Summary of Medical Benefits and Coverage

Basic Information about the Health Insurance Marketplace and the Ambassador Sponsored health coverage that may be available to you.

Eligibility and Enrollment Information for the

Blue Ribbon Medical Plan

For the Plan Years beginning January 1, 2023 – December 31, 2024

Health Insurance Marketplace Coverage Options & Your Health Insurance Coverage

Part A: General Information

When parts of the health care law took effect in 2014, it created a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace as well as information on the employer-sponsored health coverage that may be available to you as an employee.

Information Regarding Ambassador Sponsored Benefits

Initial Benefit Enrollment Period – Within the First 90 Days of Employment.
This notice is provided to you on behalf of Ambassador Personnel, Inc. All full-time employees are eligible to enroll in the Ambassador sponsored benefits at the end of their initial eligibility period. If you are eligible to participate, a Benefit Enrollment Packet will be mailed to you after you have been employed sixty (60) days. This packet will include important plan information, plan updates (if any), step-by-step on-line instructions, and information regarding other employer sponsored insurance benefits. Your benefits will begin on the first day of the month following your 90th day of employment. A benefits specialist is available to assist you in evaluating your options and making your selection if necessary.

It is mandatory that you participate in your initial benefit enrollment period even if you do not want to participate in any Ambassador sponsored benefits. It is your responsibility to go on line at www.teamambassador.com and either enroll in your benefits or "decline" coverage before your 90th day of employment. If you fail to go online and enroll or decline coverage by the end of your initial enrollment period, you will automatically be enrolled in the lowest cost medical plan offered to you. Premiums will automatically be deducted from your paycheck beginning on the first payroll period after your effective date. In most cases, unless you have a Qualifying Event, you will not be able to enroll later or make changes to your plan options until the next annual open enrollment period.

Annual Open Enrollment Period Begins on November 1st of Each Year.
In November of each year, you will have the opportunity to enroll, re-enroll, decline coverage, or make changes to your benefit elections for the next plan year. Annual Open Enrollment information will be mailed to you on or before October 1st each year. This packet will include important plan information, plan updates (if any), step-by-step on-line instructions, and information regarding other employer sponsored insurance benefits.

Employees Must Re-Enroll Each Year.
Your benefits will not automatically be carried over from year to year. Each year during Annual Open Enrollment, you must go online and re-enroll or decline benefits for the next plan year. In other words, your benefits will automatically expire on December 31st of each year unless you go online in November and re-enroll for the next year. In most cases, unless you have a Qualifying Event, you will not be able to enroll later or make changes to your plan options until the next annual open enrollment period next year.

Employees Must Decline Coverage Each Year.
Even if you declined coverage during your initial enrollment period, you will be required to go on-line and "Decline Coverage" again during Annual Open Enrollment each year. If you fail to go on-line during Open Enrollment and "Decline Coverage" for a valid reason, you will AUTOMATICALLY be enrolled in the lowest cost medical plan offered to you. Premiums will automatically be deducted from your paycheck effective the first payroll period in January. In most cases, unless you have a Qualifying Event, you will not be able to enroll later or make changes to your plan options until the next annual open enrollment period next year.

Information Regarding the Health Insurance Marketplace

What is the Health Insurance Marketplace?
The Marketplace is a place to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November 15th of each year and ends on February 15th of the following year.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the minimum value standard if the plan's share of the total allowed benefit cost covered by the plan is no less than 60% of such cost.)

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

How Can I Get More Information?
For more information about the employer-sponsored health coverage that may be available to you as an employee, please contact Ambassador Personnel, Inc. at 844-292-9904 or via email at Benefits@teamambassador.com. More benefit information is available online at www.teamambassador.com/Benefits.

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

PART B: Information about Health Coverage Available to You

This section contains information about health coverage available to you at your worksite. If you decide to complete an application for coverage in the Marketplace, you may be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: Ambassador Personnel, Inc.	**4. Employer Identification Number (EIN)** 27-4676978	
5. Employer address: PO Box 2057	**6. Employer phone number:** 229-226-2909	
7. City: Thomasville	**8. State:** GA	**9. Zip Code:** 31799
10. Who can we contact about employee health coverage at this job? Carol Dixon		
11. Phone number (if different from above): 844-292-9904	**12. Email address**: benefits@teamambassador.com	

Here is some basic information about health coverage offered by Ambassador Personnel, Inc.:

Ambassador Personnel, Inc. offers a health plan to eligible employees. Eligible employees are:

Regular full-time or part-time employees residing or working in the United States who are scheduled to work a minimum of 30 hours per week that have been with the company for at least 90 days are eligible to purchase health insurance through Ambassador Personnel, Inc.

Coverage is offered to eligible dependents. Eligible dependents include spouse and children (natural born, step children, or legally adopted, up to age 26).

The coverage provided meets the minimum value standard, and the cost of this coverage to you is intended to be affordable based on the ACA guidelines and the employee wages.

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact the Plan Administrator at Benefits@teamambassador.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.teamambassador.com or call 1-844-292-9904 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,750/Individual or $3,500/Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	There are no other specific deductibles.
What is the out-of-pocket limit for this plan?	For network providers $7,500 individual / $15,000 family; for out-of-network providers $15,000 individual / $30,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.firsthealth.com or call 1-844-292-9904 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	This plan will pay some or all of the costs to see a specialist for covered services but you do not need a referral to see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 copay/office visit deductible does not apply	50% coinsurance after deductible	
	Specialist visit	$100 copay/office visit deductible does not apply	50% coinsurance after deductible	Preauthorization is not required.
	Preventive care/screening Immunizations, physicals, well woman visits, mammograms, colonoscopies, etc.	No charge/No Annual Limit	50% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance after deductible	50% coinsurance after deductible	NONE
	Imaging (CT/PET scans, MRIs)	25% coinsurance after deductible	50% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Caremark.com	Generic drugs (Tier 1)	$10 copay	$10 copay	Mail Order – Prescriptions are free with no copay and no deductible. Excludes Injectables (except insulin) $10,000 Annual Pharmacy Maximum on Specialty Drugs.
	Preferred brand drugs (Tier 2)	25% coinsurance after deductible	25% coinsurance after deductible	
	Non-preferred brand drugs (Tier 2)	25% coinsurance after deductible	25% coinsurance after deductible	
	Specialty drugs (Tier3)	25% coinsurance after deductible	25% coinsurance after deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	25% coinsurance after deductible	50% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	25% coinsurance after deductible	25% coinsurance after deductible	Non-Emergency visits are not covered.
	Emergency medical transportation	25% coinsurance after deductible	25% coinsurance after deductible	
	Urgent care	$75 copay/visit deductible does not apply	$75 copay/visit deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	25% coinsurance after deductible	50% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Office Visits	25% coinsurance after deductible	50% coinsurance after deductible	
	Outpatient services	25% coinsurance after deductible	50% coinsurance after deductible	Limited to 31 days per year per person
	Inpatient services	25% coinsurance after deductible	50% coinsurance after deductible	Limited to 31 days per year per person
If you are pregnant	Office visits	25% coinsurance after deductible	50% coinsurance after deductible	
	Childbirth/delivery professional services	25% coinsurance after deductible	50% coinsurance after deductible	
	Childbirth/delivery facility services	25% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	25% coinsurance after deductible	50% coinsurance after deductible	60 visits per year per person

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Rehabilitation services	25% coinsurance after deductible	50% coinsurance after deductible	60 visits per year per person
	Habilitation services	25% coinsurance after deductible	50% coinsurance after deductible	60 visits per year per person
	Skilled nursing care	25% coinsurance after deductible	50% coinsurance after deductible	60 visits per year per person
	Durable medical equipment	25% coinsurance after deductible	50% coinsurance after deductible	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	25% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Coverage limited to one exam per year
	Children's glasses	No Charge	Not Covered	Coverage limited to one pair of glasses/year.
	Children's dental check-up	No Charge	Not Covered	Coverage limited to two exams per year.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Dental Care
- Infertility Treatment
- Hearing Aids
- Injectable Medication (except for Insulin)
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Bariatric Surgery
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Preventative Care & Wellness
- Annual Lab/ X-Ray Tests
- Diagnostic Tests
- Rehabilitation Services
- Colonoscopies (Routine/Preventative)
- Well Baby Care
- Child Eye and Dental Care
- Emergency Services
- Prescription Coverage
- Sick Visits & Hospitalization
- Chemo & Radiation
- Renal & Dialysis Services

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-844-292-9904 or visit www.teamambassador.com/benefits.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,750
Specialist copayment	$100
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,730**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,750
Copayments	$100
Coinsurance	$2,745
What isn't covered	
Limits or exclusions	$ 0
The total Peg would pay is	**$4,595**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,750
Specialist copayment	$100
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,750
Copayments	$ 100
Coinsurance	$175
What isn't covered	
Limits or exclusions	$ 0
The total Mia would pay is	**$2,025**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,750
Specialist copayment	$100
Hospital (facility) coinsurance	25%
Other coinsurance	25%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,750
Copayments	$700
Coinsurance	$1,238
What isn't covered	
Limits or exclusions	$ 0
The total Joe would pay is	**$3,688**

Blue Ribbon Medical Plan – Summary Plan Description		
Coverage Description	**In-Network**	**Out-of-Network**
Deductible (Individual / Family)	$1,750 / $3,500	$3,500 / $7,000
Co-Insurance	75%/25% (Plan pays 75% & you pay 25%)	50% / 50% (Plan pays 50% & you pay 50%)
Maximum Out-of-Pocket (Individual / Family)	$7,500 / $15,000	$15,000 / $30,000
Preventive Care- Routine Physicals, Well Woman Visits, Mammograms, Prostate Exams, Cancer Screenings & Colonoscopies. Well Child Visits & Immunizations.	Plan Pays 100%	50% after deductible
Physician Office Visits Primary Care Physician & Urgent Care Centers Specialists	 $50 copay $100 copay	 50% after deductible 50% after deductible
Emergency Services	25% after deductible Non-Emergency Services are not covered.	40% after deductible Non-Emergency Services are not covered.
Maternity Services	25% after deductible	50% after deductible
Labs, MRI, X-Ray & Diagnostic Test	25% after deductible	50% after deductible
Chemo, Radiation & Renal Dialysis	25% after deductible	50% after deductible
Facility Services (Inpatient & Outpatient)	25% after deductible	50% after deductible
Medical Equipment &Home Health	25% after deductible	50% after deductible
Mental Health & Substance Abuse Services In-patient and Out-patient Services Office Visits	Limited to 31 days per year per person 25% after deductible 25% after deductible	Limited to 31 days per year per person 50% after deductible 50% after deductible
Out-Patient Rehab Therapy Services	Limited to 60 visits per year per person 25% after deductible	Limited to 60 visits per year per person 50% after deductible
Prescription Services Annual Pharmacy Maximum Generic Branded Specialty Injections	 $10,000 Annual Maximum on Specialty Prescriptions $10 copay (Free through Mail Order) 25% after deductible (Free through Mail Order) 25% after deductible up to $10,000 Annual Maximum (Free if through Mail Order) Not Covered (except Insulin)	

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used term's, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

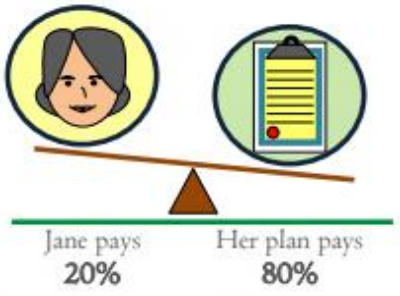
Allowed Amount
This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal
A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim
A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance
Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your dec of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



Complications of Pregnancy
Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a nonemergency caesarean section generally aren't complications of pregnancy.

Copayment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

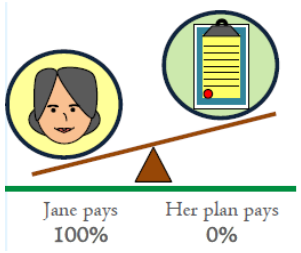
Cost Sharing

Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federallyrecognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible



An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement
Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange".

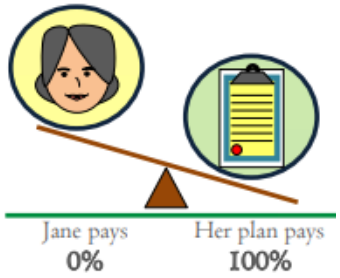
The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage
Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Out-of-network Provider (Non-Preferred Provider)
A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-particiapting" instead of "out-of-network provider".

Out-of-pocket Limit


The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services
Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan
Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Preauthorization
A decision by your health insurer or **plan** that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits
Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage
Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs
Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)
Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you

Primary Care Provider
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider
An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is not the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

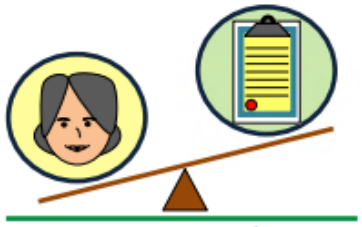
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs – Example

Jane's Plan Deductible: $1,500 **Coinsurance: 20%** **Out-of-Pocket Limit: $5,000**

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



more costs

Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

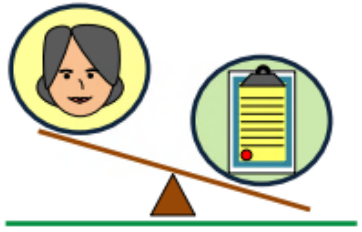
Office visit costs: $125
Jane pays: $125
Her plan pays: $0

more costs

Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100



Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125

COBRA Continuation of Coverage

This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.
- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 after the qualifying event occurs. You must provide this notice to: Ambassador Personnel, Inc. at P.O. Box 2057, Thomasville, GA 31799.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

coverage. You can learn more about many of these options at **www.healthcare.gov**.

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

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

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

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage.

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

However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

All Correspondences relating to the contents of this Notice should be directed as follows:

Ambassador Personnel, Inc.

P.O. Box 2057

Thomasville, Georgia 31799

Phone Number: 844-292-9904

Benefits@teamambassador.com

www.teamambassador.com