BeneFITting you.

TMC HEALTH

2025

BENEFITS GUIDE

LIST OF CONTACTS

Benefits Administration:

Benefits Service Center
(520) 324-5275, Option 4
Fax: (520) 324-4435
AskBenefits@tmcaz.com

Hours:
Monday-Friday, 7:30 a.m. - 4:30 p.m.
Walk-in Assistance Available:
Human Resources
Atrium Bldg., 5099 E. Grant Road

Benefits Self-Service
(HR/Payroll Self-Service)
Online Enrollment and Info
Use link on eConnection (Main Page)

Dental:

MetLife PPO Dental
Group #95322
(800) 942-0854 • *Metlife.com/mybenefits*
or *metlife.com/dental*

EDS Dental
Group #G001844
(800) 722-9772
To change dentist: (520) 696-4343
www.employersdental.com

Vision:

MetLife
Group #95322
(855) 638-3931 • *Metlife.com/mybenefits*
or *metlife.com/vision*

Disability Insurance:

Lincoln Financial Group
Group #09-LF0980
(866) 340-0351
www.MyLincolnPortal.com
Company Code: TMCH

Retirement:

T. Rowe Price
(800) 922-9945 (Plan Account Line)
(800) 368-2768 (Spanish)
rps.troweprice.com

Employee Assistance:

OPTUM
Employee Assistance Program (24/7)
(855) 205-9185
Access Code: TMCH2775
www.liveandworkwell.com

Medical:

UMR
Group #76412212
(844) 614-8437 • *www.umr.com*
(Provider Directory – Choice Plus)
Nurse Line: (877) 950-5083

TMCOne
(520) 324-4774 • *www.TMCOne.com*
TMCOne FAST PASS
(520) 324-PASS (7277)

TMC Urgent Care
Main Campus
2424 N. Wyatt, Suite 140
Tucson, AZ 85712
(520) 324-4690 • Fax: (520) 324-4691

Rincon Campus
10350 E. Drexel Road, Suite 170
Tucson, AZ 85747
(520) 324-8070

Pharmacy/Prescription:

TMC Pharmacy
(520) 324-1890 or (520) 324-2520
Fax: (520) 324-2529
Required for Specialty/T3 Rx

MTM Appointment
(520) 324-5233

Alluma Customer Service
(800) 818-9290 • *www.allumaco.com*

Rx Savings Solutions
(800) 268-4476 • *www.rxsavingssolutions.com*
Register: *www.myrxss.com*

Live Well Credit/Wellness:

wellness@tmcaz.com
https://econnection.tmcaz.com/s/LiveWell

Health Savings Account (HSA):

Optum Bank
(866) 234-8913 • *www.optumbank.com*

Flexible Spending Account (FSA):

HealthEquity
(855) 692-2959 • Fax: (866) 643-2219
https://participant.wageworks.com

Other Benefits:

CorporateCARE Solutions, Inc.
Sick Child and Emergency
Child and Adult Care
(844) 888-2273 • Fax: (520) 308-5743
www.corporateCAREsolutions.com
Information on eConnection Benefits homepage

MetLife Legal Plans
(800) 821-6400
legalplans.com
Access Code: MetLaw

ASPCA Pet Health Insurance plan
(866) 861-9092
www.aspcapetinsurance.com/tmc
TMC Priority Code: EB14TMC

Critical Illness, Hospital Indemnity, Accident Insurance:

Lincoln Financial Group (LFG)
(800) 423-2765
fileclaim@lfg.com
www.MyLincolnPortal.com
Company Code: TMCH

Long-Term Care Insurance:

Lovitt & Touché, Inc.
Frank Lesselyong
(620) 245-1661
Frank.Lesselyong@MarshMMA.com

Auto/Home Insurance Plans:

Farmers GroupSelect (formerly MetLife)
(800) 438-6381
www.myautohome.farmers.com

COBRA:

HealthEquity (WageWorks)
(855) 556-5737
https://mybenefits.wageworks.com

Questions?
Call the Benefits Line (520) 324-5275
or
Visit eConnection Employee Territory Benefits homepage for information, forms and plan documents

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2025 Medical, Dental, Vision and Legal Rates

Rates do not include the Live Well Credit

MEDICAL PLAN OPTIONS	FULL-TIME (FT)**			PART-TIME (PT)**		
	Per Pay Period*	Employee Annual	TMCH Annual	Per Pay Period*	Employee Annual	TMCH Annual
TEAL PLAN (PPO)						
Employee Only	$44.50	$1,068.00	$4,200.00	$90.00	$2,160.00	$3,108.00
Employee + Spouse/DP	$110.50	$2,652.00	$8,640.00	$191.50	$4,596.00	$6,696.00
Employee + Child(ren)	$80.50	$1,932.00	$8,028.00	$173.00	$4,152.00	$5,808.00
Family	$137.50	$3,300.00	$13,944.00	$272.50	$6,540.00	$10,704.00
PURPLE PLAN (PPO)						
Employee Only	$80.50	$1,932.00	$4,116.00	$ 120.00	$2,880.00	$3,168.00
Employee + Spouse/DP	$193.50	$4,644.00	$8,496.00	$ 262.50	$6,300.00	$6,840.00
Employee + Child(ren)	$142.50	$3,420.00	$7,776.00	$ 222.00	$5,328.00	$5,868.00
Family	$285.00	$6,840.00	$13,524.00	$ 391.00	$9,384.00	$10,980.00
RED PLAN (PPO)						
Employee Only	$161.00	$3,864.00	$4,464.00	$ 189.50	$4,548.00	$3,780.00
Employee + Spouse/DP	$348.00	$8,352.00	$9,012.00	$ 398.50	$9,564.00	$7,800.00
Employee + Child(ren)	$286.50	$6,876.00	$8,520.00	$ 350.50	$8,412.00	$6,984.00
Employee + Family	$510.00	$12,240.00	$14,352.00	$ 596.00	$14,304.00	$12,288.00
YELLOW PLAN (HDHP2)						
Employee Only	$48.50	$1,164.00	$4,008.00	$ 90.50	$2,172.00	$3,000.00
Employee + Spouse/DP	$102.00	$2,448.00	$8,340.00	$ 192.00	$4,608.00	$6,180.00
Employee + Child(ren)	$79.50	$1,908.00	$7,656.00	$ 167.50	$4,020.00	$5,544.00
Family	$135.50	$3,252.00	$13,296.00	$ 282.00	$6,768.00	$9,780.00
BLUE PLAN (HDHP1)						
Employee Only	$67.00	$1,608.00	$4,164.00	$ 108.00	$2,592.00	$3,180.00
Employee + Spouse/DP	$152.50	$3,660.00	$8,652.00	$ 229.00	$5,496.00	$6,816.00
Employee + Child(ren)	$115.00	$2,760.00	$7,944.00	$ 201.00	$4,824.00	$5,880.00
Family	$219.50	$5,268.00	$13,788.00	$ 339.00	$8,136.00	$10,920.00

EMPLOYER HSA CONTRIBUTION (FT or PT) – Amount received by employee					
BLUE PLAN	Per Pay Period	Total Annual	YELLOW PLAN	Per Pay Period	Total Annual
Employee	$20.83	$500.00	Employee	$31.25	$750.00
Employee + 1 or more	$41.67	$1,000.00	Employee + 1 or more	$62.50	$1,500.00

SURCHARGES (FT or PT): Medical Coverage Only – Coverage available through other employer / Medicare					
Type	Per Pay Period*	Annual Amount	Type	Per Pay Period*	Annual Amount
Spouse/DP	$50.00	$1,200.00	Tobacco/Nicotine	$30.00	$720.00

DENTAL	FULL-TIME (FT)**			PART-TIME (PT)**		
	Per Pay Period*	Employee Annual	TMCH Annual	Per Pay Period*	Employee Annual	TMCH Annual
PPO PLAN (MetLife)						
Employee Only	$12.23	$293.52	$210.00	$20.98	$503.52	$0.00
Employee + Spouse/DP	$32.64	$783.36	$210.00	$41.39	$993.36	$0.00
Employee + Child(ren)	$34.91	$837.84	$210.00	$43.66	$1,047.84	$0.00
Employee + Family	$58.73	$1,409.52	$210.00	$67.48	$1,619.52	$0.00
EDS						
Employee Only	$3.33	$79.80	$74.40	$6.43	$154.20	$0.00
Employee + Spouse/DP	$8.26	$198.24	$74.40	$11.36	$272.64	$0.00
Employee + Child(ren)	$10.40	$249.60	$74.40	$13.50	$324.00	$0.00
Employee + Family	$12.51	$300.24	$74.40	$15.61	$374.64	$0.00
VISION (MetLife)						
Employee Only	$3.78	$90.72	$0.00	$3.78	$90.72	$0.00
Employee + Spouse/DP	$8.14	$195.36	$0.00	$8.14	$195.36	$0.00
Employee + Child(ren)	$6.14	$147.36	$0.00	$6.14	$147.36	$0.00
Employee + Family	$11.17	$268.08	$0.00	$11.17	$268.08	$0.00
LEGAL						
Employee Only	$8.25	$198.00	$0.00	$8.25	$198.00	$0.00

* All benefit premiums will be deducted over 24 paychecks (except 401(k), deducts over 26 paychecks). Newly eligible benefits are effective the 1st of the month following date of hire, rehire or if you move from PD to Core. If you enroll after your effective date, retro premiums will be owed and taken out of a future paycheck in a lump sum. Premium rates from status changes (PT to FT, FT to PT) are effective on the event date. Premium rate changes for Life and Disability are based on age and salary, and are effective on the pay period end date.

** Full Time = 30 to 40 assigned hours per week | Part Time = 24 to 29 assigned hours per week | DP = Domestic Partner

i **Medicare Creditable Coverage Notice:** If you or your covered 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 contact the Benefits Service Center.

INTRODUCTION

Our focus is on you. We believe that our benefits offer you both choice and opportunity. Our benefits package is competitive in the marketplace and yet affordable for TMC Health, which includes TMCOne, SAMS, Tucson Medical Center, Benson Hospital and Northern Cochise Community Hospital. Best of all, it provides you with great health care value.

The online Benefits Self-Service system allows you to:

- Enroll in benefits for the first time or during Open Enrollment
- Review and update your dependent and beneficiary information
- Review your current benefits

Forms, resources and links to health care providers are always available on the Employee Benefits homepage on eConnection.

This guide provides general information and a summary of all the benefit plans and programs TMC Health offers. Detailed information is available through eConnection on the Benefits homepage as well as our Policies and Procedures portal. **If you need clarification or specifics regarding any of the benefit plans and programs, the actual legal documents and policies will always govern and determine the exact benefits. The information contained in this guide is subject to change throughout the plan year with or without notice.**

If you need more information, please contact the Benefits Service Center at (520) 324-5275, Option 4. To better assist you, we will ask you for your employee ID#.

Enrollment Instructions

Review the different levels of coverage for each plan and use the benefit comparisons to determine the best options for you and your family. Follow these easy steps to enroll in benefits:

Review your Personalized Worksheet

You should receive a personalized worksheet in the mail after your date of hire, status change, or before annual Open Enrollment. The worksheet lists the benefits that are specifically available to you. If you do not enroll in benefits, you will be defaulted to the benefits coverage indicated by the text in bold on an annual basis. **You will need to actively designate a contribution for your Healthcare or Limited Purpose, and Dependent Care Flexible Spending Accounts if you wish to participate.**

Review your options carefully

Take advantage of the information and web links provided to do more in-depth research. Links are available on the eConnection Benefits homepage, which includes plan documents, summaries and coverage certificates.

Make your decision

Once you make your election decisions, mark them on your Personalized Worksheet before you actually log onto the Benefits Self-Service site. This way, the online enrollment process should only take about 15 minutes.

HOW to Enroll

Enrollment must be made online through Benefits Self-Service

- Using a TMC Health computer, click on the HR/Payroll Self-Service link under Employee Territory on eConnection or the Benefits Self-Service link on the Benefits homepage.
- To log in to eConnection from a home laptop or desktop computer (tablets not supported), go to *https://access.tmcaz.com*. Click "eConnection" then "Employee Territory" and then click on the **Benefits** link.
- To log in, use your assigned TMC Health user ID number, starting with a "t" and your personally created password.
- If using a shared TMC Health computer, always be sure to log off before leaving the workstation.

Important Online Enrollment Information

- You will need to provide applicable dependent information. Before you begin any enrollment process, you need to have the date of birth and Social Security number for each dependent you wish to cover. Due to the ACA (Affordable Care Act) reporting requirements to the IRS, the legal name and Social Security number (SSN) entered for each dependent must match what is registered with the Social Security Administration.
- Federal law requires group health insurance plans to report specific information, such as Social Security numbers, about Medicare beneficiaries who have other group coverage, whether or not they plan on having Medicare coverage. This reporting is to assist the Centers for Medicare and Medicaid Services and other health insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

ELIGIBILITY Definitions

Benefits-Eligible Employee and Dependents

Employees assigned to a regular schedule of at least 24 hours per week are benefits-eligible. Employees may elect coverage for themselves, a spouse or domestic partner, and dependent child(ren) of both you and your spouse or domestic partner.

Benefits-Eligible Dependent Age

For purposes of Medical, Prescription, Dental, Vision and Child Life benefit plans, a child up to age 26 is considered eligible for coverage. The child is not required to be a full-time student, unmarried, or totally disabled and dependent upon your care to be covered.

Domestic Partnerships

TMC Health defines "domestic partner" as a committed, financially interdependent relationship between two same-sex or opposite-sex partners who live together. Employees of TMC Health may enroll domestic partners in the Medical, Prescription, Vision and Dental plans. The following requirements must be met to qualify for domestic partner coverage:

- Both the employee and the domestic partner have reached the age of 18.
- Neither is married.
- Neither would be prevented under law from marrying the other as a result of a blood relationship.
- All statements made at the time that the Declaration of Domestic Partnership was completed remain true, and both members intend them to remain true indefinitely.
- Both members have maintained cohabitation for at least 12 months and intend to do so indefinitely.
- Both members are responsible for the welfare and financial obligations of each other.
- Neither member has had a different domestic partner in the last 12 months. Not applicable if the employee had a partner who died.

To qualify for coverage of a domestic partner, the employee and his or her domestic partner must complete, sign and have notarized the Declaration of Domestic Partnership. The declaration must be returned to the Benefits Service Center. You can find the Declaration of Domestic Partnership form on the eConnection Benefits homepage.

Because the IRS does not usually recognize domestic partners to be qualified dependents, the cost of this coverage will be considered income to the employee and will result in additional income tax withholding. The additional taxable amount called "imputed income" may be shown on the employee's pay advice designated as an employer-paid taxable benefit and reported as "other compensation" on the W-2.

Note: Domestic Partners may only be enrolled/added within 31 days of employee's initial date of benefits eligibility, Open Enrollment, reaching the 12-month milestone, or Qualifying Life/ Status Event. Children of your Domestic Partner are not qualified dependents, therefore TMC Health does not allow coverage unless your domestic partner is enrolled in that plan.

For more information, refer to the Domestic Partner Benefit Eligibility policy.

Spouse/Domestic Partner Surcharge

If your spouse/domestic partner is offered medical insurance through his/her own employer or Medicare, but elects to be covered under TMC Health's plan, you will be charged a medical surcharge of $100 per month (pre-tax) in addition to your monthly premiums. During your medical plan enrollment you will answer a question related to your spouse or domestic partner being offered medical coverage under his/her employer. If your spouse or domestic partner is not employed or is not offered coverage through an employer or Medicare the surcharge does not apply.

The surcharge may be removed effective the first of the following month your spouse or domestic partner is no longer employed, has an employer that no longer offers medical insurance or has a loss of any other coverage. Proof of the change must be submitted to the Benefits Service Center within 31 days of the change.

Tobacco/Nicotine-Use Medical Surcharge

If you and/or your dependent(s) covered under TMC Health's medical insurance use tobacco/nicotine products, you will be charged a medical surcharge of $60 per month (pre-tax) in addition to your monthly premiums. During your medical plan enrollment you will answer a question related to you and your dependent(s) tobacco/nicotine usage. If you and your covered dependents do not use tobacco/nicotine products, the surcharge does not apply.

The surcharge may be removed at the next Open Enrollment following when you and/or your covered dependent(s) have been tobacco-free for six months and/or if you have a qualifying life event or status change.

If it is medically inadvisable or unreasonably difficult due to a medical condition for you to qualify for the standards for elimination of the tobacco surcharge, call the Benefits Service Center and we will work to assist you with ways to help you qualify.

EFFECTIVE DATES of Coverage

For Medical, Prescription, Vision, Dental, Flexible Spending Accounts, Voluntary Life Insurance, Accidental Death and Dismemberment (AD&D), Short-Term Disability, Critical Illness, Hospital Indemnity and Accident benefits, the eligibility and effective date of coverage is as follows:

Newly hired/eligible employees

Newly hired/eligible employees have 31 days from their date of hire to enroll in their benefits. Benefits will be effective the first of the month following date of hire; therefore, retroactive premiums may apply.

If newly hired/eligible employees do not enroll in benefits within 31 days of their date of hire they will still be enrolled in 100% company-paid benefits only (i.e., Basic Life, Long-Term Disability, EAP). The next time employees are eligible to change their benefits is during the fall Open Enrollment period for the following year, or following a qualified life event or status change.

Continuing employees

Each fall during the Open Enrollment period, benefits-eligible employees have the opportunity to elect or change their existing benefits. The newly elected coverage starts the following Jan. 1. Employees can only change or elect benefits during Open Enrollment, or when they experience and report a qualified life event or status change.

Employees with a qualified life event or family status change

IRS qualifying life events allow employees the opportunity to make certain benefits-enrollment changes within 31 days of the event. Events must be reported to the Benefits Service Center by faxing required documentation to (520) 324-4435 with your name, employee ID number and brief description. A list of acceptable documentation is available on the Benefits homepage on eConnection. You must then make your benefits enrollment changes online within the same 31-day window.

Examples of qualifying events include:

- Birth (new parents must report and elect coverage for a newborn) or adoption
- Loss or gain of insurance coverage
- Marriage or newly eligible domestic partnership
- Divorce, legal separation or dissolution of domestic partnership
- Qualified medical court order
- Change in dependent-care cost
- Change in dependent status affecting eligibility

The following qualifying events do not need to be reported, but you must make desired enrollment changes within 31 days of the event:

- Change in employment status (i.e., part-time to full-time or full-time to part-time)
- Leave of Absence
- Newly Eligible (per diem to full-time or part-time)

Premium rates from status changes (PT to FT, FT to PT) are effective on the event date. Premium rate changes for Life and Disability are based on age and salary, and are effective on the pay period end date.

Remember, you only have 31 days from the date of a qualifying event to supply documentation and make enrollment changes.

Submit documentation by fax to: (520) 324-4435 or email: AskBenefits@tmcaz.com

To ensure your private information is protected, send from your TMC Health address and [encrypt]. Include employee name and ID number.

OVERVIEW of Benefits

TMC Health offers a number of benefits to employees and their families. Medical, Prescription, Vision, Dental, Accident, Critical Illness and Hospital Indemnity insurance benefits are offered to domestic partners and their dependent children.

Medical Insurance Plans

Administered by UMR

UMR is a third-party administrator owned by UnitedHealth Group

TMC Health offers a choice of five medical plans. The selections are offered in response to employee feedback about the differing needs of TMC Health's employees.

- The TEAL Plan, the PURPLE Plan and the RED Plan (PPO)
- The BLUE Plan and the YELLOW Plan
  High-Deductible Health Plans (HDHP) which can be paired with a Health Savings Account (HSA) through Optum Bank

While each plan has varying coverage levels, you will find there are several features that are the same on all plans. Here are a few: You are not required to choose a primary care physician, but it helps to have one. If you want to see a specialist, you can do so without a referral in most cases. All plan options cover certain preventive services at 100% without charging a copay, coinsurance or deductible, as long as they are delivered by a TMC Health Preferred Network or Choice Plus Network provider. Lastly, coverage is available nationwide, but remember you will receive the highest level of benefits when you use providers in the TMC Health Preferred Network, as well as discounted charges.

TMC Health and employees both pay a portion of the medical premiums. The amount you pay depends on the coverage you elect, your employment status and any earned Live Well Credit.

Getting the most from your medical plan:

All plans offer three network-level providers to select from:

TMC Health Preferred Network (Tier 1) – TMC, TMCOne, Benson Heathcare, Northern Cochise Community Hospital and other specific TMC Health or related providers as determined by Benefits Administration. A list of these providers is available on the eConnection Benefits homepage and *www.umr.com.* Not all services are available in this tier.

Choice Plus Network (Tier 2) – UnitedHealthcare's Choice Plus Network of providers. A list of these providers is available at *www.umr.com*.

Out-of-Network (Tier 3) – Non-contracted providers.

TMCOne FASTPASS

TMCOne Fast Pass is an expedited service for TMC Health employees and their families. With Fast Pass, a patient ambassador is dedicated to scheduling same-day and primary care appointments. As part of the TMC Health family, you now have access to convenient, quality care that works with your schedule. Call (520) 324-PASS (7277) to speak with the TMCOne patient ambassador.

TMC URGENT CARE

Quality care when you need it.
8 a.m. – 8 p.m., 7 days a week

Main Campus
2424 N. Wyatt Drive #140
(520) 324-4690

Rincon Campus
10350 E. Drexel Road #170
(520) 324-8070

Employee Plan Copays:

Teal Plan (*Tier 1): $10 copay

Red Plan (*Tier 1): $20 copay

Purple Plan (*Tier 1): $30 copay

Blue Plan / Yellow Plan (*Tier 1): 10% after deductible

What we treat: fever, sore throat or cough, wheezing, flu-like symptoms, nausea, urinary tract infections, sinusitus and allergies, general/mild abdominal pain, sprains and fractures, minor burns or skin infections, small cuts that may require stitches.

*Includes the following: TMC, TMCOne, Benson Hospital, Benson HealthCare, Northern Cochise Community Hospital and other specific TMC Health or related providers as determined by Benefits Administration. Refer to *www.umr.com* for updated TMC Health preferred provider list.

OVERVIEW of Benefits *(continued)*

TMC Health Medical Appeals

TMC Health provides an appeal process for internal and external benefit claims determination review. This offers employees and/or dependent(s) with denied claims the opportunity to have them reviewed for final determination. Please contact the Benefits Service Center directly for more information.

Programs for Medical Plan Participants

TMC Health provides several important educational and wellness services under our health plans. Additional information on the following programs may be found on eConnection.

Maternity Management

UMR Maternity Management can teach you how to reduce your risk of complications and prepare you to have a successful, full-term pregnancy and healthy baby. The program is free to you. To enroll, simply go to *www.umr.com*, or call (888) 438-8105. Once enrolled, you'll receive:

- Comprehensive pre-pregnancy and prenatal assessment
- Educational information before you become pregnant and throughout your pregnancy
- Ability to call with any questions or concerns
- UMR continues to reach out each trimester and again after your delivery to see how you and your baby are doing

Enroll during your first or second trimester and continue to actively participate in the program each trimester of your pregnancy including completing the post-delivery survey to receive a $25 gift card.

NurseLine, (877) 950-5083

NurseLine gives you the ability to call a Registered Nurse with medical-related questions and concerns, 24 hours a day, seven days a week. The nurses provide guidance and support for members making decisions about their health and the health of their dependents.

UMR Mobile

As a UMR member, you can access your benefit and claim information from your mobile device when you're "on the go." Just use your mobile browser to log in using the same username and password that you use on the full site. There's no app to download, nothing to install, no waiting.

You can:

- Find an in-network provider
- Look up claims for yourself or your authorized dependents
- View your medical benefits
- View your ID card, allow providers to scan the on-screen bar code for instant access to your benefit information and/or fax a copy to a provider.

HSA BASICS and HIGH DEDUCTIBLE HEALTH PLANS (Blue and Yellow)

Both the Blue and Yellow plans give you the option of opening a Health Savings Account (HSA), **if you are eligible**. An HSA is a personal bank account that you own. You can use it to save money, income-tax free to pay for qualified medical expenses. When you have medical expenses, including those that may apply to your annual deductible, you can choose to pay for them using the money in your HSA. Or, you can save the money for a future need, even into retirement. It's your choice.

Visit *optumbank.com* to learn about HSA eligibility requirements.

How an HSA Works

An HSA works with your health plan to help you plan, save and pay for health care.

In order to open and contribute to an HSA you must be enrolled in the **BLUE** or **YELLOW** plan (a qualified high-deductible health plan). If you are covering your dependents (spouse and/or children), you must first meet the family deductible before the plan shares in the cost under the Blue plan.

HSA BASICS and HIGH DEDUCTIBLE HEALTH PLANS (Blue and Yellow) *(continued)*

Yellow plan must meet the individual deductible. See No. 4 on page 7 for more information.

Under the **BLUE** and **YELLOW** plans, the deductible and coinsurance are waived for preventive services provided by a TMC Health Preferred Network or Choice Plus Network provider. Certain preventive medications are not subject to the deductible.

HSA offers tax savings:

- The money you put in your Health Savings Account is tax deductible, up to a legal limit of $4,300 (employee only coverage) or $8,550 (employee + dependent(s) coverage). Please read the information on HSAs and domestic partners on the Benefits homepage. The limits include employee and employer contributions.
- If you are age 55 or over you may contribute an additional $1,000 annually.
- Your savings grow tax-free.
- Any money you use to pay for eligible medical expenses is not taxed.

The money in your HSA is always yours. There is no "use it or lose it" rule. All amounts in your HSA belong to you, and balances in your account remain in your account until spent. Your account is portable, meaning the money stays put even if you:

- Change jobs
- Change medical coverage
- Become unemployed
- Move to another state
- Get married or divorced

With an HSA, **you are in charge**. You decide:

- How much you will contribute to your account. You may contribute the difference between TMC Health's contribution and the legal limit. Note that funds from the most recent contribution may not be available until a week following a payday.
- When you want to use your savings to pay for or reimburse yourself for eligible medical expenses.
- Whether to invest some of your savings in mutual funds for greater potential long-term growth.

TMC Health Contribution

Blue Plan: Employee only $500 or Employee + 1 or more $1,000 annually, pro-rated

Yellow Plan: Employee only $750 or Employee + 1 or more $1,500 annually, pro-rated

Blue Plan: $20.83 per pay period for employee only plans or $41.67 for employee + 1 or more plans (up to 24 pay periods).

Yellow Plan: $31.25 per pay period for employee only plans or $62.50 for employee + 1 or more plans (up to 24 pay periods).

If you need assistance in maximizing your HSA contribution through Benefits Self-Service, please contact the Benefits Service Center.

For those employees who currently have an HSA account through Optum Bank your account number will not change. Your debit card will continue to work until the expiration date. When your debit card expires, a new card with the Optum Bank logo will be sent to you automatically.

You can access your Optum Bank account through *www.optumbank.com.*

HSA Enrollment Criteria

To open an HSA, you must meet these criteria:

- You must be enrolled in the **BLUE** or **YELLOW** plan.
- You cannot be covered by any other medical insurance plan.
- **You cannot be enrolled in Medicare (part A or B), Medicaid or AHCCCS.**
- You cannot be enrolled in TRICARE or TRICARE for Life, a military benefits program.
- You cannot have received Veterans Administration (VA) benefits within the past three months (some exceptions apply).
- You cannot be eligible to be claimed as a dependent on someone else's tax return.
- You cannot be covered by a Health Care Flexible Spending Account (FSA) for the tax year in which you will claim your HSA deposits as tax deductions; however, you may enroll in the Limited Purpose FSA account.

If your circumstances change and you are no longer eligible to contribute to an HSA, you can keep the account as long as you like and use it to pay for eligible medical expenses tax-free.

HSA BASICS and HIGH DEDUCTIBLE HEALTH PLANS (Blue and Yellow) *(continued)*

How the Blue and Yellow Plans Work

1. Your Deductible – You pay the full cost of services until you reach the deductible.

When you have an eligible expense, such as a doctor's visit, the entire cost of the visit will apply to your deductible. You will pay the full cost of your health care expenses until you meet your deductible. You can choose to pay for care from your HSA or you can choose to pay another way (e.g., cash, credit card) and let your HSA grow. It's your money, it's your choice.

2. Your Coverage – Your plan pays a percentage of your expense once the deductible is met. This is called coinsurance.

With coinsurance, the plan shares the cost of expenses with you. The plan will pay a percentage of each eligible expense, and you will pay the rest. For example, if your plan pays 90% of the cost, you will pay 10%.

3. Your Out-of-Pocket Maximum – You are protected from major expenses.

The out-of-pocket maximum, excluding balance bill amounts, is the most you will have to pay in the plan year for covered services. The plan will then pay 100% of all remaining covered expenses for the rest of the plan year. Your deductible, copays and coinsurance will go towards your out-of-pocket maximum.

4. Embedded Deductibles – Embedded deductibles have two components: the individual deductibles for each family member and the family deductible. When a family member meets his or her individual deductible, the insurance company will begin paying according to the plan's coverage for that member. If only one person meets an individual deductible, the rest of the family still has to pay their deductibles. (Yellow plan)

Non-Embedded Deductibles: The full deductible has to be met before the insurance company begins paying according to the plan's coverage for the entire family. (Blue plan)

Paying for Prescriptions

The Blue and Yellow plans have a combined medical and pharmacy deductible. This means that prescription costs will apply towards your deductible. You will pay out-of-pocket for covered prescriptions and qualifying medications until you meet the deductible maximum. Remember, you can use your HSA to pay these expenses.

Your pharmacy benefit plan includes special coverage for preventive medications. Drugs on your plan's list of preventive medications are not subject to a deductible. You'll pay your coinsurance only.

Qualified Medical Expenses

The IRS determines which expenses qualify to be paid from an HSA. You can find a list of common qualified expenses at *optumbank.com* or the Benefits homepage.

Optum Bank

With your online authorization TMC Health will open an HSA bank account in your name with Optum Bank. **Please note a mailing address (not a P.O. Box) is required.** In order for this account to be opened, you must complete the acknowledgements and authorizations in the online enrollment system. If your account is not opened within 60 days of enrollment, you will forfeit all TMC Health contributions until you have opened the account. TMC Health's HSA contribution will NOT be made until you have an active HSA account with Optum Bank. TMC Health will open the following HSA account for you:

- Optum eAccess℠, which has a monthly maintenance fee of $1 per month for average balances under $500. **This monthly maintenance fee will be your responsibility.** There is no fee for accounts with average balances over $500.
  - This account does not have an annual percentage yield
  - Investment options are available for accounts with balances above $2,000
  - The monthly maintenance fee for investment funds is $3 per month

After 90 days of opening your account, Optum Bank will offer you the option of switching from the Optum eAccess℠ account to the Optum eSaver℠ or Optum eInvestor℠. It is your choice to switch to one of these accounts which offer an annual percentage yield and/or investment options at a lower fee. Should you wish to switch your account at an earlier time, please contact Optum Bank directly.

If you will become eligible for Medicare in 2025 and choose to enroll, you are no longer eligible to participate in the HSA. Severe tax penalties can apply.

Please contact the Benefits Service Center (520) 324-5275, Option 4

How do the medical plans work with other accounts?

Eligible For:	TEAL Plan	RED Plan	PURPLE Plan	BLUE Plan	YELLOW Plan
Health Savings Account (HSA)				X	X
TMCH HSA Contribution				X	X
Healthcare Flexible Spending Account (FSA)	X	X	X		
Limited Purpose (Healthcare) FSA				X	X
Defined Prescription Plan w/co-pays	X	X	X		
Dependent Care FSA	X	X	X	X	X

Health Savings Account vs. Flexible Savings Account Comparison

Question	HSA	Healthcare FSA
Who owns the money in the account?	Individual	Individual; however it is subject to "use it or lose it" rule at end of plan year, except for up to $640, which may be rolled over to the following year.
Does the unused money roll over from year to year?	YES	NO, except up to $640 rollover rule at the end of the year.
Can the money be invested and earn interest?	YES, tax-free	NO
Are the funds portable?	YES	NO
Are the funds taxable?	Employee contributions are pre-tax. TMC's contributions are not taxable income. Funds spent on medical expenses are tax-free for life. At 65, funds used to supplement income are tax-deferred.	Deductions are pre-tax.
Can the funds be used for non-medial expenses?	YES, but they are subject to taxes and a 20% penalty.	NO
How can an employee access funds?	Employee has direct access to funds with debit card or automatic payment.	Employee has direct access to funds with debit card. Substantiation needed for some claims.
When are funds available?	As contributions are made to the account.	At the beginning of the plan's effective date.
Who contributes to the account?	TMCH and/or Employees	Employees
What type of health plan is required?	High-Deductible Health Plan (Blue or Yellow Plan)	No requirements.
Is there a "catch up" provision for older individuals?	Yes, an individual age 55 or older may contribute an extra $1,000 per year.	NO
Is there a maximum contribution per year?	Single coverage $4,300 Dependent coverage $8,550 (Employee + Employee Combined Max)	$3,200
What are qualified medical expenses on the plan?	- Qualified medical expenses as defined in IRC 213(d) - COBRA premiums - Long -Term Care	Qualified medical expenses as defined in IRC 213(d).
What happens upon the death of the account holder?	Surviving spouse only (if designated beneficiary) entitled to use remaining account monies for qualified medical expenses. Otherwise it is taxable to beneficiary.	Eligible dependents entitled to use remaining account monies for qualified medical expenses during the current plan year in accordance with plan document.
How are claims substained?	Sole taxpayer responsibility.	Claims are adjudicated by third-party administrator (HealthEquity)

2025 TMC Health Medical Plan Design

If a hospital-based medical service is not available at TMC Health, prior to receiving the service, please contact the Benefits Service Center for coverage information.

Benefits	TEAL Plan (PPO)	
	TMC Health Preferred Network (TMC/TMCOne*)	Choice Plus Network (UHC)
Deductible *(single/family)*	$750 / $1,500	$2,000 / $4,000
Out-of-Pocket Maximum *(includes deductible & copays)*	$2,000 / $4,000	$8,500 / $15,000
**Embedded Deductible / Out-of-Pocket Maximum	Yes	
HSA Contribution	N/A	N/A
PHYSICIAN		
Preventive Care *(including immunizations)*	0% no deductible	0% no deductible
Primary Care Physician (PCP) / Telehealth Visit	$5 copay	$35 copay
Specialist	$10 copay	$75 copay
Retail / Convenience Clinic	N/A	$50 copay
Telemedicine (TMCOne)	$10 copay	N/A
OTHER SERVICES		
Urgent Care	$10 copay	$100 copay
Emergency Room *(Waived if admitted)*	$350 copay	$350 copay
Outpatient Surgery *Physician*	0% no deductible	0% no deductible
Outpatient Surgery *Facility*	10% after deductible	If available must be done at TMCH - otherwise 10% after deductible
Inpatient Hospital *Facility & Physician*	10% after deductible	If available must be done at TMCH - otherwise 10% after deductible
Outpatient Lab Services	10% no deductible	If available must be done at TMCH - otherwise 10% after deductible
Outpatient X-rays & Diagnostic Services Facility & *Physician*	10% no deductible	If available must be done at TMCH - otherwise 10% after deductible
Advanced Imaging *Physician*	10% no deductible	If available must be done at TMCH - otherwise 10% after deductible
Advanced Imaging (MRI/CT, etc) Outpatient Facility	10% after deductible	If available must be done at TMCH - otherwise 10% after deductible
Allergy Shots	N/A	$25 copay
Diabetes Self-Management Training	$15 / $25 copay	N/A
Diabetes Education Group, Individual & Counseling	0% no deductible	N/A
Manipulations *(Limit 20 visits/year)*	$15 / $60 copay	N/A
Skilled Nursing Facility *(Limit 120 days/year)*	N/A	30% after deductible
Ambulance Services (Emergency)	N/A	$350 copay
Ambulance Services (Non-Emergency)	N/A	20% after deductible
Outpatient Rehabilitation *(Authorization required after 25 visits/year - 36 for cardiac)*	$25 copay	N/A
Bariatric Surgery *Facility*	$2,500, then 10% after deductible	Not covered
Bariatric Surgery *Physician*	10% after deductible	Not covered

TMC Health Preferred Network (Tier 1)* coverage includes services performed at Tucson Medical Center, TMCOne, TMC Urgent Care, Benson Hospital, Northern Cochise Community Hospital, related clinics and other specific providers as determined by Benefits Administration. TMC Health Preferred Network (Tier 1)/Choice Plus Network (Tier 2) deductibles and Out-of-Pocket maximums cross apply. Refer to www.umr.com for the TMC Health Preferred provider list. TMC Health Preferred Network does not include all specialties and services.

Choice Plus Network (Tier 2) Coverage includes services performed by a UnitedHealthcare provider, but not at a TMC Health Preferred provider. TMC Health Preferred Network (Tier 1)/Choice Plus Network (Tier 2) deductibles and Out-of-Pocket maximums cross apply.

Out-of-Network (Tier 3) Coverage includes services performed at an Out-of-Network provider meaning the provider is not contracted with UnitedHealthcare.

**Embedded deductibles have two components: the individual deductible for each family member and the family deductible. See page 7 for details.

This table is updated annually and provides general information about the medical plans. For detailed information, refer to the specific benefits document or Summary Plan Description (SPD). In all cases the actual legal plan documents will govern and determine exact benefits.

2025 TMC Health Medical Plan Design

If a hospital-based medical service is not available at TMC Health, prior to receiving the service, please contact the Benefits Service Center for coverage information.

Benefits	PURPLE Plan (PPO)		
	TMC Health Preferred Network (TMC/TMCOne*)	Choice Plus Network (UHC)	Out-of-Network
Deductible *(single/family)*	$2,000 / $4,000	$4,000 / $8,000	$7,000 / $14,000
Out-of-Pocket Maximum *(includes deductible & copays)*	$5,000 / $7,000	$8,500 / $15,000	$14,000 / $28,000
**Embedded Deductible / Out-of-Pocket Maximum	Yes		
HSA Contribution	N/A	N/A	N/A
PHYSICIAN			
Preventive Care *(including immunizations)*	0% no deductible	0% no deductible	N/A
Primary Care Physician (PCP) / Telehealth Visit	$25 copay	$35 copay	80% after deductible
Specialist	$60 copay	$80 copay	80% after deductible
Retail / Convenience Clinic	N/A	$50 copay	80% after deductible
Telemedicine (TMCOne)	$10 copay	N/A	N/A
OTHER SERVICES			
Urgent Care	$30 copay	$75 copay	$80 copay
Emergency Room *(Waived if admitted)*	$350 copay	$350 copay	$350 copay
Outpatient Surgery *Physician*	0% no deductible	0% no deductible	80% after deductible
Outpatient Surgery *Facility*	20% after deductible	$2,000 admit copay, 30% after deductible	$2,000 admit copay, 80% after deductible
Inpatient Hospital *Facility & Physician*	20% after deductible	$3,500 admit copay, 30% after deductible	$3,500 admit copay, 30% after deductible
Outpatient Lab Services	10% no deductible	20% no deductible	80% after deductible
Outpatient X-rays & Diagnostic Services Facility & *Physician*	20% no deductible	40% no deductible	80% after deductible
Advanced Imaging *Physician*	20% no deductible	20% no deductible	80% after deductible
Advanced Imaging (MRI/CT, etc) Outpatient Facility	20% after deductible	40% after deductible	80% after deductible
Allergy Shots	N/A	$35 copay	80% after deductible
Diabetes Self-Management Training	$20 / $30 copay	$35 / $70 copay	80% after deductible
Diabetes Education Group, Individual & Counseling	0% no deductible	N/A	N/A
Manipulations *(Limit 20 visits/year)*	$25 / $60 copay	$35 / $75 copay	80% after deductible
Skilled Nursing Facility *(Limit 120 days/year)*	Benson and NCCH only – 10% After Deductible (Not Available at TMC)	40% after deductible	80% after deductible
Ambulance Services (Emergency)	N/A	$350 copay	$350 copay
Ambulance Services (Non-Emergency)	N/A	40% after deductible	80% after deductible
Outpatient Rehabilitation *(Authorization required after 25 visits/year - 36 for cardiac)*	$35 copay	$35 copay	80% after deductible
Bariatric Surgery *Facility*	$3,500, then 20% after deductible	Not covered	Not covered
Bariatric Surgery *Physician*	20% after deductible	Not covered	Not covered

TMC Health Preferred Network (Tier 1)* coverage includes services performed at Tucson Medical Center, TMCOne, TMC Urgent Care, Benson Hospital, Northern Cochise Community Hospital, related clinics and other specific providers as determined by Benefits Administration. TMC Health Preferred Network (Tier 1)/Choice Plus Network (Tier 2) deductibles and Out-of-Pocket maximums cross apply. Refer to www.umr.com for the TMC Health Preferred provider list. TMC Health Preferred Network does not include all specialties and services.

Choice Plus Network (Tier 2) Coverage includes services performed by a UnitedHealthcare provider, but not at a TMC Health Preferred provider. TMC Health Preferred Network (Tier 1)/Choice Plus Network (Tier 2) deductibles and Out-of-Pocket maximums cross apply.

Out-of-Network (Tier 3) Coverage includes services performed at an Out-of-Network provider meaning the provider is not contracted with UnitedHealthcare.

**Embedded deductibles have two components: the individual deductible for each family member and the family deductible. See page 7 for details.

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2025 TMC Health Medical Plan Design

If a hospital-based medical service is not available at TMC Health, prior to receiving the service, please contact the Benefits Service Center for coverage information.

Benefits	RED Plan (PPO)		
	TMC Health Preferred Network (TMC/TMCOne*)	Choice Plus Network (UHC)	Out-of-Network
Deductible *(single/family)*	$1,250 / $2,500	$2,250 / $4,500	$7,000 / $14,000
Out-of-Pocket Maximum *(includes deductible & copays)*	$3,000 / $5,000	$8,500 / $15,000	$14,000 / $28,000
**Embedded Deductible / Out-of-Pocket Maximum	Yes		
HSA Contribution	N/A	N/A	N/A
PHYSICIAN			
Preventive Care *(including immunizations)*	0% no deductible	0% no deductible	N/A
Primary Care Physician (PCP) / / Telehealth Visit	$15 copay	$35 copay	80% after deductible
Specialist	$50 copay	$80 copay	80% after deductible
Retail / Convenience Clinic	N/A	$40 copay	80% after deductible
Telemedicine (TMCOne)	$10 copay	N/A	N/A
OTHER SERVICES			
Urgent Care	$20 copay	$75 copay	$80 copay
Emergency Room *(Waived if admitted)*	$350 copay	$350 copay	$350 copay
Outpatient Surgery *Physician*	0% no deductible	0% no deductible	80% after deductible
Outpatient Surgery *Facility*	10% after deductible	$2,000 admit copay, 30% after deductible	$2,000 admit copay, 80% after deductible
Inpatient Hospital *Facility & Physician*	10% after deductible	$4,500 admit copay, 30% after deductible	$4,500 admit copay, 80% after deductible
Outpatient Lab Services	10% no deductible	20% no deductible	80% after deductible
Outpatient X-rays & Diagnostic Services Facility & *Physician*	10% no deductible	30% no deductible	80% after deductible
Advanced Imaging *Physician*	10% no deductible	10% no deductible	80% after deductible
Advanced Imaging (MRI/CT, etc) Outpatient Facility	10% after deductible	30% after deductible	80% after deductible
Allergy Shots	N/A	$25 copay	80% after deductible
Diabetes Self-Management Training	$15 / $25 copay	$30 / $60 copay	80% after deductible
Diabetes Education Group, Individual & Counseling	0% no deductible	N/A	N/A
Manipulations *(Limit 20 visits/year)*	$15 / $60 copay	$30 / $60 copay	80% after deductible
Skilled Nursing Facility *(Limit 120 days/year)*	Benson and NCCH only – 10% After Deductible (Not Available at TMC)	30% after deductible	80% after deductible
Ambulance Services (Emergency)	N/A	$350 copay	$350 copay
Ambulance Services (Non-Emergency)	N/A	20% after deductible	80% after deductible
Outpatient Rehabilitation *(Authorization required after 25 visits/year - 36 for cardiac)*	$25 copay	$25 copay	80% after deductible
Bariatric Surgery *Facility*	$2,500, then 10% after deductible	Not covered	Not covered
Bariatric Surgery *Physician*	10% after deductible	Not covered	Not covered

TMC Health Preferred Network (Tier 1)* coverage includes services performed at Tucson Medical Center, TMCOne, TMC Urgent Care, Benson Hospital, Northern Cochise Community Hospital, related clinics and other specific providers as determined by Benefits Administration. TMC Health Preferred Network (Tier 1)/Choice Plus Network (Tier 2) deductibles and Out-of-Pocket maximums cross apply. Refer to www.umr.com for the TMC Health Preferred provider list. TMC Health Preferred Network does not include all specialties and services.

Choice Plus Network (Tier 2) Coverage includes services performed by a UnitedHealthcare provider, but not at a TMC Health Preferred provider. TMC Health Preferred Network (Tier 1)/Choice Plus Network (Tier 2) deductibles and Out-of-Pocket maximums cross apply.

Out-of-Network (Tier 3) Coverage includes services performed at an Out-of-Network provider meaning the provider is not contracted with UnitedHealthcare.

**Embedded deductibles have two components: the individual deductible for each family member and the family deductible. See page 7 for details.

This table is updated annually and provides general information about the medical plans. For detailed information, refer to the specific benefits document or Summary Plan Description (SPD). In all cases the actual legal plan documents will govern and determine exact benefits.

2025 TMC Health Medical Plan Design

If a hospital-based medical service is not available at TMC Health, prior to receiving the service, please contact the Benefits Service Center for coverage information.

Benefits	YELLOW Plan (HDHP)		
	TMC Health Preferred Network (TMC/TMCOne*)	Choice Plus Network (UHC)	Out-of-Network
Deductible *(single/family)*	$3,300 / $6,600	$4,500 / $8,750	$7,000 / $14,000
Out-of-Pocket Maximum *(includes deductible & copays)*	$3,500 / $7,000	$6,750 / $10,250	$14,000 / $28,000
**Embedded Deductible / Out-of-Pocket Maximum	Yes		
HSA Contribution	$750 / $1,500		
PHYSICIAN			
Preventive Care *(including immunizations)*	0% no deductible	0% no deductible	N/A
Primary Care Physician (PCP) / Telehealth Visit	10% after deductible	20% after deductible	80% after deductible
Specialist	10% after deductible	20% after deductible	80% after deductible
Retail / Convenience Clinic	N/A	20% after deductible	80% after deductible
Telemedicine (TMCOne)	10% after deductible	N/A	N/A
OTHER SERVICES			
Urgent Care	10% after deductible	30% after deductible	80% after deductible
Emergency Room *(Waived if admitted)*	10% after deductible	10% after deductible	10% after deductible
Outpatient Surgery *Physician*	0% after deductible	0% after deductible	80% after deductible
Outpatient Surgery *Facility*	10% after deductible	$2,500 admit copay, 30%after deductible	$2,500 admit copay, 80% after deductible
Inpatient Hospital *Facility & Physician*	10% after deductible	$4,000 admit copay, 30% after deductible	$4,000 admit copay, 80% after deductible
Outpatient Lab Services	10% after deductible	20% after deductible	80% after deductible
Outpatient X-rays & Diagnostic Services Facility & *Physician*	10% after deductible	30% after deductible	80% after deductible
Advanced Imaging *Physician*	10% after deductible	10% after deductible	80% after deductible
Advanced Imaging (MRI/CT, etc) Outpatient Facility	10% after deductible	30% after deductible	80% after deductible
Allergy Shots	N/A	30% after deductible	80% after deductible
Diabetes Self-Management Training	10% after deductible	30% after deductible	80% after deductible
Diabetes Education Group, Individual & Counseling	0% after deductible	N/A	N/A
Manipulations *(Limit 20 visits/year)*	10% after deductible	20% after deductible	80% after deductible
Skilled Nursing Facility *(Limit 120 days/year)*	N/A	30% after deductible	80% after deductible
Ambulance Services (Emergency)	N/A	20% after deductible	20% after deductible
Ambulance Services (Non-Emergency)	N/A	20% after deductible	20% after deductible
Outpatient Rehabilitation *(Authorization required after 25 visits/year - 36 for cardiac)*	20% after deductible	20% after deductible	80% after deductible
Bariatric Surgery *Facility*	10% after deductible	Not covered	Not covered
Bariatric Surgery *Physician*	10% after deductible	Not covered	Not covered

TMC Health Preferred Network (Tier 1)* coverage includes services performed at Tucson Medical Center, TMCOne, TMC Urgent Care, Benson Hospital, Northern Cochise Community Hospital, related clinics and other specific providers as determined by Benefits Administration. TMC Health Preferred Network (Tier 1)/Choice Plus Network (Tier 2) deductibles and Out-of-Pocket maximums cross apply. Refer to www.umr.com for the TMC Health Preferred provider list. TMC Health Preferred Network does not include all specialties and services.

Choice Plus Network (Tier 2) Coverage includes services performed by a UnitedHealthcare provider, but not at a TMC Health Preferred provider. TMC Health Preferred Network (Tier 1)/Choice Plus Network (Tier 2) deductibles and Out-of-Pocket maximums cross apply.

Out-of-Network (Tier 3) Coverage includes services performed at an Out-of-Network provider meaning the provider is not contracted with UnitedHealthcare.

**Embedded deductibles have two components: the individual deductible for each family member and the family deductible. See page 7 for details.

This table is updated annually and provides general information about the medical plans. For detailed information, refer to the specific benefits document or Summary Plan Description (SPD). In all cases the actual legal plan documents will govern and determine exact benefits.

2025 TMC Health Medical Plan Design

If a hospital-based medical service is not available at TMC Health, prior to receiving the service, please contact the Benefits Service Center for coverage information.

Benefits	BLUE Plan (HDHP)		
	TMC Health Preferred Network (TMC/TMCOne*)	Choice Plus Network (UHC)	Out-of-Network
Deductible *(single/family)*	$1,650 / $3,300	$2,300 / $4,250	$7,000 / $14,000
Out-of-Pocket Maximum *(includes deductible & copays)*	$2,500 / $5,000	$6,750 / $10,250	$14,000 / $28,000
**Embedded Deductible / Out-of-Pocket Maximum	No		
HSA Contribution	$500/$1000		
PHYSICIAN			
Preventive Care *(including immunizations)*	0% no deductible	0% no deductible	N/A
Primary Care Physician (PCP) / Telehealth Visit	10% after deductible	20% after deductible	80% after deductible
Specialist	10% after deductible	20% after deductible	80% after deductible
Retail / Convenience Clinic	N/A	20% after deductible	80% after deductible
Telemedicine (TMCOne)	10% after deductible	N/A	N/A
OTHER SERVICES			
Urgent Care	10% after deductible	30% after deductible	80% after deductible
Emergency Room *(Waived if admitted)*	10% after deductible	10% after deductible	10% after deductible
Outpatient Surgery *Physician*	0% after deductible	0% after deductible	80% after deductible
Outpatient Surgery *Facility*	10% after deductible	$2,500 admit copay, 30%after deductible	$2,500 admit copay, 80% after deductible
Inpatient Hospital *Facility & Physician*	10% after deductible	$4,000 admit copay, 30% after deductible	$4,000 admit copay, 80% after deductible
Outpatient Lab Services	10% after deductible	20% after deductible	80% after deductible
Outpatient X-rays & Diagnostic Services Facility & *Physician*	10% after deductible	30% after deductible	80% after deductible
Advanced Imaging *Physician*	10% after deductible	20% after deductible	80% after deductible
Advanced Imaging (MRI/CT, etc) Outpatient Facility	10% after deductible	30% after deductible	80% after deductible
Allergy Shots	N/A	30% after deductible	80% after deductible
Diabetes Self-Management Training	10% after deductible	30% after deductible	80% after deductible
Diabetes Education Group, Individual & Counseling	0% after deductible	N/A	N/A
Manipulations *(Limit 20 visits/year)*	10% after deductible	20% after deductible	80% after deductible
Skilled Nursing Facility *(Limit 120 days/year)*	N/A	30% after deductible	80% after deductible
Ambulance Services (Emergency)	N/A	20% after deductible	20% after deductible
Ambulance Services (Non-Emergency)	N/A	20% after deductible	20% after deductible
Outpatient Rehabilitation *(Authorization required after 25 visits/year - 36 for cardiac)*	20% after deductible	20% after deductible	80% after deductible
Bariatric Surgery *Facility*	10% after deductible	Not covered	Not covered
Bariatric Surgery *Physician*	10% after deductible	Not covered	Not covered

TMC Health Preferred Network (Tier 1)* coverage includes services performed at Tucson Medical Center, TMCOne, TMC Urgent Care, Benson Hospital, Northern Cochise Community Hospital, related clinics and other specific providers as determined by Benefits Administration. TMC Health Preferred Network (Tier 1)/Choice Plus Network (Tier 2) deductibles and Out-of-Pocket maximums cross apply. Refer to www.umr.com for the TMC Health Preferred provider list. TMC Health Preferred Network does not include all specialties and services.

Choice Plus Network (Tier 2) Coverage includes services performed by a UnitedHealthcare provider, but not at a TMC Health Preferred provider. TMC Health Preferred Network (Tier 1)/Choice Plus Network (Tier 2) deductibles and Out-of-Pocket maximums cross apply.

Out-of-Network (Tier 3) Coverage includes services performed at an Out-of-Network provider meaning the provider is not contracted with UnitedHealthcare.

**Embedded deductibles have two components: the individual deductible for each family member and the family deductible. See page 7 for details.

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OVERVIEW of Benefits

Pharmacy and Prescription Coverage

Administered by Alluma

Our prescription provider is Alluma. You must be enrolled in one of TMC Health's medical plans in order to participate in this pharmacy benefit. Mail order services are also available through Alluma's preferred mail order pharmacy, Mayo Clinic Pharmacy Mail Service.

TMC Pharmacy provides service and some cost savings

The TMC Pharmacy usually offers the lowest employee cost for prescriptions for employees covered under the medical insurance plans. The TMC Pharmacy can save you money and provide the added convenience of having your prescriptions filled where you work. The pharmacy will be happy to transfer your existing prescriptions from another pharmacy to TMC Health. Please contact the TMC Pharmacy, (520) 324-1890 or (520) 324-2520, for more information about its products and services.

Understanding Tier Levels

Tier 1 medications are typically generics or drugs covered at the lowest member cost share.

Tier 2 medications are typically preferred or formulary brands.

Tier 3 medications are typically non-preferred or non-formulary drugs.

If you currently are taking brand-name medications, ask your doctor if there is a generic medication that may be right for you.

Obtaining 93-day supplies

For established maintenance prescriptions you must have a valid 93-day prescription from your provider. You may then fill these prescriptions at the TMC Pharmacy and/or Mayo Clinic Mail Service.

Formulary List

The Alluma Advantage Formulary is developed through a Pharmacy & Therapeutics Committee and Clinical Advisory Board based upon clinical and economic information and decisions. To access the formulary, you may go to *www.allumaco.com* or call the toll-free number on your Member ID card. It is also available on the Benefits homepage through eConnection.

The Alluma Advantage Formulary lists the applicable tier of the medication and other important information about the medication, including: utilization management programs (step therapy, prior authorization), specialty pharmacy status and brand/generic status. In addition, the formulary shows alternatives for excluded medications.

Pharmacy Prior Authorization Process

Some medications are subject to prior authorization or quantity limitations. The Alluma Advantage Formulary includes codes for the medications subject to these guidelines. If you are taking one of these medications, have your physician contact Alluma prior to going to the pharmacy to purchase the medication. If you find out your medication can't be filled when you are at the pharmacy, contact your physician immediately and ask for assistance. Alluma uses FDA guidelines to establish these limits.

Specialty, Tier 3 (T3) and Non-Specialty Restricted Drug Program

Certain medications are considered "specialty" medications. These medications are generally high-cost, injectable, oral or inhaled that may or may not require ongoing clinical oversight, have unique storage or shipping requirements, and have no generic alternatives. Specialty medications include treatments for cancer, certain rheumatoid arthritis treatments and treatment for other conditions. The TMC Pharmacy provides care coordination for members with chronic and complex conditions that are often life-threatening or debilitating. Members are provided support through clinical management programs.

Please review the Alluma Advantage Formulary for the medications designated as Specialty and Tier 3 (T3) medications as these are required to be filled through the TMC Pharmacy. In addition, your medication may be on our Non-Specialty Restricted Drug List, and the specific drugs on this list are also required to go through the TMC Pharmacy. As referenced above, the TMC Pharmacy has a Medication Therapy Management (MTM) Program, where the member can visit with a Pharmacist or other provider (depending on the specific medication) either in person or virtually on a one-time annual basis. Your drug may require this appointment so please contact the TMC Pharmacy at (520) 324-1890 to determine if you need to schedule an MTM appointment. To schedule the MTM appointment please call (520) 324-5233. Please review the Benefits Homepage for all related formularies and drug lists. MTM appointments are available to all plan members.

Lower the Cost of Your Prescriptions

TMC Health works with RxSS to help you manage the rising cost of prescription drugs. This free and confidential service connects with your TMC Health prescription plan to show you all the lower-cost options you have for your medications. RxSS does not replace your AllumaRx prescription plan; it's an additional program designed to help you and your family save money.

How it Works:

1. RxSS pharmacists find equally effective, affordable medications covered by your TMC Health prescription plan.
2. Your online account lets you compare prices and all your options. It will automatically list any medications you've filled so you can easily manage everything from one place.
3. RxSS will contact you when you're spending too much on medications you're currently taking or new ones you're prescribed in the future.
4. Switching to a more affordable prescription is easy. RxSS will work with your doctor to get their approval on any changes that will save you money.

(800) 268-4476
Visit *www.rxsavingssolutions.com* for more information and register at *www.myrxss.com*

rxss® Rx Savings Solutions

Mobile App Version

TMC Pharmacy

TMC Pharmacy stocks a wide variety of medications and can provide these medications to our members, often at a lower cost than other pharmacies. All employees are encouraged to have their medications filled at the TMC Pharmacy.

ALL Specialty / Tier 3 (T3) drugs as designated in the Alluma Advantage formulary are required to be filled at the TMC Pharmacy. In addition, other non-specialty drugs may be restricted to be filled at the TMC Pharmacy. Please call the TMC Pharmacy at (520) 324-1890 to inquire about your specific prescription.

Refer to the Alluma Advantage Formulary for the applicable tier level of medications, including those designated as specialty drugs, and other important information. Please also refer to the RX plan design for your TMCH medical insurance coverage as there are varying costs between Tier 1 and Tier 2.

Additional details are available on the Benefits Homepage on **eConnection**.

TMC Pharmacy

5310 E. Grant Road, Tucson, AZ 85712
(Conveniently located across from TMC with drive thru)

Phone: (520) 324-1890 **Fax:** (520) 324-2529

Medication Therapy Management (MTM) Appointment Line: (520) 324-5233

Some medications require an annual visit with a pharmacist or other provider, please call the TMC Pharmacy to determine if a MTM appointment is needed. MTM appointments are available for all members.

Hours: Monday – Friday, 8 a.m. – 9 p.m.
Saturday/Sunday 9 a.m. – 3 p.m.
Limited hours on all major holidays.

Of note, HIV, Contraceptive, and ACA mandated medications may be filled at any pharmacy, TMC Pharmacy or Mayo Clinic Specialty Pharmacy (1-800-337-3736) based on member preference.

OVERVIEW of Benefits *(continued)*

2025 TMC Health Prescription Plan Design

	TEAL PLAN		PURPLE PLAN		RED PLAN		Yellow Plan	Blue Plan
31-DAY SUPPLY	**TMC Pharmacy**	**All Others**	**TMC Pharmacy**	**All Others**	**TMC Pharmacy**	**All Others**	**Any Contracted Pharmacy**	
ACA Mandated Preventive Prescription	100% covered	100% covered	100% covered	100% covered	100% covered	100% covered	100% covered, deductible waived	
Generic (T1)	$5 copay	Must use TMC Pharmacy for all non-limited distribution drugs – Members pay 100% of cost of medications filled outside of TMC Pharmacy (these costs will not apply to deductible and out of pocket maximums)	$15 copay	**$30 copay**	$15 copay	**$25 copay**	Preventive (on approved list*): 10% NO deductible	
Preferred Brand Name[1] (T2)	35% to a $45 maximum		35% to a $75 maximum	35% to a $100 maximum	35% to a $60 maximum	35% to a $80 maximum		
Non-Preferred Brand Name[1] (T3) - MUST USE TMC	50% to a $100 maximum		50% to a $200 maximum	50% to a $250 maximum - **Limited Distribution (LD) meds only**	50% to a $150 maximum	50% to a $200 maximum - **Limited Distribution meds Only**	Non-Preventative medications: 10% after Tier 1 deductible	
SPECIALTY (SP) DRUG PROGRAM 31-Day Fills Only	20% to a $175 maximum ONLY TMC Pharmacy		20% to a $250 maximum ONLY TMC Pharmacy	**Must use TMC Pharmacy for all non-limited distribution drugs**	20% to a $250 maximum ONLY TMC Pharmacy	**Must use TMC Pharmacy for all non-limited distribution drugs**	10% after deductible ONLY TMC Pharmacy	
Weight Loss medication 31-Day Fills Only	$175 Copay		$250 Copay	$500 Copay	$250 Copay	$500 Copay	$250, after deductible at TMC Pharmacy	$500, after deductible outside of TMC
93-DAY SUPPLY	**TMC Pharmacy**		**TMC Pharmacy**	**Mail Order Only**	**TMC Pharmacy**	**Mail Order Only**	**Any Contracted Pharmacy[2]**	
Generic (T1)	$10 copay		$20 copay	**$50 copay**	$20 copay	**$40 copay**	Tier 1 Deductible and Out-of-Pocket Maximums apply	
Preferred Brand Name[1] (T2)	25% to a $90 maximum		25% to a $150 maximum	25% to a $200 maximum	25% to a $120 maximum	25% to a $160 maximum		
Non-Preferred Brand Name[1] (T3) - MUST USE TMC	40% to a $200 maximum **ONLY TMC Pharmacy**		40% to a $300 maximum	40% to a $450 maximum **Limited Distribution (LD) meds only**	40% to a $300 maximum	40% to a $400 maximum **Limited Distribution (LD) meds only**		

[1] Specific non-specialty medications may require fills be completed at the TMC Pharmacy. If these prescriptions are filled outside of the TMC Pharmacy they may not be covered by the plan. Please see the Non-Specialty Restricted Drug List available on the Benefits Homepage via eConnection (Benson/NCCH - Contact HR / Benefits Department) for what medications fall under these requirements. In addition, please review the Alluma Advantage Fomulary to see what Tier level your medication falls under or if it is designated as a Specialty or T3 drug as both are also required to be filled at the TMC Pharmacy.

***Alluma mail order pharmacy services are provided by Mayo Clinic Pharmacy – Mail Service.*

[2] TMC Pharmacy offering 20%-30% discount off of medications filled at TMC for Yellow and Blue plan members.

LIVE WELL Credit (LWC)

This program is designed to reward employees with a medical insurance premium credit by taking preventive-health action steps and adopting healthy behaviors. Actions are typically completed the year prior to the award period.

2025 Live Well Credit (LWC)

The earning period runs Jan. 1 to Nov. 30, 2024 with wellness physical exam and lab work accepted for December 2024. The maximum credit amounts are $400 per employee. Credit may be earned for completion of the TMC Health Live Well Credit program based on national targets or improved numbers. Employees who are newly eligible for medical insurance will earn the full credit when completing the program for the first time. Employees who were previously eligible for the program who have not yet participated may complete the program as newly eligible employees.

TMC Health Live Well Credit Program

This program is designed to help you understand your current health status and make positive lifestyle and behavioral changes that may reduce your health risks and save you money.

The program offers the following benefits:

- An opportunity to learn about your potential health risks
- The ability to work with your doctor to establish a personalized treatment plan
- Ways to manage your current health based on health screenings and physician recommendations
- A chance to reduce your health risks so you can live a healthier lifestyle

Achieving Goals – Onsite Health Coaching

In addition to the variety of telephonic wellness coaching options available to medical plan participants, TMC Health offers all employees to work one-on-one with a personal health coach for assistance in achieving goals. Personal and small group coaching sessions are available throughout the year. View information on eConnection for registration.

2026 Live Well Credit (LWC)

Earning period is Jan. 1 to Nov. 30, 2025 with wellness physical exam and lab work accepted for December 2024. Remember that dollars will only be awarded by completing the program (see program information below).

Questions may be directed to the TMC Health Benefits Service Center (520) 324-5275, Option 4 or via email at *AskBenefits@tmcaz.com* or TMC Health Wellness, (520) 324-4163 or via email at *wellness@tmcaz.com*.

SECTION 1 – REQUIRED

Must complete all items in Section 1 in order to qualify for Participation Credit

	Employee Credit Amount
Complete **Doctor Verification Form** and include copy of **Lab Results**	$150
Lab Results / Goal Achievement	$150
Total Possible Credit (Section 1)	**$300**

*Achievement includes meeting the target/standard or the guideline for clinical improvement *(see below)*

- Keep copies of your Doctor Verification Form and Lab Results for your own records.
- Please refer to the Live Well Credit page on eConnection and FAQs for additional details.

SECTION 2 – PARTICIPATION CREDIT

Participation credits can be earned anytime throughout the year, but they will only be valid for credit if Section 1 has been completed before Nov. 30, 2025. Section 1 includes: Doctor Verification Form and a copy of your Lab Results.

You may complete up to 2 activities to earn a maximum of 2 credits at $50 each. (2 x $50 = $100 maximum participation credit per employee.)

Ongoing and Q1-Q4 Live Well Participation approved self paced activities are always being updated and can be found at *https://econnection.tmcaz.com/s/Livewell/Pages/Home.aspx*

Total Possible Credit (Section 1 + Section 2)
$400 for Employee

TMC Live Well
Everyone Can Do It.

All plan members must complete all the following steps to earn credits:

- Obtain lab work through health care provider and obtain a copy of lab results
- Visit provider for annual physical wellness exam and complete Doctor Verification Form
- See eConnection's Live Well Credit page for a helpful checklist and various submission options.

Visit eConnection's Wellness Department page for more information on wellness offerings as well as the Live Well Credit program. Email: *wellness@tmcaz.com.*

OVERVIEW of Benefits *(continued)*

Dental Insurance Plans

TMC Health offers two dental plans from which to choose.

Employees in positions with assigned hours of 30 or more per week will have a portion of the dental insurance premiums paid by TMC Health. The employee cost depends on the dental coverage you elect and your employment status.

Employees in positions with assigned hours of less than 30 hours will pay the full dental insurance premium.

DHMO Plan Administered by Employers Dental Services (EDS)

EDS is a prepaid dental care organization that has committed to delivering dental care at an affordable cost. You must use a dentist that is contracted with EDS to receive benefits. Services provided by a general dentist are covered for a copay. Services provided by specialists are at a 25% discount of their fee schedule.

PPO Plan Administered by MetLife

The MetLife PPO plan allows covered members to receive care from any licensed provider and have claims paid based upon reasonable and customary charges. Under the PPO plan, if you access a Preferred Provider utilizing the PDP PLUS network from the MetLife contracted network you will minimize your expense.

TMC Health Dental Plan Design

DENTAL PLANS: TWO CHOICES		
BENEFITS	EDS PLAN	METLIFE PPO PLAN
Deductible	No deductible	$50 Single/$150 Family
Payment	Fee schedule	Pays a specific percentage of reasonable and customary charges with some deductibles
Dentists	Must use EDS dentist	May use MetLife PPO dentist or may go outside the network
ELIGIBLE EXPENSES		
Preventive	$5 office visit and paid on a fee schedule	100% / no deductible
Basic amalgams		20% coinsurance after deductible
Major services, such as crowns		50% coinsurance after deductible
Orthodontia	Discounts available	50% up to $1,500 lifetime benefit maximum
Maximum annual benefit per person	N/A	$2,500

OVERVIEW of Benefits *(continued)*

Vision Plan

Administered by MetLife Vision

Employees can choose to enroll in the Voluntary Vision Plan that pays for selected lenses, frames, contacts and complete eye examination every year.

Employees receive discounts on additional eyewear including discounts on lens options and upgrades. MetLife Vision has a nationwide network of refractive surgeons who offer discounts on LASIK surgery.

Employees have a choice of using in-network providers contracted with MetLife Vision or out-of-network providers. When using out-of-network providers, the copay will be deducted from the out-of-network reimbursement.

TMC Health Vision Plan Design

BENEFITS	METLIFE IN-NETWORK	METLIFE OUT-OF-NETWORK
Refractive Eye Exam (once in a 12-month period)	MetLife providers will be covered at a $10 copay. All other providers - the $10 copay will be deducted from the out-of-network reimbursement.	
Frames and lenses (once in a 12-month period)	Selected lenses and frames will be covered at the $10 copay at MetLife providers. Most providers have a $150 allowance (except Costco, Walmart and Sam's Club have an $85 allowance). See Benefit Summary for details.	
Contact Lenses (once in a 12-month period)	$150 retail allowance in lieu of frames and lenses.	

Note: An eye examination is available with the medical coverage every two years through a UnitedHealthcare network provider for those employees not selecting the vision plan.

Employee Assistance Program (EAP)

Administered by Optum (part of UnitedHealthcare group)

Call (855) 205-9185, 24 hours a day, seven days a week
All employees, their dependents and their household members are eligible for this benefit from date of hire. Optum's EAP gives you and your family access to a wide range of tools and resources to help you balance work and life, improve health and wellness, and enhance emotional well-being. From managing stress to coping with trauma to working out your personal finances, Optum provides expert support – and representatives are available around the clock every day of the year to provide professional clinical support in the event of an emotional crisis.

Employee Assistance Program

24/7 access to clinicians for topics such as:

- Marital, relationship and family concerns
- Stress, anxiety and sadness
- Alcohol
- Substance use
- Work problems

Call (855) 205-9185

Optum

Stress less, sleep better and live more mindfully

To register and download the app, scan the QR code for the Calm registration page and enter your company access code **TMCH2775**

Plan Highlights

- Up to six face-to-face, telephonic or web-video clinical EAP counseling sessions per issue per year (with unlimited issues) for help coping with stress, anxiety, grief, family and relationship issues, and other emotional health issues.
- Talkspace: Support when you need it —no appointments necessary. With Talkspace, you can reach out to a licensed, in-network EAP provider, 24/7. To get started, call your EAP to obtain an authorization code.
- Interactive e-learning programs packed with strategies and tips you can use right away to make strides in personal finance, health and wellness, personal development and stress management.
- Legal consultation and mediation services include a free 30-minute consultation, per separate issue, with a state-specific attorney. Ongoing consultation is available at a 25% discount.
- Financial consultation includes up to 60-minutes of telephonic consultation, per separate issue, from a credentialed financial professional.
- Broad-ranging work and life services that can help you get out of debt, solve legal problems or just balance everything on your to-do list.

Expert Clinical Support

With Optum, you have a large network of psychologists, psychiatrists, clinicians and mental health specialists from which to choose. You can call Optum for help selecting the provider who's right for you, or you can take advantage of its online provider search. *www.liveandworkwell.com*

FLEXIBLE SPENDING ACCOUNTS (FSA)

Administered by HealthEquity

Flexible Spending Accounts offer you another way to reduce your taxable income.

Healthcare Spending Account – allows you (and your eligible dependents) to pay for many health care expenses such as deductibles, copays and some over-the-counter costs.

Dependent Care Spending Account – allows you to pay certain dependent care expenses such as child care providers, nannies and adult care services.

Here's how these accounts work:

- You can contribute to one or both FSA accounts through payroll deduction on a pre-tax basis, reducing your taxable income.
- Employees selecting a Health Savings Account are only eligible for a Limited Purpose FSA as well as the Dependent Care FSA.
- Submit eligible expenses with a claim form to be reimbursed from your account.
- Your reimbursement check is not taxed and will be mailed (or direct deposited).
- Eligible dependents are those under the age of 13, unless disabled.

If you elect to enroll in any FSA option, some of the administrative conveniences provided to you will include: account access via the web, claims submission via toll-free fax and direct deposit of reimbursements to your bank account.

Find information about the use and benefits of your FSA at ***https://myspendingaccount.wageworks.com.***
On this site you will find:

- Health care and dependent care claim forms
- Expense substantiation form (credit card)
- Direct deposit authorization
- A list of all eligible expenses

While the HealthEquity FSA web portal is the best place to start looking for information, if you are unable to find the answers for which you are looking online you may call Participant Services, (855) 692-2959 (8 a.m. – 8 p.m. EST). Automated account information is also available 24 hours a day using this same phone number.

NOTE: Effective Jan. 1, 2020, all employees whose annual salary exceeds $100,000 will be ineligible to participate in the dependent care and health care FSA plans.

Stored Value (Credit) Card – Healthcare FSA participants receive a Stored Value Card to access FSA funds. Save your receipts, as you may be required to submit expense substantiation (form plus receipts).

Submitting a Claim – Please submit a claim at *https://myspendingaccount.wageworks.com.* Please allow four business days for processing and the reimbursement release.

View Your Account Online. To establish access to your FSA account online, go to *https://myspendingaccount.wageworks.com*, select the "First time Participants must Register" link and follow the prompts to establish a unique username and PIN.

Minimum/Maximum Contributions. The minimum and maximum contributions to your FSA are as follows:

	ANNUAL MINIMUM	ANNUAL MAXIMUM
Healthcare or Limited Purpose FSA	$300	$3,200
Dependent Care FSA	$120	$5,000

The Dependent Care FSA maximum is limited to the smallest of the following amounts:

- $5,000 if the employee is married and filing a joint return or if the employee is a single parent ($2,500 if the employee is married but filing separately);
- The employee's earned income for the year; or
- The spouse's earned income, if the employee is married at the end of the taxable year.

Choosing the Right Contribution Amount. It is important to calculate the right amount to contribute to an FSA account. IRS rules state that if an employee does not use all of the money in the account by Dec. 31 of the same year those unused funds will be forfeited.

Employees should not contribute more than they expect in expenses to the Healthcare FSA and Limited Purpose FSA. You must use it or you will lose it, except for up to $640 that you may roll over to the following year. Employees do not have to re-enroll to carry over. Any amount over $640 of unused funds will be forfeited. Remember, expenses can be incurred by an employee, spouse or any eligible dependent. You have until March 31 of the following year to submit all your prior year FSA claims for reimbursement.

FLEXIBLE SPENDING ACCOUNTS (FSA) *(continued)*

Limited Purpose Flexible Spending Account

ONLY for those participating in the HSA

If you enroll in the Blue or Yellow plan (HDHP), and participate in the Health Savings Account (HSA), you are eligible for a Limited Purpose FSA.

The Limited Purpose FSA is a Medical Flexible Spending Account designed to allow HSA participants to set aside pre-tax funds to pay for specific out-of-pocket expenses rather than using their HSA accounts.

Funds in the Limited Purpose FSA cannot be used to pay for all medical expenses, but may be used for dental care and vision care expenses.

Employees MUST re-enroll in an FSA to continue participation. This benefit election does not continue without enrollment each year.

LIFE INSURANCE Plans

Basic Life (Group Term Life)

Administered by Lincoln Financial Group (LFG)

TMC Health provides all benefits-eligible employees with a Basic Life Insurance benefit equal to two times their base annual salary, rounded to the next highest multiple of $1,000, to a maximum of $250,000. *For example:* if your annual salary is $20,800, your benefit coverage would be $20,800 x 2 = $41,600 rounded to $42,000. This formula applies to all eligible employees up to a maximum of $250,000.

TMC Health pays the full cost of the Basic Life coverage, meaning there is no premium cost to you.

- If you become disabled, you may apply for a premium waiver and an accelerated death benefit, if applicable.
- Your benefit will be reduced to 70% upon turning 70.

Life Insurance Continuation Options

You may have the option to port or convert your life insurance coverage (Basic and Voluntary/Supplemental Life) with LFG upon termination of employment or loss of coverage. You need to contact LFG, (877) 321-1015, within 31 days to obtain an application for coverage.

Imputed Income

Basic Life (Group Term Life) amounts more than $50,000 are subject to imputed income. Employees whose coverage through this plan exceeds the allowable exclusion of $50,000 are subject to imputed income as required by Section 79 of the Internal Revenue Code. Imputed income is calculated monthly, based on each $1,000 of coverage greater than $50,000. The value of this coverage is based on your age.

If you are subject to imputed income for your group term life, you may see on your pay statement imputed income as an employer-paid taxable benefit. This amount is not a deduction, but is used to calculate taxes based on the Omnibus Budget Reconciliation Act of 1987 (OBRA), which requires employers to calculate FICA and FHI tax on imputed income. FICA and FHI taxes are deducted from your pay and included in your FICA and FHI deductions on your pay statement.

Death of an Employee or Dependent

In the event of the death of an employee or dependent, the beneficiary should contact the Benefits Service Center at the earliest possible convenience. The beneficiary will be asked to provide a certified death certificate and complete paperwork and send to LFG.

Voluntary/Supplemental Life

In addition to the Basic Life benefit provided to you at no cost, a Voluntary/Supplemental Life Insurance plan is offered to provide added flexibility for you and your family's life insurance needs. Employees may obtain Voluntary/Supplemental term life insurance on themselves, their spouse and/or dependents.

Guaranteed Issue Coverage

This insurance is guaranteed issue to newly hired/eligible employees. Employees who miss enrollment in their guaranteed issue timeframe may enroll at Open Enrollment and may be subject to an Evidence of Insurability (EOI) form. Spouses may be subject to an EOI form.

Note: If you apply for this benefit when first eligible, the guaranteed issue is the lesser of three times your annual compensation or $150,000 and the first $30,000 for your spouse. Your child may be insured for a maximum of $15,000 and your spouse for a maximum of $150,000 as long as this is not greater than your own Voluntary/Supplemental Life coverage. "Guaranteed issue" means you are not required to complete an EOI form.

Eligibility

Employees are first eligible for voluntary group term life insurance when they are newly hired or if a change in employment status makes them benefits-eligible.

Premium rates from status changes (PT to FT, FT to PT) are effective on the event date. Premium rate changes for Life and Disability are based on age and salary, and are effective on the pay period end date.

Newly hired/eligible employees

Newly hired benefits-eligible employees must enroll in the voluntary group term life insurance plan within 31 days of their date of hire or eligibility date to receive the guaranteed issue. Coverage is effective the first of the month following date of hire/job status change; therefore, retroactive premiums may apply.

If a newly hired/eligible employee does not enroll within 31 days of his or her date of hire, the employee is eligible to enroll at either Open Enrollment or after a qualified life or status change event, but he or she may not be eligible to receive the guaranteed issue. In this case, the employee may have to show Evidence of Insurability and complete an EOI form to obtain insurance coverage.

Continuing employees

If an employee is eligible but not enrolled in the voluntary group term life insurance, the employee may be required to complete an Evidence of Insurability form to obtain insurance coverage. Employees may only make changes during Open Enrollment or after a qualified event or status change.

Effective Date of Coverage

Your guaranteed issue amount is effective the first of the month following your date of hire or newly eligible status once you complete your enrollment. Retroactive premiums may apply. The insurance above your guaranteed issue amount and your spouse's guaranteed issue insurance, or any amount subject to Evidence of Insurability / Medical Questionnaire will be effective following approval of the applications by the insurance carrier.

Facts You Should Know About Voluntary Group Term Life Insurance

- **You must cover yourself in order to elect spouse or child life insurance.**
- You may provide spousal insurance up to the same amount of insurance that you carry for yourself up to $150,000.
- Insurance is available in multiples of your base salary up to $750,000 or a maximum of six times your annual salary, whichever is less.
- An EOI form is required if you are electing coverage other than when newly eligible or electing amounts for yourself and your spouse above the guaranteed issue. Only exception is when a salary increase causes you to move above the guaranteed issue amount.
- As you age, you may move into a higher premium range.
- Children may only be covered up to age 26. A disabled child who is over age 26 may be enrolled if primarily supported by the employee and incapable of self-sustaining employment by reason of mental or physical disability. The insurance company may require proof of the continuation of such condition and dependence.
- Your spouse or dependent coverage cannot exceed your own coverage amount.
- You may, upon termination of employment, have the option to port or convert your life insurance with Lincoln Financial Group (LFG). You need to contact (877) 321-1015, within 31 days to obtain an application for coverage.

LIFE INSURANCE Plans *(continued)*

Designating a Beneficiary (Basic & Voluntary/Supplemental Life)

You must designate one or more beneficiaries to whom the insurance will be paid in the event of your death. To designate beneficiaries, log in to Benefits Self-Service, Benefits, Insurance Summary and click on Basic Life edit. If you choose to name children who are under age 18, then a guardian must be appointed to receive the benefit, or you may designate a trust. You may designate a percentage of benefit to be paid to one or more beneficiaries, or you may designate a primary beneficiary who would be the first person you name to receive death benefits and a secondary (contingent) beneficiary who would be next in line if the primary beneficiary cannot be located or is deceased. If you do not name a beneficiary or if you are not survived by one, benefits will be paid in equal shares to the first surviving class of the following: your spouse, children, parents, brothers and sisters, then your estate. Employee is automatically beneficiary for spouse and child(ren) life insurance policy.

LIFE	RATE - PER $1,000 PER MONTH
Employee/Spouse Voluntary Life Under Age 30	0.037
Employee/Spouse Voluntary Life 30-34	0.046
Employee/Spouse Voluntary Life 35-39	0.060
Employee/Spouse Voluntary Life 40-44	0.091
Employee/Spouse Voluntary Life 45-49	0.150
Employee/Spouse Voluntary Life 50-54	0.230
Employee/Spouse Voluntary Life 55-59	0.430
Employee/Spouse Voluntary Life 60-64	0.513
Employee/Spouse Voluntary Life 65-69	0.959
Employee/Spouse Voluntary Life 70+	1.994
VOLUNTARY - CHILD LIFE (FLAT RATE)	
$2,500	0.333
$5,000	0.417
$7,500	0.791
$10,000	1.250
$15,000	1.583

EXAMPLE

Employee - Age 35
Salary: $31,200/year

Rate	0.060
3x Salary Election	$93,600
Round Up to Next $1,000	$94,000
Volume on per $1,000 basis	$94,000/$1,000 = $94
Monthly Premium	$94 x 0.060 = $5.64
Per Pay Period Deduction	$5.64 x 12 / 24 = $2.82

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) Insurance Plan

Administered by Lincoln Financial Group (LFG)

The Accidental Death and Dismemberment (AD&D) insurance pays benefits to you or your beneficiaries if you die or are seriously injured in an accident according to the following chart:

LOSS DESCRIPTION	PLAN PAYS (INSURED)
Loss of life	Principal Sum
Loss of one member (hand, foot or eye)	50% Principal Sum
Loss of thumb and index finger	25% Principal Sum
Loss of two or more members	Principal Sum
Loss of speech and hearing in both ears	Principal Sum
Loss of either speech or hearing in both ears	50% Principal Sum
Quadriplegia	Principal Sum
Hemiplegia	50% Principal Sum
Paraplegia	75% Principal Sum
Uniplegia	25% Principal Sum

Facts You Should Know

- You may elect coverage for yourself only or for your family. Benefits for your dependents are based on the amount you elect.
- Insurance is available in multiples of your base salary up to $750,000 or a maximum of six times your annual salary, whichever is less.
- Children may only be covered up to age 26.
- Benefits reduce when an employee reaches age 70 on Basic Life Policy only

AD&D (VOLUNTARY ONLY)	RATE - PER $1,000 PER MONTH
Single Coverage	0.024
Family Coverage (EE + Sp + Ch)	0.041

EXAMPLE:

Salary: $42,135/year	Rate (Single): 0.024
2x Salary Election	$84,270
Round Up to Next $1,000	$85,000
Volume on per $1,000 basis	$85,000/$1,000 = $85
Monthly Premium	$85 x 0.024 = $2.04
Per Pay Period Deduction	$2.04 x 12 / 24 = $1.02

DEPENDENT COVERAGE	PRINCIPAL SUM (OF INSURED)
Spouse and each child, if insured person, spouse and children covered	Spouse 40%, each child 10%
Spouse, if insured person and spouse only covered	50% of insured person's principal sum
Each child, if insured person and children only covered	15% of insured person's principal sum

DISABILITY Plans

Voluntary Short-Term Disability

Administered by Lincoln Financial Group (LFG)

If you are unable to work due to a pregnancy or a non-work-related illness or injury, you may be eligible for short-term disability (STD) if you have elected to enroll in this voluntary benefit. (Any illness or injury that is work-related must be filed in Employee Health Services under workers' compensation.)

Guaranteed Issue of Coverage

This insurance is guaranteed issue to all employees. For all employees enrolling on or after Jan. 1, 2019 (including newly eligible), a pre-existing condition clause will apply. Any condition the employee has 6 months prior to the effective date of coverage may not be covered until the employee has been enrolled in the plan for 12 consecutive months. Employee may be eligible for a weekly benefit even if a condition is pre-existing. See certificate on the Benefits homepage for details.

Your short-term disability payment may be reduced by other income you are eligible to receive including employer-funded retirement plans. For more information see the Lincoln Financial Group Short-Term Disability Certificate on eConnection.

SHORT-TERM DISABILITY	PER $10 OF COVERAGE/ MONTHLY RATE
Under age 30	1.309
30-39	0.964
40-49	0.702
50-59	0.857
60 and over	1.023

EXAMPLE:

Employee - Age 49

Salary: $31,200/year ($2,600/month)

Rate	0.702
Weekly Salary	$31,200 / 52 = $600
Weekly Benefit	$600 x 0.60 = $360
Volume on per $10 basis	$360 / 10 = $36
Monthly Premium	$36 x 0.702 = $25.27
Per Pay Period Deduction	$25.27 x 12 / 24 = $12.64

Benefit Highlights

- Weekly Benefit: 60% of weekly base earnings, reduced by other income benefits, if applicable.
- Minimum Weekly Benefit: $50
- Maximum Weekly Benefit if Pre-existing Condition applies: $100
- Maximum Weekly Benefit if Pre-existing Condition does not apply: $2,000
- Maximum Duration of Benefits: 25 weeks
- STD may be reduced by the amount of compensation received by other sources such as retirement benefits, salary continuation, workers' compensation and veterans benefits.
- Elimination Period: Benefits begin for disability caused by illness or injury on the eighth day of disability; for hospitalization on the first day of disability.
- Pre-existing conditions may apply. Please refer to the certificate for specific details. Any condition the employee has 6 months prior to the effective date of coverage may not be covered until the employee has been enrolled in the plan for 12 consecutive months. Employee may be eligible for a weekly benefit even if a condition is pre-existing. See certificate on the Benefits homepage for details.

Benefit Cost

You pay 100% of the cost of this benefit. The cost is based on your salary and your age. See your Personalized Worksheet for applicable rates or see table for rate calculation example.

Disability Checks

Disability checks will be issued by LFG directly to you. These checks will NOT be TMC Health-issued payroll checks.

While You're Away

- No salary increases will be processed and no bonuses will be paid while you are on STD or workers' compensation. All applicable increases or bonuses will be processed or paid when you return to your regular position with no restriction in hours or duties.
- All qualified status changes (birth, adoption, death, marriage, divorce, etc.) that impact your benefits must be reported to the Benefits Service Center within 31 days.
- Accrued PTO/PST hours will be used in accordance with TMC Health's Leave of Absence policy.
- Time away from work on STD will concurrently reduce any Family Medical Leave Act (FMLA) allowance for which you may qualify, otherwise you will be placed on a Medical Leave of Absence (MLOA) for a period typically not to exceed six months (180 days) from your last day worked regardless of whether or not any of that time qualified for FMLA.

Note: You will pay the full cost for this benefit. The premium is deducted from your pay on an after-tax basis, so the benefits paid under the policy will be tax-free.

DISABILITY Plans *(continued)*

Long-Term Disability

Administered by Lincoln Financial Group (LFG)

TMC Health provides long-term disability insurance at no cost to employees who are assigned to a regular schedule of at least 24 hours per week.

Effective Date of Disability Benefits

You must first be disabled for 25 weeks due to an illness or injury (work- or nonwork-related). A separate form, including medical documentation of your health condition, must be completed. Approval or denial of your claim is determined by LFG. (If someone is enrolled in Voluntary STD we do not require a separate form, and it's a seamless transition.)

- "Illness" means an illness or disease causing total disability that begins while long-term disability insurance coverage is in effect.
- "Injury" means bodily injury resulting directly from an accident causing total disability that begins while long-term disability insurance coverage is in effect.

Definition of Disability

Due to a sickness, or as a direct result of accidental injury:

- You are receiving appropriate care and treatment and complying with the requirements of such treatment, and
- During the elimination period and the next 24 months are unable to earn more than 80% of your predisability earnings at your own occupation for any employer in your local economy, and
- You are unable to perform each of the material duties of your own occupation;
- After such period you are unable to earn more than 80% of your predisability earnings at any gainful occupation for any employer in your local economy; and
- Unable to perform the duties of any gainful occupation for which you are reasonably qualified taking into account your training, education and experience.

Disability Benefits

Long-term disability benefits are intended to replace 60% of your covered monthly earnings to a maximum of $12,000 per month. **Long-term disability benefits will be reduced by the amount of compensation you receive from other sources such as Social Security disability, workers' compensation and veterans benefits.**

Pre-existing condition clauses may apply, along with a maximum duration of benefits, based on age at time of disability.

SUPPLEMENTAL Benefits

Legal Plan

Administered by MetLife Legal

This benefit is available to newly eligible employees and can only be added or dropped during Open Enrollment.

MetLife Legal administers this plan and offers a wide range of personal legal services for employees, their spouses and dependents. The plan excludes business- and employment-related matters. This benefit is available through payroll deduction only. The plan includes:

- Unlimited telephone advice and office consultations on virtually any personal legal matter with a plan attorney of your choice.
- Preparation of wills, codicils, living wills and living trusts.
- Preparation of powers of attorney, deeds, promissory notes and mortgages.
- Representation for purchase, sale or refinancing of your primary residence; debt collection defense; civil litigation defense; tenant negotiations and eviction defense; name change; uncontested adoptions and guardianships.
- Lifestages Identity Restoration Services. This benefit provides the Participant with access to LifeStages Identity Restoration Services provided by IdentityForce, A TransUnion® Brand.

Automobile and Home Owners Insurance Plan

Administered by Farmers Auto & Home

This benefit provides group insurance rates for home, renters, auto, boat, motorcycle and recreational vehicles. This benefit is available only through payroll deduction. Call Farmers at (800) 438-6381, for more information. Deductions to be taken over 26 pay periods.

Accident Insurance

Administered by Lincoln Financial Group (LFG)

Accident insurance works to complement your medical coverage – and pays in addition to what your medical plan may or may not cover. It's coverage that provides a financial cushion for life's unexpected events by providing you with a lump-sum payment when your family needs it most. The payment you receive is yours to spend however you like. It pays if you have tests, receive medical services, treatment or care for one of more than 150 covered events as defined in your group certificate. This includes hospitalization resulting from an accident, and accidental death or dismemberment. "Hospital" does not include certain facilities such as nursing homes, convalescent care or extended care facilities. LFG's coverage offers these important features:

- Payments will be paid directly to you.
- You can enroll both yourself and eligible family members; domestic partner and domestic partner child(ren) are eligible.
- Your accident coverage is guaranteed, regardless of your health. There are no medical exams to take and no health questions to answer.
- This coverage is portable, meaning you can take it wherever you go.
- You can use your payment as you see fit.
- Once we receive all the information, claims are generally processed within 3-5 business days.
- No age limit if actively employed.

Coverage Level	Monthly Rates
EE Only	$6.96
EE + Spouse/DP	$10.80
EE + Child(ren)	$13.30
EE + Family	$20.74

Critical Illness Insurance

Critical illness insurance works to complement your medical coverage – and pays in addition to what your medical plan may or may not cover. It's coverage that provides financial support when you or a loved one becomes seriously ill. Upon initial diagnosis, it provides you with a lump-sum payment of $15,000 or $30,000 in initial benefits. If you are diagnosed with a different and subsequent covered illness at least 90 days after the diagnosis of the first critical illness, you will receive an additional Critical Illness benefit. The payment you receive is yours to spend however you like. LFG's coverage offers these important features:

If you meet the group policy and certificate requirements, **critical illness insurance provides you with a lump-sum payment upon initial diagnosis of these conditions:** full benefit cancer, stroke, advanced Alzheimer's disease, cancer, major organ failure, heart attack and more. There are 18 covered conditions along with 8 childhood diseases so please see your certificate of coverage for details.

- Your plan pays an additional 100% of the original benefit amount (recurrence benefit) if you are diagnosed with a covered illness again after a treatment-free period of 12 months.
- You can enroll both yourself and your eligible family members; domestic partner and domestic partner child(ren) are eligible.
- Your critical illness coverage is guaranteed, regardless of your health. There are no medical exams to take and no health questions to answer.
- It's easy to pay premiums through payroll deduction and the benefits will be paid directly to you.
- This coverage is portable, meaning you can take it wherever you go.
- Rates are shown monthly but are deducted from 24 paychecks.

Lincoln Financial Group (LFG) health screening benefit provides you coverage for taking care of your health.

You're likely already getting one of these health screenings annually, so why not receive a benefit for doing so? With LFG's health screening benefit, available with critical illness insurance, you'll receive $50 each calendar year you take one of the covered screenings or tests (maximum annual benefit $50). Some of the covered screenings/prevention measures are:

- Pap smear, colonoscopy, mammograms and more.
- For a complete list see a copy of your Plan Summary located on the Benefits homepage.

Note: *You will pay the full cost for this benefit. The premium is deducted from your pay on an after-tax basis, so the benefits paid under the critical illness policy will be tax-free.*

SUPPLEMENTAL Benefits *(continued)*

Critical Illness				
	Rate - Per Month $15k Option		Rate - Per Month $30k Option	
Attained Age	EE only/EE + Child(ren)	EE + Spouse/EE + Family (SP 50% of EE)	EE Only/EE + Child(ren)	EE + Spouse/EE + Family (SP 50% of EE)
<25	$4.66	$6.98	$9.30	$13.96
25-29	$4.96	$7.42	$9.90	$14.86
30-34	$6.60	$9.90	$13.20	$19.80
35-39	$8.56	$12.82	$17.10	$25.66
40-44	$12.90	$19.36	$25.80	$38.70
45-49	$19.06	$28.58	$38.10	$57.16
50-54	$25.96	$38.92	$51.90	$77.86
55-59	$36.60	$54.90	$73.20	$109.80
60-64	$52.80	$79.20	$105.60	$158.40
65-70	$73.96	$110.92	$147.90	$221.86
71-74	$104.56	$156.82	$209.10	$313.66
75+	$146.26	$219.38	$292.50	$438.76

Hospital Indemnity Insurance

Hospital indemnity insurance works to complement your medical coverage – and pays in addition to what your medical plan may or may not cover. It's coverage that can help safeguard your finances for life's unexpected events by providing you with a lump-sum payment when your family needs it most. The payment you receive is yours to spend however you like. It typically pays, as long as the policy and certificate requirements are met, a flat amount upon your hospital admission and a daily amount paid for each day of your stay (confined to the hospital). It also provides payment if you're admitted to or have to stay in an Intensive Care Unit (ICU), as well as other added benefits and services.

LFG's coverage offers these important features:

- You can enroll both yourself and eligible family members; domestic partner and domestic partner child(ren) are eligible.
- Your accident coverage is guaranteed, regardless of your health. It's easy to pay premiums through payroll deduction and the benefits will be paid directly to you.
- This coverage is portable, meaning you can take it with you wherever you go.
- Once we've received all the necessary information, claims are generally processed within 3-5 business days.
- Rates are shown monthly but are deducted from 24 paychecks.

Coverage Level	Monthly Rates	Covered Benefits
Employee Only	$16.96	$200 per day for confinement (ICU or non-ICU) up to 15 days $1,000 for admission (ICU or non-ICU); 1x per calendar year hospitalization can be for an accident or sickness.
Employee + Spouse/DP	$36.04	
Employee + Children	$33.04	
Employee + Family	$55.80	

NOTE: ***For Accident, Critical Illness and Hospital Indemnity benefits, please review the employee certificates located on the Benefits homepage or www.mylincolnportal.com as coverage limits vary by plan (e.g., pre-existing conditions, dependent coverage is equal to 50% of employee coverage amount or benefits reduction due to age. These benefits do not replace medical plan coverage).***

SUPPLEMENTAL Benefits *(continued)*

*Enrollment in the **Critical Illness**, **Hospital Indemnity** or **Accident** Insurance offerings through Lincoln Financial Group (LFG) requires coverage under a medical plan, even if not through TMC Health. These benefits are under limited benefit insurance policies and are a supplement to health insurance and are **not** a substitute for major medical coverage. They do NOT provide the minimum essential coverage required by the Affordable Care Act (ACA). Certificates and other legal documents related to this coverage are located on eConnection and should be reviewed as there may be coverage limitations. By submitting your enrollment, you are acknowledging that you have read the enrollment documentation and that all the information is true and complete to the best of your knowledge and belief. Changes are only allowed if you have a Qualifying Event/Status Change or at the next Open Enrollment period.*

Long-Term Care Insurance

Employees interested in obtaining information about Long-Term Care Insurance can contact the Lovitt & Touché Insurance Agency. Plans are available for employees, their spouses or domestic partners. Types of plans include Traditional LTCi, Indemnity LTCi and Combination Life / LTCi. Lovitt & Touché can provide you with brochures, education material and policy quotes. Please contact Frank Lesselyon, (602) 245-1661 or by email at *Frank.Lesselyong@MarshMMA.com*

Sick Child and Emergency Child and Adult Care Program

Administered by CorporateCARE Solutions, Inc.

TMC Health offers Backup Child and Adult Care to all benefits-eligible employees through CorporateCARE Solutions, Inc. CorporateCARE Solutions (CCS) is a national backup care provider that maintains a network of highly vetted care providers throughout the United States. This benefit enables you to go to work when you are experiencing a breakdown in family care (e.g., sick child, babysitter cancels, non-medical adult care need, etc.). CCS comes to you…so you can go to work! A professional caregiver will provide care in your home, hotel if traveling for business or anywhere in the United States your elderly loved ones reside. Care requests can be submitted up to 30 days in advance. All caregivers undergo a rigorous background check and have previous child/adult care experience.

TMC Health picks up the majority of the cost of this program. You can request care for 15 days/per year. You will be responsible for a minimal copay of $6/hour. The co-pay will not alter for child or adult care or the number of children. All copays are payable by credit card. There are no additional employee fees. There is a four-hour minimum for all care requests, regardless of the number of hours worked. You are expected to come to work on the day you utilize services. This program is closely monitored for misuse and any future usage could be denied.

Please note - You can still request a caregiver from Choice Options. Choice Options is one of the many care providers within the CCS network.

Pre-registration is a requirement. Please register as soon as possible to ensure availability of care providers in your serviceable ZIP code(s). Registration does not require you to utilize services. A complete list of policies and procedures is available in your employee portal once you have completed the registration process.

Be sure you fully understand the program guidelines before requesting services from CorporateCARE Solutions. *www.corporateCAREsolutions.com*

Pet Insurance

Offered through ASPCA Pet Health Insurance and underwritten by US Fire Insurance Co.

To help you manage the rising costs of veterinary care, we're proud to offer a special employee discount on an ASPCA Pet Health Insurance plan. With this discount, you'll save up to 10% on your base plan premium for eligible plans. That's in addition to our 10% multiple pet discount. Along with this valuable savings, here are some more great reasons to protect your pet with ASPCA Pet Health Insurance:

- Choose from four increasing levels to cover your dog or cat for accidents, illnesses, wellness care, ongoing conditions and more.
- Use any licensed veterinarian in the United States or Canada. Just pay for the services at the time of the visit and submit our simple claim form with your receipts.
- Enjoy convenient online account access, simple claim filing and excellent customer service—all from a trusted source.

To take advantage of this benefit, visit *www.aspcapetinsurance.com/tmc* and enter the TMC Priority Code: EB14TMC to start your free quote. Then you can enroll quickly and easily online. Your discount will be applied to your base plan premium automatically.

If you need help or have any questions, please feel free to call (866) 861-9092 Monday to Friday 8 a.m. to 9 p.m. EST and Saturday 9 a.m. to 5 p.m. EST. Don't wait until something unexpected happens. Save on valuable protection for your pet today!

RETIREMENT Savings Plan 401(k)

Administered by T. Rowe Price

The TMC Health 401(k) Plan allows you to contribute up to $23,500 on a pre- or post-tax basis.*

There are multiple investment funds to choose from, ranging from high-risk/reward to low-risk/reward opportunities.

An automatic 401(k) enrollment is in effect for all employees hired or rehired on or after Jan. 1, 2008. You will automatically be enrolled in the 401(k) plan with a 6% payroll deduction (pre-tax) commencing approximately 30 days following the date that you become eligible to participate in the plan (usually date of hire). Your deferrals will be invested in the age-appropriate retirement fund (Target Date Fund). If you do not wish to participate in the 401(k) plan you must contact T. Rowe Price and opt out.

Deductions are taken from your paycheck and your savings accrue on a pre-tax or post-tax (Roth) basis.

T. Rowe Price is the fund manager for the TMC Health 401(k) Plan and handles all transactions.

Please contact T. Rowe Price, (800) 922-9945, or access your account information at *rps.troweprice.com* for any of the following transactions:

- Enrolling
- Changing your contribution rate (including Roth contributions)
- Receiving general account information
- Changing your investment allocation
- Taking out a loan
- Changing or getting your PIN/password
- Changing beneficiaries

Designating a Beneficiary

You must designate one or more beneficiaries to whom the benefit will be paid in the event of your death. To designate beneficiaries, log into ***rps.troweprice.com*** to update online or print out beneficiary forms. If you choose to name children who are under age 18, then a guardian must be appointed to receive the benefit. You must designate your spouse as your primary beneficiary, unless he or she signs a waiver form allowing you to designate someone else. Your primary beneficiary is the first person to receive death benefits. Your spouse will automatically receive your benefits in the event of your death, but it is still important to designate by name in case you have been married multiple times. You may also name a secondary (contingent) beneficiary or beneficiaries who would be the next in line if the primary beneficiary cannot be located or is deceased. If you do not name a beneficiary or if you are not survived by one, benefits will be paid as determined by the carrier and/or your plan administrator.

Vesting Period

You are always 100% vested in your own contributions. This means you take 100% of your contributions with you if you leave TMC Health.

You are 100% vested in TMC Health's matching contributions (employer monies) after you have completed two years of service from date of hire or professional service date (re-hires only). This means 100% of TMC Health's matching contribution belongs to you.

Please refer to the Summary Plan Description (SPD) for more information. Prospectuses are available through T. Rowe Price by requesting to have them mailed to your home or you may view them online using T. Rowe's website *rps.troweprice.com*. The SPD is also available on TMC's eConnection Employee Benefits homepage.

Maximum Contributions and Catch-Up Contributions

Maximum pre-tax or post-tax (Roth) contributions to 401(k) plans may continue to increase over the next few years. Additionally, if you are age 50 or older, a catch-up contribution of $7,500* is available through the 401(k) plan.

Please contact T. Rowe Price, (800) 922-9945, for specifics about this benefit.

Catch-up contributions must be elected separately from your regular contribution amount.

Maximizing the Employer Match

With your first contribution TMC Health matches 50% of an employee's deferrals on a pay period basis up to 6% of an employee's compensation. The match is discretionary so TMC Health is not obligated to continue the match or match at the same rate. To maximize the TMC Health match, an employee should elect to defer a minimum of 6%. Match contributions will be "trued up" for employees after the last contribution for the plan year. To be eligible for the "true up," you must be employed on the last day of the plan year (Dec. 31).

*Annual maximum subject to change each plan year as determined by the IRS code. See the Benefits Homepage for annual plan limitations by year.

Effective Jan. 1, 2021 NEWLY Hired/Rehired Per Diem employees will no longer be eligible for match:

- Per Diems can still contribute to the 401(k) on a pre-tax or after-tax basis (Roth)
- Per Diems will still be auto-enrolled at 6% (and can opt out, increase or decrease their contribution percentage)

Those who were receiving match or were active employees (participating or not) prior to Dec. 31, 2020, will be **grandfathered**. The grandfathered flag is based on employment dates and will only be removed upon termination.

Example 1: If hired in Dec. 2020 (Core), EE is eligible for match, but then transfers to Per Diem in Feb. 2021, still eligible for match (grandfathered).

Example 2: if hired in April 2021 (Core), EE is eligible for match, but then transfers to Per Diem in July 2021, NOT eligible for match (not grandfathered).

RETIREMENT Savings Plan 401(k) *(continued)*

Payment of Benefits Prior to End of Employment

The TMC Health plan does not permit an employee to receive payment of any portion of his or her account balance for any reason, unless he or she terminates employment or meets the withdrawal conditions as described below.

Prior to end of employment, an employee may elect to withdraw all or any portion of his or her account under the plan if he or she has attained age 59½. If an employee has not attained age 59½, he or she may elect to withdraw a portion of his or her Employee Deferral Contributions Account (other than earnings) if he or she incurs a hardship or becomes disabled.

For more detailed information on the rules governing TMC Health's 401(k) plan, please refer to the plan's Summary Plan Description (SPD) located on T. Rowe Price's website *rps.troweprice.com* or on TMC Health's eConnection Employee Benefits homepage. Human Resources can also provide a copy upon request.

Eligibility

All employees are eligible to participate in making pre-tax or post-tax contributions. TMC Health begins matching a portion of your contribution with your first contribution.

WORKERS' COMPENSATION Insurance

TMC Health provides compensation for loss of salary and medical care under the Arizona Workers' Compensation statutes for injuries or illnesses that arise from and within the scope of employment.

TMC Health is self-insured for workers' compensation insurance. All work-related injuries must be evaluated at Employee Health Services. If necessary, you will be referred through Employee Health Services for specialist care.

- If you are injured while at work, the incident should be reported immediately to the supervisor or person in charge, and an online injury report needs to be completed.
- Complete injury report via eConnection: under Clinical Territory select Quality Alert, click on the image (green guy with hello head), sign in, click on employee event (green square with white T-shirt) and enter incident.
- Serious injuries should report to the TMC Health Emergency Department with immediate follow-up at Employee Health Services.
- Hours of operation are Monday to Friday, 7:30 a.m. to 3 p.m. The direct line is (520) 324-5291.

It is your responsibility to work within the restrictions prescribed during your healing process.

TUITION REIMBURSEMENT

TMC Health recognizes that the skills and knowledge of its employees are critical to the success of the organization. To that end, the Tuition Reimbursement program encourages employees to improve their job-related skills and enhance their ability to compete for reasonably attainable jobs within TMC Health. Core employees in good standing who have worked at TMC Health for at least 6 months may be eligible for up to $6,500 per calendar year, not to exceed a $16,000 lifetime maximum.

Acceptance into the Tuition Reimbursement program does not guarantee a future position at TMC Health in that field of study. Tuition reimbursement is not intended to cover expenses incurred to attend professional seminars or conferences, nor to prepare for, obtain or maintain licenses, certifications or designations.

Additional information including forms and policies related to this program may be found on eConnection or by contacting Human Resources at (520) 324-4526.

ACCRUAL RATES for Paid Time Off (PTO) and Paid Sick Time (PST)

Core Employee Accrual Rates				
Years of Service	Accrual per Hour Paid	Maximum Per Pay Period Accrual (based on 80 hours)	Maximum Annual Accrual (based on 2,080 hours)	Total Days (based on 8 hour days)
Through 1	.0807	6.456 hours	167.952 hours	21
1 to 4	.0885	7.080 hours	184.080 hours	23
4+ to 9	.1077	8.616 hours	224.016 hours	28
9+ to 20	.1269	10.152 hours	263.952 hours	33
20+	.1346	10.768 hours	279.968 hours	35
Management Accrual Rates				
Years of Service	Accrual per Hour Paid	Maximum Per Pay Period Accrual (based on 80 hours)	Maximum Annual Accrual (based on 2,080 hours)	Total Days (based on 8 hour days)
0 to 4	.0924	7.392 hours	192.192 hours	24
4+ to 9	.1077	8.616 hours	224.016 hours	28
9+ to 20	.1269	10.152 hours	263.952 hours	33
20+	.1346	10.768 hours	279.968 hours	35
Director Accrual Rates				
Years of Service	Accrual per Hour Paid	Maximum Per Pay Period Accrual (based on 80 hours)	Maximum Annual Accrual (based on 2,080 hours)	Total Days (based on 8 hour days)
Through 1	.0924	7.392 hours	192.192 hours	24
1+ to 4	.1077	8.616 hours	224.016 hours	28
4+ to 9	.1269	10.152 hours	263.952 hours	33
9+ to 20	.1462	11.696 hours	304.096 hours	38
20+	.1538	12.304 hours	319.904 hours	40

Per Diem/Temporary/Seasonal (13 Weeks or Less) Employees PST Accrual Rate			
Accrual per Hour Worked	Maximum Per Pay Period Accrual	Maximum Annual Accrual	Maximum hours eligible for rollover per calendar year
.034	No maximum	40	40

Please reference HR-02-01 Paid Sick Time (PST) and Paid Time Off (PTO) policy on eConnection for detailed information

APPENDIX

The Women's Health and Cancer Rights Act of 1998

THIS NOTICE CONTAINS VALUABLE INFORMATION ABOUT YOUR EMPLOYEE HEALTH BENEFIT PLAN.

Please read it carefully to assure that you are able to obtain the maximum benefit from your coverage.

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: see pages 9 -13 of this guide depending on plan chosen. If you would like more information on WHCRA benefits, call your plan administrator 520-324-1543.

Newborns and Mothers' Health Protection Act Notice - 2010

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

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 its 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 not 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). Full disclosure available on Benefits Homepage via eConnection.

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

ARIZONA – CHIP
Website: *www.azahcccs.gov/applicants*
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): (602) 417-5437

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

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

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

HIPAA Medical Privacy Notice

HIPAA Medical Privacy Notice available in the medical insurance Summary Plan Description (SPD).

GINA

The Genetic Information Nondiscrimination Act (GINA) states that under a 2009 federal law, group health plans are prohibited from adjusting premiums or contribution amounts for a group on the basis of genetic information. A health plan is also prohibited from requiring an individual or his/her family member to undergo a genetic test, although the plan may request that a voluntary test be taken for research purposes.

NOTES

5301 E. Grant Road • Tucson, AZ 85712
www.tmcaz.com