are considered to be "in control" of the outside business.

What types of retirement plans fall within the meaning of a "qualified retirement plan?

For this purpose, a "qualified retirement plan" includes certain defined contribution plans that receive special tax benefits under the Internal Revenue Code. These include defined contribution plans that qualify under Code §401(a) (such as a profit sharing, 401(k) or money purchase plan), another 403(b) plan, or a simplified employee pension (SEP) plan.

What is the maximum annual contribution limit?

The maximum annual limit for 2020 generally is $57,000. *This annual contribution limit is subject to change each year, depending on Social Security Administration Cost of Living adjustments, if any*. However, certain participants (such as those who are at least age 50) may have a higher limitation, if provided for under the Plan.

What amounts are counted for purposes of determining whether you exceed the maximum annual contribution limit?

The following amounts are counted towards the maximum annual contribution limit:

- Employer contributions (including matching contributions and SEP contributions)
- Salary deferrals
- After-tax contributions
- Certain other amounts allocated to your account (this does not include earnings or rollover amounts)

Additional information. If you would like additional information regarding your right to make Salary Reduction Contributions under the Plan or the requirements for required contribution aggregation if you are "in control" of another business, please contact:

SMH Health Care, Inc.
1700 South Tamiami Trail
HR Benefits – Second Floor
Sarasota, FL 34239
941-917-9000

SARASOTA MEMORIAL
HEALTH CARE SYSTEM

2021 Benefits Enrollment Guide

For more information, visit www.mymobilewalletcard.com/smh

About This Guide

This benefit summary provides selected highlights of the Sarasota Memorial Health Care System (“the Company”) employee benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the Company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. Sarasota Memorial Health Care System reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.