SPRINKLERMATIC
FIRE PROTECTION SYSTEMS, INC.

Sprinklermatic FPS 2022-2023 Benefit Guide

Benefits Designed for You

WELCOME TO YOUR 2022-2023 BENEFIT GUIDE

Sprinklermatic FPS is proud to serve you and your family through our 2022-2023 Health and Welfare Benefits Plan. We understand that our employees have diverse needs, and so we have developed a well-rounded plan capable of helping to protect you and your family members in the case of illness or injury.

This Benefits Information Guide provides necessary plan and program information to help you understand your many benefit options and ultimately enroll in the benefits that work best for you and your family for the 2022-2023 Plan Year. We hope that our guide can be an effective and comprehensive resource while you consider your benefit elections.

Table of Contents

This document contains a summary in English of information about your upcoming benefits enrollment. If you have difficulty understanding any part of this document, contact your Plan Administrator at 877-327-7823 Ext. 263 during regular business hours or by email at giselle@sprinklermatic.net.

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 17 for more details.

BENEFIT OFFERING DIRECTORY

Benefit	Carrier Options	Contact
Medical	**Humana** Open Access HMO Plan **Humana** Employee Assistance Program	1-800-448-6262 www.humana.com 1-866-440-6556 (TTY: 711) www.humana.com/eap username: eap3 password: eap3
Dental	**Humana** DHMO HS190 **Humana** DPPO TRP185	1-800-448-6262 www.humana.com
Vision	**Humana** Vision 130	1-800-448-6262 www.humana.com
Voluntary Benefits	**AFLAC** Accident Protection	1-800-433-3036 www.aflac.com
	AFLAC Hospital Indemnity	1-800-433-3036 www.aflac.com
	AFLAC Critical Illness	1-800-433-3036 www.aflac.com

For any questions regarding your benefits, please connect with your Human Resources below:
Giselle Aquino, HR Manager
877-327-7823 Ext. 263
giselle@sprinklermatic.net

Important

This information is not accounting, tax, or legal advice—please contact your accounting, tax, or legal professional for such guidance. This information should not be relied upon as advice regarding any individual situation.

It is a general outline of covered benefits and does not include all the benefits, limitations, and exclusions of the policy. If there are any discrepancies between the illustrations contained herein and the insurance carrier proposal or contract, the insurance carrier materials prevail. See insurance company contract for full list of exclusions.

BENEFIT ENROLLMENT INFORMATION

When do I Enroll?

Current colleagues will make all of your benefit elections for the upcoming plan year during Open Enrollment from 07/19/2022 through 07/23/22. During this time, you will be able to enroll in new benefits or change your current elections as well as add or remove dependents. Any of these changes or additions will be effective from August 1, 2022 to July 31st, 2023.

How do I Enroll?

- All enrollment applications must completed using the ADP Employee Portal. Completing and returning the enrollment applications is your responsibility.
- Steps on **How to Enroll through your ADP Mobile App** included on the following page.

Who Can Enroll?

There are certain restrictions surrounding eligibility for benefit enrollment. If you are an employee who regularly works 30 hours or more per week, you will be eligible for benefits on the 1st day of the month following 60 days of full-time employment.

If you meet the above requirements, your legal spouse, or dependent child(ren) are also eligible for our benefits plan.

As a reminder, a dependent child is:

- your natural born child,
- legally adopted child,
- stepchild,
- a child you have been appointed legal guardian of as a foster parent,
- a child you are required to cover under a Qualified Medical Child Support Order, or
- a child who is totally and permanently disabled, incapable of self-support because of a mental or physical handicap, and is financially supported by you

Please note that your dependent children are generally eligible only up until age 26, but can be eligible up until age 30 if they meet specific requirements.

Making Plan Changes

Existing employees can only make plan changes during the Open Enrollment window and cannot make additional changes to your coverage during the year unless you experience a qualified family status change. Below, we have included a few examples of qualified family status change events:

1. Special Enrollment Events (Add coverage for yourself and/or dependents).
   - Involuntary loss of other group coverage
   - Acquisition of new dependent through marriage, birth, or adoption
   - Change in Medicaid or CHIP eligibility

2. IRC Section 125 Status Change Events (Add, cancel, or change coverage for yourself and/or dependents).
   - Involuntary loss or gain of other group coverage
   - Divorce
   - Death of covered spouse or child
   - Change in employment status
   - Medicare entitlement

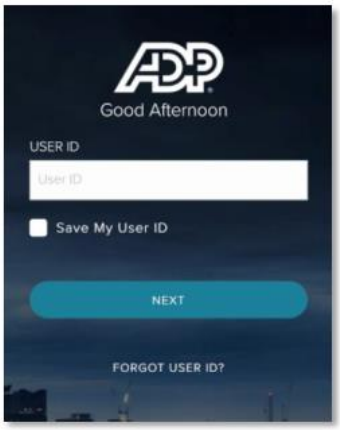
If you think you have experienced a qualified family status change event, you will need to verify the event with Human Resources within 30 days of its occurrence. (60 days in the case of Medicaid or CHIP eligibility).

HOW TO ENROLL

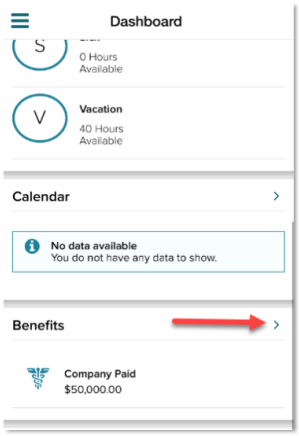
ADP Mobile Solutions Features

- **Benefit Plan Info**
- **Open Enrollment**

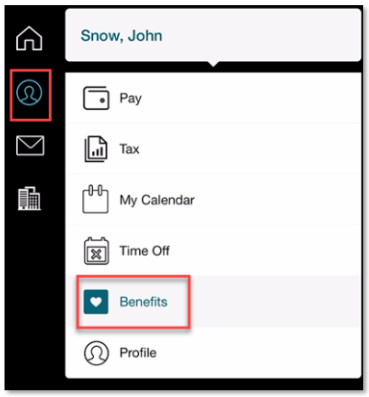
❶ Enter your User ID and Password, Sign In



❷ From the dashboard, scroll down to Benefits



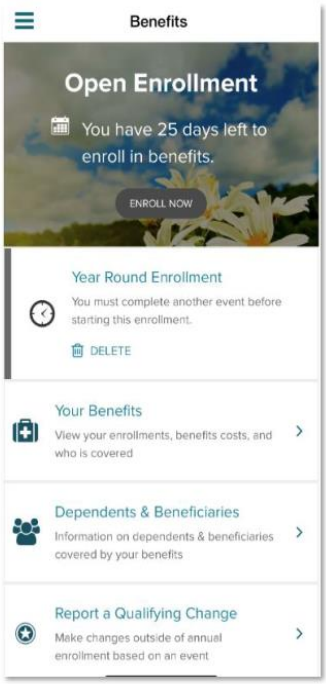
or go to **Myself – Benefits**



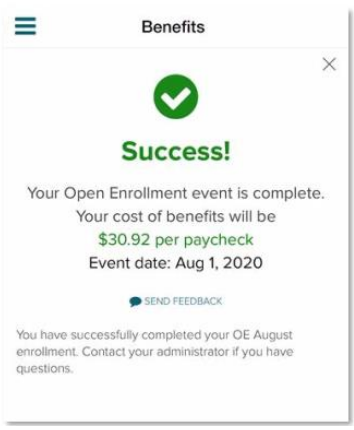
From here, you should be able to look up your Benefit information, view your enrollments, benefit costs (weekly payroll) and see who is covered for Medical, Dental or Vision coverage.

Be sure to go through all of the enrollment screens, and confirm your choices for the policies being offered. IF you do **NOT** want to participate in benefits being offered by Sprinklermatic FPS, you still **MUST** go through the screens and **WAIVE** the benefits. Take some time and review the following steps to learn more about the benefits being offered.

❸ To start, click Enroll Now



❹ Review and Submit



MEDICAL PLANS

Sprinklermatic FPS offers a medical plans through **Humana**:

- A Health Maintenance Organization (HMO) plan

You will find more plan highlights as well as your payroll contributions on the following page.

HMO Plan: This plan only covers services performed by health care providers in the plan's network, with the exception of true emergencies.
Open Access Plans Add: This version of an HMO plan is open access. You do not need to select a Primary Care Provider (PCP). You can visit a specialist without referrals.

Insurance Glossary

Here is a list of relevant insurance-related terms to help you navigate the information provided in this guide.

- **Health Care Provider**: A health care provider is a person or company that provides a health care service to you, such as a dentist, primary care physician, chiropractor, clinical social worker, etc.
- **In-Network**: Doctors, clinics, hospitals, and other providers are considered in network when they have made an agreement to care for the health plan's members. Health plans cover a greater share of the cost for using in-network health care providers than for providers who are out of network.
- **Preventive Care Services**: Covered services intended to prevent disease or to identify disease while it is more easily treatable. Examples of preventive care services include screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. Your policy specifies what qualifies as preventive coverage at a 100% level.
- **Copay**: A copay is a fixed-dollar amount that a plan member pays to a participating network doctor, caregiver, or other medical provider or pharmacy each time health care services are received.
- **Coinsurance**: The portion of an eligible medical bill a plan member must pay. Coinsurance amounts are usually a percentage of the total eligible medical bill, such as 20%. Coinsurance applies after the member meets a required deductible or copay amount. Coinsurance is part of certain health care plans.
- **Deductible:** A fixed-dollar amount that a plan member must pay for eligible services before the insurer begins applying insurance benefits. Deductibles are part of certain health care plans and based on a plan member's specific benefit period.
- **Out-of-Pocket Maximum**: The highest dollar amount you will need to pay during your benefit period for covered medical services from network providers. See your plan benefit for a list of services included.

PLAN HIGHLIGHTS	HMO OA HMO 16 Canopy 50
	In-Network
Calendar Year Deductible	
Individual	$6,500
Family	$13,000
Member Coinsurance	50%
Calendar Year Out-of-Pocket Maximum	
Individual	$8,550
Family	$17,100
Physician Visit	
Preventive Care	Covered in Full
Primary Care Physician (PCP)	$20 copay
Specialist	$70 copay
Telemedicine / Virtual Visit	$10 copay
Lab Work and Diagnostic Imaging	
Diagnostic test i.e., blood work, x-ray	50% after deductible
Imaging (MRI, PET, CT)	50% after deductible
Hospital Services	
Inpatient Hospital	50% after deductible
Outpatient Surgery	50% after deductible
Emergency Medical Care	
Urgent Care	$100 copay
Emergency Room	50% after deductible
Prescription Drugs (30-day supply)	
Level 1	$10 copay
Level 2	$40 copay
Level 3	$70 copay
Level 4	25% coinsurance
Specialty	Preferred Network 25%; Network 35%
Mail Order (90-day supply)	2.5x copay
Payroll Contributions	**Weekly**
Employee Only	$49.59
Employee + Spouse	$148.77
Employee + Child(ren)	$133.89
Family	$233.07

Humana's lab facilities are: Quest Diagnostics LabCorp

You can search for participating providers by visiting www.humana.com, Scroll to bottom of website and clicking "Find a Doctor Tool", enter your zip code, lookup method - **Insurance through your employer** and select the Network.

Find a Doctor – HMO Network is **HMO Premier**
Find a Dentist - DHMO **HumanaDental DHMO HS190** or DPPO **PPO/Traditional Preferred**
Find a Vision Center - **Humana Insight Network**

MYHUMANA MOBILE APP

Access your health information anytime, anywhere
Whether you prefer downloading a mobile application, using your mobile device or receiving text messages, you have the ability to manage your healthcare needs virtually anywhere, anytime. Use the MyHumana Mobile app to:

- View your plans and coverage details
- View medical, dental and pharmacy claims
- View, fax or save medical, dental and pharmacy ID cards
- View vision coverage information or ID cards
- Find a doctor, pharmacy, dentist, hospital, urgent care center or retail clinic in your network
- Research drug prices

Download the MyHumana Mobile app:
Download the MyHumana Mobile app from your app store. Search "MyHumana" in the Google Play® or App Store®.

PREVENTATIVE CARE – WELL PERSON VISITS

These plans cover certain preventative services without cost sharing and before you meet your deductible. Services must be performed by an IN-NETWORK Provider. See a list of covered preventative services at www.healthcare.gov/coverage/preventive-care-benefits/

Screens available for Preventative care

- Blood pressure
- Cholesterol (certain age or at high risk)
- Colorectal
- Diabetes (type 2 – adults 40-70 who are overweight)

Immunizations available for Preventative care - doses, ages vary

- Influenza (flu shot)
- Hepatitis
- Pneumococcal
- Tetanus

Well woman services for Preventative care

- Breast cancer mammography screenings every 1 to 2 years for women over 40
- Pap test (also called a Pap smear) every 3 years for women 21 to 65

ADDITIONAL WAYS TO SAVE

Outside of an HSA, there are additional ways for you to save on health care expenses and stay on budget.

1. Look into discount drug programs offered by local pharmacies:

Pharmacy	Offer
Winn-Dixie	FREE select Antibiotics and Maintenance Medications 30-day supply starting at $4 | 90-day supply starting at $10
Walmart	30-day supply starting at $4 | 90-day supply starting at $10

**Membership Fees may apply. Offers are subject to change*

2. Research brand name drug rebates online

Website	Description
www.needymeds.org	Find help with the cost of medicine
www.gskforyou.com	Help with GSK medications and vaccines for qualified patients
www.rxpharmacycoupons.com	Search for drug coupons to use at your local pharmacy
www.goodrx.com	Compare Rx prices, print free coupons and save on your meds
www.internetdrugcoupons.com	Hundreds of free manufacturer drug coupons

3. Use Freestanding Surgical & Diagnostic Centers when possible.

Ambulatory Services

- Save on a covered surgery by having it done at an in-network, non-hospital-affiliated ambulatory surgical center.

Freestanding Diagnostic Centers

- Save on MRIs, CAT scans, X-rays, etc. by having them done at participating freestanding diagnostic centers.

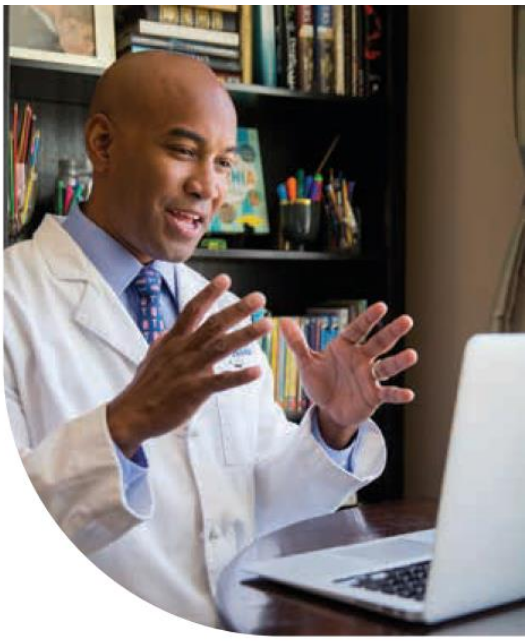
4. Save time and money when you choose the right level of care.

Convenience Clinic	Urgent Care	Emergency Room
$	**$$**	**$$$**
Use for preventive care services and common colds when your doctor is not available. This is a low-cost option.	Use for immediate attention for non-threatening situations. Getting care will cost less than the ER and is generally quicker.	Use for life-threatening injuries, as ERs are best suited for medical emergencies. ER follow-ups are not covered so it is best to schedule with your PCP for a follow-up visit.

DOCTOR ON DEMAND

Quality care that's virtually there 24/7

Same price as your PCP Office Visit



Doctor On Demand® is there for your everyday health needs

See a **board-certified doctor, psychiatrist or licensed therapist**—for nonemergency care—in minutes from your home, office or while you're traveling in the United States, from your smartphone, tablet or computer. It's easy.

For everyday health needs, Doctor On Demand usually costs less than a visit to the emergency room or urgent care.

DOCTOR ON DEMAND	COST
Everyday health concerns • Colds, flu and sore throat • Upper respiratory infections • Mild to moderate depression and anxiety • Skin and eye problems • Urinary tract infections • Prescriptions and refills • Labs and screenings	**$0–$56**
Mental health services • Depression • Stress • Anxiety • Talk therapy • Trauma • Other nonemergency mental health concerns	The cost for a visit will vary based on your plan. You'll know the cost of your visit when you schedule your appointment.

Download the Doctor On Demand app today

1. Go to the App store or Google Play to get it on your smartphone or tablet. You can also visit DoctorOnDemand.com.
2. Enter your health insurance information; select Humana and enter your group ID and member ID.
3. Enter a payment method (you'll always see your cost upfront).
4. See a doctor within minutes.

Humana. | dr on demand

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DENTAL PLANS

SPRINKLERMATIC FPS offers two **Humana** Dental Plans:

- A Dental Health Maintenance Organization (DHMO) plan *and*
- A Dental Preferred Provider Organization (DPPO)

We have included an explanation of each plan below. On the following page are plan highlights and your payroll contributions.

DHMO Plan: If you decide to enroll in the DHMO plan, please keep in mind that you and your enrolled dependents will need to select a primary care dentist who participates in the plan's network. A primary care dentist (PCD) may decide that a member needs to see a contracted dental specialist. No referral is necessary to see a network specialist. Please refer to your primary care dentist's Patient Charge Schedule for procedures and applicable copays. A DHMO plan provides you with an unlimited benefit maximum.

DPPO Plan: The DPPO plan gives you the freedom to receive dental care from any licensed dentist of your choice. You will receive the highest level of benefit from the plan if you select an in-network, contracted PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rates. A calendar year maximum benefit will apply to in- and out-of-network services.

Note: You can search for providers by visiting www.humana.com/dental-insurance and entering your search criteria:

- **DHMO HumanaDental DHMO HS190**
- **DPPO PPO/Traditional Preferred**

PLAN HIGHLIGHTS	DHMO
Office Visit (D9430)	No charge
Routine Cleaning (1110/1120) 2 in any 12 months	No charge
Routine X-Rays	No charge
Amalgam (Filling) (2140)	No charge
Extraction	$15 copay
Root Canal – Molar (3330)	$190 copay
Periodontics (D4210)	$110 copay
Orthodontics – Child/Adult	$1,650 / $1,650
Implants – max $1,500	50% coinsurance
Payroll Contributions	**Weekly**
Employee Only	$4.06
Employee + Spouse	$7.14
Employee + Child(ren)	$8.84
Family	$11.22

PLAN HIGHLIGHTS	DPPO	
	In-Network	Out-of-Network
Annual Maximum Benefit (excludes Ortho max.)	Unlimited	
Annual Deductible (DED)		
Individual Family	$50 $150	$50 $150
Preventive Services (no DED needed)		
Exams (3 per year)	100%	100%
Cleanings (3 per year)	100%	100%
X-Rays	100%	100%
Basic Services (after DED) Fillings, Oral Surgery, Pero & Endo	80%	80%
Major Services		
Crowns, Dentures, Bridges	Plan pays 50% after DED	Plan pays 50% after DED
Implants	Not Covered	Not Covered
Orthodontics; $2,000 lifetime max		
	To age 19 only 50%	
Payroll Contributions	**Weekly**	
Employee Only	$7.31	
Employee + Spouse	$14.61	
Employee + Child(ren)	$21.89	
Family	$29.97	

VISION PLAN

You can receive the following vision benefits when enrolled in **Humana's** vision plan:

- Every 12 months, **Humana** covers your eye exam and either lenses *or* contact lenses
- Every 24 months, **Humana** covers your frames
- **Note:** You can search for providers by visiting **https://www.humana.com/vision-insurance**, clicking "Find a doctor," and entering your search criteria: Find a Vision Center - **Humana Insight Network**

Below are plan highlights and your payroll contributions.

PLAN HIGHLIGHTS	VISION
	In-Network
Exam *1 every 12 months*	$10 Copay
Lenses *1 every 12 months*	
Single	$15 Copay
Bifocal	$15 Copay
Trifocal	$15 Copay
Frames *1 every 24 months*	$130 Allowance, then 20% off remaining balance
Contact Lenses[1] *1 every 12 months*	Up to $130
Lasik Surgery	Not Covered
Payroll Contributions	**Weekly**
Employee Only	$1.43
Employee + Spouse	$2.86
Employee + Child(ren)	$3.02
Employee + Family	$4.58

In addition to Independent Humana Providers, specific retail locations are also in the network.

INDEPENDENT PROVIDER NETWORK

LENSCRAFTERS

For Eyes

AMERICA'S BEST CONTACTS & EYEGLASSES

OPTICAL

PEARLE VISION

EMPLOYEE ASSISTANCE PROGRAM (EAP)

We understand that you and your family members might experience a variety of personal or work-related challenges. The Employee Assistance Program through **Humana** is a company paid benefit offered to you and your family members and provides you with confidential access to resources, information, and counseling.

With the **LifeWorks by Humana** app, you can connect quickly and easily to all your EAP resources, tools, and our new Connection Hub. Download the EAP app from the App Store or Google Play and you will have instant access to EAP whenever you need it, wherever you are.

Connect with an EAP Professional

- Interact with a mental health expert when it is convenient for you, from your smartphone or tablet.

Find local resources

- Get the help you or your household members need, in your community or close to work.

Explore well-being topics

- Find helpful information on career and work, family and relationships, health and well-being any time you need it, anywhere you are.

Use the Connection Hub

- Connect with three new well-being experiences —Talkspace, Stop, Breathe and Think, or the Five Minute Journal – wherever you are and when you are ready.

It has never been easier to make the most of your EAP program!

Download the **LifeWorks by Humana** app from the App Store or Google Play:

- EAP app username: **hum**
- EAP app password: **hum**

LIFE MADE EASIER. FOR FREE, CONFIDENTIAL EAP ASSISTANCE

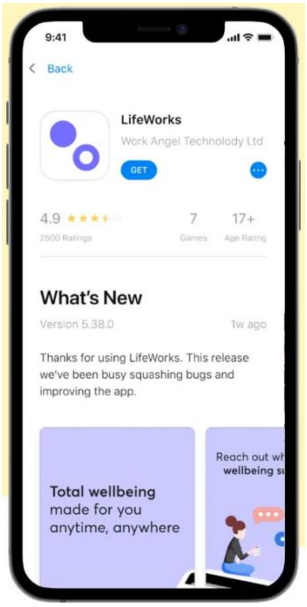
Call: 1-844-264-3286

TTY: 711

Sign In: www.login.lifeworks.com

Username: **hum**

Password: **eap**



ADDITIONAL COVERAGES

Accident Protection Plan

Helps provide financial stability for everyday expenses and medical treatment if a covered accident occurs. Benefits include:

- Ambulance
- Emergency room treatment
- Chiropractic and alternative therapies
- Pain management
- Prosthesis repair/replace
- Wellness

Payroll Contributions	Weekly
Employee Only	$2.84
Employee + Spouse	$4.39
Employee + Child(ren)	$5.46
Employee + Family	$7.01

Hospital Indemnity Plan

Eases the financial burden of hospital visits by providing cash benefits to help with any out-of-pocket costs not covered by your major medical insurance. Your benefits include:

- Hospital confinement
- Hospital admission
- Hospital intensive care
- Intermediate intensive care step down unit
- Everyday living expenses
- Coverage for newborn children 60 days from the birth

Payroll Contributions	Weekly
Employee Only	$11.02
Employee + Spouse	$21.31
Employee + Child(ren)	$17.66
Employee + Family	$27.95

Critical Illness Plan

$10,000 Lump Sum payout upon diagnosis of:

- Internal/Invasive Cancer
- Heart Attack
- Stroke
- End Stage Renal Failure
- Major Organ Transplant
- Sudden Cardiac Arrest

Employee Age	Per Week $10,000 Benefit
18-25	$0.99
26-30	$1.30
31-35	$1.54
36-40	$2.02
41-45	$2.44
46-50	$2.90
51-55	$4.51
56-60	$4.45
61-65	$9.09
66+	$15.96

Spouse Age	Per Week $10,000 Benefit
18-25	$0.65
26-30	$0.81
31-35	$0.93
36-40	$1.17
41-45	$1.37
46-50	$1.61
51-55	$2.41
56-60	$2.38
61-65	$4.70
66+	$8.13

ANNUAL NOTICES

Medicare Part D Creditable Coverage Notice
Important Notice from SPRINKLERMATIC FPS

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 SPRINKLERMATIC FPS 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. **SPRINKLERMATIC FPS has determined that the prescription drug coverage offered by the Health 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 while enrolled in SPRINKLERMATIC FPS coverage as an active employee, please note that your SPRINKLERMATIC FPS coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in SPRINKLERMATIC FPS coverage as a former employee.

You may also choose to drop your SPRINKLERMATIC FPS. If you do decide to join a Medicare drug plan and drop your current SPRINKLERMATIC FPS coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with SPRINKLERMATIC FPS and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. **Note**: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through SPRINKLERMATIC FPS changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: August 26, 2022
Name of Entity/Sender: SPRINKLERMATIC FPS
Contact--Position/Office: Giselle Aquino / Human Resources Manager
Address: 4740 Davie Road Davie, FL 33314
Phone Number: 877-327-7823 Ext 263

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in the group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days or any longer period that applies under the plan after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

You may have additional time to request enrollment due to COVID-19. To request special enrollment or obtain more information, contact:

Giselle Aquino
877-327-7823 Ext 263
Giselle@sprinklermatic.net

Women's Health Cancer Rights Act (WHCRA) Notice

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

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

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

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

New Health Insurance Marketplace Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

Part A: General Information

Now that key parts of the health care law have taken effect, there is 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 the fall of 2022 for coverage starting January 1, 2023.

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 9.61% (for 2022)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 Human Resource department.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name	**4. Employer Identification Number (EIN)**	
Sprinklermatic FPS	65-0733326	
5. Employer Address	**6. Employer Phone Number**	
4740 Davie Road	877-327-7823 Ext 263	
7. City	**8. State**	**9. Zip Code**
Davie	FL	33314
10. Who Can We Contact About Employee Health Coverage At This Job?		
Giselle Aquino		
11. Phone number (if different from above)	**12. Email address**	
	Giselle@sprinklermatic.net	

[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.

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

- As your employer, we offer a health plan to:

  ☐ All employees.

  ☑ Some employees. Eligible employees are:

  - Employees working 30 or more hours per week.

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are:

  - Spouse or domestic partner and children to age 26 or 30, if they qualify

  ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

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 January 31, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Programhttp://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	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 711Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA-Medicaid	**MAINE-Medicaid**
A 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	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
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840

IOWA-Medicaid and CHIP (Hawki)	MINNESOTA-Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-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	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA-Medicaid	**SOUTH CAROLINA-Medicaid**
Medicaid Website: http://dhcfp.nv.govMedicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.govPhone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345,ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.htmlCHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chipPhone: 1-877-543-7669

NORTH CAROLINA-Medicaid	VERMONT-Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	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
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

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

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.

OMB Control Number 1210-0137 (expires 1/31/2023)

Model General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

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

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

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

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

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

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

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

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

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

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, or a longer period permitted under the terms of the Plan after the qualifying event occurs.

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 period[2] 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.

[2] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you have questions

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

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

Name of Entity/Sender: SPRINKLERMATIC FPS
Contact--Position/Office: Giselle Aquino / Human Resource Manager
Address: 4740 Davie Road Davie, FL 33314
Phone Number: 877-327-7823 Ext 263

EEOC Wellness Program Notice

NOTICE REGARDING WELLNESS PROGRAM

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

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

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

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

Protections from Disclosure of Medical Information

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

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) a registered nurse, a doctor, or a health coach, in order to provide you with services under the wellness program.

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

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

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

Notice of Patient Protections

The carrier will generally require 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. Until you make this designation, [name of group health plan or health insurance issuer] designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact HR.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from SPRINKLERMATIC FPS or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact HR.

Designed By: Marsh McLennan Agency FL