TARTA

TAKING YOU PLACES

2025 FULL-TIME EMPLOYEE BENEFITS GUIDE

TARTA.com - TARTA

Dear Employees,

We are is pleased to once again offer a comprehensive benefits package that provides quality plans and programs for you and your family. We remain committed to providing you with the best plan options and tools to optimize your health, wellness, and financial security.

Open Enrollment for your benefit elections will take place from November 18th through 29th. The choices you make during this time will take effect on January 1st and will remain in place for the entire policy year. If you are making changes to your current elections, please login to ADP Workforce Now to complete your enrollment. We encourage all employees to log into their ADP Workforce Now account to double check elections, as well as to make decisions on the newest benefits made available through TARTA. Please note, if you wish to continue contributing to the FSA, you must re-elect that coverage for the new Benefit Plan Year.

To ensure you are selecting the best benefit options for you and your family, please spend some time reviewing the plan information in this guide, including the costs and coverage levels.

We look forward to a successful Open Enrollment campaign. Comprehensive information on our plans and partners are available online through Workforce Now. Please email Human Resources if you have any questions or need assistance with the enrollment process.

Sincerely,

Laura Koprowski
Chief Executive Officer
Toledo Area Regional Transit Authority

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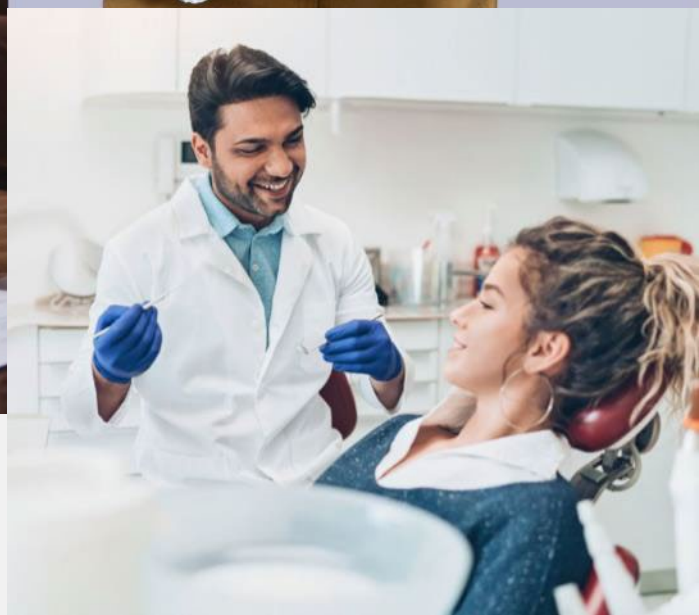


ELIGIBILITY

We encourage you to read the information in this benefit guide very carefully. This benefit guide provides an overview of the benefits available to you as an eligible TARTA employee. It is intended only as a general summaryof the various options & is not a legal document. Refer to your summary plan description & carrier certificates for final confirmation of coverage.

Employees

Full-Time Eligible Employees

Full-time employees who are regularly scheduled to work at least 30 hours/week are eligible for Medical, Dental, Vision, Basic Life/AD&D, Voluntary Life, and Supplemental coverage on the 1st of the month following date of hire.

New Hire Full-Time Employees

Enroll in your benefits during your initial new, full-time hire eligibility period;1st of the month following date of hire. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period or if you experience a qualifying event.

Termination of Coverage

If employment is terminated, coverage will cancel at the end of the month. The company paid life insurance and voluntary life will end on the date of termination. You may elect to continue all or part of your life insurance through Guardian. Please contact Guardian for details.

Dependents

An eligible dependent may be:

- Your legal spouse
- Domestic partners (Domestic Partner Affidavit must be completed)
- **A dependent child until the child reaches his or her 26th birthday; includes**:
- Natural biological child
- Stepchild
- Legally adopted child or a child legally placed for adoption
- Child for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwiserequired by law
- A child who is considered an alternate recipient under a Qualified Medical Child Support Order
- Your dependent child who is Disabled either mentally or physically may continue beyond the day the child otherwise ceases to be a Dependent under the terms of the plan.

Dependent Verification

You will be asked to provide Human Resources proof of dependent eligibility, which include marriage certificate, birth certificate, affidavit of qualifying adult, placement certificate, document of guardianship, etc.

Making Enrollment Changes during the Year

In most cases, your benefit elections remain in effect until the next Open Enrollment period. To make changes outside of the Open Enrollment period, you must incur a qualifying life event.

A qualifying event includes marriage, birth, adoption, divorce, death, loss of eligibility, change in Medicare or Medicaid eligibility, decree or court order, change in dependent eligibility status.

COST OF COVERAGE

Anthem Blue Cross & Blue Shield

Elect to cover yourself and your dependents. The medical plan is offered through Anthem Blue Cross & Blue Shield and include prescription coverage. Follow the instructions below to search for a provider.

Find Care & Estimate Costs for Doctors Near You | Anthem.com

- Click **"Basic search as a guest"**
- On the next screen, from the drop-down boxes choose:
    1. Select the type of plan or network – **Medical Plan or Network**
    2. Select **Ohio** as the state where the plan or network is offered
    3. Select how to get health insurance – **Medical (Employer Sponsored)**
    4. Select a plan or network – **Blue Access PPO for ERC Health**

WEEKLY Rates	Employee	Employee + Family
MEDICAL *Blue Cross Blue Shield*	$20.92	$55.45
DENTAL *Blue Cross Blue Shield*	$0.92	$2.16
VISION *Blue Cross Blue Shield*	$0.13	$0.36

BI-WEEKLY Rates	Employee	Employee + Family
MEDICAL *Blue Cross Blue Shield*	$41.83	$110.90
DENTAL *Blue Cross Blue Shield*	$1.83	$4.31
VISION *Blue Cross Blue Shield*	$0.26	$0.72

MEDICAL/RX

Plan Option:

Anthem

Preferred Provider Organization (PPO)

Designed for those who prefer the predictability of set payments for doctor appointments & other medical services.

Benefits	In-Network	Out-of-Network
Deductible: Single/Family	$500 / $1,000	$1,000 / $2,000
Annual Out-of-Pocket Maximum	$3,000 / $6,000	$3,600 / $7,200
Coinsurance *What you pay after your Deductible*	20%	40%
Primary Care Visits	$25 copay	40% after deductible
Preventive Care	$0 copay	40% after deductible
Specialist Visits	$25 copay	40% after deductible
Virtual Care: *Primary care/Mental Health/Specialist*	$0 copay / $0 copay / $25 copay	40% after deductible
Inpatient Visit	20%	40% after deductible
Outpatient Services	20%	40% after deductible
Facility Fee *(i.e., hospital, skilled nursing)*	$100 copay, then 20%	$100 copay, then 40%
Emergency Room	$250 copay, then 20%	Covered as In-Network
Urgent Care	$25 copay	40% after deductible
Rx Retail (30-day supply)		
Generic	$10 copay	50%
Preferred Brand	$20 copay	50%
Non-Preferred Brand	$35 copay	50%
Specialty	25% up to $200	50%
Rx Home Delivery (90-day supply)		
Generic	$20 copay	Not covered
Preferred Brand	$40 copay	Not covered
Non-Preferred Brand	$70 copay	Not covered
Specialty	25% up to $200	Not covered

ERChealth

Anthem

Smart Rewards

When an employee enrolls in the medical plan offered through Anthem BCBS, members are enrolled in the ERChealth program. Members are eligible to earn $300 max per enrolled employee. You can earn these rewards by completing the following:

Annual Well Exam or Annual Well Woman Exam

$100 per plan year

Completing an annual well exam or well woman exam is an essential step in understanding your health and building an on ongoing relationship with your primary care physician.

Preventive Cancer Screenings

$50 per plan year

Get rewarded for completing one of the following preventive cancer screenings: mammogram, colorectal screening, prostate screening, and skin cancer screening.

ConditionCare

$100 per plan year

If you're dealing with a chronic condition like asthma or diabetes, you can get one-on-one help from a health care professional to help you manage your health and reach your goals.

Steps Tracking

$25 per month

Employees and spouses can earn up to $25 per month for meeting a minimum of 240,000 steps. Keep track manually or by linking a wearable device or app.

Building Healthy Families

$75 per plan year

Work with a Family Care Coach who provides personalized support to help you navigate your family's unique journey.

Health Assessment

$50 per plan year

Receive a reward for completing your Health Assessment by answering questions about your overall health, medical history, diet, and exercise.

Well-being Coach

$100 per plan year

A live health coach motivates and supports you through making meaningful changes towards quitting smoking or weight management.

DENTAL & VISION

DENTAL:

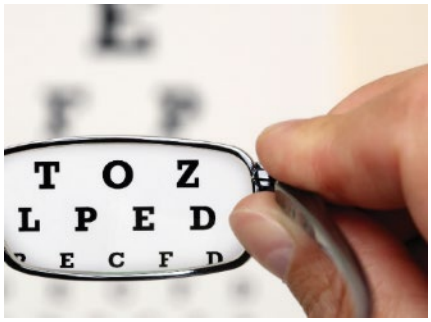
Anthem

Select Anthem and choose providers from the Dental Complete Network. Out-of-pocket costs are likely to be less when you choose an in-network dentist.

- To find a dentist by name or location, go to www.anthem.com or call dental customer service at the number listed on the back of your ID card.
- Out-of-Network Reimbursement: 90th percentile

Services	In-Network	Out-of-Network
Deductible	$50 Single / $150 Family	$50 Single / $150 Family
Annual Maximum Benefit	$1,500	$1,500
Coinsurance reflects what you pay		
Preventive Care	0%	0%
Basic Care	20% after Deductible	20% after Deductible
Major Care	50% after Deductible	50% after Deductible
Orthodontia (Children)	40% after Deductible	40% after Deductible
Lifetime Ortho Maximum	$1,000	$1,000

VISION:



When you elect Vision coverage you have:

- Access to one of the Blue View Vision network.
- To locate a participating network eye care doctor or location, log in at www.anthem.com or the Sydney App. You may also call member services for assistance at 1-866-723-0515

Services	In-Network	Out-of-Network
Exam *Once every 12 months*	$0 copay	$42 allowance
Frames *Once every 24 month*	$150 allowance + 20% discount	$45 allowance
Lenses *Once every 12 months*	$0 copay	Varied allowance
Contact Lenses: *Once every 12 months*	Elective: $150 allowance Medically Necessary: $0 copay	$105 allowance $210 allowance

FLEXIBLE SPENDING ACCOUNT

What is an FSA?

Flexible Spending Accounts (FSA) provide you with an important tax advantage that can help you pay health care expenses on a pretax basis. By anticipating your family's health care and dependent care costs, you can lower your taxable income and that means you get to keep more of what you earn.

There are two types of FSA's that allow you to make deductions to pay for expenses:

HEALTH CARE FSA

Contributions

You may contribute up to $3,300 per year as a before-tax contribution to your Health Care FSA.

TARTA will make a $750 FSA contribution for the 2025 year if you are enrolled in the medical plan. This amount will be included in the $3,300 limit that can be deposited into the FSA.

Eligible Dependents

In general, an eligible dependent under the Health Care FSA is anyone you list as a dependent on your federal income tax return. This includes your immediate family members, a close relative or other person whose primary residence is your home and for whom you provide over 50% support

CARRYOVER

You are permitted to carryover up to $640 of unused funds at the end of calendar year 2024.

IMPORTANT REMINDER: When making your Health Care Flexible Spending Account election, please be aware that over-the-counter medications and menstrual products are eligible for reimbursement beginning January 2021.

DEPENDENT CARE FSA

Contributions

In the Dependent Care FSA, you may contribute up to $5,000 per year. The $5,000 annual maximum applies to all contributions made by you and your spouse to a dependent care account. If you are married and filing separately for federal income tax purposes, you may elect to contribute up to $2,500 per year.

Eligible Dependents

You can be reimbursed for day care expenses you have in a plan year, if the expenses are necessary to allow you and your spouse—if you're married— to work. These services may be provided inside or outside your home by babysitters, companions or eligible day care centers. Services may not, however, be provided by someone you claim as a dependent on your tax return.

Grace Period

You are permitted to a 2 ½ month grace period to allow active members to use any remaining funds from the previous plan for 2 ½ months.

PAYING YOUR FSA EXPENSES

There are two ways to pay for eligible expenses:

- FSA Claim Form – You pay your health care providers directly and then file a claim for reimbursement.
- Debit Card – You can use your FSA debit card to pay for eligible health care expenses at any health care provider or approved merchant. With the Debit Card, participants have instant access to the money in their FSA, which is automatically drawn from their account as purchases are made.

FLEXIBLE SPENDING ACCOUNT QUALIFIED MEDICAL EXPENSES

Categories of FSA-eligible items

- **Home healthcare:** Thermometers, pain relief devices, blood pressure monitors, medical alert devices, blood sugar test kits, and more
- **Over-the-counter (OTC) medications**: Cough, cold, flu, allergy, asthma, pain relief, and more
- **Baby and child supplies**: Breast pumps, bed mats, bedwetting underwear, baby monitors, and more
- **Skin care:** Sunscreen, acne products, medicated lip balms, and more
- **Eye care:** Contact lenses, eye solutions, lens cleaning cloths, and more
- **Oral care**: Pain relief, water flossers, denture cleanser tablets, and more
- **Foot care:** Orthotics, foot creams, callus and corn removers, blister treatment, and more
- **Digestive health**: Heartburn relief, antacid tablets, laxatives, acid reflux pillows, and more
- **Vitamins**: Prenatal, nutritional supplements, multivitamins, and more
- **First aid supplies**: Bandages, pain relief creams, antibiotic ointments, first aid kits, and more
- **Sexual health medications and products**: OTC and prescription birth control, condoms, ED medications, fertility tests, and more
- **Menstrual products**: Pads, tampons, menstrual underwear, menstrual pain relief, and more
- **Incontinence supplies**: Pads, underwear, bed under pads, and more
- **Smoking cessation**: Programs, products, and more

Categories of FSA-eligible expenses

- Health insurance copayments, office visits, co-insurance payments, and deductibles
- Dental work and orthodontia
- Vision expenses, eyeglasses, and contact lenses
- Prescriptions
- Therapy and counseling services
- Chiropractic care and acupuncture
- Hospital fees, surgery, and diagnostic services
- Allergy testing

The above is a brief summary of FSA eligible items and expenses. For a complete listing, please visit:

- Topic no. 502, Medical and dental expenses | Internal Revenue Service (irs.gov)
- FSA Eligibility List | FSA Store | FSA Store

LIFE INSURANCE

Basic Life Insurance

We know you want to protect your loved ones in case of life's uncertainties. Guardian offers Basic Term Life Insurance and Accidental Death & Dismemberment (AD&D) coverage at no cost to you. You may purchase additional, supplemental coverage to increase your coverage amounts.

At no cost to you, Basic Term Life Insurance gives you:

- Coverage of $50,000
- AD&D coverage as part of your life insurance
- The ability to convert to an individual policy if you leave
- Waiver of premiums if you become disabled – Insurance will continue until age 65 or no longer disabled.
- Possible accelerated death benefit if you are diagnosed with a terminal disease
- No age reduction schedule

Voluntary Life Insurance

Employees have the opportunity to elect to purchase Voluntary Life Insurance that provides an additional life insurance benefit for you, your spouse and/or child(ren). If you waive voluntary life coverage when you are initially eligible you will be required to provide Evidence of Insurability (EOI) when enrolling at a later date.

	EMPLOYEE	SPOUSE	DEPENDENT CHILD(REN)
Benefit Election	$10,000 increments	$5,000 increments, not to exceed 100% of employee's amount	$1,000 increments, not to exceed 10% of employee's amount
*Guarantee Issue Amount	$150,000 (under 65)	$25,000 (under 65)	$10,000
Maximum	$300,000	$250,000	$10,000
Benefit Reduction Schedule	35% at age 65 50% at age 70	25% at age 65 50% at age 70	N/A

*Employees & spouses over 65 will have a reduced guaranteed issue amount

Actively at Work Requirement for Basic and Supplemental Life Insurance:

You must be actively at work on the day coverage is scheduled to being. If you are not actively at work on that day, coverage for you will begin once you have returned to work.

Don't forget to designate a beneficiary for employee life insurance.

HOSPITAL INDEMNITY

Guardian

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Why do I need a Hospital Indemnity plan?

Hospital indemnity insurance can cover some of the cost associated with a hospital stay, letting you focus on your recovery.

*MONTHLY Rates	Employe Only	Employee + Spouse	Employee + Child(ren)	Family
Hospital Indemnity Plan	$20.85	$41.46	$33.98	$54.59

*See Rate Page for bi-weekly and weekly per pay cost

ACCIDENT

Guardian

Why do I need an Accident plan?

When you, your spouse or child has a covered off-the-job accident, like a fall from a bicycle that requires medical attention, you can receive cash benefits to help cover the unexpected costs. While health plans may cover direct costs associated with an accident, you can use accident benefits to help cover related expenses like lost income, childcare, deductibles and copays…or any way you see fit.

Injury	Cash Payment
Accidental Death	EE: $25,000 Spouse: $12,500 Child: $5,000
Hospital Admission	$1,000 ICU: $2,000
Hospital Confinement	$250/day – up to 1 year
Fracture	Schedule up to $6,000
Ambulance	Ground: $200 Air: $1,000
Emergency Room	$200
Dislocations	Schedule up to $5,000
Coma	$10,000
Concussion	$200

The Accident plan includes a **Wellness benefit** that will pay **$75** for receiving Preventive Care

*MONTHLY Rates	Employe Only	Employee + Spouse	Employee + Child(ren)	Family
Accident Plan	$13.75	$23.20	$24.52	$33.97

*See Rate Page for bi-weekly and weekly per pay cost

CRITICAL ILLNESS

Guardian

Why do I need a Critical Illness plan?

No one is ever really prepared for a life-altering critical illness diagnosis. The whirlwind of appointments, tests, treatments and medications can add to your stress levels. Critical Illness coverage helps provide financial support if you are diagnosed with a covered critical illness.

Features & Plan Provisions

- Coverage is available to all family members: spouses up to 100% of the face amount elected by the employee; children up to 25%
- Elect $10,000, $20,000, or $30,000 in coverage
- Guarantee Issue for employee & spouse is $30,000 (no medical questions asked)
- Includes an **annual Wellness benefit that pays you $100 per person per year** for many common preventive screenings

Provides a large, lump sum benefit to help you bounce back when you suffer a major health event. The Critical Illness benefit pays cash, on top of any other medical, disability or supplemental plan.

Covered Conditions:

Heart Attack (Myocardial Infarction)
Stroke
Cancer
Renal Failure
Carcinoma in Situ
Coronary Artery Bypass Surgery
Alzheimer's Disease
Multiple Sclerosis
Parkinson's Disease

Childhood Conditions:

Cerebral Palsy
Cleft Lip/Palate
Club Foot
Cystic Fibrosis
Down's Syndrome
Muscular Dystrophy
Spina Bifida
Type I Diabetes

*See Guardian summary for full listing of covered conditions

*MONTLY Rates	<30	30-39	40-49	50-59	60-69	70+
$10,000	$5.20	$8.30	$15.10	$28.80	$48.10	$75.60
$20,000	$10.40	$16.60	$30.20	$57.60	$96.20	$151.20
$30,000	$15.60	$24.90	$45.30	$86.40	$144.30	$226.80

*Spouse coverage premium is based on Employee age; Child cost is included with employee election

***See Rate Page for bi-weekly and weekly per pay cost**

CANCER

Why do I need Cancer coverage?

No one is ever prepared in life for a cancer diagnosis. Unfortunately, cancer touches almost everyone at some point in their lives and everyone's story is unique – especially when it comes to treatment. Cancer coverage helps offset the costs of treatments and keeps you focused on your recovery, not your finances.

Features & Plan Provisions

- Coverage is available to all family members: Employee, Spouse and Child(ren).
- The coverage pays $2,500 upon initial diagnosis.
- The benefit waiting period is 30 days after your effective date during which the initial diagnosis benefits will not be payable.
- The benefit will pay based on each specific service or treatment received from your cancer diagnosis. For example: radiation therapy, bone marrow/stem cell, home health care, immunotherapy, reconstructive surgery, and more.
- Includes an **annual Wellness benefit that pays you $50 per person per year** for many common preventive screenings

*MONTHLY Rates	Employe Only	Employee + Spouse	Employee + Child(ren)	Family
Cancer Plan	$24.26	$48.06	$26.94	$50.74

*See Rate Page for bi-weekly and weekly per pay cost

SUPPLEMENTAL RATES

Guardian

ACCIDENT	Employe Only	Family
Weekly	$3.17	$7.84
Bi-Weekly	$6.35	$15.68

HOSPITAL	Employe Only	Family
Weekly	$4.81	$12.60
Bi-Weekly	$9.62	$25.19

CRITICAL ILLNESS			
Per thousand Unit Rate			
Attained Age	Employee	Spouse	Child(ren)
25	$0.52	$0.52	Included in EE Election
35	$0.83	$0.83	
45	$1.51	$1.51	
55	$2.88	$2.88	
65	$4.81	$4.81	

CANCER	Employe Only	Family
Weekly	$5.60	$11.71
Bi-Weekly	$11.20	$23.42

EMPLOYEE ASSISTANCE PROGRAM

We all need a little support now and then.

The Employee Assistance Program (EAP) provides guidance for personal issues that you might be facing and information about other concerns that affect your life, whether it's a life event or on a day-to-day basis.

- Consultative services are available to provide direct support and assistance.
- Work/life assistance that can help you save money and balance commitments.
- Access legal and financial assistance and resources – including WillPrep Services

Uprise Health EAP can offer help with:

Education

- Admissions testing & procedures
- Adult re-entry programs
- College planning
- Financial aid resources

Lifestyle & Fitness Management

- Anxiety & depression
- Divorce & separation
- Drugs & alcohol

Dependent Care & Caregiving

- Adoption assistance
- Before/after school programs
- Elder care

Working Smarter

- Career development
- Effective managing
- Relocation

Legal & Financial

- Basic tax planning
- Credit & collections
- Debt counseling
- Home buying

COMPLETELY CONFIDENTIAL

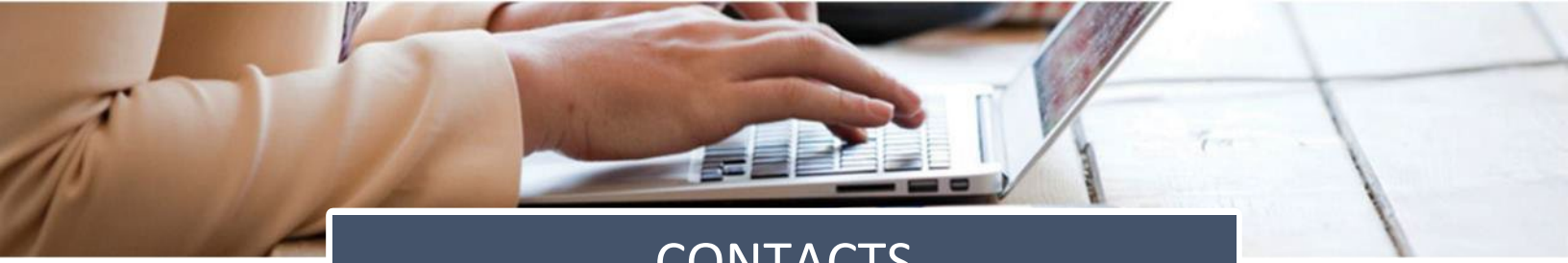
1-800-386-7055

Uprise Health Member Portal

Access Code: worklife

24-hour crisis help available

Regular Office Hours: Monday – Friday 6:00am – 5:00pm PST



CONTACTS

Benefit	Administrator	Contact Information
Medical/Rx	Anthem BCBS ERC Policy# L09804	www.anthem.com
Dental	Anthem Policy# L09804	www.anthem.com (833) 639-1634
Vision	Anthem - Blue View Vision Policy# L09408	www.anthem.com (866) 723-0515
Basic Life/AD&D Voluntary Life/AD&D	Guardian Group#: 00059382	www.guardianlife.com (888) 600-1600
Accident Cancer Critical Illness Hospital	Guardian Group#: 00059382	www.guardianlife.com (888) 600-1600
Employee Assistance Program (EAP)	Guardian Access Code: worklife	www.worklife.uprisehealth.com (800) 386-7055

TARTA Human Resources

Mary Lambert	Human Resources Manager - Benefits	mlambert@tarta.com Office - (419) 245-5216 Cell – (734) 777-6032

Toledo Area Regional Transit Authority
2025 OPEN ENROLLMENT & PLAN PARTICIPANT NOTICES

ARE YOU, OR A FAMILY MEMBER, MEDICARE ELIGIBLE (OR ABOUT TO BECOME MEDICARE ELIGIBLE)? IF SO, PLEASE READ AND KEEP FOR YOUR RECORDS!

Notice of Creditable Coverage

Your prescription drug coverage provided under Toledo Area Regional Transit Authority's Anthem BCBS plan is expected to pay out, on average, the same or more than what the standard Medicare prescription drug coverage will pay. This is known as "creditable coverage".

Why This is Important

This information is to help you decide whether or not you want to join a Medicare drug plan. It is important for those eligible for both Medicare and a group health plan to look ahead and weigh the costs, benefits, and participation terms of the various options on a regular, if not annual, basis. Based on individual facts and circumstances some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would *reduce payment* in order to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

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

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

2. Toledo Area Regional Transit Authority has determined that the prescription drug coverage offered by the Anthem BCBS plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When May You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current Toledo Area Regional Transit Authority coverage may or may not be affected as well as dependent coverage. Additional guidance is available at https://www.cms.gov/medicare/prescription-drug-coverage/creditablecoverage?redirect=/creditablecoverage/ which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Toledo Area Regional Transit Authority and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage
Contact the person listed below for further information **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Toledo Area Regional Transit Authority changes. You also may request a copy of this notice at any time.

Contact--Position/Office: Mary Lambert – HR Manager
Address: 1127 W. Central Avenue, Toledo, OH 43697-0792
Phone Number: 419-245-5216

For More Information Regarding Your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

HIPAA Notice of Privacy Practices

You are receiving this Privacy Notice because you are eligible to participate in an employer sponsored group health plans. The Health Plans are committed to protecting the confidentiality of any health information collected about an individual. This Notice describes how the Health Plan may use and disclose, "protected health information" (PHI). For information to be considered "PHI", it must meet three conditions:

Information is created or received by a health care provider, health plan, employer, or health care clearinghouse; Information relates past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and the information either identifies the individual or provides a reasonable basis for believing that it can be used to identify the individual.

The Health Plan is required by the Health Insurance Portability and Accountability Act (HIPAA) to provide this Notice to an individual. Additionally, the Health Plan is required by law to:

Maintain the privacy of an individual's "protected health information" (PHI) and provide you with the Privacy Notice of its legal duties and privacy practices with respect to an individual's PHI and follow the terms of its Privacy Notice that is currently in effect.

Employees of the plan sponsor who administer and manage this Health Plan may use PHI only for appropriate plan purposes (such as for payment or health care operations), but not for purposes of other benefits not provided by this plan, and not for employment-related purposes of the plan sponsor. These individuals must comply with the same requirements that apply to the Health Plan to protect the confidentiality of PHI.

Uses and Disclosures of Protected Health Information (PHI)

The following categories describe the ways that the Health Plan may use and disclose protected health information. For each category of uses and disclosures, examples will be provided. Not every use or disclosure in a category will be listed. However, all the ways the Health Plan is permitted to use and disclose information will fall within one of these categories.

Treatment Purposes. The Health Plan may disclose PHI to a health care provider for the health care provider's treatment purposes. For example, if an individual's Primary Care Physician (PCP) or treating medical provider refers the individual to a specialist for treatment, the Health Plan can disclose the individual's PHI to the specialist to whom they have been referred so (s)he can become familiar with the individual's medical condition, prior diagnoses and treatment, and prognosis.

Payment Purposes. The Health Plan may use or disclose health information for payment purposes; such as, determining eligibility for plan benefits, obtaining premiums, facilitating payment for the treatment and services an individual receives from health care providers, determining plan responsibility for benefit payments, and coordinating benefits with other benefit plans. Examples of payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a specific treatment is covered under the plan

Health Care Operations. The Health Plan may use PHI for its own health care operations and may disclose PHI to carry out necessary insurance related activities. Some examples of Health Care Operations may include: underwriting, premium rating and other activities related to plan coverage; conducting quality assessment and

improvement activities; placing contracts; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration of the Health Plan.

To a Business Associate of the Health Plan. The Health Plan may disclose PHI to a Business Associate (BA) of the Health Plan, provided a valid Business Associate Agreement is in place between the Business Associate and the Health Plan. A Business Associate is an entity that performs a function on behalf of the Health Plan and that uses PHI in doing so or provides services to the Health Plan such as legal, actuarial, accounting, consulting, or administrative services. Examples of Business Associates include the Health Plan's Third-Party Administrators (TPAs), Actuary, and Broker.

To the Health Plan Sponsor. The Health Plan may disclose PHI to the Plan Sponsor as long as the sponsor has amended its plan documents, provided a certification to the Health Plan, established certain safeguards and firewalls to limit the classes of employees who will have access to PHI, and to limit the use of PHI to plan purposes and not for non-permissible purposes, as required by the Privacy Rule. Any disclosures to the plan sponsor must be for purposes of administering the Health Plan. Some examples may include: disclosure for claims appeals to the Plan's Benefits Committee, for case management purposes, or to perform plan administration functions.

The Health Plan may also disclose enrollment/disenrollment information to the plan sponsor, for enrollment or disenrollment purposes only, and may disclose "Summary Health information" (as defined under the HIPAA medical privacy regulations) to the plan sponsor for the purpose of obtaining premium bids or modifying or terminating the plan.

Required by Law or Requested as Part of a Regulatory or Legal Proceeding. The Health Plan may use and disclose PHI as required by law or when requested as part of a regulatory or legal proceeding. For example, the Health Plan may disclose medical information when required by a court order in a litigation proceeding, or pursuant to a subpoena, or as necessary to comply with Workers' Compensation laws.

Public Health Activities or to Avert a Serious Threat to Health or Safety. The Health Plan may disclose PHI to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Law Enforcement or Specific Government Functions. The Health Plan may disclose PHI to law enforcement personnel for purposes such as identifying or locating a suspect, fugitive, material witness or missing person; complying with a court order or subpoena; and other law enforcement purposes.

Other uses and disclosures will be made only with an individual's written authorization or that of their legal representative, and the individual may revoke such authorization as provided by section 164.508(b) (5) of the Privacy Rule. Any disclosures that were made when the individual's Authorization was in effect will not be retracted.

An Individual's Rights Regarding PHI

An individual has the following rights with respect to their PHI:

Right to Inspect and Copy PHI. An individual has the right to inspect and copy health information about them that may be used to make decisions about plan benefits. If they request a copy of the information, a reasonable fee to cover expenses associated with their request may be charged.

Right to Request Restrictions). An individual has the right to request restrictions on certain uses and disclosures of their PHI (although the Health Plan is not required to agree to a requested restriction).

Right to Receive Confidential Communications of PHI). An individual has the right to receive their PHI through a reasonable alternative means or at an alternative location if they believe the Health Plan's usual method of communicating PHI may endanger them.

Right to Request an Amendment. An individual has the right to request the Health Plan to amend their health information that they believe is incorrect or incomplete. The Health Plan is not required to change the PHI but is required to provide the individual with a response in either case.

Right to Accounting of Disclosures. An individual has the right to receive a list or "accounting of disclosures" of their health information made by the Health Plan, except the disclosures made by the Health Plan for treatment, payment, or health care operations, national security, law enforcement or to corrections personnel, pursuant to the individual's Authorization, or to the individual. An individual's request must specify a time period of up to six years and may not include dates prior to May 1, 2010 (effective date of this regulation). The Health Plan will provide one accounting of disclosures free of charge once every 12-month period.

Breach Notification. An individual has the right to receive notice of a breach of your unsecured medical information. Notification may be delayed if so, required by a law enforcement official. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Optional if covered entity engages in underwriting **Genetic Information** An individual's genetic information will not be used for underwriting except for long term care plans.

Right to Paper Copy. An individual has a right to receive a paper copy of this Notice of Privacy Practices at any time.

The Health Plan's Responsibilities Regarding an Individual's PHI

The Health Plan is a "covered entity" (CE) and has responsibilities under HIPAA regarding the use and disclosure of PHI. The Health Plan has a legal obligation to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. The Health Plan is required to abide by the terms of the current Notice of Privacy Practices (the "Notice"). The Health Plan reserves the right to change the terms of this Notice at any time and to make the revised Notice provisions effective for all PHI the Health Plan maintains, even PHI obtained prior to the effective date of the revisions. If the Health Plan revises the Notice, the Health Plan will promptly distribute a revised Notice to all actively enrolled participants whenever a material change has been made. Until such time, the Health Plan is required by law to comply with the current version of this Notice

The complaint will be investigated, and a written response will be provided to the individual within 30 days from receipt of the complaint. A written summary of the complaint and any correction action taken will be filed with the Privacy Officer. The Health Plan will not retaliate against the individual in any way for filing a complaint.

If an individual would like their complaint reviewed by an outside agency, they may contact the Department of Health and Human Services at the following address:

Department of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20210

HIPAA Plan Special Enrollment Notice

If you are declining your enrollment under the Plan, or declining coverage for your spouse or one of your dependents, because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage, or if the employer stops contributing toward such other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends, or after the period for which the employer ceased contributing toward such other coverage if such payment applied to your circumstances.

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

To request special enrollment or obtain more information, please contact the Plan Administrator listed in the Summary Plan Description or contact the Human Resources department staff for furtherinformation.

Genetics Information Notice

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

"Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Mental Health/Substance Use Disorder Parity

Effective for Plan Years on and after July 1, 2010, benefits under Plans that provide Mental Health Benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Newborns and New Mothers Care Disclosure

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

Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual and Regular Notice

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, notwithstanding anything herein to the contrary, the Plan provides coverage for: 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact the Plan Administrator listed in the Summary Plan Description or contact the Human Resources department staff for further information.

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.
If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272). If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

STAY CONNECTED.

TARTA

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