



Leland
MANAGEMENT
Lifestyle

2025 - 2026 TEAM MEMBER BENEFIT ENROLLMENT GUIDE

Plan Year: December 1, 2025 - November 30, 2026

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This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

ENROLLMENT ELIGIBILITY

WHOM MAY I COVER?

- Team members are eligible for benefits first of the month following 30 days.
- When making your medical, dental and vision selections, you may choose either: Team Member only, Team Member + Spouse, Team Member + Child(ren) or Team Member + Family (includes spouse + children) coverage.

WHO ARE MY ELIGIBLE DEPENDENTS?

Medical Plan

- Your legal spouse
- Coverage under the Affordable Care Act: Eligible children*, up to the date in which the child turns age 26, can join the medical, dental and vision plans whether or not they are married; living with you; in school; or financially dependent on you.

Dental, Vision, Voluntary Life and AD&D, Voluntary Critical Illness, Accident, Hospital Indemnity, and Cancer

- Your legal spouse
- Domestic partners* Must have lived together at the same residence for at least twelve (12) months.
- Eligible children*, up to the end of the calendar year in which the child turns age 26, can join the dental and vision plans if the child is dependent for support and is: (i) living in the employee's household; or (ii) a full-time or part-time student.
- Eligible children under the IRS Code 152 (f)(1) are: sons, daughters, stepchildren, adopted children including children placed for adoption, and foster children.

IMPORTANT INFORMATION

- Team members will receive email information on how to enroll in benefits in Employee Navigator (Upswing) soon after their hire date.
- Team members should complete their enrollment online at least 2 weeks prior to their effective date.
- Should any team member need assistance with their enrollment, they can contact Human Resources prior to effective date for individual assistance.
- Team members who fail to complete their online enrollment at least 2 weeks prior to their effective date, will not be eligible to enroll in benefits until Leland Management's open enrollment period.
- All eligible team members will be enrolled in the Leland Group Life and AD&D policy which is provided by Leland Management at no cost to the team member.

The Annual Open Enrollment Period is your opportunity to review your elections and enroll or make any necessary changes to ensure your benefits continue to meet your needs.

QUALIFIED LIFE EVENTS

WHEN CAN I MAKE CHANGES?

Open Enrollment is your time to make benefit plan changes for the upcoming plan year. Information may be provided electronically and by hard copy by request.

Can I enroll or make changes outside of the open enrollment period?

Since your premiums are deducted on a pre-tax basis, federal law limits your ability to change your elections outside of open enrollment; changes are allowed only if there is a "qualifying event" and the change requested is consistent with the event. In addition, the change must be requested within 30 days of the event. For example, if you marry on June 1st, you may add your new spouse to your health care plan by submitting a new enrollment form, along with appropriate documentation, by July 1st. Qualifying events include, but are not limited to:

- Changes in your legal marital status
- Birth or adoption (or placement for adoption) of a child
- Death of a covered dependent
- Loss or gain of eligibility for group insurance coverage for you or a covered dependent (coverage must not be a student or individual policy)
- Change in spouse's employment status
- Change in health insurance eligibility due to a relocation of residence or workplace
- Dependent satisfies or ceases to satisfy eligibility requirements
- Judgment, Decree or Order

If you experience a change in status, you must notify Human Resources and provide documentation within 30 days of the change to update your benefit selections. You may be asked to present documentation such as a birth, marriage or death certificate, or a divorce decree.



This enrollment guide highlights the benefit plan choices available to eligible employees and their dependents. This enrollment guide serves as a summary of the benefits described in the official summary plan documents for these plans. It does not interpret, extend or change the plan in any way. The benefits that you receive are based upon the plan's official plan documents, not this guide or any other written or oral statement. If there is a conflict between this guide and the official plan documents, the official plan documents will govern in all cases. Your Employer reserves the right at any time to change or terminate these plans.

HOW TO ENROLL: EMPLOYEE NAVIGATOR

With Employee Navigator (Upswing), team members can enjoy convenient online access to benefits coverage 24 hours a day, seven days a week. On this site you will be able to update your personal profile, report life events, make eligible benefit elections and qualifying enrollment changes, and access a complete document library.

The image shows a screenshot of the Employee Navigator website. The header includes the logo, navigation links (PRODUCTS, PRICING, MARKETPLACE, COMPANY), and a Login button. The main banner features the text 'All-in-One Benefits, HR, & Compliance' and a description of the platform. Below the banner, there is a list of instructions for enrollment. To the right, a login form is displayed with fields for Username and Password, a Login button, and links for 'Forgot Username?', 'Forgot Password?', and 'Register as a new user'. The 'Register as a new user' link is circled in red.

employee NAVIGATOR

PRODUCTS ▾ PRICING MARKETPLACE COMPANY ▾ Login

All-in-One Benefits, HR, & Compliance

Thousands of brokers use Employee Navigator's software with their customers to manage their benefits, onboarding, ACA and more in our simple intuitive platform.

1. You may begin your enrollment by going to www.employeenavigator.com
2. **Returning users (new system):** Please use your previously chosen Username and Password.
3. **First time users:** Click on Register as a new user. Create an account and create your own username and password.
4. The company identifier will be: Leland Management
5. Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks click [Start Enrollment](#) to begin your enrollments.

employee NAVIGATOR

Username

Password

Login

[Forgot Username?](#) [Forgot Password?](#)

[Register as a new user](#)

Key points to remember when making your elections!

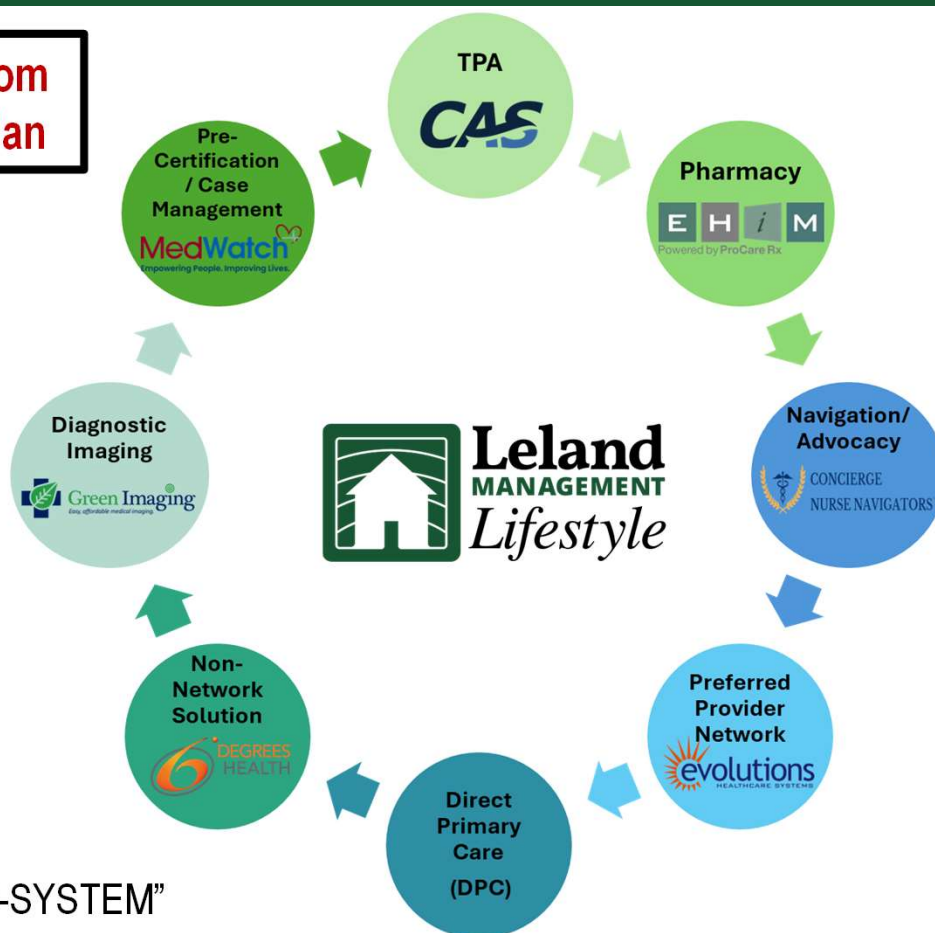
- Dependents need to be added on dependent screen before you can add them to any plan election in Employee Navigator
- On the plan election page (Medical, etc...) Check the box next to the dependent's name to add them to the plan (*rates will adjust automatically*)
- If electing Medical with Direct Primary Care, be sure to enter your selected provider's full name.
- All Plan documents are available on the right side of the screen
- All rates are represented "per pay period" on the plan screens
- Remember to add (or review) beneficiary information for the Life/AD&D Insurance (Only beneficiary name, relationship and benefit percentage are required - SSN is highly recommended)
- Be sure to complete "all Steps" and electronically sign your Open Enrollment Elections
- Team members may make changes to benefits until the enrollment deadline. (*Indicated on the home page next to the start button*)

YOUR HEALTH PLAN

Leland Management's Custom High-Performance Health Plan

Our plan focuses on:

- ✓ Quality Care
- ✓ Access to Care
- ✓ Member experience
- ✓ Fair price
- ✓ Full Transparency



THE PARTNERS OF THE “ECO-SYSTEM”



- Coastal Administrative Services (CAS) administers your health plan.
- Medical claims are submitted to CAS for processing. CAS Customer Service can assist you with questions on benefits and claims.



- Your prescription drug benefits are managed by EHIM.
- You can save money on copays by visiting preferred pharmacies like Publix, Walmart (Sam's Club), and independent pharmacies.



- Concierge Nurse Navigator is available to assist you with choosing providers and facilities that provide high-quality care, understanding your diagnosis and treatment, and help you in understanding your benefits better. When you engage with the nurse navigator, and utilize any of the providers researched and recommended, the deductible and coinsurance will be WAIVED.



- This is your preferred network of healthcare providers who are contracted for services at preferred rates.
- Your benefits are far more generous with in-network providers.



- DPC (Direct Primary Care) is the purest form of a healthcare relationship. Enrolled members have unlimited access to their provider via visits, text, virtual, email, and phone.
- There is no copay if you elect to participate in this voluntary program.



- 6 Degrees Health handles all the non-network claims. They will negotiate agreements with providers and facilities and handle any balance billing issues that may arise.



- Green Imaging helps provide imaging for members covered under the medical plans at NO COST.
- Members receive a “voucher” when services are scheduled. Simply present the voucher when you arrive for your appointment.



- MedWatch reviews, monitors, and advises on the most acute and complex cases to improve quality of patient care and minimize treatment costs.
- MedWatch also evaluates outpatient services, including surgical care and diagnostic tests for medical necessity and appropriateness of care.

MEDICAL BENEFITS

Carefully consider you and your family's anticipated healthcare usage as you compare these plans to determine which one best matches your needs. Please keep in mind that the option you select will be in place for the entire 2025-2026 plan year, unless you have a Qualifying Life Event.

MEDICAL BENEFITS	LIFESTYLE PLAN		LIFESTYLE PLUS PLAN	
	Evolutions Network		Evolutions Network	
Preventive Services	\$0 copay		\$0 copay	
Recuro Telehealth (Virtual Visit/Urgent Care)	\$0 copay		\$0 copay	
Primary Care Office Visit	Evolutions Network: \$25 copay All others (RBP): \$35 copay		Evolutions Network: \$5 copay All others (RBP): \$15 copay	
Specialist Office Visit	Evolutions Network: \$50 copay All others (RBP): \$75 copay		Evolutions Network: \$20 copay All others (RBP): \$35 copay	
Independent Lab (Blood work) (non-hospital)	Quest Diagnostics: \$0 LabCorp: \$20 copay All others (RBP): \$50 copay		Quest Diagnostics: \$0 LabCorp: \$10 copay All others (RBP): \$25 copay	
Diagnostic Imaging (X-ray) At Independent Facility (non-hospital)	Green Imaging: \$0 See page 12 Evolutions Network: \$10 copay All others (RBP): \$50 copay		Green Imaging: \$0 See page 12 Evolutions Network: \$10 copay All others (RBP): \$35 copay	
Advanced/Complex Imaging (MRI,CT) At Independent Facility (non-hospital)	Green Imaging: \$0 Evolutions Network: \$50 copay All others (RBP): \$200 copay		Green Imaging: \$0 Evolutions Network: \$25 copay All others (RBP): \$75 copay	
Convenient Care Centers	<u>Evolutions Network:</u> CVS Minute Clinic: \$25 copay		<u>Evolutions Network:</u> CVS Minute Clinic: \$5 copay	
Urgent Care Centers	Evolutions Network: \$50 copay All Others (RBP): \$80 copay <i>i.e: Guidewell, CareSpot</i>		Evolutions Network: \$35 copay All Others (RBP): \$50 copay <i>i.e: Guidewell, CareSpot</i>	
Emergency Room	\$400 copay		\$200 copay	
Outpatient Surgery (non-hospital) <i>ASC: Ambulatory Surgical Center</i>	Out-Patient Surgical (ASC) (Facility + Providers) Deductible + Co-Insurance		Out-Patient Surgical (ASC) (Facility + Providers) Deductible + Co-Insurance	
Inpatient Hospital	In-Patient Surgical (ASC) (Facility + Providers) Deductible + Co-Insurance		In-Patient Surgical (ASC) (Facility + Providers) Deductible + Co-Insurance	
Deductible (Indiv/Fam) PLAN YEAR DEDUCTIBLE (Dec-Nov)	\$2,000 / \$4,000 If member engages with Nurse Navigator and utilizes recommended provider: \$0 <i>More information on page 10</i>		\$500 / \$1,000 If member engages with Nurse Navigator and utilizes recommended provider: \$0 <i>More information on page 10</i>	
Coinsurance (Team Member Pays)	50% If member engages with Nurse Navigator and utilizes recommended provider: 0% <i>More information on page 10</i>		10% If member engages with Nurse Navigator and utilizes recommended provider: 0% <i>More information on page 10</i>	
Out-of-Pocket Maximum (Indiv/Fam)	\$6,350 / \$12,700		\$3,500 / \$7,000	
Pharmacy Benefits	Preferred Pharmacies: Publix, Walmart, Independent	Non-Preferred Pharmacies: CVS, Walgreens	Preferred Pharmacies: Publix, Walmart, Independent	Non-Preferred Pharmacies: CVS, Walgreens
Preventive Care Medications per ACA guidelines	\$0 copay		\$0 copay	
Tier 1- Generic	\$5 copay	\$20 copay	\$5 copay	\$10 copay
Tier 2- Preferred Brand	\$40 copay	\$60 copay	\$25 copay	\$50 copay
Tier 3- Non-Preferred Brand	\$100 copay	\$150 copay	\$75 copay	\$100 copay
Tier 4- Specialty Drugs	\$250 copay	Not covered	\$100 copay	Not covered
2025 Bi-Weekly Payroll Deductions	LIFESTYLE PLAN		LIFESTYLE PLUS PLAN	
Team Member Only	\$105.00		\$240.00	
Team Member + Spouse	\$476.13		\$797.42	
Team Member + Child(ren)	\$394.98		\$676.82	
Team Member + Family	\$742.74		\$1,193.68	

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MEDICAL PLAN ADMINISTRATOR: CAS



We have a new member Portal!

Introducing AccessCAS

www.casbenefits.com/AccessCAS

Phone Number: 855-373-8232

Available Monday-Friday from 10am-7pm EST

CAS is your third-party administrator (TPA). CAS processes claims for your health plan.

Understanding your benefits and managing a claim shouldn't add stress to your life. Should you need assistance in getting the most out of your benefits, CAS is here to help.

Get forms and resources you need quickly and simply manage your healthcare online.

- Download and send your ID card directly to your provider's office
- Check claim status
- View your benefits coverage

AccessCAS – member portal

www.casbenefits.com/accesscas



Scan QR code to set up your account under the "member" portal

LOCATING A MEDICAL PROVIDER

We want you to get the BEST MEDICAL CARE available.

Under our custom plan, the BEST way for you to find a medical provider is to work with your Dedicated Nurse at **Concierge Nurse Navigator (CNN)**. The nurse will listen to your needs and conduct research to locate the BEST QUALITY provider / facility for your care. Should you have a provider that you have used in the past, the nurse can check their quality scores for you and let you know if they are already in our HIGH-PERFORMANCE network. If your provider is not an existing part of the network, don't panic. We have steps in place for you to still seek treatment.

- 1 **Reach out to your Concierge Nurse Navigator (440) 534-0583** and explain your medical needs, i.e., doctor, facility, medical supplies.
- 2 If applicable, your Concierge Nurse Navigator will provide information on any **special plan programs** that are available to you, i.e. preferred labs, preferred imaging solution.
- 3 **If a provider / facility recommendation is needed, the Concierge Nurse Navigator (CNN) will do research and provide you with several recommended providers.** These providers are recommended by CNN for their medical quality, outcomes, complication rates, appropriateness of care, billed charges and willingness to work with our plan. Willingness to work with our plan could mean that they are already part of our HIGH-PERFORMANCE network, they want to become part of our network or are willing to work with us on a special agreement (Single Case Agreement) for your care.
- 4 Great news! If you choose use the CNN recommended providers, an "authorization ticket" will be established for you. **Any applicable deductible and co-insurance associated with this provider will be WAIVED!**
- 5 Should you decide to use a **non-recommended provider**, that is still available to you. The regular plan provisions will apply.

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OUR CUSTOM “HIGH PERFORMANCE” NETWORK

You will have access to our custom “HIGH PERFORMANCE” network.

This is the same network that Rosen Hotels & Resorts uses. These are providers that have been selected carefully.

Members may search for providers on the Evolutions website. However, the best way to locate providers is engaging with CNN (see previous page). The incentive to use our preferred providers takes the form of greater benefits paid by the plan and lower costs for you.



When you visit your provider show them your ID Card. Your plan ID card provides all the necessary information needed to submit a claim to your plan.

If there are any specific providers that a member would like, you can “Nominate a provider” by scanning the QR code below.



Find a Provider

CAS provides your plan access to healthcare providers through the Evolutions Network - Website: www.ehsppo.com

WEBSITE INSTRUCTIONS:

- Click “Find Your Provider” at the top of the Home Page to begin your search.
- Type the first 3 letters of the group name: **LELAND MANAGEMENT** and click “Continue”.
- Choose YOUR COMPANY NAME and click “Continue”.
- Review the special instructions provided on the WELCOME screen.
- Now begin your search by clicking on the round button next to the type of search you want to perform:
 - Location
 - Physician Name
 - Physician Group
 - TIN (Tax ID)

You can also search by the provider type by clicking one of the following buttons:

- (1) Search for Physician
- (2) Group Specialties

NON-NETWORK: 6 DEGREES HEALTH

Leland Management has partnered with 6 Degrees Health to help members with Non-Network claims (Non-Evolutions).

1

Should a provider or facility be outside of the Evolutions network, members should work with Concierge Nurse Navigator for a provider recommendation.

2

CNN will work with Evolutions to identify quality providers. Evolutions will reach out to those providers proactively to establish a network contract. If that is not feasible, 6 Degrees Health will work with the provider to establish an understanding of how the claim will be paid. **Great news! If you use the recommended providers that have been approved by CNN and will work with 6 Degrees Health, any applicable deductible and co-insurance associated with this provider will be WAIVED!**

3

What if I don't want to engage with CNN or what if I don't want to use the recommended provider?

Before visiting a physician's office, you can inform 6 Degrees Health about the healthcare provider you wish to see by calling 888-615-6398, and they will take care of calling ahead to ensure access.

*Call Ahead is not currently available for any in-network providers, hospitals, ambulatory surgical centers, imaging centers, or labs.

Nurse Nicole – CNN
Nicole@MyNurseNavigators.com
Call or Text 440-534-0583



SURPRISE MEDICAL BILLS + BALANCE BILLING

BE SMART: SURPRISE MEDICAL BILLS ARE REAL



Open the mail from any providers or facilities. PLEASE don't just throw them away or put them aside. Should you receive an unexpected bill, don't panic. There are resources to help determine if the bill is applicable.



Go online to the CAS member portal: www.casbenefits.com

Look for your "Explanation of Benefits" EOB for the date of service with that provider.



Compare the bill received and the EOB

Compare your explanation of benefits (EOB) from CAS to the bill received in the mail.
The EOB indicates what your costs are.



Does the bill match the EOB?



No, my bill and EOB do NOT match.

If the balance due on the bill is more than the EOB states that you owe... this is a **BALANCE BILL**.

Do NOT pay this BALANCE BILL.

Contact Nurse Nicole and she will facilitate with 6 Degrees Health for assistance.

6 Degrees Health will assist and take responsibility of this BALANCE BILL.



To facilitate, call your Concierge Nurse Navigator at 440-534-0583

Yes, the EOB and provider bill match.

If the amount on the bill from your provider and the EOB match, then pay your provider the amount due.

Call your Concierge Nurse Navigator

(440) 534-0583

This is the direct line for Leland Management's dedicated nurse navigator.

For assistance navigating the complex healthcare system

ADVOCACY: CONCIERGE NURSE NAVIGATOR

Leland Management's Dedicated Nurse



Nurse Nicole
*Leland Management's
Dedicated Nurse*



CONCIERGE SERVICES: Let's find the highest-quality outcomes for **YOU!**

- Choosing doctors and facilities that deliver proven high-quality care
- Choosing doctors and facilities that gladly accept your health plan
- Help maximizing your benefits and reducing your out-of-pocket costs
- Understanding your diagnosis and treatment options
- When is a second opinion appropriate?
- Support and a helping hand through the health care experience

Call ahead when you need to have an:
Inpatient Stay - Outpatient Procedure/Surgery - Diagnostic Test/Service
CNN will provide you with recommended providers.

**IF MEMBER USES THESE PROVIDERS, DEDUCTIBLE AND COINSURANCE WILL
BE WAIVED!**

WHY SEEK QUALITY FIRST?

- Less misdiagnosis
- Lower infection rates
- Less complications
- Lower readmission rates
- Less patient harm and death rates
- Appropriateness in care



Call your Concierge Nurse Navigator

(440) 534-0583

This is the direct line for Leland Management's dedicated nurse navigator.

For assistance navigating the complex healthcare system

DIRECT PRIMARY CARE (DPC) OPTION 1

Enhance your healthcare journey with greater ease of accessibility to your doctor and 24/7 care with a Direct Primary Care (DPC) Provider. The providers deliver primary care services to you, your spouse and dependents that enroll in the DPC program. People One Health has four locations in Orlando for ease of access to care.



100% Paid For By Your Employer

Your Newest Health Benefit

PeopleOne Health is an award-winning health benefit with one of the **highest customer satisfaction ratings** in the world.

Employees and their dependents receive award-winning healthcare **without any out-of-pocket costs.**

PeopleOne Health unites health treatment & building a healthy lifestyle, the way healthcare should be done.

Central Florida Only



Health Center Care Team

- Physician
- Clinical Pharmacist
- Physician Assistant/ Nurse Practitioner
- Licensed Social Worker
- Registered Dietician
- Health Coach

Unlimited Services

- Advanced Primary Care visits (30-45 minutes) and virtual consults
- Laboratory testing
- Over 300+ generic prescription drugs

Essentials Plan

No Costs to Employee

- Women's health
- Pediatric care (Ages 2+)
- General and sports physicals
- Same or next-day sick appointments

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DIRECT PRIMARY CARE (DPC) OPTION 2

Enhance your healthcare journey with greater ease of accessibility to your doctor and 24/7 care with a Direct Primary Care (DPC) Provider with Persona Health Care Direct. Their providers deliver primary care services to you, your spouse and dependents that enroll in the DPC program. You will spend less time in waiting rooms, more time with your doctor, and are promised same-day/next-day appointments. Enjoy greater accessibility to your doctor through telehealth services like phone visits, video visits, text and email, all with no copays or hidden costs.



SERVICES PROVIDED BY YOUR DPC DOCTOR

- ✓ Acute care and chronic disease management
- ✓ Allergy Evaluation
- ✓ Dermatology Evaluation
- ✓ Cryotherapy (service varies by provider)
- ✓ Mental health, including treatment for depression, anxiety and other mood disorders
- ✓ School, sports, and annual wellness physicals
- ✓ Office testing such as EKG, urinalysis, strep test and pregnancy test
- ✓ Sleep assessments and support
- ✓ Stress management
- ✓ Treatment of sprains and minor lacerations (service varies by provider)
- ✓ Joint injections (service varies by provider)
- ✓ Weight management and health risk assessment
- ✓ Women's health
- ✓ Well child exams (service varies by provider)
- ✓ Preventative health care
- ✓ Same day or next day appointments
- ✓ Virtual doctor visits
- ✓ Direct Access to Member's Physician/Provider (via telemedicine, email, and/or patient portal)
- ✓ Priority scheduling
- ✓ 24/7 access to your physician
- ✓ Coordination of urgent care, emergency and specialty care services
- ✓ Wellness coaching
- ✓ Smoking cessation and weight loss programs

HOW DO I ENROLL?

- ✓ Election into the DPC Program is done on the company enrollment system, Employee Navigator. Enrollments are on a monthly basis and may be elected throughout the year by contacting HR.
- ✓ Contact HR for a directory of Direct Primary Care Providers or to learn more about Direct Primary Care.



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PHARMACY BENEFITS: EHIM

When you visit your pharmacy to fill a prescription show them your health plan ID Card. Your plan health plan ID card provides the instructions needed to submit a claim to your plan for processing.



Welcome to EHIM's Prescription Benefit Program!

We are excited to serve you and would like to introduce you to our program before your benefits begin.

EHIM has a national pharmacy network, allowing you to get medications from any local retail pharmacy. If your chosen pharmacy is out-of-network, contact the Pharmacy Help Desk to enroll it.

Prescription drugs are so expensive, especially in the United States! Brand name drugs and specialty drugs cost US employers and their employee plan members two to six times more than payers in other developed economies.

The **Personal Importation Program** is an opt-in, international mail order prescription program that provides significant savings opportunity for those expensive medications. These medications are sourced from TIER 1 countries, like Canada and UK.

Benefits to you:

- **\$0 Copay**
- **Convenient Home Delivery**

Customer Service

(800) 311-3446

www.ehimrx.com

EHIM's primary mission is to provide our members with the best customer service possible. If you are experiencing a problem filling a retail or mail order prescription, please contact the Pharmacy Help Desk. For your convenience, the help desk has representatives available **24 hours a day, 7 days a week, 365 days a year.**

The toll-free number is **printed on your ID card** for easy reference.

Utilize Preferred Pharmacies and save money with **lower copays!**

Preferred Pharmacies are **Publix, Walmart, Neighborhood Market, Sam's & Independent pharmacies.**



You will pay **higher copays** at **NON-Preferred Pharmacies**: CVS, Walgreens.

CASE MANAGEMENT: MEDWATCH



Better Programs. Superior Outcomes.

MedWatch's nurse case managers proactively engage patients and work with their physicians to help ensure effectiveness of treatment plans and quality of patient care while reducing the overall costs.

Early identification and action is critical to reducing costs and improving patient outcomes.

MedWatch identifies opportunities through:

- Pre-certification Activity
- Multiple Admissions
- Trigger Diagnoses
- Pathology, Radiology, and Other Diagnostic Outcomes
- Referrals from the Plan, Administrator, or Patient

Contact MedWatch at (888) 743-6702

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MEDICAL: DIAGNOSTIC IMAGING



IMAGING AT NO COST TO YOU

Call your Concierge Nurse Navigator at (440) 534-0583 to start the process.

HOW IT WORKS



Your doctor has given you an order for diagnostic imaging services.



Contact Green Imaging
Text: 713.524.9190
Chat: greenimaging.net
Call: 844.968.4647



You will be contacted to schedule your procedure and will receive a voucher for the service.



At your appointment, show your voucher to the front desk. **Do NOT present your medical insurance card.**



You will have no copay and no after procedure bill. Leland Management pays 100% of the cost for members.



The report from your exam will be sent directly to your referring doctor.

WHAT IS GREEN IMAGING?

The Green Imaging Network is made up of high-quality imaging facilities across the nation. In fact, they are many of the same facilities you'd choose for yourself. Green Imaging will consider the procedure you need and find a network facility that is not only close to your home but has the right type of equipment for the exam your doctor ordered. Your exam will be interpreted by the right radiologist too. Radiologists are board-certified, fellowship-trained and include sub-specialists for more complex exams such as neurology, musculoskeletal and oncology.



DIAGNOSTIC IMAGING

MRI • CT • PET • ULTRASOUND
MAMMOGRAM • X-RAY • BONE DENSITY
NUCLEAR MEDICINE • ARTHROGRAM
ECHOCARDIOGRAM

1. Text our Patient Concierge at **713.524.9190** and include:
 - > picture of your physician order
 - > your zip code
 - > a few dates/times that work best for you
2. We'll schedule your appointment and send you a voucher for service.
3. That's it! You're ready for your appointment!



TEXT (713) 524-9190



CALL (844) 968-4647

Leland Management has partnered with Green Imaging to provide imaging for members covered under the medical plans at **NO COST!** For these services, you will not file with your insurance company. Instead, you receive a "voucher" when you schedule your services. Simply present the voucher when you arrive for your appointment.

MEDICAL: TELEHEALTH

\$0 copay

This benefit can be used by anyone in the household, even if they are not enrolled in the health plan.

Virtual Urgent Care

24/7 Acute Care Access

24/7 access to board-certified doctors for treatment of common medical concerns with ongoing communication with your doctor.



✓ 24/7 Access

✓ Integrated Prescriptions

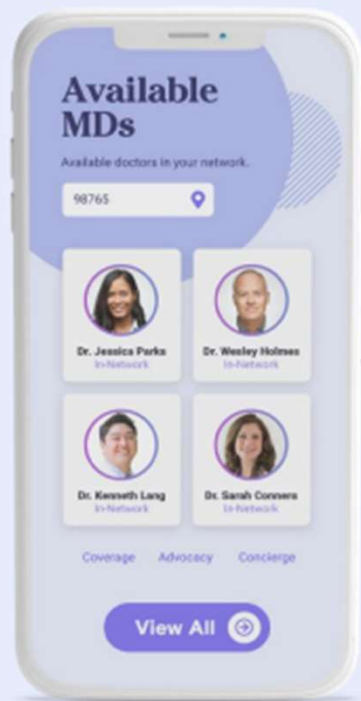
✓ Multi-Channel Options

✓ Primary Care Coordination

✓ Consult Transcription

Conditions Treated

- Acne / Rashes
- Allergies
- Cold / Flu / Cough
- GI Issues
- Ear Problems
- Fever / Headache
- Insect Bites
- Nausea / Vomiting
- Pink Eye
- Respiratory Issues
- UTI's / Vaginitis
- And More



Product Details

24/7 Access

Recuro physicians are available whenever our patients need them, day or night.

Integrated Prescriptions

Prescriptions are immediately sent to the patient's preferred pharmacy for easy pickup.

Primary Care Coordination

Primary care and behavioral health can be integrated with urgent care.

Multi-Channel Options

Live video, phone, and messaging options let each patient receive care the way they like.

Consult Transcription

Consults can be recorded and transcribed, allowing patients continuous access to information.



844.979.0313



info@recurohealth.com



www.recurohealth.com



Scan QR code to access website for more details about Recuro

This enrollment guide highlights the benefit plan choices available to eligible employees and their dependents. This enrollment guide serves as a summary of the benefits described in the official summary plan documents for these plans. It does not interpret, extend or change the plan in any way. The benefits that you receive are based upon the plan's official plan documents, not this guide or any other written or oral statement. If there is a conflict between this guide and the official plan documents, the official plan documents will govern in all cases. Your Employer reserves the right at any time to change or terminate these plans.

EMPLOYEE ASSISTANCE PROGRAM: EAP

EAP provides you and your household members with free, confidential, in-the-moment support to help with personal or professional problems that may interfere with work or family responsibilities.

Phone: 1-800-854-1446

24-hour crisis help available.

Website: <https://www.unum.com/lifebalance>



New Carrier
for 2025

A Licensed Professional Counselor can help you with:

- Stress, depression, anxiety
- Relationship issues
- Divorce
- Anger, grief and loss
- Job stress, work conflicts
- Family and parenting problems
- And more

You can also reach out to a specialist for help with balancing work and life issues. Ask our Work/Life Specialists about:

- Childcare
- Elder care
- Financial services
- Debt management, credit report issues
- Identity theft
- Legal questions



Travel Essential services are provided by Assist America, Inc., a leading provider of global emergency assistance services through employee benefit plans. Assist America's medically certified personnel are ready to help 24 hours a day, 365 days a year, and can connect you with pre-qualified, English-speaking and Western-trained medical providers anywhere in the world.

Use your travel assistance phone number to access:

- Hospital admission assistance*
- Emergency medical evacuation
- Prescription replacement assistance
- Transportation for a loved one to join a hospitalized patient
- Care and transport of unattended minor children
- Assistance with the return of a vehicle
- Emergency message services
- Critical care monitoring
- Emergency trauma counseling
- Legal and interpreter referrals
- Passport replacement assistance

* Hospital admission is coordinated by Assist America, Inc. It may require a validation of your medical insurance or an advance of funds to the foreign medical facility

If you need travel assistance anywhere in the world, contact us day or night.



Within the U.S.

1-800-872-1414



Outside the U.S.

(U.S. access code) +609-986-1234



Via e-mail:

medservices@assistamerica.com

DENTAL

New Carrier
for 2025

Dental insurance offers eligible team members the choice of two dental plans offered through **Unum**. You have the option of seeing a dentist in the Unum network or going to a dentist of your choice. If you seek care from an out-of-network dentist, your claims will be reimbursed at a lower rate, and you may be subjected to balance billing (additional amount not covered by insurance).



FINDING A PROVIDER: You can find in-network providers at unumdentalcare.com

***Calendar Year Deductible has been changed to Plan Year Deductible.**

Dental Benefits (limits apply)	ACTIVE MAC PLAN		ACTIVE PPO PLAN	
	Unum National Network	Out-of-Network	Unum National Network	Out-of-Network
Plan Year Deductible (December – November) Individual/ Family	\$50/ \$150	\$100/ \$300	\$50/ \$150	\$100/ \$300
Out-of-Pocket Max (per person)	\$1,000 per person plus dental carryover		\$1,500 per person plus dental carryover	
Preventative Services (limits apply)				
Routine Oral Exam	Covered 100%, no Deductible	Deductible, then 0% by member, 100% by Unum up to MAC	Covered 100%, no Deductible	Deductible, then 0% by member, 100% of U&C by Unum
Routine Cleaning				
Routine Bitewing X-rays				
Basic/Major* Services (limits apply)				
Fillings & General Services	Deductible, then 20% by member, 80% by Unum up to maximum benefit	Deductible, then 50% by member, 50% by Unum up to MAC	Deductible, then 10% by member, 90% by Unum up to maximum benefit	Deductible, then 20% by member, 80% of U&C by Unum
Surgical Extractions				
Endodontics				
Periodontics	Deductible, then 50% by member, 50% by Unum up to maximum benefit	Deductible, then 25% by member, 50% by Unum up to MAC	Deductible, then 40% by member, 60% by Unum up to maximum benefit	Deductible, then 50% by member, 50% of U&C by Unum
Single Crowns (limits apply)				
Inlays, Onlays				
Bridges, Dentures (limits apply)				
Orthodontic Services				
Orthodontic Benefit (lifetime maximum)	50% to \$1,000 max per lifetime Dependent children under age 19		50% to \$1,000 max per lifetime Dependent children under age 19	
Out-of-Network Reimbursement	Based on Unum Maximum Allowable Charge (MAC)		90 th Percentile of Usual and Customary (U&C)	



Bi-Weekly Deductions	Active MAC	Active PPO
Team Member Only	\$9.53	\$17.45
Team Member + Spouse	\$19.75	\$36.51
Team Member + Child(ren)	\$25.68	\$44.49
Team Member + Family	\$33.66	\$59.40

Call the Unum Customer Support at (866) 679-3054

Available weekdays at 8:00 AM to 8:00 PM EST

DENTAL CARRYOVER BENEFIT

New Carrier
for 2025



Dental Carryover Benefit: The Unum dental carryover plan allows you to carry over a portion of your unused annual maximum benefit to the next benefit year, effectively increasing your annual maximum. To qualify, you must meet certain criteria each year, such as having one cleaning and one exam, and staying under a specific "threshold limit" for the benefits you use. These accrued benefits are stored in a carryover account and can be used for future dental services. Members who take care of their teeth but use only part of their annual maximum benefit during a benefit period are rewarded with extra benefits in future years!



One Cleaning



One Regular Exam



Total dental claims paid during the year for preventive, basic and major services below the threshold limit

	Active PPO	Active MAC***
Carryover benefit	\$350	\$250
Threshold limit	\$700	\$500
Carryover account limit	\$1,250	\$1,000

Dental Carryover Example

\$1,500 Annual Maximum + \$0 Carryover Account \$1,500 Total Available for One Year	BENEFIT IN YEAR ONE In the first qualifying year, the member has one cleaning, one exam and incurs \$300 in paid claims. Member earns a \$350 carryover benefit that is applied to the next year's annual maximum.
\$1,500 Annual Maximum + \$350 Carryover Account \$1,850 Total Annual Maximum with Carryover	BENEFIT IN YEAR TWO Member gets one cleaning, one regular exam and incurs \$300 in paid claims. Member earns a \$350 carryover benefit that is applied to the next year's annual maximum. Carryover Account Balance \$350
\$1,500 Annual Maximum + \$700 Carryover Account \$2,200 Total Annual Maximum with Carryover	BENEFIT IN YEAR THREE Member gets one cleaning, one regular exam and incurs \$1,800 in paid claims. Member does not earn the carryover benefit in year three but is able to utilize the carryover benefits earned in previous years to help pay the \$1,800 in claims. Because the entire \$700 would not be utilized by the \$1,800 claim, \$400 will carry over to the next year. Carryover Account Balance \$700
\$1,500 Annual Maximum + \$400 Carryover Account \$1,900 Total Annual Maximum with Carryover	BENEFIT IN YEAR FOUR Member has \$1,900 available to use in this year because of the \$1,500 regular annual maximum plus \$400 in remaining carryover benefit. Carryover Account Balance \$400

Specifications

- Each covered family member receives their own carryover benefit.
- Carryover benefit must be in effect for one benefit year before any member can utilize carryover benefits.
- A member must be on the plan for a minimum of four months before accruing carryover benefits.
- Carryover benefit cannot be used for orthodontia.

VISION

New Carrier
for 2025

Vision insurance helps pay the cost of periodic vision examinations and necessary lenses and frames. The vision plan covers an annual eye exam, eyeglass lenses or contacts and frames every 12 months. The plan allows you to see any provider, but you will receive the highest level of benefit when you utilize in-network providers through EyeMed (Unum National Network). Login to www.eyemedvisioncare.com/unum for a list of participating providers.



Unum Vision Plan	In-Network	Out-of-Network
Exam	\$10 copay	Reimbursed up to \$40
LENSES		
Single, Bifocal, Trifocal	\$25 copay	Reimbursed up to \$30/ \$50/ \$70
FRAMES		
Retail Frame Equivalent	Up to \$120 allowance	Reimbursed up to \$84
CONTACT LENSES		
Contact Lens Fitting	Up to \$40 allowance	Not Covered
Elective	Up to \$120 allowance	Reimbursed up to \$120
SERVICE FREQUENCIES		
Exams	Every 12 months	
Lenses (for glasses or contact lenses)	Every 12 months	
Frames	Every 12 months	

New! This enhanced benefit covers a new pair of eyeglass frames every 12 months.

Have Vision Plan Questions?
Contact Unum at

866-679-3054

(Monday-Friday 8:00 am-8:00 pm ET)

www.eyemedvisioncare.com/unum

Bi-Weekly Payroll Deductions

Team Member Only	\$3.52
Team Member + Spouse	\$5.84
Team Member + Child(ren)	\$5.97
Team Member + Family	\$9.44

INCOME PROTECTION

New Carrier
for 2025

BASIC LIFE AND AD&D

Basic Life and Accidental Death & Dismemberment coverage is provided for all eligible employees through Unum at no cost to you. This insurance may be available for conversion at your own cost should you leave the company. Please remember to keep up to date on your Beneficiary designations.



Basic Life and AD&D Coverage	
Coverage Amount	Age Reduction Schedule
\$20,000 Life Benefit & \$20,000 AD&D Benefit <i>Includes Accelerated Life Benefit, Exposure & Disappearance Benefit, Repatriation Benefit, Seat Belt-Air Bag Benefit, Portability & Conversion. See plan summary for details.</i>	Benefit reduces to 65% at age 65, to 50% at age 70

VOLUNTARY LIFE AND AD&D

Employees are also provided the opportunity to purchase additional life insurance through Unum to help protect their families. You must purchase Voluntary Life on your legal spouse and/or child(ren). If you are a late entrant, you will have to provide a statement of good health called evidence of insurability.



Guarantee Issue at this Open Enrollment Only
**If you decline this benefit this open enrollment, you will be asked to submit an EOI if you enroll in the future.*

Voluntary Life and AD&D Benefits	
Team Member	\$10,000 increments up to \$500,000 <i>To a maximum of 5 x your annual earnings</i> Initial Enrollment Guarantee Issue amount: \$150,000
Legal Spouse/	\$5,000 increments up to \$250,000 Initial Enrollment Guarantee Issue amount: \$35,000
Child(ren)	Live birth to 14 days: \$1,000, 14 days to 6 months old: \$1,000 6+ months and older: \$1,000 increments to a maximum of \$10,000

Insurance coverage will be delayed if the employee is not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Suicide Exclusion: No benefits are paid if the insured's death is due to a suicide within two years from the insured's original effective date.

Voluntary Life & AD&D Monthly Rates per \$1,000 Minimum Benefit: \$10,000 EE/ \$5,000 SP			
Age	Team Member* Rate per \$1,000 Life Benefit Amount	Team Member Rate per \$1,000 AD&D Benefit Amount	Spouse* Rate per \$1,000 Life Benefit Amount
25-29	\$ 0.06	\$ 0.02 Combined with Life	\$ 0.06
30-34	\$ 0.08		\$ 0.08
35-39	\$ 0.09		\$ 0.09
40-44	\$ 0.15		\$ 0.15
45-49	\$ 0.24		\$ 0.24
50-54	\$ 0.36		\$ 0.36
55-59	\$ 0.64		\$ 0.64
60-64	\$ 1.05		\$ 1.05
65-69	\$ 1.68		\$ 1.68

**Spouse rates are based on the employee age, not the spouse's age.*



Have Questions?
Contact Unum at 866-679-3054

(Monday-Friday 8:00 am-8:00 pm ET)

Child Monthly Rates per \$1,000 Benefit Amount	
Child(ren) Life Monthly Rate per \$1,000 Benefit Amount <i>*Benefit Limitations apply based on age of child(ren)</i>	\$ 0.28

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INCOME PROTECTION: DISABILITY

New Carrier
for 2025

VOLUNTARY SHORT-TERM DISABILITY

The loss of income due to illness or disability can cause serious financial hardship for your family. Leland Management's disability insurance programs, offered through Unum, work together to replace a portion of your income when you're unable to work. The disability benefits you receive allow you to continue paying your bills and meeting your financial obligations during this difficult time.



Voluntary Short-Term Disability	
Elimination Period	7 days due to an Accidental Injury or Illness
Benefit Duration	Up to 25 weeks
Benefit Amount	60% of weekly salary
Maximum Benefit	\$1,000 per week
Pre-Existing Condition Limitation	3 months look back; 12 months after exclusion

Voluntary Short-Term Disability	
Age	Rate per \$10 of Weekly Benefit
<25	\$0.68
25-29	\$0.74
30-34	\$0.68
35-39	\$0.52
40-44	\$0.48
45-49	\$0.48
50-54	\$0.54
55-59	\$0.71
60+	\$0.71

VOLUNTARY LONG-TERM DISABILITY

Long Term Disability (LTD) protects a portion of your income if you become disabled because of a non-work-related illness or injury for longer than 180 days. Benefits begin the day after the elimination period is completed. Certain exclusions, as well as pre-existing condition limitations may apply. If you previously applied and were declined, you will need to complete an evidence of insurability (EOI).

Voluntary Long-Term Disability	
Elimination Period (Day benefits begin on)	After 180 days of disability due to an Accidental Injury or Illness
Monthly Benefit	60% of salary up to \$5,000 maximum
Pre-Existing Condition Limitation	3 months look back; 12 months after exclusion
Own Occupation	After 24 months of payments, the employee is disabled when Unum determines that due to the same sickness or injury, he or she is unable to perform the duties of any gainful occupation for which he or she is reasonably fitted by education, training or experience.
Return-To-Work Program	After a disability, most people want to get back to work. Unum will provide an additional 10% in disability benefits (to a maximum amount per month) if employee is eligible and participating in the rehabilitation and return-to-work program.

Voluntary Long-Term Disability	
Age	Rate per \$100 of Covered Earnings
<25	\$0.14
25-29	\$0.20
30-34	\$0.26
35-39	\$0.38
40-44	\$0.55
45-49	\$0.89
50-54	\$1.19
55-59	\$1.32
60-64	\$0.85
65-69	
70+	

ADDITIONAL BENEFITS

New Carrier
for 2025



VOLUNTARY ACCIDENT INSURANCE

You can't always avoid accidents - but you can help protect yourself from accident-related costs that can strain your budget. Accident insurance supplements your primary medical plan and disability programs by providing cash benefits in cases of accidental injuries. You can use this money to help pay for uncovered medical expenses, such as your deductible or coinsurance, or for ongoing living expenses, such as your mortgage or rent. Benefits are paid directly to you - unless assigned to someone else - and are also paid in addition to other coverages you may have, such as medical or an AD&D plan.

Accident Insurance pays a benefit for a wide array of events, medical services and treatments. The plan provides a lump-sum payment for many covered events such as:

- Fractures
- Dislocations
- Cuts or lacerations
- Coma and more

You'll receive a lump-sum payment when you have these covered medical services/treatments related to a covered accident:

- Ambulance
- Emergency care
- Surgery
- Physician follow-up visits
- Transportation
- Medical Testing Benefits (includes x-rays, MRIs and CT Scans)
- Physical therapy

Voluntary Accident Plan Bi-Weekly Payroll Deduction	
Team Member Only	\$ 4.96
Team Member + Spouse	\$ 8.80
Team Member + Child(ren)	\$ 10.65
Team Member + Family	\$ 14.48



**Guarantee Issue at
this Open Enrollment**

This plan provides protection for covered events experienced while off the job only.

VOLUNTARY HOSPITAL INSURANCE

A trip to the hospital can be stressful, and so can the bills. Even with a major medical plan, you may still be responsible for copays, deductibles, and other out-of-pocket costs. A hospital indemnity plan provides supplemental payments directly to you - unless assigned to someone else - that you can use to cover expenses that your medical plan doesn't cover for hospital stays. If you are admitted to a hospital for a covered sickness or injury, you'll receive payments that can be used to cover all sorts of costs, including:

- Deductibles and co-pays.
- Travel to and from the hospital for treatment.
- Childcare service assistance while recovering.

Voluntary Hospital Indemnity Benefits	
Hospital / ICU Admission	\$1,000 per admission, limited to 1 admission per year per insured.
Hospital / ICU Confinement	\$100 per day, limited to 30 day(s) per insured per benefit year.
Pre-existing Conditions	3 month look back period, 12-month exclusion period, Continuity of Coverage
Wellness Benefit	Unum will provide a \$50 payment for various health screenings.

Voluntary Hospital Indemnity Plan Bi-Weekly Payroll Deduction	
Team Member Only	\$ 7.34
Team Member + Spouse	\$ 13.65
Team Member + Child(ren)	\$ 10.20
Team Member + Family	\$ 16.51



**Guarantee Issue at
this Open Enrollment**

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INCOME PROTECTION: CRITICAL ILLNESS

CRITICAL ILLNESS

When a serious illness strikes, critical illness insurance can provide financial support to help you through a difficult time. The Guardian Critical Illness program pays up to \$10,000 (\$5,000 for Spouse / \$2,500 for Child(ren) in the event you are diagnosed with one of these illnesses. It protects against the financial impact of certain illnesses, such as a heart attack, stroke, or cancer.

You receive a lump-sum benefit to cover out-of-pocket expenses for your treatments, even if they are covered by your medical plan. You can also use the money to take care of your everyday living expenses, such as housekeeping services, special transportation services, and day care. Benefits are paid directly to you, unless assigned to someone else.

Health questions are required if the elected amount exceeds the Guarantee Issue, as well as for all applicants age 70+ regardless of elected amount.

As long as you or your dependents meet the policy and certificate requirements, the following medical conditions are covered:

- Invasive and Non-Invasive Cancer
- Heart Attack, Coronary Arteriosclerosis, Stroke
- Major Organ Failure (Heart, Kidney...)
- Alzheimer's Disease, Parkinson's Disease, Multiple Sclerosis
- Certain Childhood Conditions such as Down's Syndrome
- And many more!

Staying with  Guardian®

- Premiums will not increase as you age
- Spouse premium is based on Employee age
- Guaranteed Issue, no health questions to answer if enrolling during new hire eligibility or during the annual Open Enrollment only
- \$10,000 for team members less than age 70
- \$5,000 for spouse less than age 70
- Child Eligible from birth to age 26
- Benefits reduce by 50% at age 70
- Portability is included

Pre-existing Condition Limitation: 12 / 12, Any condition for which you, consulted with a physician, received treatment, or took prescribed drugs 12 months before the effective date will not be covered for the first 12 months of the policy.

Critical Illness Bi-Weekly Payroll Deductions

Benefit Amount	Age <25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
\$1,000	\$0.17	\$0.18	\$0.26	\$0.33	\$0.46	\$0.66	\$0.90	\$1.22	\$1.62	\$2.15	\$2.75
\$2,000	\$0.34	\$0.35	\$0.52	\$0.66	\$0.91	\$1.31	\$1.80	\$2.45	\$3.25	\$4.29	\$5.49
\$3,000	\$0.51	\$0.53	\$0.79	\$0.98	\$1.37	\$1.97	\$2.70	\$3.67	\$4.87	\$6.44	\$8.24
\$4,000	\$0.68	\$0.70	\$1.05	\$1.31	\$1.83	\$2.62	\$3.60	\$4.89	\$6.50	\$8.58	\$10.98
\$5,000	\$0.85	\$0.88	\$1.32	\$1.64	\$2.28	\$3.28	\$4.50	\$6.12	\$8.12	\$10.73	\$13.73
\$6,000	\$1.02	\$1.05	\$1.58	\$1.97	\$2.74	\$3.93	\$5.40	\$7.34	\$9.75	\$12.88	\$16.48
\$7,000	\$1.20	\$1.23	\$1.84	\$2.29	\$3.20	\$4.59	\$6.30	\$8.56	\$11.37	\$15.02	\$19.22
\$8,000	\$1.37	\$1.40	\$2.10	\$2.62	\$3.66	\$5.24	\$7.20	\$9.78	\$13.00	\$17.17	\$21.97
\$9,000	\$1.54	\$1.58	\$2.37	\$2.95	\$4.11	\$5.90	\$8.10	\$11.00	\$14.62	\$19.32	\$24.72
\$10,000	\$1.71	\$1.75	\$2.63	\$3.28	\$4.57	\$6.55	\$9.00	\$12.23	\$16.25	\$21.46	\$27.46

NOTE: Child cost is included with employee election.

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ADDITIONAL BENEFITS

VOLUNTARY CANCER ADVANTAGE PLAN

This Cancer Plan pays a benefit for a wide array of medical services and treatments, and covered events, such as:

- Initial Diagnosis: \$2,500 (Team Member/Spouse/Child)
- Cancer Screening: \$50; \$50 for follow-up screening

If diagnosed with cancer, you have these benefits related to cancer-covered medical services/treatments:

- Scheduled Surgical Benefit up to \$4,125 (refer to policy for additional information)
- Hospital confinement benefit \$300/day for first 30 days \$600/day for 31st day thereafter per confinement
- ICU confinement benefit \$400/day for first 30 days \$600/day for 31st day thereafter per confinement
- Anesthesia up to 25% of surgery benefit
- Attending Physician Visit: \$25/ while hospital confined. Limit 75 visits
- Anti-Nausea benefit pays \$50 per day up to \$150 per month
- Bone Marrow-up to \$7,500 / Stem Cell-up to \$1,500
- Scheduled Radiation/Chemotherapy Benefit per treatment week (refer to policy for additional information)
- Medical Imaging benefit pays \$100/image up to 2 per year
- And many more!

Benefits are subject to a Pre-Existing Limitation of 12/12 (12-month look back period, 12-month exclusion period).



Voluntary Cancer Advantage Plan	
Bi-Weekly Payroll Deduction	
Team Member Only	\$ 10.03
Team Member + Spouse	\$ 19.48
Team Member + Child(ren)	\$ 11.32
Team Member + Family	\$ 20.77



IMPORTANT NOTICES

2025 Plan Notices- Leland Management Inc: 59-3498435

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

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

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or aren't required to pay] for COBRA continuation coverage.

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs.

You must provide this notice to: Leland Management Human Resources department, hr@lelandmanagement.com, (407) 781-1170

IMPORTANT NOTICES

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan Contact Information

Leland Management,

6972 Lake Gloria Blvd, Orlando, FL 32809

(407) 781-1170

hr@lelandmanagement.com

IMPORTANT NOTICES

INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE

Important Notice from LELAND MANAGEMENT INC About Your Prescription Drug Coverage and Medicare

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

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

.Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

.**LELAND MANAGEMENT INC** has determined that the prescription drug coverage offered by the **EHIM** plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current **EHIM** coverage will not be affected. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current **LELAND MANAGEMENT INC** coverage, be aware that you and your dependents will not be able to get this coverage back.

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

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

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

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

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **LELAND MANAGEMENT INC** changes. You also may request a copy of this notice at any time.

Human Resources Department: 6972 Lake Gloria Blvd, Orlando, FL 32809 Phone Number: (407) 781-1170

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

For more information about Medicare prescription drug coverage: **Visit www.medicare.gov**

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

Date: 12/01/25

Name of Entity/Sender: LELAND MANAGEMENT INC

IMPORTANT NOTICES

MARKETPLACE NOTICE

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the healthcare law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15. Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan. There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the “minimum value standard” if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

IMPORTANT NOTICE: MARKETPLACE

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name Leland Management, Inc.		4. Employer Identification Number (EIN) 59-3498435	
5. Employer Address 6972 Lake Gloria Blvd.		6. Employer Phone Number (407) 781-1170	
7. City Orlando	8. State FL	9. ZIP code 32809	
10. Who can we contact about employee health coverage at this job? Human Resources			
11. Phone number (if different from above)		12. Email address hr@lelandmanagement.com	

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

As your employer, we offer a health plan to:

☒ All employees. Eligible employees are:

All Full-time employees who are regularly scheduled and working an average of 30 or more hours per week and have satisfied their waiting period.

☐ Some employees. Eligible employees are:

With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Legal Spouse and Eligible Dependent Children, up to age 26.

☐ We do not offer coverage.

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

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

IMPORTANT NOTICE: MARKETPLACE

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☒ Yes (Go to question 15)

☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ **105.00**

b. ☐ Weekly ☒ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16.

If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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

IMPORTANT NOTICES

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include case management.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be adjudicating a claim and reimbursing a provider for an office visit.
- Healthcare operations include the business aspects of running our health plan, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not, however, required to agree to a requested restriction, unless the request is made to restrict disclosure to the insurer for purposes of carrying out payment or healthcare operations (and is not for purposes of carrying out treatment), and the protected health information pertains solely to a healthcare item or service for which you have paid out of pocket in full. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of non-routine disclosures of protected health information. We have the obligation to provide, and you have the right to obtain a paper copy of this notice from us at least every three years.
- We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

PATIENT PROTECTION MODEL DISCLOSURE

Your health plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Human Resources department.

IMPORTANT NOTICES

This notice is effective as of May 20, 2011 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201

202.619.0257

Toll Free: 877.696.6775

healthadvocate.com/members

HIPAA SPECIAL ENROLLMENT NOTICE

Loss of Other Coverage

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption. Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

To request special enrollment or obtain more information, contact the Plan Administrator, Leland Management Human Resources Department:

Leland Management, Inc.

6972 Lake Gloria Blvd, Orlando, FL 32809

(407) 781-1170

hr@lelandmanagement.com

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

The Women's Health and Cancer Rights Act (WHCRA) requires annual distribution of a notice to all participants and beneficiaries in a group medical plan advising them of their rights to post-mastectomy breast reconstruction. The DOL has approved using an abbreviated notice to fulfill the annual notice requirement, but most employers do not use it. A more detailed notice (see DOL model enrollment notice below) is required at enrollment and it is easier for most employers to use the same text for both notices. For additional details on WHCRA, see WHCRA and Michelle's Law Requirements.

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

IMPORTANT NOTICES

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268

IMPORTANT NOTICES

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dftr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

IMPORTANT NOTICES

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

IMPORTANT NOTICES

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

CONTACT INFORMATION



Benefit	Administrator	Phone	Website / Email
Medical	Coastal Administrative Services (CAS)	855-373-8232	www.casbenefits.com
	Evolutions Network	727-938-2222	www.ehsppo.com
	MedWatch	800-432-8421	www.medwatch.com
	Concierge Nurse Navigator (CNN)	440-534-0583 <i>*Dedicated Leland Management Line</i>	Nicole@MyNurseNavigators.com
	Recuro: Telehealth	844-979-0313	www.recurohealth.com/tag/telehealth
Diagnostic Imaging	Green Imaging	844-968-4647	www.greenimaging.net
Pharmacy	EHIM	800-311-3446	www.ehimrx.com
Dental, Vision, Life and AD&D, Disability, Accident and Hospital Indemnity Insurance	Unum	866-679-3054	www.unum.com/employees/benefits
EAP	Unum	1-800-854-1446	www.unum.com/lifebalance
Critical Illness and Cancer Insurance	Guardian	1-800-541-7846	www.guardianlife.com
Benefits Assistance	RosenSure	407-370-0776	Service@RosenSure.com <i>*Mention Leland Management in your email subject line.</i>

NEED HELP? CONTACT YOUR DEDICATED HUMAN RESOURCES TEAM!

(407) 781-1170 or HR@LelandManagement.com



The Management Company You Don't Have To Manage



CONTACT INFORMATION

PHONE NUMBER: 407.370.0776

E-MAIL: SERVICE@ROSENSURE.COM

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