Tampa General Hospital BROOKSVILLE

Tampa General Hospital CRYSTAL RIVER

Tampa General Hospital SPRING HILL

2026 Benefits Guide



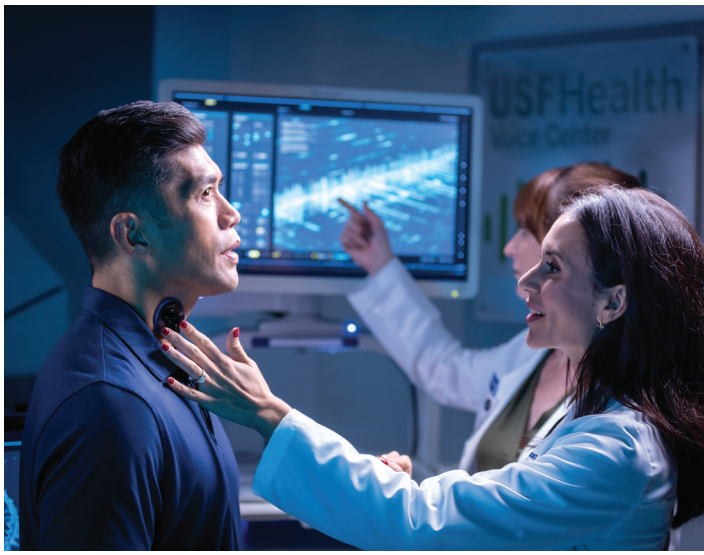




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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Contact Information

Important Numbers

Contact	Phone Number	Email or Website
Benefit Inquiries	813-844-7551	Submit a ticket to the ServiceNow People & Talent Employee Center
Blue Cross Blue Shield Representative	813-882-7950	Kristen.Hosmer@bcbsfl.com
Team Wellness	813-844-7935	teamwellness@tgh.org
New Hire Enrollments	844-940-3779	TGH.MyBenefitsAppointment.com
TGH Urgent Care	813-660-6900	www.tghurgentcare.com
TGH Outpatient Pharmacy	813-844-7688	www.tgh.org/institutes-and-services/tgh-pharmacy

Benefit Vendor Contacts

Plan Type	Provider or Administrator	Group Number or Employer ID	Phone Number	Website
Medical	Blue Cross Blue Shield of Florida	EPO: #96501 OOA EPO: #96503 HDHP: #96515 OOA HDHP: #98758	844-594-6012	FL.ExploreMyPlan.com
Dental	Delta Dental	#23136	800-521-2651	deltadentalins.com
Vision	EyeMed	#1057092	866-723-0513	eyemed.com/member
Employee Assistance Program (EAP)	GuidanceResources	Username: LFGSupport Password: LFGSupport1	888-628-4824	www.GuidanceResources.com
Health Savings Account / Flexible Spending Accounts	HealthEquity		877-722-2667	my.healthequity.com/clientlogin.aspx
Life & Disability	Lincoln Financial	#09-LF0974	888-408-7300	www.lincolnfinancial.com
LifeTime Benefit Term Insurance with Long Term Care	Chubb		855-241-9891	csmail@gotoservice.chubb.com
Accident Insurance	Lincoln Financial	#0000377052	800-423-2765	www.lincolnfinancial.com
Critical Illness Insurance	Lincoln Financial	#0000377051	800-423-2765	www.lincolnfinancial.com
Hospital Indemnity Insurance	Lincoln Financial	#0000377053	800-423-2765	www.lincolnfinancial.com
Pet Insurance	PetPartners, Inc.		866-774-1113	help@petpartners.com
Identity Theft Insurance	MetLife (Aura)	143078	833-552-2123	
Legal Plan	MetLife	143078	800-821-6400	members.legalplans.com
Retirement - 403(b)	Fidelity		800-603-4015	netbenefits.com/atwork
COBRA	HealthEquity		844-341-4935	memberservices@healthequity.com

Our benefits program includes, but is not limited to, the following benefits:

- Medical plan options for those living inside and outside of the TGH service area
- Two dental plans
- One vision plan
- Basic, supplemental life, and dependent life insurance
- Short-term and long-term disability insurance
- Accidental death & dismemberment insurance
- Flexible spending accounts
- Voluntary benefit plans
- Pre- and post- tax retirement saving options

TGH's Commitment

TGH remains committed to providing an affordable, quality benefits program designed to help you avoid having to pay large health care costs on your own. TGH continues to look for ways to reduce the impact of rising health care costs on our medical plans and, in turn, on our team members.

Online Benefits Library

To learn more about your benefit options, visit **TGH.MyBenefitsLibrary.com**. This online resource puts all of the benefits information right at your fingertips – anytime, anywhere.



How to Enroll

This is a passive enrollment which means unless you'd like to make changes to your benefit elections you do not need to take action. However, all **Flexible Spending Account (FSA) participants must update their contributions for 2026.** If you fail to make a change during this enrollment period, you will not have another opportunity to enroll until the next open enrollment unless you experience a qualifying life event.

There are two ways to elect benefits:

1. Online at **TGH.bswift.com**
2. With the Support of an Enrollment Counselor

   Visit **TGH.MyBenefitsAppointment.com**

   Call 844-940-3779, Monday - Friday, from 7 a.m. - 6 p.m. ET

   SCAN ME

   Speak with an enrollment counselor to learn more about your benefit options. During your individual appointment, the enrollment counselor will:

   - Review your benefits options
   - Answer questions and provide additional information
   - Enroll you in your benefit selections

   Counselors are available by phone. Bilingual support is also available. If you are covering your dependent(s), you will be required to provide their Social Security Number(s) or Tax Identification Number(s) and date(s) of birth as well as their birth certificate(s), marriage certificate(s), or court-ordered documentation to complete your enrollment. A physical copy of their SSN card is not needed. If you plan to elect coverage for a Domestic Partner, please visit TGH.MyBenefitsLibrary.com for a full list of required criteria and acceptable documentation.

After you complete your enrollment, we strongly encourage you to log into bswift to retrieve for your records and review your **2026 Confirmation Statement** to ensure your benefit elections and dependent information are accurate. We also encourage you to check your benefit deductions on your first January paycheck for any discrepancies.

Evidence of Insurability Note:
If you elect life insurance over the guaranteed issue amount, your Confirmation Statement will indicate that your benefits are pending the completion and approval of an Evidence of Insurability (EOI) form. Your pending benefit election(s) and payroll deductions will not take effect until your EOI is approved by the insurance carrier.



Rising Health Care Cost

While the cost of medical and prescription drugs continue to rise each year, we evaluate ways we can continue providing high quality coverage at the lowest cost possible. We have been able to structure our contributions so they remain competitive in our industry.

TGH team members will continue to pay less for medical coverage than the national average and less than our peers at other local hospitals.

We will continue to offer services at TGH for certain physician, hospital and prescription medications at a significantly lower cost to you. This is our TGH Advantage. In addition, we also have All Children's Hospital and Moffitt Cancer Center, as well as other select providers within our local community.

Use TGMG Family Care Center Clinics' Physicians

EPO medical plan participants will be charged a $10 copay when you visit a primary care physician and a $25 copay when you visit a specialist at any of our TGMG clinics. That's a $20 savings every time you or a covered dependent use the TGH Advantage network.

Enroll in a Health Savings Account (HSA) or Flexible Spending Account (FSA)

If you believe you will spend money for medical, dental, vision, or dependent daycare in 2026, setting pretax money aside for these expenses will save you substantial dollars!

If you enroll in the High Deductible Health Plan (HDHP), you are eligible to contribute to a Health Savings Account (HSA). An HSA is a triple tax-advantaged savings account you can use for healthcare expenses. Along with saving you money on taxes, HSAs can help you grow your nest egg for retirement. The IRS limits how much you can contribute to your HSA each year. You can contribute up to the 2026 IRS maximum of $4,400 for an employee and $8,750 for a family. Those 55+ can contribute an additional $1,000 on an annual basis over the IRS maximum amount. Refer to pages 17 - 18 to learn more.

Flexible Spending Accounts are tax-advantaged savings accounts that allow you to deposit a portion of your pre-tax income into a spending account which is used to pay for medical, dental, and vision expenses, as well as dependent daycare expenses. The IRS limits how much you can contribute to your FSA every year. You can contribute up to the 2026 IRS maximum to your Health Care Flexible Spending Account. Refer to pages 27 - 29 to learn more.

If you enroll in the HDHP, you can also enroll in a Limited Purpose Flexible Spending Account (LPFSA). LPFSAs are also tax-advantaged savings accounts that allow you to deposit a portion of your pre-tax income into a spending account. However, an LPFSA only covers eligible dental and vision expenses not medical expenses. This account is for people who want to contribute to an HSA, but also have expected dental and vision expenses. The IRS limits how much you can contribute to your LPFSA every year. You can contribute up to the 2026 IRS maximum to your LPFSA. Refer to pages 27 - 29 to learn more.

A Dependent Care Flexible Spending Account (DCFSA) is a pre-tax benefit account used to pay for expenses for any eligible work-related dependent care expenses you incur for your eligible dependent child(ren). The IRS limits how much you can contribute to your DCFSA every year. You can contribute up to the 2026 IRS maximum of $7,500, depending on your marital status. Refer to page 31 to learn more.

Eligibility Information

Regular full- and part-time team members budgeted to work at least 32 hours per pay period are eligible for benefits. If you are a new team member or pool team member with a qualified change in status, your coverage will begin on the first day of the month after 30 days of continuous employment in a benefits-eligible position, as long as you enroll within your designated enrollment period.*

You can elect medical, dental, and/or vision coverage for:

- Yourself only
- Yourself and your spouse
- Yourself and your domestic partner
- Yourself and your child(ren)
- Yourself and eligible dependents

** If your 30th day falls on the first of the month, your benefits will be effective on that date.*

Covering Your Dependents

In addition to enrolling your eligible dependents in medical, dental, and/or vision coverage, you may also enroll them in dependent life insurance.

Eligible dependents include your:

- Legally married spouse**
- Domestic partner
- Children through the end of the month in which he or she reaches age 26, or

Eligible children include your:

- Disabled child up to age 65 if he or she is incapable of self-sustaining employment
- Step-children or adopted children
- Dependent children of a covered domestic partner
- Other legally dependent children (you must provide court ordered documentation)

Are you enrolling a dependent?
If you are a new or current team member enrolling a dependent for the first time, you will be asked to provide the following proof of your dependent's eligibility:

- Spouse—marriage license
- Domestic Partner—please visit TGH.MyBenefitsLibrary.com for a full list of required criteria and acceptable documentation
- Child—birth certificate
- Step-child—birth certificate
- Dependent children of a covered domestic partner—birth certificate
- Other child(ren)—court order and/or legal documents
- Social Security Numbers for all dependents

Enrolling an ineligible dependent is insurance fraud and a violation of the TGH Code of Conduct. Some examples of ineligible dependents include children for whom you do not have legal custody, significant others, and ex-spouses.

Please contact the TGH Benefits Department if you have eligibility questions.

Are you and your spouse (or other eligible dependents) both TGH team members?
If you are, you cannot cover yourself and also be covered as a dependent by your spouse's medical, dental, vision and/or life insurance plan. Likewise, only one of you can cover your eligible children for medical, dental, and/or vision care.

***** Common-law relationships are not recognized in Florida and do not qualify as legally married.***

Change in Employment Status

A change in position classification commonly has the following impact on a team member's plan coverage and/or cost sharing:

Full-time Regular to Part-time Regular - team member's medical premium will not increase to part-time rates until the next plan year. Dental and Vision rates will remain the same. Life and Disability coverage and premium will be reduced to reflect the new level of pay.

Part-time Regular to Full-time Regular - team member's medical premium will decrease to full-time rate. Dental and Vision rates will remain the same. Life and Disability coverage and premium will be increased to reflect the new level of pay.

Full-time Regular to Pool - team members will not lose access to all health and welfare benefits until the following plan year unless the team member chooses to decline coverage within 31 days of the employment status change. Team members who decline coverage will be eligible for COBRA benefits to continue health coverage if they choose to do so. Team members will no longer accrue ATO hours or be eligible for tuition assistance. However, team members can continue to participate in the Retirement Savings plans.
***** Please note - benefits are NOT automatically cancelled upon changing to a Pool position from Full-time. Team members must initiate the process submitting a ticket to the ServiceNow People & Talent Employee Center.***

Part-time Regular (under 30 hours) to Pool - team members will lose access to all health and welfare benefits until the following plan year. You will be eligible for COBRA benefits to continue health coverage if you choose to do so. Team members will no longer accrue ATO hours or be eligible for tuition assistance. However, team members can continue to participate in the Retirement Savings plans.

Pool to Regular (Full-time or Part-time) - team members will be eligible for benefits on the first of the month following 30 days of employment in a regular position. Team members will receive an email to their work account notifying them of their eligibility and how to make elections.

Note: Your TGH benefits coverage will end on the last day of the month in which you terminate employment (unless you are eligible for and elect continuation of coverage through COBRA). If you are rehired, a waiting period for benefits will apply before your coverage is reinstated.

If you, your spouse, or eligible dependent lose coverage under the following TGH group benefit plans because of a qualifying event under the Consolidated Omnibus Budget Reconciliation Act (COBRA), then you may have the right to continue the following coverages:

- Medical
- Dental
- Vision

New Address or Phone Number?
Please log into PeopleSoft to update your address and/or phone number.

Qualifying Life Events

TGH recognizes that each team member has different benefit needs and that our life circumstances can change from year to year, which is why you have the opportunity to redesign your benefits every year during Annual Enrollment. Because a change can sometimes occur between enrollment periods, there is a way to make changes during the year under certain circumstances.

Most TGH plans are offered to you on a tax-free basis—your contributions are deducted from your paycheck before taxes are withheld. As a result, you may only make changes to your elections during Annual Enrollment or if you experience an Internal Revenue Service (Section 125) or Health Insurance Portability and Accountability Act (HIPAA) change in status. Once you enroll in tax-free benefits, your choices will remain in effect for the plan year (January 1 – December 31) unless otherwise communicated. Under Section 125 and HIPAA, certain life events, such as marriage, divorce, or birth are defined as qualifying changes in status.

Experiencing a life event qualifies you to make mid-year changes to those benefits affected by the event within 31 days of the life event. The change(s) you make must be consistent with the change in status event. For example, getting married is a change in status, so you can add your new spouse to your coverage or drop your coverage if you will be covered by your spouse's plan within 31 days of the date of your marriage.

Changes in status include, but are not limited to:

- Marriage, divorce, or annulment
- Birth, adoption, or death of a dependent
- Beginning or ending of your spouse's or dependent's employment resulting in gain or loss of insurance coverage
- A dependent's eligibility changes due to age
- Changes in employment status such as Full-Time to Pool, Part-Time to Full-time, etc.
- Moving out of one of the following counties: Citrus, Hernando, Hillsborough, Manatee, Pasco, Pinellas, Polk, and Sarasota



Acceptable Documents for Covering Eligible Dependents

- **Spouse**
  - Marriage certificate
- **Domestic Partner**
  - Specific criteria must be met; this includes but is not limited to:
    - » Been living in a committed exclusive relationship for at least 12 months
    - » Shared the same principal residence for at least 12 months prior to enrollment in benefits
    - » Intend for the Domestic Partnership to be permanent
    - » Please visit TGH.MyBenefitsLibrary.com for a full list of required criteria and acceptable documentation
- **Biological Child**
  - Birth certificate of biological child
- **Adopted Child**
  - Official court/agency papers (initial stage)
  - Official Court Adoption Agreement (mid-stage)
  - Birth certificate (final stage)
- **Stepchild**
  - Child's Birth certificate showing the child's parent is the team member's legal spouse
  - Certificate showing legal marriage between the team member and the child's parent
  - Court document showing that your spouse has custody of the child or is required to cover child
- **Guardianship**
  - Court papers demonstrating legal guardianship, including the person named as legal guardian
  - Court-Ordered Medical Coverage
  - Qualified Medical Child Support Order (QMCSO)
  - National Medical Support Notice (NMSN)
- **Child Age 26 or Older**
  - Benefit Verification Letter or Award Letter from the Social Security Administration

If you are unable to locate your marriage and/or birth certificate(s) by the deadline, please contact the Benefits Department.

Making Benefit Elections	Action Steps
When You Experience a Change In Status Have you experienced an IRS (Section 125) or Health Insurance Portability and Accountability Act (HIPAA) change in status and want to make a change to your benefit elections? ▶ You must notify the TGH Benefits Department **within 31 days of the event**. ▶ Your current coverage will terminate at the end of the month of your status change date. ▶ Your new coverage will begin the first of the month following the status change.	Submit a ServiceNow ticket to request a change to your benefit elections due to a Qualifying Life Event ▶ Log in to the bswift benefit portal at TGH.bswift.com and upload supporting documentation such as marriage certificate, divorce decree, birth certificate, proof of gain or loss of coverage.
When You Change Companies Have you changed companies and need to enroll in your new company benefits? ▶ Current elections will not roll over to your new company. You must elect your new company benefits within 30 days of your transfer. ▶ Your new coverage will begin the first of the month following the transfer date.	

Do I Need a Form?

Some of the elections you make will require you to complete a *Beneficiary Designation and/or Evidence of Insurability* form. You may also need to complete certain forms if you experience a change in status during the year. The following chart can help you determine what forms you need to request from the TGH Benefits Department or download from the TGH Benefits Portal.

Making Benefit Elections	Action Steps
Question: ***During Your Enrollment Window*** Did you elect coverage greater than the guaranteed issue amount for any of the below benefits? ▶ Additional life insurance ▶ Dependent life insurance ▶ Lifetime benefit term insurance	***Answer*** You will be directed to a link to complete the Evidence of Insurability form when completing your enrollment information online or with a counselor. ▶ *"Evidence of Insurability"(EOI) or (E of I)* is a statement or proof of your medical history by which the carrier(s) will determine your acceptance for insurance. **IMPORTANT:** If you enroll in one of these benefits and do not submit your completed *EOI* form within 31 days of your effective date, your pending election will be cancelled.
When You Are a New Team Member Are you a new team member?	Review benefit plans information on the TGH Benefit Library at TGH.MyBenefitsLibrary.com. Schedule an appointment with an Enrollment Counselor at TGH.MyBenefitsAppointment.com or enroll online at TGH.bswift.com. ▶ If covering dependents, upload dependent verification documents to bswift after you complete your enrollment, **prior to your benefit effective date**. Uploading instructions are available under "Employee Notices" on the bswift homepage.
When You Need to Change Your Beneficiary Are you planning to change your beneficiary for your life insurance policy?	▶ Log in to TGH.bswift.com, click on *My Profile*, then *Beneficiaries*.

2026 Medical Plan Options:

- TGH EPO Plan
- TGH High Deductible Health Plan
- TGH Out of Area High Deductible Health Plan**
- TGH Out of Area EPO Plan**

TGH offers medical plans that provide you with comprehensive coverage with low out-of-pocket costs.

Each plan gives you maximum flexibility with these important features in common:

- Direct access to network physicians
- Care coordination
- Health education and wellness programs
- Urgent care centers

For more information, please contact Blue Cross and Blue Shield of Florida or the TGH Benefits Department for a Summary Plan Description.

Features include:

- No primary care physician requirement—you can visit any network physician and directly access network specialists without any referral
- An emphasis on wellness—annual physical, well-woman, mammograms and/or well-child examinations are covered at 100%
- No claim forms to fill out or hospital notification required
- Protection against paying amounts over the usual and customary (U&C) charge—so you do not have to worry about paying more than you expected
- A vision care benefit that helps with the cost of eye exams (once every 24 months)
- An unlimited lifetime maximum to safeguard against the cost of a major illness or injury

**TGH offers medical plans that provide you with comprehensive coverage with low out-of-pocket costs.

Network Advantage

When you use TGH for care or to fill your prescriptions, you will significantly lower your costs!

Choose the TGH Advantage and Save!

TGH Advantage benefits offer significant savings when you use TGH for certain doctor and hospital services and to purchase prescription drugs. Note: When you use a TGH facility, you are expected to pay your copayment at the time of service.

Additional Savings when you use the TGH Pharmacy

TGH offers a tiered benefit. Refer to pages 13-15 to learn more. The TGH pharmacy copayment is significantly lower than retail drug copayments.

Special Discounts If You and Your Dependents Are Tobacco Free

People in healthcare know that it is easier and more cost-effective to stay healthy than to fight disease. TGH gives you a discount if you and your covered dependents are tobacco free—this means you and your covered dependents are NOT currently using any tobacco products. Tobacco products include, but are not limited to:

- e-cigarettes
- cigarettes
- pipes
- cigars
- chewing tobacco
- snuff
- vaping

Cost of Medical Coverage

Both you and TGH share in the cost of medical coverage, with TGH paying more than 80% of the total cost for full-time benefit-eligible team members. How much you pay is based on the number of hours you are budgeted to work each pay period, the level of coverage you choose, and whether or not you are tobacco free.

Prescription Drug Program
You have a choice when you get a prescription filled. While you can fill it at TGH or a network pharmacy, you'll save money when you fill a prescription at TGH. The charts on pages 13 - 15 show pharmacy benefits for each medical plan. It is important to remember the following:

- You must show your identification (ID) card to the pharmacist each time you have a prescription filled.
- The Blue Cross and Blue Shield of Florida Standard Prescription Drug List (PDL) is developed by physicians and pharmacists and consists of a wide selection of FDA approved generic and brand name drugs. The list is reviewed and updated regularly. For more information about which drugs are listed in the PDL, please visit the Blue Cross and Blue Shield of Florida web site at www.floridablue.com. For more information about which drugs are covered on the Standard Drug List please visit FL.ExploreMyPlan.com/DrugList.
- Drugs over $400 must be filled at the TGH pharmacy. If you participate in the OOA EPO or OOA High Deductible Health Plan, you must use a pharmacy within the Prime Participating Network as there is not out-of-network coverage.

Home Delivery from Amazon Pharmacy
Amazon Pharmacy offers a home delivery service that lets you easily order and quickly get your non-specialty medicines delivered at home. And as a member of your health plan, you get access to the MedsYourWay® prescription drug discount pricing, administered by Inside Rx. The prescription discount gives you up to 80% savings on brand and generic medicines and is seamlessly built into the Amazon Pharmacy experience. Using the MedsYourWay discount pricing is not insurance; however, using it for covered medicines will also count toward your out-of-pocket maximum. To get started, visit www.amazon.com/MYW. Make sure you have your member ID card information ready.

Emergency Care
You are covered for the treatment of life-threatening emergencies whether you are at home or out of the network area as long as your situation meets emergency guidelines.

A medical emergency is a serious accident or sudden illness resulting from injury, sickness, or mental illness and, in the judgment of a reasonable person, requires immediate care and treatment to avoid a long-term medical problem or loss of life. For an emergency to be covered you must follow certain procedures:

- If you have a non-life-threatening emergency, call your network physician (leave a message if you are calling after regular business hours). Your network physician or the physician on call will return your call with instructions on how to handle your emergency needs by either giving you medical advice, prescribing medication, scheduling an office appointment, or directing you to the nearest emergency treatment facility.
- In the case of suspected heart attack, stroke, poisoning, loss of consciousness, shock, trauma, impaired breathing, or convulsions, proceed immediately to the nearest emergency facility and contact your network physician when the emergency is stabilized.
- If you are traveling away from home and need emergency care, you may be responsible for paying for treatment at the time of your visit. If this happens, you can file a claim with Blue Cross and Blue Shield of Florida for reimbursement. Please call the customer service telephone number on your ID card for instructions on how to file a claim.

Medical Coverage (cont)

Urgent Care Centers
Illness and injuries that are of a less serious nature than an emergency may require urgent care. Urgent Care Centers are designed to give patients fast, effective service and to prevent a serious decline in health. Urgent Care Centers commonly treat conditions like:

- Minor injuries, sprains, and cuts
- Sore throats and upper respiratory infections
- Ear infections
- Urinary tract infections

TGH Virtual Health
Now you can visit a medical care professional live anytime, anywhere on your smartphone, tablet, or computer. Get the care you need to treat conditions like:

- Sinusitis
- Sore throat
- Flu
- Cold
- Bronchitis
- Rash
- Asthma
- And more...

Download the TGH Virtual Health app or visit TGH.org/virtualhealth.

TGH at Home
TGH at Home gives eligible patients an opportunity to receive best-in-class clinical hospital care from the comfort of their own home. To be enrolled, patients must be seen in the Emergency Department or admitted to the hospital to be considered for the TGH at Home program. The program combines daily in-home visits from health care providers, virtual visits and 24/7 remote patient monitoring.

Care Coordination
The Blue Cross and Blue Shield of Florida Care Coordination program promotes preventive care and wellness through a variety of educational resources that members can access.

Pre-admission Certification
Precertification is required for all hospital admissions (general hospitals and psychiatric specialty hospitals) except for medical emergency services and maternity admissions. For medical emergency services, Blue Cross and Blue Shield of Florida must receive notification within 48 hours of the admission.

Generally, if precertification is not obtained, no benefits will be payable for the hospital admission or the services of the admitting physician. For more information, call the customer service number on the back of your ID card.

Know What's Covered Before You Use These Services

- Outpatient Rehab Therapy Services include physical, occupational, speech, pulmonary, and cardiac rehabilitation and are limited to a maximum of 40 visits per year.
- Routine Outpatient Diagnostic Therapy Services include routine lab and radiology/X-ray services as well as mammography screenings and ultrasounds.
- Advanced Outpatient Services and Treatments include CT scans, MRIs, nuclear medicine, dialysis, intravenous chemotherapy, and other intravenous infusion therapy.
- Outpatient Surgery includes the facility charge and the charge for required hospital-based professional services, supplies, and equipment provided at a hospital or ambulatory surgery center.

This is not an all-inclusive list of services. Some restrictions may apply. Please refer to your Summary Plan Description for more details.

Blue Cross and Blue Shield of Florida Medical Plan Comparison (Effective Jan. 1, 2026)				
	Tier 1 TGH, TGH Urgent Care, TGMG, TGH Outpatient Center, TGH Rehabilitation Hospital, TGH Brooksville, TGH Crystal River, TGH Spring Hill, TGH Imaging, Florida Kidney Physicians, USF Health, Morsani & FOI	**Tier 2** Johns Hopkins All Children's Hospital and Moffitt Cancer Center	**Tier 3** Blue Cross and Blue Shield of Florida BlueOptions Network	**Tier 4** Out-of-Network
Annual Deductible (single / family)	$0	$0	$1,000 / $2,000	$1,000 / $2,000
Annual Out-of-Pocket Max (single / family)	$1,500 / $3,000	$2,500 / $5,000	$5,000 / $10,000	$5,000 / $10,000
Inpatient Hospital	$250	$1,000	N/A	N/A
Outpatient Surgery / Services	$150	$500	40% after deductible*	N/A
Emergency Room (copay waived if admitted)	$250	$250	$250	$250
Preventive Care	Covered at 100%	Covered at 100%	Covered at 100%	N/A
Urgent Care	$30	$50	$50	N/A
Physician / Specialist	$10 / $25	$10 / $25	$30 / $45	N/A
Childbirth	$250	N/A	N/A	N/A
Prenatal Maternity Care	$10 copay; No overall deductible		$30 copay; No overall deductible	N/A
Chiropractic Care	$10 (Limit 40 visits/year)	$20 (Limit 40 visits/year)	$30 (Limit 40 visits/year)	N/A
PT / OT / ST	$10	$20	$30	N/A
Therapy Limits	OT / PT: Combined limit for Tier 1 & 2 is 80 visits/year; ST: Limit 40 visits/year for Tier 1, 2, 3, 4		OT/PT combined 40 visits	N/A
Outpatient Diagnostics: Lab / X-ray	$0	$25 X-ray	$50 X-ray	N/A
Imaging (MRI, CT, PET Scans, etc.)	$50	$300	40% after deductible*	N/A
Inpatient Services for Mental Health & Substance Abuse	Covered at 100%	Not covered	Not covered	N/A
Outpatient Services for Mental Health & Substance Abuse	$10 copay/visit; No overall deductible	$10 copay/visit; No overall deductible	$10 copay/visit; No overall deductible	N/A
Pharmacy	**Generics**	**Preferred Name Brand**	**Non-preferred Name Brand**	**Specialty**
TGH Pharmacy	$10	$15	$20	$80
Retail EPO Pharmacy	$45	25% ($60 min/$150 max)	35% ($80 min/$300 max)	35% ($100 min/$400 max)

* Freestanding non-Hospital based Tier 3 BlueOptions locations only.

Co-insurance is subject to calendar-year deductibles. **The percentages shown in the chart are the co-insurance amounts you are responsible for paying for an eligible medical expense after your deductible, if any, is met.** True emergency only will be covered if it meets Blue Cross and Blue Shield of Florida definition of emergency (see page 11). This summary contains highlights only and is subject to change. The specific terms of coverage, exclusions, and limitations are contained in the Summary Plan Description.

Blue Cross and Blue Shield of Florida Medical Plan Comparison (Effective Jan. 1, 2026)				
High Deductible Health Plan	**Tier 1** TGH, TGH Urgent Care, TGMG, TGH Outpatient Center, TGH Rehabilitation Hospital, TGH Brooksville, TGH Crystal River, TGH Spring Hill, TGH Imaging, Florida Kidney Physicians, USF Health, Morsani & FOI	**Tier 2** Johns Hopkins All Children's Hospital and Moffitt Cancer Center	**Tier 3** Blue Cross and Blue Shield of Florida BlueOptions Network	**Tier 4** Out-of-Network
Annual Deductible (single / family)	$3,400 / $6,600	$3,400 / $6,600	$5,000 / $10,000	$5,000 / $10,000
Annual Out-of-Pocket Max (single / family)	$3,400 / $6,600	$4,200 / $8,400	$7,000 / $15,000	$7,000 / $15,000
TGH HSA Contribution[1]	**Single: $500 / Family: $1,000**			
Inpatient Hospitalization	0% after deductible	10% after deductible	N/A - Tier 1 & 2 only	
Outpatient Surgery / Services	0% after deductible	10% after deductible	20% after deductible	N/A
Emergency Room	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Preventive Care	Covered at 100%	Covered at 100%	Covered at 100%	N/A
Physician / Specialist	0% after deductible	10% after deductible	20% after deductible	N/A
Childbirth	0% after deductible	N/A	N/A	N/A
Prenatal Maternity Care	0% after deductible	10% after deductible	20% after deductible	N/A
Urgent Care	0% after deductible	10% after deductible	20% after deductible	N/A
Chiropractic Care	0% after deductible (Limit 40 visits / year)	10% after deductible (Limit 40 visits / year)	20% after deductible (Limit 40 visits / year)	N/A
PT / OT / ST	0% after deductible	10% after deductible	20% after deductible	N/A
Therapy Limits	OT / PT: Combined limit for Tier 1 & 2 is 80 visits / year ST: Limit 40 visits / year for Tier 1, 2, & 3		OT/PT: Combined 40 visits / year	N/A
Outpatient Diagnostics: Lab / X-ray	0% after deductible	10% after deductible	20% after deductible	N/A
Therapies	0% after deductible	10% after deductible	20% after deductible	N/A
Diagnostic Lab / X-Ray	0% after deductible	10% after deductible	20% after deductible	N/A
Imaging (MRI, CT, PET Scans, etc.)	0% after deductible	10% after deductible	20% after deductible	N/A
Inpatient Services for Mental Health & Substance Abuse	0% after deductible	10% after deductible	N/A	N/A
Outpatient Services for Mental Health & Substance Abuse	0% after deductible	10% after deductible	20% after deductible	N/A
Pharmacy	**Generics**	**Preferred Name Brand**	**Non-preferred Name Brand**	**Specialty**
TGH Pharmacy	$10 after deductible	$15 after deductible	$20 after deductible	$80 after deductible
Retail Pharmacy	$45 after deductible	25% after deductible; $60 min/$150 max	35% after deductible; $80 min/$300 max	35% after deductible; $100 min/$400 max

* Freestanding non-Hospital based Tier 3 BlueOptions locations only.

[1]TGH will make a contribution to your HSA if you are enrolled in the High Deductible Health Plan. Contributions will be pro-rated on a bi-weekly basis.

Co-insurance is subject to calendar-year deductibles. **The percentages shown in the chart are the co-insurance amounts you are responsible for paying for an eligible medical expense after your deductible, if any, is met.** True emergency only will be covered if it meets Blue Cross and Blue Shield of Florida definition of emergency (see page 11). This summary contains highlights only and is subject to change. The specific terms of coverage, exclusions, and limitations are contained in the Summary Plan Description.

Blue Cross and Blue Shield of Florida Medical Plan Comparison (Effective Jan. 1, 2026)				
	OUT OF AREA HIGH DEDUCTIBLE HEALTH PLAN		OUT OF AREA EPO PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (single / family)	$5,000 / $10,000	$10,000 / $20,000	$1,000 / $2,000	$2,000 / $4,000
Annual Out-of-Pocket Max (single / family)	$7,000 / $15,000	No Limit	$5,000 / $10,000	No Limit
TGH HSA Contribution	**Single: $500 / Family: $1,000**		N/A	
Inpatient Hospitalization	20% after deductible	N/A	20% after deductible	N/A
Outpatient Surgery / Services	20% after deductible	N/A	20% after deductible	N/A
Emergency Room	20% after deductible	20% after deductible*	$250 copay	$250 copay*
Preventive Care	Covered at 100%	N/A	Covered at 100%	N/A
Physician / Specialty	20% after deductible	N/A	$30 / $45	N/A
Childbirth	20% after deductible	N/A	20% after deductible	N/A
Prenatal Maternity Care	20% after deductible	N/A	20% after deductible	N/A
Urgent Care	20% after deductible	N/A	$50	N/A
Chiropractic Care	20% after deductible (Limit 40 visits/year)	N/A	20% after deductible (Limit 40 visits/year)	N/A
PT / OT / ST	20% after deductible	N/A	$30	N/A
Therapy Limits	OT / PT: Combined limit 80 visits / year ST: Limit 40 visits / year	N/A	OT / PT: Combined limit 80 visits / year, ST: Limit 40 visits / year	N/A
Outpatient Diagnostics: Lab / X-ray	20% after deductible	N/A	Lab & Pathology: Covered at 100% X-ray: $50 copay	N/A
Imaging (MRI, CT, PET Scans, etc.)	20% after deductible	N/A	20% after deductible	N/A
Inpatient Services for Mental Health & Substance Abuse	20% after deductible	N/A	20% after deductible	N/A
Outpatient Services for Mental Health & Substance Abuse	20% after deductible	N/A	$10	N/A
Retail Pharmacy				
Generic	$45 copay		$45 copay	
Preferred Name Brand	25% after deductible, $60 min/$150 max		25%, $60 min/$150 max; No overall deductible	
Non-preferred Name Brand	35% after deductible, $80 min/$300 max		35%, $80 min/$300 max; No overall deductible	
Specialty	35% after deductible, $100 min/$400 max		35%, $100 min/$400 max; No overall deductible	

[1]TGH will make a contribution to your HSA if you are enrolled in the High Deductible Health Plan. Contributions will be pro-rated on a bi-weekly basis.

You are eligible for the Out of Area plan if you live outside of the following counties: Citrus, Hernando, Hillsborough, Manatee, Pasco, Pinellas, Polk, and Sarasota.

Co-insurance is subject to calendar-year deductibles. **The percentages shown in the chart are the co-insurance amounts you are responsible for paying for an eligible medical expense after your deductible, if any, is met.** True emergency only will be covered if it meets BCBS of Florida definition of emergency (see page 11).

This summary contains highlights only and is subject to change. The specific terms of coverage, exclusions, and limitations are contained in the Summary Plan Description.

Health Savings Account (HSA)

If you enroll in the High Deductible Health Plan (HDHP), you are eligible to contribute to a Health Savings Account (HSA) with Health Equity. HSAs are tax-advantaged member-owned accounts that let you save pre-tax dollars for future qualified medical expenses.

The advantages of these accounts are:

- Invest your HSA tax-free, like a 401(k)
- Eligible expenses are tax-free
- More spendable income, because you keep some of the money that would normally go towards your federal income and Social Security taxes
- Convenience of payroll deduction

How these accounts work:

- You decide how much you want to deposit during the calendar year.
- The money you contribute is automatically deducted from your pay before Federal and Social Security taxes are taken out. This money is deposited directly into the spending account(s) you have selected.

There are two ways to claim eligible expenses:

- Out of your pocket—you will need to submit a reimbursement form and proof of service reflecting service date, service description, and charge to the address shown on the form
- Use the HealthEquity Debit Card (see page 29 for details)

You are not eligible to open an HSA if:

- You are not enrolled in the TGH High Deductible Health Plan
- You have healthcare coverage beyond qualified health plans (including Medicare enrollment)
- If you are being claimed as a dependent on someone's tax returns
- If you have received Veterans Affairs benefits within the past three months

Take advantage of triple-tax savings:

- Make pre-tax payroll contributions
- Grow tax-free earnings
- Enjoy tax-free distributions for qualified medical expenses

Roll Over Funds

Unlike Flexible Spending Accounts (FSA), you own your HSA. That means your entire balance rolls over every year—even if you change health plans, retire, or leave TGH. After age 65 you can use your health savings account for any expense; you'll simply pay ordinary income taxes—just like a 401(k).

Your Retirement Engine

Unlike other account types, an HSA lets you invest money to build the ultimate retirement nest egg. To get you there, HealthEquity offers a powerful lineup of low-cost Vanguard mutual funds. Choose from index funds or target date funds.

- Invest your money just like a 401(k)
- Access liquid funds anytime
- Enjoy lower fees and transparent pricing
- Take advantage of powerful advisory tools offered by HealthEquity

Complement Your HSA

Because your HSA stays with you forever, it's nice if you can avoid spending your HSA dollars. That's where a Limited Purpose Flexible Spending Account (LPFSA) offers incredible flexibility. Use your LPFSA to pay for routine vision and dental expenses, then save your HSA for long-term healthcare expenses. See page 27 to learn more.

Health Savings Account (HSA)

How much does TGH contribute to my HSA?
TGH will contribute up to $500 for an individual plan or up to $1,000 for a family plan on a pro-rated, bi-weekly basis if you are enrolled in the High Deductible Health Plan (HDHP) and open an HSA.

Maximum Annual HSA Contribution

	TGH 2026 Contribution	Employee Maximum 2026 Contribution	Total Maximum 2026 Contribution
Individual	$500	$3,900	**$4,400**
Family	$1,000	$7,750	**$8,750**
Catch-up Contribution *(55 or older)*			**$1,000**

What Happens if You Don't Spend the Money in Your HSA?
Your entire balance rolls over every year—even if you change health plans, retire, or leave TGH. Plus you can invest your money tax-free, like a 401(k). The table to the right outlines how your HSA balance can grow!

*The information provided by this table is intended for illustrative purposes only. The figures generated are estimates and may not pertain to your individual situation. Be sure to consult a financial professional before making savings decisions.

Long-Term HSA Growth Potential*	
Existing Balance	$0
Employee Contribution	$2,500
TGH Contribution	$500
Annual Spending	$1,000
Rate of Return	3%
Years to Calculate	20
Estimated Tax Rate	22%
HSA Estimated Balance	**$53,740.75**
Total Tax Savings	**$20,152.78**

Examples of HSA Eligible & Ineligible Expenses

Eligible expenses include, but are not limited to:

- Medical, dental, and vision copayments, prescription copayments, deductibles, and coinsurance
- Certain over-the-counter medications
- Braces
- Eye surgery
- Hearing aids
- Motorized wheelchair
- And much more!

Ineligible expenses include, but are not limited to:

- Dietary supplements or vitamins
- Controlled substances
- Cosmetic surgery*
- Hair transplant
- Health club or gym dues
- Cosmetics and toiletries (such as face cream and toothpaste)

* Unless it is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

Medical Bi-weekly Premiums

2026 TGH Contribution and Your Bi-weekly Premiums EPO Plan & Out of Area EPO Plan*				
Budgeted hours per pay period**		You Pay	TGH Pays	Total Premium
Full-Time: 80 to 60 hours	Team Member Only	$60.00	$412.39	$472.39
	Team Member + Spouse	$150.00	$794.74	$944.74
	Team Member + Child(ren)	$140.00	$615.79	$755.79
	Team Member + Family	$200.00	$1,167.57	$1,367.57
Part-Time: 59 to 32 hours***	Team Member Only	$231.27	$241.12	$472.39
	Team Member + Spouse	$438.71	$506.03	$944.74
	Team Member + Child(ren)	$408.65	$347.14	$755.79
	Team Member + Family	$623.75	$743.82	$1,367.57

2026 TGH Contribution and Your Bi-weekly Premiums High Deductible Health Plan & Out of Area High Deductible Health Plan*				
Budgeted hours per pay period**		You Pay	TGH Pays	Total Premium
Full-Time: 80 to 60 hours	Team Member Only	$44.27	$357.00	$401.27
	Team Member + Spouse	$118.29	$684.23	$802.52
	Team Member + Child(ren)	$94.62	$547.40	$642.02
	Team Member + Family	$156.20	$1,005.49	$1,161.70
Part-Time: 59 to 32 hours***	Team Member Only	$170.64	$230.63	$401.27
	Team Member + Spouse	$345.98	$456.54	$802.52
	Team Member + Child(ren)	$276.18	$365.83	$642.02
	Team Member + Family	$487.17	$674.53	$1,161.70

* Rates are for non-tobacco users. Tobacco users will pay a higher percentage of the cost of medical coverage. ** If your budgeted hours change during the year, the TGH contribution amount may be adjusted. Please reference Enrollments and Changes on page 6-7 for more details. ***Regular Part-Time team members who are budgeted to work less than 32 hours per pay period are not eligible for the program.

Who is Blue Cross and Blue Shield of Florida?

Blue Cross and Blue Shield of Florida is a health insurance company that acts as the Third Party Administrator for the TGH medical insurance plan. As TGH's Third Party Administrator, Blue Cross and Blue Shield of Florida manages our claims processing, provider network, and eligibility as outlined by the Summary Plan Description.

My claims were denied for "Coordination of Benefits (COB)". What does this mean?

After your effective date, Blue Cross and Blue Shield of Florida sent your insurance ID cards along with a letter asking if you or your dependents were covered under any other medical insurance plans. This information allows insurance companies to determine which coverage plan should pay first. If you did not turn in the information, your claims were initially denied. We have since removed the requirement for this information in order to process claims; however, team members with covered dependents should call the number on the back of their insurance card and speak with representative about other insurance coverage. To determine if a claim was paid, please log onto FL.ExploreMyPlan.com.

When I speak with Blue Cross and Blue Shield of Florida, they mention my provider is Tier 1. What are the "Tiers" and what do they mean?

It is very important to pay attention to the provider tier level – it could have a big impact on your wallet! Using providers or facilities that are a part of Tier 1 means the insurance pays more of the cost whereas Tier 3 means you are going to be responsible for a larger portion of the claim. Whenever possible, consider using a Tier 1 or Tier 2 provider or facility in order to make the most of your insurance. Please see the chart to the right for some examples of the Tiers in our medical plan.

Facilities	
Tier 1	Tampa General Hospital (TGH), TGH Urgent Care Centers, TGH Outpatient Center, Florida Orthopedic Institute (FOI), Morsani, TGH Brooksville, TGH Crystal River, TGH Spring Hill, TGH Rehabilitation Hospital
Tier 2	Johns Hopkins All Children's Hospital and Moffitt Cancer Center

Physician Services	
Tier 1 + Tier 2	Tampa General Medical Group (TGMG), Florida Orthopedic Institute (FOI), Florida Kidney Physicians (FKP), USF physicians, All Children's Hospital and Moffitt Cancer Center
Tier 3	Blue Cross and Blue Shield of Florida BlueOptions Network

How do I know what tier my provider is in?	
Tier 1 + Tier 2 + Tier 3	Visit FL.ExploreMyPlan.com/TampaGeneral to find a provider in either Tier 1 or Tier 2 or Tier 3 simply click the find a doctor link to start your search



Where can I go for preventive screenings?
As preventive care is important to maintaining your health, these screenings are covered at 100% with any provider in Tier 1, 2, or 3.

What are some examples of preventive care?
Preventive care includes annual physicals, well-child care to age 16, well-woman exam once a year, and mammograms.

Is Moffitt Cancer Center designated as 'in-network'?
TGH continues to expand services offered to patients in our community, including services available through our infusion department. These services will continue to be paid under the Tier 1 benefit level when utilizing TGH, a Tier 1 provider. If a patient chooses to utilize Moffitt Cancer Center, the Tier 2 copays would apply.

How is maternity care covered?
Maternity care under the EPO & High Deductible Health Plan is only covered under the Tier 1 benefit level when utilizing TGH, a Tier 1 provider.

Maternity care under the OOA EPO & OOA High Deductible Health Plan are subject to the deductible and coinsurance for both prenatal and delivery.

How is in vitro fertilization (IVF) treatment covered?
While the plan does not provide coverage for IVF treatment, it's important to note that some medications used in IVF may be covered under the prescription drug benefit when they are prescribed for other medically necessary conditions. Because coverage is based on the diagnosis and intended use, members are encouraged to have their provider submit the prescription for review to confirm eligibility.

Who is considered Out of Area?
If you live outside of the following counties, you are eligible for the Out of Area plan:

- Citrus, Hernando, Hillsborough, Manatee, Pasco, Pinellas, Polk, Sarasota

What is the specialty drug tier?
TGH added a specialty drug tier to include high cost medications at a new coverage level. "Specialty" classification is based on certain factors including: special handling, restricted distribution channels, high cost, and treatment for rare conditions. The cost of these medications continues to grow at a rapid pace of approximately 20% annually. TGH added this level in order to avoid an increase in costs for medications that do not fall into the 'specialty' category. As a note, prescriptions drugs can change tiers at any time. For more information on the Standard Prescription Drug List, please visit FL.ExploreMyPlan.com/DrugList.

Where can I go for lab work?
Members and their doctors should choose in-network labs, whether they're free-standing or based in a hospital, because BCBSFL has negotiated the best rates with in-network laboratories. You can find participating laboratories — including Quest Diagnostics — by visiting FL.ExploreMyPlan.com/TampaGeneral.

Need To Find A Doctor?
If you need help finding in-network providers:

- Visit FL.ExploreMyPlan.com/FindADoctor
  - Your Contract Number can be found on your ID card
- Or call the customer service number on your ID card

With the Affordable Healthcare Act, if I change my employment status can I keep my benefits?
If you are currently a full-time team member enrolled in the TGH health plan and move to part-time or pool position, you may keep your benefits at the full-time rate for the remainder of the calendar year so long as you continue to pay the premiums each pay period. Under the Affordable Healthcare Act, at the time of annual enrollment, the Benefits Team will evaluate the number of hours you averaged for the previous 12 months. If you have worked an average of 30 or more hours each week, you will qualify to maintain health insurance for the next year at the full-time bi-weekly rates. If you averaged less than 30 hours each week, you will not qualify to continue medical insurance at the lower full-time team member rate. Team members in part-time positions will then be offered the medical insurance at the part-time bi-weekly rate. Pool team members who do not qualify for full-time medical rates are no longer eligible for the medical insurance benefit.

*Please be aware that other benefits such as Accrued Time Off (ATO) and tuition reimbursement, may also be affected by a change in employment status. Be sure to review the appropriate policies available on the TGH Portal for additional information.

Where can I receive Physical Therapy (PT) or Occupational Therapy (OT)?
TGH has excellent Rehab facilities. Each visit is just a $10 copay for EPO plan participants and payable at 100% after deductible for High Deductible Health Plan participants. PT and OT visits are capped at a combined 80 visits – meaning you can use all for PT, all for OT, or any combination of the two services. There is no visit limit for Pulmonary or Cardiac Rehab.

Who can I speak with about a claims issue?
Call the 800 number on the back of your ID card or contact our dedicated Blue Cross Blue Shield of Florida representative at 813-882-7950 or email Kristen.Hosmer@bcbsfl.com.

If my physician works out of a hospital and does not have an office, will I pay the office visit fees or the outpatient hospital fees?
Your copay and/or deductible/coinsurance will be based on how your provider bills – which is a great question to ask when you book your appointment! If your physician submits a claim with the location as an office, the office visit fees will apply. If the claim is submitted with the hospital as the place of service, services will not be covered unless it is one of the covered facilities. In this case, you would be responsible for the outpatient hospital fees.

Accident Insurance

Since accidents can happen at any time, 24 hours a day, 7 days a week, it's important to prepare for the unexpected. Accident insurance through Lincoln Financial Group helps you pay for out-of-pocket expenses associated with an accident by paying you a benefit depending on the injuries you suffer and the treatment you receive. You can use the money as you see fit, whether to pay for expenses associated with your accident, like a trip to the emergency room, or to pay for childcare so you can get to the doctor for a follow-up visit. The policy is designed to work in conjunction with your medical plan as benefits are paid on top of what your health insurance may cover and can be used at your own discretion.

Accident insurance provides extra money to help make ends meet and manage medical costs and keep your savings intact. The plan consists of a variety of benefits that can help cover you and your family from accident and medical expenses and hospital expenses due to accidents. Coverage is 100% portable at the same rates, should you change employment.

Every year that you complete a qualified health screening, you and your covered dependent(s) are eligible for a $75 Wellness Benefit.

For more detailed information, please visit TGH.MyBenefitsLibrary.com.

Sample Benefits*	
Ground Ambulance	$300
Air Ambulance	$1,500
Dislocation/Fracture	Up to $4,500
X-ray	$40
Major Diagnostic Exam	$200
Outpatient Physicians' Treatment	$100
Hospitalization Admission	$1,250
Hospitalization Confinement	$300 per day
ICU Confinement	$600 per day
Accidental Death	Employee: $50,000 Spouse: $20,000 Child: $10,000

*This is not a comprehensive list of covered injuries and treatments. Speak to an enrollment counselor for a complete list of covered events. Limitations may apply.

2026 Accident Bi-Weekly Premiums	
Team Member Only	$3.86
Team Member + Spouse	$6.70
Team Member + Child(ren)	$6.18
Team Member + Family	$9.04

Hospital Indemnity Insurance

Even with health insurance, a stay in the hospital can quickly become costly as out-of-pocket expenses begin to add up. Hospital Indemnity Insurance through Lincoln Financial Group can reduce the financial and emotional stress of a hospital stay by providing a lump sum cash benefit directly to you that can be used however you need, whether for deductibles, coinsurance, or even child care expenses. The policy is designed to work in conjunction with your medical plan as benefits are paid on top of what your health insurance may cover and can be used at your own discretion.

Plan Features:

- Every year that you complete a qualified health screening, you and your covered dependent(s) are eligible for a $50 Wellness Benefit
- No medical history is required for coverage to be issued
- Coverage available for spouse and eligible dependents
- Fully Portable: You can keep your coverage even if you change jobs or retire

Sample Benefits*	
Hospitalization Admission	$1,000
Hospitalization Confinement	$200 per day
ICU Admission	$2,000
ICU Confinement	$400 per day

*This is not a comprehensive list of covered injuries and treatments. Speak to an enrollment counselor for a complete list of covered events. Limitations may apply.

For more detailed information, please visit TGH.MyBenefitsLibrary.com.

2026 Hospital Indemnity Bi-Weekly Premiums	
Team Member Only	$12.20
Team Member + Spouse	$21.68
Team Member + Child(ren)	$19.03
Team Member + Family	$28.51

No one saves to get sick, which is why being diagnosed with a major illness can be especially draining, both emotionally and financially. Critical Illness Insurance provides you with a lump sum cash benefit in the event you or a loved one is diagnosed with a covered condition such as a heart attack, stroke, cancer, or an infectious disease. You can use this money how you see fit, but it is especially helpful to fill in the gaps not covered by your medical insurance like copays, deductibles, or expensive new prescriptions so that you can focus on what's most important — getting better.

Critical illness insurance through Lincoln Financial Group pays a lump sum benefit to each covered person at the time of diagnosis. This benefit can be used to help meet expenses that are not normally covered under traditional health insurance. Should you experience one of several life changing illnesses that would likely require you to be unable to work for an extended period of time, this policy would pay you either $10,000, $20,000 or $30,000, depending on which option you choose. When you elect coverage for yourself, you can also secure coverage for your spouse and dependent children. Spousal coverage can be selected in the amount of $5,000, $10,000, or $15,000 (up to 50% of your coverage amount). Dependent children automatically receive 50% of your coverage amount at no extra cost.

During your new hire enrollment period only, you can elect coverage without answering medical questions. For more detailed information, please visit TGH.MyBenefitsLibrary.com.

The policy benefit amount includes:

- Heart Attack: 100% of face value
- Heart Transplant: 100% of face value
- Stroke: 100% of face value
- Major Organ Transplant (other than heart): 100% of face value
- End Stage Renal Failure: 100% of face value
- Paralysis (not as a result of stroke): 100% of face value
- Advanced Alzheimer's Disease: 100% of face value
- Advanced Parkinson's Disease: 100% of face value
- Invasive Cancer: 100% of face value
- Carcinoma in Situ: 25% of face value

All plans include a $100 wellness benefit and a recurrence benefit.

This is not a comprehensive list of covered injuries and treatments. Speak to an enrollment counselor for a complete list of covered events. Limitations may apply.

2026 Critical Illness Employee Bi-Weekly Premiums per $1,000

Age	Non-Tobacco User	Tobacco User
Under 24	$0.250	$0.274
25 - 29	$0.306	$0.359
30 - 34	$0.367	$0.462
35 - 39	$0.432	$0.581
40 - 44	$0.531	$0.778
45 - 49	$0.602	$0.946
50 - 54	$0.728	$1.237
55 - 59	$0.894	$1.628
60 - 64	$1.150	$2.243
65 - 69	$1.562	$3.124
70+	$2.547	$4.383

Speak to an enrollment counselor for a complete overview of costs for your spouse and children.

Flexible Spending Accounts (FSA)

A Flexible Spending Account (FSA) empowers you to keep more of your hard-earned money. FSAs are tax-advantaged accounts that let you use pre-tax dollars to pay for eligible medical expenses. You can use an FSA to save on average 30% on healthcare costs. Don't think of it as money deducted from your paycheck—think of it as money added to your wallet.

Flexible Spending Account Options:

- A Health Care Flexible Spending Account (HCFSA) OR a Limited Purpose Flexible Spending Account (LPFSA)
- A Dependent Care Flexible Spending Account (DCFSA)

PLEASE NOTE: You can't combine an HSA with an HCFSA. However, LPFSAs make a great HSA companion.

Here is an overview of how these accounts work:

- You decide how much you want to deposit during the calendar year. From a minimum of $260 annually, up to the 2026 IRS maximum of $3,400 for an HCFSA or LPFSA. The DCFSA maximum annual contribution is $7,500.
- HCFSA or LPFSA funds can be used for expenses incurred through the end of the benefit plan year, the date of separation or benefit ineligibility, whichever comes first.
- The money you contribute is automatically deducted from your pay before Federal and Social Security taxes are taken out. This money is deposited directly into the spending account(s) you have selected.

You may claim eligible expenses in one of two ways:

- Out of your pocket—you will need to submit a reimbursement form and proof of service reflecting service date, service description, and charge to the address shown on the form
- Use the HealthEquity Debit Card (see page 27 for details)

The advantages of these accounts are:

- Eligible expenses are tax-free
- More disposable income, because you keep some of the money that would normally go toward your federal income and Social Security taxes
- Convenience of payroll deduction

To see the tax advantages of these accounts, look at the chart below. For this example, we have assumed:

- Your annual pay is $35,000
- You deposit $1,000 to your HCFSA and $3,000 to your DCFSA for a total deposit of $4,000

Clearly, the tax savings can be significant. In the example below, your disposable income would increase by $880, just by paying these eligible expenses through the spending accounts. Of course, the actual amount you save will depend on your taxable income and eligible expenses.

FSA Tax-Savings Example		Using an FSA	Not Using an FSA
$880 Increase in Spendable Income	Annual Pay	$35,000	$35,000
	Health Care FSA Deposit	- $1,000	N/A
	Dependent Care FSA Deposit	- $3,000	N/A
*This example assumes that your total federal income and Social Security taxes are 22% of your pay.	**Taxable Pay**	**$31,000**	**$35,000**
	Estimated Taxes*	- $6,820	- $7,700
	Health Care Expenses	N/A	- $1,000
	Dependent Care Expenses	N/A	- $3,000
	Annual Take-home Pay	**$24,180**	**$23,300**

Health Care Flexible Spending Account (HCFSA)

You decide how much you want to deposit during the calendar year to pay for health care expenses. You can deposit up to the 2026 IRS maximum of $3,400. Your tax-free contributions can be used to pay for health care expenses that you normally pay out of your own pocket after taxes. If you have an HCFSA, you are ineligible for contributing to an HSA. **You can be reimbursed for the types of health care expenses listed in IRS Publication 502, Medical and Dental Expenses, including:**

- Medical, dental, and/or vision deductible, copayments, and coinsurance
- Certain OTC medications
- Expenses over plan limits
- Expenses not covered by your medical plan such as contact lenses, acupuncture, weight reduction programs prescribed by a physician, and smoking cessation programs
- Special schools for the mentally or physically disabled

Be aware that IRS rules generally will not allow reimbursement for health clubs and vitamins. If you have a question regarding a particular expense, IRS Publication 502, Medical and Dental Expenses, is available at www.irs.gov/pub/irs-pdf/p502.pdf.

Examples of HCFSA Eligible & Ineligible Expenses

Eligible expenses include, but are not limited to:

- Medical, dental, and vision copayments, prescription copayments, deductibles, and coinsurance
- Certain over-the-counter medications
- Nicotine patches and gum with a prescription
- Acupuncture
- Orthopedic shoes
- Smoking cessation programs
- Wheelchairs
- And more!

Ineligible expenses include, but are not limited to:

- Dietary supplements or vitamins
- Controlled substances
- Cosmetic surgery*
- Hair transplant
- Health club or gym dues
- Cosmetics and toiletries (such as face cream and toothpaste)

* Unless it is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

Limited Purpose Flexible Spending Account (LPFSA)

A Limited Purpose Flexible Spending Account (LPFSA) is similar to an HCFSA in that it lets you use tax-free money to pay for eligible expenses. However, an LPFSA only covers eligible dental and vision expenses not medical expenses. This account is for people who want to contribute to an HSA, but also have expected dental and vision expenses. Together, these accounts allow you to maximize long-term savings. You can deposit up to the 2026 IRS maximum of $3,400. Your tax-free contributions can be used to pay for dental and vision expenses that you normally pay out of your own pocket after taxes.

Examples of LPFSA Eligible & Ineligible Expenses

Eligible expenses include, but are not limited to:

- Dental, and vision copayments, prescription copayments, deductibles, and coinsurance
- Contact lenses and solutions
- Laser eye surgery
- Eyeglasses and sunglasses (prescription)

Ineligible expenses include, but are not limited to:

- Toothpaste, toothbrush, floss, etc.
- Teeth bleaching or whitening
- Sunglasses (over-the-counter)

Flexible Spending Accounts (FSA) (cont)

Easy telephone access to your FSA account information to:

- Review account balances and claim summaries
- Request a reimbursement form

Simply call 877-722-2667 to get started!

Online access to your FSA account information at www.myhealthequity.com includes all the functions available by phone, plus you can:

- Download or print a reimbursement form
- Review frequently asked questions (FAQs)
- View eligible and ineligible expenses
- Download mobile application
- Upload claims & documentation

How To File a Claim

To file a claim for eligible expenses, you need to send a Health Care Reimbursement Account Request or a Dependent Care Reimbursement Account Request along with proof of service reflecting service date, description, and charge to the address shown on the form. These forms are available online at www.myhealthequity.com.

All claims must be filed by March 31, 2027 for expenses you incurred in 2026. You will forfeit any money remaining in your FSAs after that date in accordance with federal law. For more detailed information on itemized expenses, visit www.irs.gov/pub/irs-pdf/p502.pdf.

Tax Savings Occur Even if You Forfeit Money

In the example on page 26, we assumed you deposited $1,000 into an HCFSA and $3,000 into a DCFSA. At the end of the year, while the DCFSA balance is zero, there is a $100 balance if the HCFSA account. While the $100 balance would be forfeited, the tax savings would not. You would still see a $780 savings in taxes.

Here's How:

$880	The initial tax savings from the deposits to your FSAs
- 100	The amount forfeited at year end
$780	Total tax savings—this amount outweighs the $100 forfeited

Mobile App - access your account information on the go. Download "myhealthequity" app. With this application you can do the following:

- View all of your accounts in one place
- View up-to-date account balances
- View claims history
- Check claim status
- See payment status
- Check claim denials
- File claims

IRS Limitations of FSAs

Careful planning is the key to setting up your FSAs because of these IRS limitations:

- Once you determine the amount to contribute for the coming year, you cannot change it unless you have a change in status. Your request to change the amount you contribute must be consistent with your change in status.
- You cannot transfer money from one account to another.
- Reimbursements from the DCFSA cannot exceed the amount that is in your account when your reimbursement is processed.
- Reimbursements from the HCFSA may exceed the amount that has been deposited to your account up to the full amount that you will deposit for the entire year.
- The expenses must be incurred during 2026. If you are newly hired, expenses must be incurred after your enrollment date in the plan.
- *Any money remaining in an account after the deadline for filing claims will be forfeited*. But even if you forfeit money, your tax savings may be more than what you forfeited (see the example to the left). Because of this, be sure to plan carefully.
- You will have until March 31, 2027 to file your 2026 claims. However, if your employment ends prior to January 1, 2027, you will only be able to submit expenses incurred through your termination date.
- In general, expenses relating to grades kindergarten and higher are not reimbursable by your DCFSA. An exception may be made only if a portion of those kindergarten expenses are attributable to day care. You may be asked to produce documentation from the kindergarten provider as proof. In that case, the portion attributed to day care would be eligible for reimbursement, but the portion attributed to education would not be eligible for reimbursement.

Despite the limitations, FSAs are your opportunity to save on taxes. Today, these accounts are more important than ever. So before putting the finishing touches on your 2026 benefits, open an FSA and save on taxes.

The HealthEquity Debit Card

The HealthEquity debit card is available to all HSA and FSA participants. You can pay for qualified out-of-pocket health care and/or dependent care expenses at authorized locations that accept Visa, eliminating the need to submit claim forms and wait for reimbursements. You can use your debit card to pay for all eligible expenses that you, or your covered dependents, incur during the plan year and are not covered by your medical, dental, and/or vision plans. Please note, even though your debit card displays the Visa logo, your card cannot be used at an ATM for cash advances or at a gas station.

How the debit card works

The card is programmed with your personal account information, including the amount available under your plan. If you have a HealthEquity debit card and an **HSA**, you can only withdraw funds that have already been contributed to your HSA account, at the time of service. If you have a HCFSA, your entire annual contribution is available to you at the beginning of the plan year for you to use throughout the plan year.

It is recommended that you keep all your receipts in the event of an audit.

Debit Card FAQs

What expenses can be paid for with my HSA/FSA debit card?
You can use your debit card to pay eligible expenses not covered by your medical, dental, and/or vision plans that you, or your covered dependents, have incurred during the plan year.

Once I use my card, do I have to use it all the time?
No, you can also use other forms of payment and file a claim manually by mail, fax, email, or online.

Where can I use my debit card?

- At any pharmacy—making it even easier to save money on your prescriptions.
- At providers and retail locations programmed with valid merchant category codes that identify them as approved for services. If a device is not programmed with a valid code, your purchase will not be authorized.
- To pay a bill you received in the mail. Call your provider's office or write your card information in the space provided on the bill. Identify the payment type as Visa; then give the card number, expiration date, and any other information requested.

Can I use my debit card to pay for prescription and non-prescription items in the same transaction?
No, the non-prescription items can only be paid for with a paper claim and a copy of the Rx which is required by the IRS for HealthEquity to have a copy of. If they swipe it at the Rx counter, we do receive a copy.

How do I get a card for my dependents?
If you need additional cards, or cards in dependent's name, please call 877-223-5329, option 0.

What do I do if I have a charge that exceeds the amount available in my HSA or FSA?
If the billed amount is greater than your available balance, the entire transaction will be denied. You may ask the provider or business to submit that amount on your card and pay the balance of the charge yourself. You can view your balances online at www.myhealthequity.com, or call the number on your card for account balance information.

What documentation do I provide?
If the MyHealthEquity Debit card is used for services that do not meet a TGH Health copayment or used at a pharmacy without Inventory Information Approval System (IIAS), used at a dental or vision merchant, you will need to submit documentation of service stating service date, description of service, and charge. This can be done easily with the MyAmeriflex mobile app.

How long is my debit card valid?
Cards will be issued for 3 years at a time so the expiration date will be based on issue date.

What if my debit card is lost or stolen and someone uses my funds?
Your card will be immediately deactivated when you report it lost or stolen. It is your responsibility to monitor your account activity and report any unusual or fraudulent transactions to HealthEquity. To be mailed a new card immediately call HealthEquity lost/ stolen number to receive a new card with a new number at 877-223-5329. You can also order a new card through HealthEquity online portal.

Dependent Care Flexible Spending Account (DCFSA)

Paying for dependent care services — preschool, before- and after-school programs, child or adult daycare, and summer, winter, or spring day camps — can gobble up a large portion of a paycheck. A dependent care flexible spending account is a pre-tax benefit account used to pay for the various child and adult care programs that allow a caregiver to work. You may deposit up to $7,500 a year, tax-free, depending on your marital status (see below).

You can use the account to pay expenses on a tax-free basis for any eligible work-related dependent care expenses you incur for your eligible dependent child(ren) under age 13 and disabled dependent(s), no matter how old, who lives with you more than eight hours a day and are claimed as a dependent(s) on your tax return.

Expenses that can be reimbursed include amounts paid for:

- Babysitters who are age 19 or older
- A child or adult care center that complies with state and local regulations
- Licensed nursery schools
- Home care specialists and dependent care centers
- Summer day camp
- Dependent care duties performed by a housekeeper.

Expenses not eligible include babysitting that is not work related, overnight camp, and school costs for kindergarten (see IRS limitations) and higher grades. Also note: Registration fees must be directly related to the care of your dependent in order for expenses to be reimbursed under the DCFSA.

Contribution Limits for Dependent Care Flexible Spending Accounts If You Are Married

If This Is Your Situation…	Then Your Maximum Annual Contribution Is…
You or your spouse earns less than $7,500.	The amount the lower-paid spouse earns.
Your spouse also participates in a dependent care spending account.	$7,500 combined for both accounts.
You and your spouse file separate income tax returns.	$3,750 in the TGH DCFSA
Your spouse is a full-time student for at least five months out of the year and you have ▶ One dependent ▶ Two or more dependents	 $2,400 $4,800

Dental Options

Keep a smile on your face and more money in your pocket with our dental plans. Having a dental plan that covers exams, X-rays, fillings and more can help you save money and live healthier. You can choose from two Delta Dental plan options - PPO High or The Copay Plan. Which plan is right for you? That depends on what style of plan you prefer. Use the Plans At-A-Glance Chart to determine which plan makes the most sense for you.

Your dental plan options are:

- PPO High Plan
- The Copay Plan

Only the PPO High Plan includes orthodontic coverage. However, both plans give you the choice of in- or out-of-network dental care. Both plans feature two network options: Delta Dental PPO and Delta Dental Premier.

- Delta Dental PPO Dentist: Visiting a PPO dentist provides you with the greatest cost savings because they have the lowest contracted fees.
- Delta Dental Premier Dentist: Premier dentists are also contracted with Delta Dental, but their fees are typically not as low as PPO dentists. You can save more money when you choose a PPO dentist.
- Out-of-Network Dentist: When you visit a non-contracted dentist, there are no fee protections, so you will pay the difference between the dentist's submitted charges and Delta Dental's maximum plan allowance.

PPO High Plan

This option has an extensive network of dentists, but it also gives you the choice of going in- or out-of-network each time you need dental care.

For all covered dental services, there is a $50 calendar-year deductible for an individual and a $150 deductible for a family.

Once you have paid the deductible, the plan pays benefits based on whether you use a network dentist. Like any preferred provider plan, this plan gives you the advantage of lower costs if you use network providers. For example, preventive care is covered at 100% with no deductible and basic care is covered at 80% after the deductible for providers in the PPO network.

In contrast, care received within the Premier network costs you more. For example, preventive care is covered at 80% of the contracted rate with no deductible. The plan pays only 60% of the contracted rate for basic care with no deductible.

Covered services include:

- Preventive care—oral exams, cleanings and scalings, fluoride treatments, and dental X-rays
- Basic care—fillings and diagnostic casts
- Major care—extractions, crowns, periodontics, root canals, and dentures
- Highest calendar year maximum of the PPO Plans
- Orthodontics - $2,000 Lifetime Benefit

The Copay Plan

This option offers pre-set copayments for care received within the PPO network. However, it also gives you the freedom to visit a provider in the Premier network or choose an out-of-network dentist and still receive benefits but does not require you to assign yourself to a network provider.

The features:

- Copayment fee schedule in-network; coinsurance
- A second in-network option, where the dentists agree to a contracted rate
- Reimbursement out-of-network
- No calendar year deductible in-network
- Freedom of the PPO network
- Coverage out-of-network
- Calendar year maximum applies

TGH Dental Coverage

Delta Dental PPO High			
Coverage Type	**PPO Network**	**Premier Network**	**Out-Of-Network**
Type A – cleanings, oral examinations	100% of Negotiated Fee*	80% of Negotiated Fee*	80% after deductible
Type B – fillings	80% of Negotiated Fee*	60% of Negotiated Fee*	60% after deductible
Type C – bridges and dentures	50% of Negotiated Fee*	40% of Negotiated Fee*	40% after deductible
Deductible	**PPO Network**	**Premier Network**	**Out-Of-Network**
Individual	$50	$50	$50
Family	$150	$150	$150
Annual Maximum	**PPO Network**	**Premier Network**	**Out-Of-Network**
Per Person	$2,500	$2,500	$2,500
Orthodontia - Lifetime Benefit	$2,000	$2,000	$2,000

Delta Dental Copay Plan			
Coverage Type	**PPO Network**	**Premier Network**	**Out-Of-Network**
Type A – cleanings, oral examinations	See Schedule	85% of Negotiated Fee*	85% after deductible
Type B – fillings	See Schedule	50% of Negotiated Fee*	50% after deductible
Type C – bridges and dentures	See Schedule	30% of Negotiated Fee*	30% after deductible
Deductible	**PPO Network**	**Premier Network**	**Out-Of-Network**
Individual	None	$50**	$50**
Family	None	$150**	$150**
Annual Maximum	**PPO Network**	**Premier Network**	**Out-Of-Network**
Per Person	$2,000	$2,000	$2,000

2026 Dental Bi-Weekly Premiums		
	PPO High	**The Copay Plan**
Team Member Only	$21.46	$11.96
Team Member + Spouse	$42.86	$25.22
Team Member + Child(ren)	$34.27	$25.02
Team Member + Family	$61.02	$41.79

* Negotiated fees refers to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

**Please refer to the Assumptions and Guidelines and Table of Allowance provided.

Like most group benefit programs, benefit programs offered by Delta Dental and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Please contact Delta Dental or your plan administrator for costs and complete details.

Cost of Dental Coverage

Dental coverage is offered at low group rates. The cost of your coverage depends on which option you select and who you cover.

Vision Coverage

Even if you don't wear glasses, regular visits to your eye doctor are important to your overall health. That's because a routine eye exam can often detect early signs of serious health conditions like diabetes. Our vision plan makes it easier to get the care you need and lower your costs. A large and diverse eye care professional network.

EyeMed vision coverage provides America's largest vision network with the right mix of independent eye doctors and national and regional retail providers—so members can go where they want, when they want. Members have the option to choose an eye care professional from their network of over 26,932 locations and 119,687 provider access points. You can also use your EyeMed benefits to shop at your favorite in-network, online eyewear stores, like LensCrafters, Target Optical, Ray-Ban, Oakley, Glasses.com and ContactsDirect.

Focusing on quality plan design and choice

Members have the flexibility to visit one eye care professional for an examination and obtain eyewear from another — providing them with optimal choice and potential cost savings. Plan has no brand restrictions and no reduced benefits—providing real choice to support member savings. In addition, members can choose from any frame available in the eye care professional's office.

Dedicated to you, our members

All new members receive personalized ID cards in the mail, easy-to-understand benefit materials and access to online information. EyeMed is committed to providing you with exceptional service and value and are confident that they will provide a vision benefit plan that will exceed your expectations.

The vision plan features:

- Fully-covered exams and select lens options through in-network eye care professionals
- Discounts provided for additional lens options
- A robust network of eye care professionals
- Plan includes coverage for both glasses and contact lenses each year

Using your benefits is simple

- ID cards will be mailed to you and can also be accessed through the EyeMed mobile app for convenience.
- To locate in-network eye care professionally, simply visit eyedoclocator.eyemedvisioncare.com and fill in the required selection fields with your plan-specific information to find a location near you.
- Have questions or need help? Call 866-723-0513 to speak directly with a customer service representative.
- Members also have the option of visiting an out-of-network eye care professional, submitting a claim for their visit and receiving a partial reimbursement for those services. Claim forms are available in the Member Web account under the Claims tab.

Vision Coverage (cont)

Vision Plan	In-Network	Out-of-Network Reimbursement
Exam at PLUS Providers	$0 at a PLUS provider	Up to $40
Exam	$10 copay	Up to $40
Contact lens fitting Standard [1] Premium[1]	 $30 copay $30 copay; 10% off retail price, then apply $40 allowance	Up to $20
Frames Any available frame at PLUS Providers Frame	 $0 copay; 20% off balance over $200 allowance $0 copay; 20% off balance over $150 allowance	Up to $75
Lenses (standard) per pair Single Vision Bifocal Trifocal	$15 copay	 Up to $30 Up to $50 Up to $70
Progressive Lens Upgrade	Up to $230 copay	Up to $50
Polycarbonate for dependent children	Covered in full	Up to $20
Contact lenses Contacts – Conventional at PLUS Providers Contacts – Conventional Contacts – Disposable at PLUS Providers Contacts – Disposable Contacts – Medically Necessary	 $0 copay; 15% off balance over $200 allowance $0 copay; 15% off balance over $150 allowance $0 copay; 100% of balance over $200 allowance $0 copay; 100% of balance over $150 allowance $0 copay; paid-in-full	 Up to $75 Up to $75 Up to $75 Up to $75 Up to $300
Frequency		
Exam	Once every calendar year	
Frames	Once every calendar year	
Contact Lens Fitting	Once every calendar year	
Lenses	Once every calendar year	
Contact Lenses	Once every calendar year	

2026 Vision Bi-Weekly Premiums	
Team Member Only	$4.24
Team Member + Spouse	$7.63
Team Member + Child(ren)	$8.52
Team Member + Family	$11.98

Copays apply to in-network benefits; copays for out-of-network visits are deducted from reimbursements

[1] Standard Contact Lens Fitting applies to a current contact lens user who wears disposable, daily wear, or extended wear lenses only. Premium Contact Lens Fitting applies to new contact wearers and/or a member who wear toric, gas permeable, or multi-focal lenses.

EyeMed Member Discounts[5]	
Covered Materials*	**Discount[5]**
These discounts apply to the glasses and contacts that are covered under the vision benefits.	
Frames	20% off amount over allowance
Conventional contacts	20% off amount over allowance
Disposable contact	20% off amount over allowance
Lens Type*	**Member out-of-pocket[5]**
Scratch coat	$15
Ultraviolet coat	$15
Tints – solid or gradient	$15
Polycarbonate – non-glass	$75
Polycarbonate – standard	$40
All Other Lens Options	20% off retail price
Discounts on Non-covered Services*	**Member out-of-pocket[5]**
Retinal imaging	$39 maximum out-of-pocket

Laser vision correction (LASIK)[5]

Laser vision correction (LASIK) is a procedure that can reduce or eliminate your dependency on glasses or contact lenses. This corrective service is available to you and your eligible dependents at a special discount (up to 15%) with your EyeMed plan. Contact 800-988-4221 for more information.

Hearing discounts[5]

With EyeMed, you get access to hearing discounts through Amplifon Hearing Health Care, a nationwide hearing health care provider. Call 877-203-0675 to find a hearing care provider near you and schedule a hearing exam.

Special Offers & Discounts

You deserve special savings just for being an EyeMed member. So there's a page on eyemed.com/member that only registered members like you can see. It's a mix of the latest discounts and extra savings that give your benefits a boost. Offers are added throughout the year. Be sure to check for the latest savings before visiting your provider. Current offers include:

- 40% off additional pairs of glasses at any in-network provider at any time
- 20% off any item not covered by the plan, including non-prescription sunglasses

*The above table highlights some of the most popular lens type and is not a complete listing. This table outlines member out-of-pocket costs(5) and are not available for premium/upgraded options unless otherwise noted.

[5]Not all providers participate in EyeMed discounts, including the member out-of-pocket features. Call your provider prior to scheduling an appointment to confirm if he/she offers the discount and member out-of-pocket features. The discount and member out-of-pocket features are not insurance. Discounts and member out-of-pocket are subject to change without notice and do not apply if prohibited by the manufacturer. Lens options may not be available from all providers/all locations.

Life insurance can be an important step in safeguarding your family's overall financial plan. Have you considered all the way your family relies on you and how life insurance can help bring some peace of mind to both you and your loved ones? **TGH provides you with one (1) times your annual base pay of core life insurance up to $300,000 and Accidental Death and Dismemberment (AD&D) insurance through Lincoln Financial Group at no cost to you. See page 38 for additional details about your AD&D coverage.**

But what if you need more protection? It is important to realize that life insurance needs will vary from person to person and that your needs may change over time, so it's important to reconsider the amount of life insurance you have periodically. As such, TGH offers additional life insurance through Lincoln Financial Group. **During your new hire enrollment period only, you can elect coverage up to the guaranteed issue amount without answering medical questions.**

Base Pay
Base pay is your base salary (excluding, for example, shift differentials or overtime) or your starting salary if you are a new hire. Salary base rate changes during the year will affect your base pay for the benefits you select for 2026. However, if you change your budgeted hours during the year, your base pay and the TGH contribution will be recalculated.

Full-Time Team Member: You may purchase additional coverage of 6 times your base pay. The maximum TGH additional life insurance coverage available including your core benefit is $1,700,000 combined.

Part-Time Team Member: You may purchase optional life insurance in increments of $25,000 with a maximum of $100,000.

How Much Life Insurance Should You Purchase?

The right amount of life insurance protection can help your loved ones avoid having to drastically alter their lifestyle to cope with financial obligations if you die prematurely. You should estimate how much your family may need for:

- Funeral expenses
- Mortgage or rent
- Car loans
- Credit card and other debt
- Education for your children
- Retirement for your spouse

As a general rule of thumb, some experts say you will need up to ten times your annual gross income in life insurance, but everyone's needs differ.

Your Cost for Life Insurance

The cost of additional life insurance is based on your age as of the effective date, the amount you select, and whether you use tobacco. Most insurance companies charge tobacco users more for life insurance because they are generally in a higher risk group. A tobacco user is anyone who has used any tobacco product in the past 12 months.

Rates are age based on five year brackets (25-29, 30-34, 35-39, etc.). You only move age brackets at the beginning of each year.

Living Needs Benefit

The life insurance plan also features a living needs benefit referred to as the accelerated death benefit. This benefit allows you to receive up to 80% of your life insurance coverage up to a maximum of $500,000 to help with the cost of special care or family needs if you are diagnosed as being terminally ill with a life expectancy of less than 12 months.

New Hire Guaranteed Issue

During your new hire enrollment period only, you can purchase up to the Guarantee Issue amount of $750,000 without providing Evidence of Insurability. If you have previously been denied for additional life insurance coverage with TGH, you are not eligible to receive the limited time offer and will be subject to Evidence of Insurability.

Evidence of Insurability (EOI)

You will need to provide EOI by completing a *Personal Health Application* if you elect coverage greater than the guaranteed issue amount. If you need to provide EOI, please speak with an Enrollment Counselor or complete the form in bswift.

IMPORTANT: If you enroll in this benefit and do not submit your completed *EOI* form within 31 days of your effective date, your pending election will be cancelled.

Age Reduction Rule

Your life insurance amount in force on the day before you reach age 70; and again at age 75, will be reduced according to the Schedule of Insurance outlined in the Lincoln Financial Life and Accident Insurance Company Group Term Life Certificate and Summary Plan Description. You may obtain a copy of the certificate and summary plan description from the TGH Benefits Department.

Imputed Income

Federal regulations require you to pay imputed income taxes on the cost of life insurance in excess of $50,000. This means that the cost of your life insurance premium for coverage over $50,000 will be included as taxable income on your W-2 form based on the IRS tax table. Although imputed income tax applies to the cost of life insurance over $50,000, it is important to have enough protection for your beneficiaries. So, be sure to select the level of additional coverage that will provide enough income to your beneficiaries if you die. Remember, additional life insurance is offered at low group rates, and your payroll deduction is made with pre-tax dollars.

Naming a Beneficiary

A beneficiary is the person(s) you designate to receive your life insurance (and accidental death and dismemberment, if elected) policy's stated benefit in the event of your death. You can name more than one person with a different percentage of your benefits going to each person. You may change your beneficiary whenever you wish. Once you name a beneficiary, your beneficiary will stay the same unless you submit a new *Beneficiary Designation.*

It is important to keep your beneficiary designations up to date. Your beneficiary(ies) may need to be changed when you experience a qualifying status change event such as marriage, death, divorce, etc. Please review your beneficiary designations and remember to keep all of your beneficiary designations current. Visit TGH.bswift.com to add or change beneficiary information.

Life Insurance Designs for Your Family

Losing your spouse or a child is one of life's greatest tragedies. Yet, if such a loss should occur, would you be protected financially? To help you through such a time, TGH offers dependent life insurance options. You are automatically the beneficiary for dependent life insurance. The chart below shows your choices.

By law, the dependent life insurance you purchase through TGH is paid after-tax and cannot exceed 50% of your group life insurance amount.

If you elect an amount for your spouse greater than $25,000, the excess will be subject to medical underwriting approval. All late applications and requests for coverage increases will also require medical underwriting approval. You will be directed to a link to complete the Evidence of Insurability form when completing your enrollment information online or with a counselor.

Life Insurance Portability

Your life insurance coverage will end when your employment terminates. You may be eligible to buy portable group insurance coverage for yourself and your dependents without submitting evidence of insurability (EOI), providing you meet the following requirements.

- On the date your employment terminates, you may be eligible to port your life coverage if you and/or your dependents meet certain qualifying events. These include, for you, termination of your employment or when your membership in an eligible class ends; and for your dependents, termination of your employment, your death, when your membership in a class eligible for dependent coverage ends, or your dependent no longer meeting the definition of a dependent. However, a dependent child who reaches the limiting age under the policy is not eligible for Portability.
- On the date your employment terminates, you must be under Normal Retirement Age as defined under the U.S. Social Security Act.
- You must apply in writing and pay the first premium within 31 days after your life coverage terminates, or 15 days from the date your employer signs a Portability application, whichever is later, but never beyond 91 days from the date of coverage termination.

Please contact the TGH Benefits Department for more information.

Your Dependent Life Insurance Choices

Option 1	Option 2	Option 3	Option 4
$25,000 for your spouse and $10,000 for each child	$50,000 for your spouse and $10,000 for each child	$75,000 for your spouse and $10,000 for each child	50%* of your base pay for your spouse (increments of $25,000, up to a maximum coverage of $250,000) and $10,000 for each child **Enroll in up to the guaranteed issue amount of $25,000 without answering medical questions. Evidence of Insurability form is required for elections over $25,000.*

Notes:

- The amount of Dependent Life Insurance coverage cannot be greater than 50% of optional employee benefit.
- This benefit offered on an after-tax basis.

Accidental Death and Dismemberment (AD&D)

Accidents can happen just about anywhere – not just at work. If your you pass away or are irrevocably injured, the lump-sum benefit, can make an appreciable difference. While these are relatively rare occurrences, they are frequently life changing. Accidental Death and Dismemberment (AD&D) insurance through Lincoln Financial Group protects you and your family financially in the event of your accidental death or loss of limb.

You will receive AD&D insurance if you elect supplemental life insurance and can choose the coverage that best fits your needs:

- Full-Time Team Member: You can purchase up to one (1) times your annual base pay of AD&D insurance, up to $2,000,000.
- Part-Time Team Member: You can purchase increments of $25,000 of AD&D insurance up to $100,000.
- Spouses are eligible for coverage in increments of $5,000 up to a maximum of $100,000 not to exceed 100% of your optional life insurance amount.
- Children AD&D Option #1
  - Life birth to 14 days: $1,000
  - 14 Days & Older: $5,000
- Children AD&D Option #2
  - Life Birth to 14 Days: $1,000
  - 14 Days & Older: $10,000

Age Reduction Rule

Your AD&D amount in force on the day before you reach age 70 will be reduced according to the Schedule of Insurance outline in the Lincoln Financial Life and Accident Insurance Company Group Term Life Certificate and Summary Plan Description. You may obtain a copy of the certificate and summary plan description from the TGH Benefits Department.

This protection pays a benefit if you suffer a loss as a direct result of an accident. The full amount is paid if you die, lose both hands, both feet, or sight in both eyes. If you lose one hand or foot, or sight in one eye, 50% of the full benefit is paid.

Note: If no beneficiary(ies) is named, payment will be made according to the beneficiary designation under the group life policy issued to the Policyholder and in effect at the time of death. In the event of death as a result of a covered accident, both policies will pay out.

Buckle Up for Safety and Better Benefits

Buckle up—it is the law. The law's purpose is to help keep safe if there is an automobile accident. Consider these facts:

- Seat belts reduce the risk of death by about 40% to 70% and the risk of serious injury by 40% to 60%.
- Child passenger restraints can reduce fatalities by 50% to 90%.

The AD&D insurance options have a safety belt benefit that pays an additional amount if you sustain an injury that results in a benefit payable due to a motor vehicle accident and were wearing a seat belt when the accident occurred. When satisfactory proof is furnished that a seat belt was worn, an additional benefit (the lesser of $10,000 or your total AD&D benefit) will be paid.

So buckle up for safety first and extra survivor protection second.

Short-Term Disability

Did you know that over 25% of today's 20-year-olds will become disabled before they reach the age of 67? Whether you suffer from a back injury, are diagnosed with a serious illness, or become pregnant, you could go months without a paycheck. Short-Term Disability is designed to help protect your income while you work to get back on your feet and back to work! That is why TGH offers Short-Term Disability (STD) options through Lincoln Financial.

TGH provides you with STD coverage at no cost to you. You will receive coverage for up to 60% of your weekly base pay with a maximum benefit of $750 weekly for up to 26 weeks. You can also elect to buy-up additional STD coverage of 66 2/3% of your weekly base pay with an aggregate maximum benefit of $1,500 weekly for up to 26 weeks. Please note, the 26 week maximum coverage period includes the 14 day elimination period for a disability due to sickness. Benefits are payable immediately for a disability due to injury. Pre-existing condition limitations apply to the buy-up STD benefit only.

Cost of Buy-Up STD Coverage

The cost of your voluntary STD coverage is calculated based on your age on your policy's effective date, and your base pay. Rates are age based on five year brackets (25-29, 30-34, 35-39, etc.). You only move age brackets at the beginning of each year.

When STD Benefits Begin

Benefits begin immediately after a qualifying injury, and 14 days after a qualifying illness. To receive a benefit, your injury or illness must prevent you from performing the material duties of your regular job.

How Your Benefits Will Be Taxed

You pay for voluntary STD with after-tax dollars through convenient payroll deductions. As a post-tax benefit, all benefits paid to you will not be considered taxable income for the duration of your disability.

Maternity Coverage

Parental leave and childbirth qualify for benefits if you are unable to work due to pregnancy, childbirth, and recovery, with the certification of a physician. Benefits begin 14 days after childbirth and are approved for the standard post-partum recovery period of 6 or 8 weeks depending on delivery type. If you are disabled for your own health condition beyond the standard post-partum recovery period, Short-Term Disability benefits would be medically managed and could be paid for up to 26 weeks if supported.

Pre-existing Condition Limitations

For your employer provided STD plan, there is no pre-existing condition limitation. If you elect to participate in the buy-up STD coverage there is a pre-existing condition limitation for the first 12 months of coverage. It applies to any condition treated within six months before the coverage goes into effect. If you have a pre-existing condition, the plan may not pay a benefit for that condition until you have been continuously covered by the plan for 12 months. Please note, any condition includes maternity. For example, if you are pregnant when newly enrolling in this coverage, or become pregnant within the six months before the plan goes into effect, the plan may not pay a benefit covering maternity due to the pre-existing condition limitation.

How do I file for Short-Term Disability?

If you are enrolled in Short-Term Disability insurance and need to file a claim, please call 800-210-0268 or file online at lincolnfinancial.com (company code: TampaGen). Additional instructions may be found by visiting tgh.mybenefitslibrary.com.

Long-Term Disability

Long-Term Disability (LTD) can replace part of your paycheck if you're disabled and can't work for an extended period of time. That could be a few months to several years.

For Full-Time Team Members, LTD pays 60% of your base pay up to a monthly maximum of $10,000. For Part-Time Team Members, LTD pays 60% of your base up to a monthly maximum of $5,000. The plan has a 90-day waiting period before benefits are paid, and benefits are paid until retirement age, typically 65 years of age. This is a voluntary benefit that you must actively elect to have coverage. You pay for this plan with after-tax dollars through convenient payroll deductions.

Pre-existing Condition Limitations

You may elect or drop your LTD coverage during your new hire enrollment period. If you elect to participate in LTD coverage, there is a pre-existing condition limitation for the first 12 months of coverage. It applies to any condition treated within three months before the coverage goes into effect. If you have a pre-existing condition, the plan will not pay the higher level benefit until you have gone three months without treatment or you have been covered by the plan continuously for 12 months. Please note, if you have already satisfied the pre-existing condition limitation you will not have to do so again with the transition to Lincoln Financial. If you are currently in the process of satisfying the pre-existing condition limitation, this will also be honored with the transition to Lincoln Financial.

How Benefits Are Paid

LTD benefits will be reduced by other sources of disability income such as Social Security and Workers' Compensation. The minimum monthly benefit is $100; the maximum if you are a Full-Time Team Member is $10,000, the maximum if you are a Part-Time Team Member is $5,000.

How Your Benefits Will Be Taxed

You pay for this plan with after-tax dollars through convenient payroll deductions. As a post-tax benefit, all benefits paid to you will not be considered taxable income for the duration of your disability.

Cost of LTD Coverage

The cost of your buy-up LTD coverage depends on your age on your policy's effective date, and your base pay. Rates are age based on five year brackets (25-29, 30-34, 35-39, etc.). You only move age brackets at the beginning of each year.

LifeTime Benefit Term Insurance with Long-Term Care Coverage

LifeTime Benefit Term Insurance with Long-Term Care Coverage through Chubb is a guarantee premium term life insurance plan. The plan features premiums guaranteed for life and coverage for qualified Long-Term Care expenses like nursing home, assisted living, or home care. LifeTime Benefit Term provides money to your family at death, and while you are living too, if you need home health care, assisted living, or nursing care. The plan builds paid up death benefit values after 10 years, so if you decide to stop paying premiums at some point in the future, you are guaranteed a paid up coverage of a reduced amount.

This plan is 100% portable when you leave TGH at the same coverage and premium contribution. The plan has a unique Long Term Care feature that pays 4% of the current death benefit amount payable each month for up to 50 months. **During your new hire enrollment period only, you can elect up to $150,000 of LifeTime Benefit Term Insurance with Long Term Care coverage without answering medical questions.** Coverage is also available for spouses and children. For more detailed information, including the policy and plan limitations, please visit TGH.MyBenefitsLibrary.com.



Pet Insurance

Pet Insurance through PetPartners provides coverage for a wide range of veterinary services and helps cover the costs of unexpected veterinary bills. You can also purchase optional wellness coverage to help pay for routine care expenses. After your deductible is met, the plan reimburses a percentage of your expenses, up to certain limits. Once the policy is effective, accident and illness coverage begin immediately. For more detailed information, please visit TGH.MyBenefitsLibrary.com.

Pet Insurance Plan Options

	Accident & Illness with Wellness		Accident & Illness	
Annual Deductible	$300		$300	
Coinsurance	80%		80%	
Annual Limit	$5,000		$5,000	
	Dog	Cat	Dog	Cat
Bi-weekly Premium per Pet	$31.50	$17.41	$22.48	$10.46

Identity Theft Protection

Identity theft protection through MetLife (Aura) proactively monitors an extensive network for the use of personal information. If a threat is detected, the program alerts members by phone, email, or text to mitigate any possible damage caused by fraud or identity theft. For more detailed information, please visit TGH.MyBenefitsLibrary.com.

Services include:

- Credit Application Alerts
- Lost Wallet Protection
- Address Change Verification
- Black Market Website Surveillance
- $1 Million Total Service Guarantee
- Court Record Scanning
- Unauthorized Payday Loan Notifications
- And more!

Legal Plan

All benefit eligible team members are eligible to enroll in our Legal Plan through MetLife. The plan is voluntary and covers all dependents in the household for one low price. Legal coverage gives you easy, direct access to a national network of more than 18,000 attorneys that provide telephonic advice and office consultations on a broad range of personal legal needs. For more detailed information, please visit TGH.MyBenefitsLibrary.com.

Services include:

- Preparation of wills and trusts
- Real estate matters
- Debt matters
- Document preparation and review
- Traffic matters
- Juvenile matters
- Divorce & Family law
- And more!

Employee Assistance Program (EAP)

Everyone needs help sometimes solving problems. Your wellbeing, productiveness and happiness depend on balancing your life at home and your life at work. We recognize that it's difficult to be on task at work when you are worrying about problems at home, and you can't devote sufficient time to yourself and your family if you're feeling overwhelmed by the demands of your job. Your benefits package includes the EAP at no cost to you.

Who is eligible?
You and your immediate household family members are eligible to access *GuidanceResources* services. All services are confidential.

How do I get started?
To get started, visit GuidanceResources.com, download the GuidanceNow mobile app, or call 888-628-4824.

Login credentials:
- Username: LFGSupport
- Password: LFGSupport1

What experience and credentials will my counselors have?
By phone: When you call the toll-free line, you'll talk to an experienced professional who will provide counseling, work-life advice and referrals. All counselors hold master's degrees, with broad-based clinical skills and at least three years of experience in counseling on a variety of issues.

In person: For face-to-face sessions, you'll meet with a credentialed, state-licensed counselor.

What services can I access?
- Unlimited, 24/7 access the following services anytime — online, on the mobile app or with a toll-free call:
  - Information and referrals on family matters, such as child and elder care, pet care, and more
  - Legal information and referrals for family law, estate planning, consumer and civil law
  - Financial guidance on household budgeting and short- and long-term planning
- In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year)
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and 25% off subsequent meetings
- Expert advice and support tools are just a click away when you visit GuidanceResources.com or download the GuidanceNow mobile app.

Tava Mental Health Service

Tava is a free, confidential mental health benefit available to all team members, their spouses and dependent children (age 13-25). You do not need to be enrolled in the TGH medical plan in order to take advantage of this benefit. The benefit provides up to 12 free sessions annually with licensed clinicians through Tava's secure, web-based technology platform. All you need for a live, video-based session is reliable internet access and a connected device with a camera (smartphone, computer, or tablet).

- **Free to Use:** No claims, no co-pays, no deductibles. You and your dependents will have 12 sessions (per person per year) completely covered.
- **Convenient:** Self-scheduled online video sessions means you get care whenever works best for you: days, nights, or weekends.
- **Confidential:** We don't tell your employer who used the service. Your identity and anything you discuss is confidential.
- **Top Quality:** Quality care from quality therapists. Tava's clinicians are licensed, vetted, and use evidence based treatments.

Schedule your first appointment today at care.tavahealth.com.

What is it?
Defined Contribution Retirement plan.

When am I eligible?
You are eligible to participate in this plan on your date of hire.

How can I enroll in the 403(b) Plan?
To encourage participation, all team members will be automatically enrolled at 2% pre-tax of your pay unless you opt out of the plan.

How can I make changes to my 403(b) Plan?
Changes can be made online to your account by visiting netbenefits.com/atwork or you can also contact Fidelity at 800-603-4015.

What type of contributions can be made to the 403(b) Plan?
Team members can contribute a whole percentage amount of their pre-tax pay. You can start or stop your contributions at any time. Team members can also contribute on an after-tax basis with the Roth 403(b) option.

What is the difference between a traditional 403(b) Plan and a Roth 403(b) Plan?
Most of the provisions of both plans are the same. The main difference is the tax treatment of contributions and distributions. A detailed FAQ is available on the Fidelity website for your reference. Please visit with a Fidelity representative to see which plan is best for you.

What is the maximum you can contribute to the 403(b) plan?
Team members can contribute up to the IRS annual maximum contribution for the plan year. Team members who are 50 years and older can contribute an additional amount in catch-up contributions. Both Pre-tax and After-tax contributions combine to apply to the IRS limits.

Will TGH contribute to an eligible team member's 403(b) plan?
TGH will contribute via an employer match: 100% of the first 4% of salary you contribute to the plan and 50% of the next 2% of salary you contribute to the plan.

When am I eligible for the TGH matching contributions?
TGH will begin matching your 403(b) plan contributions on the first pay period after you attain 21 years of age and complete 12 months of service in which you work 1,000 hours or more. TGH matching contribution is immediately vested at 100%.

Does TGH contribute any other funds?
Yes, on an annual basis: all eligible team members that work 1,000 hours are qualified for a 0.5% nondiscretionary contribution. These other contributions are vested at 100% after 3 years of service.

May I receive a withdrawal of any portion of my account while still employed?
Yes, the plan allows team members to receive a distribution from your account if you qualify due to a financial hardship or the attainment of age 59 1/2. Hardship distributions may prevent additional contributions for 6 months.

May I borrow from my Account?
Yes, the plan allows you to take a loan of at least $1000 or 50% of your account balance. You may have a maximum of 2 loans outstanding at a time. To inquire about a loan or distribution, please call Fidelity at 800-603-4015.

For complete details on the 403(b) plan, please visit TGH.MyBenefitsLibrary.com.

Accrued Time-Off (ATO) Program

TGH believes that team members need time to rest and get away from everyday routines. That is why we provide an Accrued Time-Off (ATO) system. New team members automatically begin accruing time in the ATO system when they are hired.

Important ATO Information

As a regular full- or part-time team member who is budgeted to work 16 hours or more per week, you are eligible to accrue and use ATO hours based on the ATO policy.

- You are eligible to use your earned ATO after 90 days of employment.
- Your accrual is based on hours paid to a maximum of 80 hours per pay period, your team member status and your tenure.
- ATO hours are to substitute for time not worked, resulting in wages not being earned. Examples are vacation, holiday, and sick time.
- ATO hours used for vacation, holiday, and sick time are paid at 100% of their value. Team members cannot use or cash in ATO hours during their first 90 days of employment.
- The use of ATO hours is mandatory for time off, except where prohibited by law.
- Team members may, but do not have to, use their ATO time if they are required to take time off due to temporary/short-term cancellation of shifts; or being sent home early due to hospital-initiated reasons, such as low census, or facility/environmental circumstances.
- **Eligible team members can accrue up to a maximum of 280 hours of ATO.**

Termination and ATO

- ATO hours not used will be paid following separation from employment.
- No payment of ATO hours will be made if separation from employment is during the first 90 days of employment.

Scheduling

- Scheduling of time off for vacations, holidays, etc., requires prior approval of management.
- Team members must meet acceptable attendance standards. Payment of ATO for time not worked without prior approval will not remove the requirement for acceptable overall attendance. This would include the substitution of ATO for illness or leaving work early, among other reasons.

ATO Accrual System (Full-time Team Members)

Tenure	0 - 3.99 Years	4.0 - 9.99 Years	10 or More Years
Annual hourly accrual	200 hours	224 hours	248 hours
Maximum bank	280 hours	280 hours	280 hours



TGH normally designates six holidays each year:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving
- Christmas/Winter holiday

Family Medical Leave Act (FMLA)

The FMLA gives eligible team members up to 12 workweeks or up to 480 hours of unpaid, job protected leave for certain family or medical needs.

When am I eligible for FMLA?

To be eligible, you must have been employed at TGH for at least 12 months (including any previous employment at TGH in the past 7 years), and you must have worked at least 1,250 hours in the 12-month period preceding the leave.

FMLA may be taken for you, your spouse, your child (biological, adopted, foster, or step), or your parents (biological, step or someone who has stood in loco parentis).

What conditions make me eligible for FMLA?

- Your own serious health condition
- The birth of your child
- Care of your newborn (mother or father)
- Placement of a child with you for adoption or foster care
- To care for a spouse, parent or child with a serious health condition
- Military Leave for a qualifying exigency or Service member caregiver

Pregnant Workers Fairness Act (PWFA) Leave

The Pregnant Workers Fairness Act (PWFA) gives you the right to reasonable accommodations for pregnancy, childbirth, and related health needs unless the accommodation will cause undue hardship to operations. This can include time off for recovery, medical appointments, or reduced schedules—even if you're not eligible for FMLA. Note: this does not include bonding time.

ADA Leave

Under the Americans with Disabilities Act (ADA) and the Americans with Disabilities Amendments Act (ADAAA), team members with disabilities may be entitled to leave as a reasonable accommodation when needed for a medical condition, as long as it does not cause undue hardship to the employer.

Medical Leave of Absence

A Medical Leave of Absence (MLOA) may be requested for any leave over 10 calendar days that does not meet the requirements of FMLA or is able to be accomodated through an ADA Accommodation. MLOA does not grant position protection, can only be taken for a team member's own serious health condition (family members are not eligible), and is only available as a continuous leave of absence.

- Team members who have worked at TGH for **90 days** are entitled to up to twelve (12) weeks of MLOA in a 1-year rolling period.
- Team members who have worked **less than 90 days** (1-89 days) will not be eligible for a Medical Leave.

Military Leave of Absence

Any team member who is a member of the National Guard or a reserve component of the Armed Forces of the United States will be granted leave without loss of benefits (including retirement) during the period in which the team member is ordered to active duty and/or training.

Leave of Absences - Frequently Asked Questions (FAQs)

How am I paid while I am on approved leave?
You may elect to use your ATO for any type of leave. If you choose to not use ATO, your leave will be unpaid.

What will happen to my health insurance and benefits?
During leave, your benefits under the group health plan must be maintained under the same conditions as if you were continuously employed.

If you deplete your ATO, you will be responsible for paying the team member portion of your health, life, disability and other benefit premiums. Arrears balances are viewable on the PeopleSoft Self-Service homepage.

What if I have disability coverage?
You will need to apply for disability for your own serious health condition through our third party vendor. Please see the Disability section for more information.

Where can I find additional information on leave policy and procedures?
Please visit https://email.eoiservice.com/tgh-leave for more information.

How do I file for leave?
You may request a leave of absence online via our AbsenceSoft ESS Portal.

- Website: https://tgh-ss.ess-absencetracker.com/
- Login: Click the Login with SSO

Questions?
Please submit a ServiceNow ticket at https://service.tgh.org/esc.



Jury Duty
When you are required to serve on jury duty, you will be paid the amount that you would have earned had you worked the time served for jury duty.

Bereavement Leave
Regular team members may be granted bereavement leave with pay due to a death in the family.

Direct Deposit
All team members are required to have direct deposit. When you sign up for direct deposit, your paycheck is automatically deposited into the bank account of your choice.

Educational Assistance
For team members enrolling in the education assistance benefit, the program reimburses employees working a minimum of 36 hours per week up to $5,000 per calendar year for pre-approved nursing school programs and advanced nursing degrees and $2,500 per year for all other work-related courses and degrees.

Employees working 20 - 35 hours per week may receive up to $2,500 per calendar year for pre-approved nursing school programs and $1,250 per academic year for other work-related degrees.

Courses must be completed at a recognized, accredited educational institution, college, and university or business college. Eligible expenses include tuition, books, feeds, equipment and supplies used for and necessary to the course.

For every $2,500 reimbursement received, employees must sign a commitment to one year of employment.

Glossary Of Medical Terms

Term	Here is What It Means
Coinsurance	The percentage you are responsible for paying for an eligible medical expense after your deductible, if any, is met.
Copayment	The amount you pay for an eligible health care expense (for example, a $30 copayment for in-network doctor's office visits or a $45 copayment for specialist's office visits).
Deductible	The amount you pay each year before payments begin. There is an individual and family deductible. The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered family members. When the family deductible is met, there is no further deductible for any covered family member for the rest of the year.
Dependent	Eligible dependents include: your legally married spouse, your children through the end of the month they reach age 26, qualified disabled children up to 65 years of age who are incapable of self-sustaining employment and your grandchildren from the date of birth up to 18 months (must meet eligibility criteria).
In-Network Care	The services delivered by the Blue Cross and Blue Shield of Florida "BlueOptions" providers. Receiving services in-network means you pay less for medical care.
Out-Of-Network Care	The services delivered by a non-network provider. Receiving care out-of-network means that you pay more for services.
Out-Of-Pocket	The total amount you will have to pay in coinsurance, copayments, and/or deductibles for the calendar year, depending on your plan.
Tobacco/Non Tobacco	At TGH, a non tobacco user means you and your covered dependents are currently not using any tobacco products. Tobacco products include cigarettes, pipes, cigars, chewing tobacco and snuff.
True Emergency	A serious medical condition or symptom resulting from injury, sickness, or mental illness in which both: ► arises suddenly **AND** ► in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.
Usual And Customary (U&C)	The fee that BCBS of FL considers appropriate for a medical expense. It's based on the typical rate (U&C) charged for a comparable service within the provider's zip code.



TGH Tampa General Hospital BROOKSVILLE

TGH Tampa General Hospital CRYSTAL RIVER

TGH Tampa General Hospital SPRING HILL

About this Benefit Guide

This benefit guide is designed to provide an easy-to-read over view of the TGH plans. Should there be any conflict between the explanations in this guide and the actual terms and provisions of the plan documents and contracts, the terms of the plan documents and contracts will govern in all cases. You will not gain any new rights or benefits because of a misstatement or omission in this guide. None of the information should be interpreted as a guarantee of employment. TGH reserves the right to amend, change, or terminate any benefit at any time.