new york sports clubs

and our family of brands

2023 Employee Benefits Guide

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A Message to Our Employees

Better Benefits, Better you.

At New York Sports Clubs and Our Family of Brands, we believe that you, our employees, are essential in our mission of Improving Lives Through Exercise. Helping you and your families achieve and maintain excellent physical, emotional, and financial health is the reason that we offer this benefits program. We believe in working with passion and integrity, so we are providing you with this overview to help you understand the available benefits and how to use them best. Please review it carefully and make sure that to ask about any important issues not addressed here. A list of plan contracts is provided at the back of this summary.

While we've made every effort to ensure that this guild is comprehensive, it cannot fully describe all benefit provisions. Please refer to your plan benefit booklets or summary plan descriptions (SPDs) for more detailed information. The plan benefit booklets determine how all benefits are paid. You can find all of our benefit plan documents at - https://nysc.retailzipline.com/library/resources/3ab2ea04-benefits .

The benefits in this summary are effective:
January 1, 2023 – December 31, 2023

Making the Most of Your Benefits Program

Helping you and your family members stay healthy and making sure you use your benefits program to its best advantage is our goal in offering this program. Here are a few things to keep in mind.

STAY WELL!

Harder than it sounds, of course, but many health problems are avoidable. Take action—from eating well, to getting enough exercise and sleep. Taking care of yourself takes care of a lot of potential problems.

ASK QUESTIONS AND STAY INFORMED

Know and understand your options before you decide on a course of treatment. Informed patients get better care. Ask for a second opinion if you're at all concerned.

GET A PRIMARY CARE PROVIDER

Having a relationship with a PCP gives you a trusted person who knows your unique situation when you're having a health issue. Visit your PCP or clinic for non-emergency healthcare.

GOING TO THE DOCTOR?

To get the most out of your doctor visit, being organized and having a plan helps. Bring the following with you:

- Your plan ID card
- A list of your current medications
- A list of what you want to talk about with your doctor

If you need a medication, you could save money by asking your doctor if there are generics or generic alternatives for your specific medication.

AN APPLE A DAY

Eating moderately and well really does help keep the doctor away. Stay away from fat-heavy, processed foods and instead focus on whole grains, vegetables, and lean meats to be the healthiest you can be.

EMERGENCY ROOM ALTERNATIVES

Did you know most ER visits are unnecessary? Use them only in a true emergency—like any situation where life, limb, and vision are threatened. Otherwise, call your doctor, your nurse line, or go to an Urgent Care clinic. You'll save a lot of money and time!

BE MED WISE!

Always follow your doctor's and pharmacist's instructions when taking medications. You can worsen your condition(s) by not taking your medication or by skipping doses. If your medication is making you feel worse, contact your doctor.

Benefits for You & Your Family

WHO IS ELIGIBLE?

Team members who meet the eligibility requirements below will qualify for the benefits outlined in this overview. Please see the eligibility section below for specific details. You can enroll yourself and the following family members in our plans.

- Your spouse (the person who you are legally married to under state law) or qualified domestic partner.
- Your children:
    - Under the age of 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
    - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

ELIGIBILITY

There are two classifications of employees:

- **Regular Full-Time** (generally club managers – GMs, FMs, FS, CSMs, corporate staff) - Employees who are reasonably expected to work 30+ hours/week are considered Regular Full-Time and are eligible for healthcare benefits on the first of the month following 60 days of employment.
- **Part-Time/Variable Hour** (generally, non-managerial club employees including welcome team, clean team, PTs, GEIs, SCFK Instructors, MCs, etc.) - Employees who are expected to work less than 30 hours per week are considered "Part-Time/Variable Hour" and placed into a one-year waiting period when they are hired, called an initial measurement period (IMP) and if they satisfy the minimum hours requirement (average of 30 hours/week), they are eligible for health benefits on the first of the 14th month following their hire date. Each year, employees in this category are measured again to determine their eligibility status for the upcoming plan year.

If you are a regular full-time employee as defined above, you and your dependents are eligible for health plan coverage the first of the month coinciding with or following 60 days.

If you are a part-time/variable hour employee as defined above, you will be placed into a one-year measurement period upon hire. At the end of your 12-month measurement period, if you have averaged 30 or more hours per week, you will be eligible for the full healthcare benefits package. Then, on an annual basis, your hours will be measured to determine eligibility status for the upcoming plan year. Your health benefits status will remain in effect for 12 months.

For more specific examples, please refer to the detailed explanation on the company intranet.

WHO IS NOT ELIGIBLE?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Any individual who is covered as an employee of NYSC cannot also be covered as a dependent.
- Employees who work less than an average of 30 hours per week, or contract employees.

WHEN CAN I ENROLL?

Coverage for regular full-time employees begins on the 1st of the month following 60 days of employment. Part-Time/Variable hour employees will be eligible to enroll if you meet the 30-hour threshold on the first of the 14th month following date of hire.

Open enrollment is the one time each year that employees can elect or make changes to their benefit elections without a qualifying life event.

Make sure to notify the Benefits Department right away at benefits@nysc.com or 914-347-4009 x1477 if you do have a qualifying life event and need to make a change (add or drop) to your coverage election. These changes include (but are not limited to):

- Birth or adoption of a child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- You or your spouse have a change in employment status
- Marriage
- Divorce

Please be aware that you have 31 days from the date of the qualifying event to make any changes to your insurance and submit the required supporting documentation. If you do not submit the documentation within the 31 days, then you will have to wait until the next Open Enrollment period to make changes which would be effective on the first of the upcoming calendar year.

Medical Insurance

NYSC offers medical coverage through Aetna. Medical coverage provides you with benefits that help keep you healthy like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition. NYSC provides you with comprehensive medical/Rx coverage with the choice of two plans: Basic and Buy-Up Plans. Both plans offer In-Network and Out-of-Network coverage.

The chart below is a brief outline of the plans offered. Please refer to the summary plan description for complete plan details.

Benefits Coverage	Basic Plan	Buy-Up Plan
Annual Deductible		
Individual	$4,000	$2,000
Family	$8,000	$4,000
Coinsurance (% you pay after deductible)	30%	20%
Maximum Out-of-Pocket		
Individual	$6,000	$5,000
Family	$12,000	$10,000
Physician Office Visit		
Teladoc Visits (general, Dermatology and Mental Health)	$0 Cost!	$0 Cost!
Primary Care (Includes Dermatology & OBGYN)	$25 Copay	$25 Copay
Specialty Care	$60 Copay	$50 Copay
Preventive Care		
Adult Periodic Exams	Covered 100%	Covered 100%
Well-Child Care	Covered 100%	Covered 100%
Diagnostic Services		
X-ray and Lab Tests	70% after deductible	80% after deductible
Complex Radiology	70% after deductible	80% after deductible
Urgent Care Facility	$60 Copay	$50 Copay
Emergency Room Facility Charges	70% after deductible	$500 copay; waived if admitted
Inpatient Facility Charges	70% after deductible	80% after deductible
Outpatient Facility and Surgical Charges	70% after deductible	80% after deductible
Out-Of-Network		
Deductible (Individual / Family)	$6,000/$12,000	$5,000/$10,000
Maximum Out of Pocket (Individual / Family)	$12,000/$24,000	$12,000/$24,000
Coinsurance (% you pay after deductible)	40%	40%

Prescription Drugs

In-Network Benefits Coverage	Basic Plan	Buy- Up Plan
Prescription Deductible		
Individual	$250	$100
Family	$500	$300
Retail Pharmacy (30 Day Supply)		
Generic (Tier 1)	$10 Copay	$10 Copay
Preferred (Tier 2)	$50 Copay	$45 Copay
Non-Preferred (Tier 3)	$80 Copay	$75 Copay
Mail Order Pharmacy (90 Day Supply)		
Generic (Tier 1)	$20 Copay	$20 Copay
Preferred (Tier 2)	$100 Copay	$90 Copay
Non-Preferred (Tier 3)	$160 Copay	$150 Copay

Teladoc

Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits. Set up your account today so when you need care, a Teladoc doctor is just a call or click away. Teladoc is available to you and covered dependents **at no cost to you**!!

Teladoc does not replace your primary care physician; it is a convenient and free option for quality care. When considering the ER or urgent care for a non-emergent issue, consider using Teladoc. You can even get a prescription! Teladoc physicians can treat many conditions, including, cold/flu, allergies, bronchitis, UTI, respiratory infection, sinus problems and more!

To set up your account, follow the steps below:

1.) Set up your account by phone or mobile app

- **Online**: Go to www.teladoc.com/Aetna and click "set up account."
- **Mobile App:** Download the app and click "activate account." Visit Teladoc.com/mobile to download the app.
- **Call Teladoc**: 1-855-835-2362 - Teladoc can help you register your account over the phone.

2.) Provide Medical History

- Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.

3.) Request a Consult

- Once your account is set up request a consult anytime you need care and talk to a doctor by phone, web, or mobile app

TELADOC.

Where To Go For Care

Where	What	When	Base Plan	Buy-Up Plan
Virtual Visits (Teladoc) ***Now includes Mental Health and Dermatology***	See a doctor using your smartphone, tablet or computer. You can even get a prescription sent to your pharmacy all in 30 minutes or less.	- Allergies - Cough/cold/sinus - Bladder infection - Bronchitis - Mild COVID symptoms - Diarrhea - Fever - Pink eye - Rashes - Mental Health - Dermatology	**$0—no cost to you!**	**$0—no cost to you!**
Preventive Care	See a doctor for routine, annual screenings.	- Annual routine physical - Annual blood work - Age/gender appropriate screenings (i.e., mammogram)	$0—no cost to you!	$0—no cost to you!
Primary Care Physician	Visit your doctor when you need routine care. Your primary doctor can access your medical records, manage your medications and refer you to a specialist, if needed.	- General health management - Minor skin conditions - Vaccinations	$25 Copay	$25 Copay
Urgent Care Facility	Urgent care is ideal when you need care quickly, but it's not an emergency (and your doctor isn't available). Urgent care centers treat issues that aren't life-threatening	- Sprains - Strains - Stitches - Minor burns - Minor infections - Minor broken bones	$60 Copay	$50 Copay
Emergency Room	ER is for life-threatening or very serious conditions that require immediate care. This is also when to call 911 or your local emergency number.	- Breathing difficulty - Chest pain - Major broken bones - Spinal injuries - Head injury - Heavy bleeding - Large, open wounds - Severe COVID Symptoms	Plan pays 70% / you pay 30% after the annual deductible	$500 Copay (waived if admitted)

Dental Insurance

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

NYSC gives you a choice between three dental plans: a DMO Plan and a Basic and Buy-Up PPO Plan.

	Aetna Dental DMO Plan	Aetna Dental Basic PPO Plan		Aetna Dental Buy-Up PPO Plan	
	In- Network	In- Network	Out of Network	In- Network	Out of Network
CYD Individual Family	$0 $0	$75 $225	$75* $225*	$50 $150	$50* $150*
Annual Plan Maximum	Unlimited	$1,000	$1,000*	$2,000	$2,000*
Waiting Period	Does not apply	Late entrant penalty applies	In-network limitation	Late entrant penalty applies	In-network limitation
Diagnostic and Preventive	$0-$80 copay then plan pays 100%	Plan pays 80%	Plan pays 80%	Plan pays 100%	Plan pays 100%
Basic Services	See contract for fee schedule	Plan pays 50% after CYD	Plan pays 50% after CYD	Plan pays 80% after CYD	Plan pays 80% after CYD
Major Services	$6-$315 copay then plan pays 100%	Plan pays 50% after CYD	Plan pays 50% after CYD	Plan pays 60% after CYD	Plan pays 60% after CYD
Orthodontic Services Lifetime Max Children only	$1,945 copay then plan pays 100% Unlimited	Plan pays 50% to $1,000 maximum	Plan pays 50% to $1,000 maximum*	Plan pays 50% to $2,000 maximum	Plan pays 50% to $2,000 maximum*

CYD = calendar year deductible
*Combined with in-network deductible

Reward Provision Program for Basic and Buy-Up DPPO Plans Only. Eligible for $200 Annual Maximum increase for obtaining ANY preventive services per each covered member. (Capped at three times). If no preventive services obtained, annual maximum will remain at current level. Does not apply to Orthodontia services.

Please Note: The DMO is not available in the following states: AL, AK, AR, HI, ID, LA, ME, MS, MT, NH, NM, ND, SC, SD, VT, WY

Vision Insurance

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions. We offer you a vision plan through Vision Service Plan (VSP).

	In-Network	Out-of-Network
Copay		
Routine Exams (Annual)	$10 Copay	Reimbursed up to $45
Vision Materials		
Materials Copay	$20 Copay	Reimbursed up to $70
Lenses	Benefit varies by type of lens. Covered every 12 months	Reimbursed from $30-$65
Contacts covered in lieu of frames. Medically necessary contacts may be covered at a higher benefit level.	Elective contacts covered $180 Retail Allowance every 12 months	Reimbursed up to $105
Frames	Covered at $180 allowance every 12 months	Reimbursed up to $70

Flexible Spending Accounts (FSA)

Flexible Spending Accounts for health care and dependent care can help you save money. The money you contribute to these accounts is not taxed, and you withdraw the money tax-free when paying for eligible expenses. It can potentially save you 30% or more on eligible healthcare and/or qualifying child and adult dependent care expenses. In addition to the pre-tax savings, you also benefit from using pre-tax dollars to pay for things such as medical co-pays and deductibles, dental and vision expenses, medications and before-school and after-school day care expenses.

HEALTH CARE FSA

The Health Care FSA allows you to put aside money before taxes are withheld so that you can pay for eligible medical, dental, and vision expenses that are not reimbursed by any other coverage you and your qualifying family members have.

Due to IRS rules, the maximum amount you can contribute to a Health Care FSA in 2023 is $3,050.

DEPENDENT CARE FSA

The Dependent Care FSA allows you to put aside money before taxes are withheld so that you can pay someone to care for an eligible child or adult while you and your spouse (if you are married) work, look for work, or attend college full-time (this account cannot be used for health care expenses). You can also contribute to this account for care of a disabled spouse.

You may contribute up to $5,000 per calendar year ($2,500 if married and filing separately) on a before-tax basis to a Dependent Care FSA in 2023.

IMPORTANT FSA GUIDELINES REGARDING ROLLOVER FUNDS

Keep in mind, Flexible Spending Accounts (FSAs) are typically “use-it-or-lose-it” accounts. Due to a recent IRS change, you may now rollover up to $610 in unused 2022 healthcare FSA contributions to use for eligible expenses in 2023. You will forfeit any money above $610 left in the account at the end of the plan year, so it’s important to carefully estimate your contribution amount. The rollover provision does not apply to dependent care FSAs.

COMMUTER BENEFITS PLAN

Commuter Benefit Transit and Parking Plans are pre-tax benefit plans that are used to pay for the following:
Monthly Bus, Train or Metro Passes
Transportation between home and work in “Commuter Highway Vehicle”
Parking provided at or near your business premises or parking provided on or near a location from which you commute to work.

The IRS pre-tax maximum for Transit is $300/month. The IRS pre-tax maximum for Parking is $300/month.

www.briweb.com

Life Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security.

LIFE AND AD&D

Basic Life Insurance pays your beneficiary a lump sum if the event of your death. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by the company. Coverage is provided by MetLife Inc.

Basic Life Amount	1x your annual covered earnings to a maximum of $25,000
Basic AD&D Amount	1x your annual covered earnings to a maximum of $25,000

VOLUNTARY LIFE

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by MetLife Inc.

Employee Voluntary Life Amount	Increments of $10,000 up to $100,000
Spouse Voluntary Life Amount	Increments of $5,000 up to $100,000, but not to exceed
Dependent Child Voluntary Life Amount	$10,000

Voluntary Spouse and Child Life benefits are only eligible for those employees who elect Voluntary Employee Life themselves.

Evidence of Insurability: Upon your initial eligibility date, you may elect up to 3x your base annual earnings (up to $100,000), with no medical questions asked. You may also elect up to $25,000 for your spouse (not to exceed 100% of your election), with no medical questions asked. For elections over these guarantee issue amounts, you must complete an evidence of insurability form.

During the annual open enrollment period, all elections or increases require medical evidence.

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

Employee Voluntary Life Rates

Age	Monthly Cost Per $10,000	Bi-Weekly Deduction	Annual Premium
24 & Under	$0.50	$0.23	$5.98
25 to 29	$0.60	$0.28	$7.28
30 to 34	$0.80	$0.37	$9.62
35 to 39	$0.90	$0.42	$10.92
40 to 44	$1.00	$0.46	$11.96
45 to 49	$1.60	$0.74	$19.24
50 to 54	$2.70	$01.25	$32.50
55 to 59	$4.30	$1.98	$51.48
60 to 64	$6.60	$3.05	$79.30
65 to 69	$13.80	$6.37	$165.62
70 to 74	$24.60	$11.35	$295.10

Voluntary Spouse Life Rates

Age	Monthly Cost Per $10,000	Bi-Weekly Deduction	Annual Premium
24 & Under	$0.55	$0.25	$6.50
25 to 29	$0.55	$0.25	$6.50
30 to 34	$0.64	$0.30	$7.80
35 to 39	$0.88	$0.41	$10.66
40 to 44	$1.19	$0.55	$14.30
45 to 49	$1.74	$0.80	$20.80
50 to 54	$2.77	$1.28	$33.28
55 to 59	$5.02	$2.32	$60.32
60 to 64	$9.54	$4.40	$114.40
65 to 69	$16.14	$7.45	$193.70
70 to 74	$30.01	$13.85	$360.10

Voluntary Child Life Rate

$1.30 per $10,000 benefit

Short-Term Disability Insurance

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

SHORT-TERM DISABILITY INSURANCE

Short-Term Disability coverage pays you a benefit if you temporarily can't work because of a non-work related injury, illness, or maternity leave. New York and New Jersey have state-mandated short-term disability benefits so employees who work in those states get coverage automatically, regardless of their NYSC benefits-eligibility status. In New Jersey, coverage is available directly through the state and in New York, ShelterPoint administers this plan for us.

Benefits-eligible employees in all other states may elect **voluntary** short-term disability (mirrors NY state's benefit) which provides an optional salary continuation plan through ShelterPoint. Details are shown below.

Under Voluntary STD, you may receive replacement income for a period of up to 26 weeks in a 52-week period for a qualifying non-occupational injury or illness. If you elect this optional benefit, you will receive 50% of your gross salary up to a maximum of $340 per week.

Weekly Benefit Amount	Plan pays 50% of covered weekly earnings
Maximum Weekly Benefit	$340
Benefits Begin After: **Accident** **Sickness**	 7 days of disability 7 days of disability
Maximum Payment Period*	26 weeks of disability

*Maximum payment period is based on the first day you are disabled, not when benefits begin.

Accident Insurance

You may be completely healthy and active today. You are not worried about medical bills because you do not have any. But accidents happen to all of us — at work or at play — young and old. Accident insurance from Aetna is designed to provide you with cash to cover those unexpected medical bills, along with any other surprise expenses associated with the accident.

Meeting Your Needs

- Guaranteed coverage – no evidence of insurability required
- 24-hour coverage for you and your family (on or off the job)
- Cash benefits paid directly to you
- Affordable premiums
- You may continue enrollment in this plan even if your employment terminates by paying premiums directly to Aetna.

Accidents Covered Include (and much more)

- Dislocations
- Burns
- Ligaments
- Fractures
- Lacerations
- Ruptured Disks
- Ambulance
- Hospital Admissions
- Anesthesia

Accident Plan Highlights	Covered Benefit
Accidental Death Employee Spouse Child(ren)	 $50,000 $25,000 $25,000
Dislocations and Fractures	Up to $3,000
Hospital Benefits Initial Hospital Admission (non-ICU) Intensive Care (ICU) Admission Hospital Confinement (non-ICU) Intensive Care (ICU)	 $1,000 $2,000 $200 $400
Initial Treatment	
ER/Physicians Office/Urgent Care	$150
X-ray/Lab	$50
Medical Imagine (PET, CT, CAT, MRI, EEG)	$150
Follow-Up Care	
ER/Physicians Office/Urgent Care	$50
Major Appliances (back brace, knee scooter, wheelchair)	$200
Minor Appliances (brace, cane, crutches, walker, walking boot)	$100
Chiropractic Treatment or Alternative Therapy	$25
Therapy (speech, occupational, physical, cognitive)	$25
Coma	$10,000
Concussion	$150
Ambulance	$300
Laceration	Up to $600
2nd Degree Burns (greater than 5% of total body surface)	$1,000
Ruptured Disk	$750
General Anesthesia	$100

Hospital Indemnity Insurance

Hospital Indemnity coverage is provided by Aetna. This coverage provides a lump sum benefit if you are admitted to the hospital, plus per day payments. Payments are made directly to you and not to an insurance company and can be used for any reason. There are no pre-existing condition limitations.

Meeting Your Needs

- Guaranteed coverage – no medical questions
- 24-hour coverage for you and your family (on or off the job)
- Cash benefits paid directly to you
- Affordable premiums
- You may continue enrollment in this plan even if your employment terminates by paying premiums directly to Aetna.

Hospital Indemnity Plan Highlights	
Hospital	**Covered Benefit**
Admission (1 per plan year)	$1,000
Confinement per day (up to 30 days per plan year)	$100
Intensive Care Unit	
Admission (1 per plan year)	$1,500
Confinement per day (up to 30 days per plan year)	$300

Critical Illness Insurance

Critical Illness is provided by Aetna. This coverage provides a fixed, lump-sum benefit upon the unfortunate diagnosis of a critical illness, which can include a heart attack, stroke, paralysis, and more.

Meeting Your Needs:

- Guaranteed coverage – no medical questions
- 24-hour coverage for you and your family (on or off the job)
- Cash benefits paid directly to you
- Affordable premiums
- You may continue enrollment in this plan even if your employment terminates by paying premiums directly to Aetna.
- You can choose between a $10,000 or $20,000 benefit.

DIAGNOSIS	BENEFIT	
Employee Coverage Amounts	$10,000	$20,000
Spouse Coverage Amounts	$5,000	$10,000
Children Coverage Amounts (to age 26 or 26+ if medically dependent on parents)	$5,000	$10,000
Coronary Artery Condition (requiring bypass surgery)	25% of benefit amount above	
Heart Attack (myocardial infarction)	100% of benefit amount above	
Sudden Cardiac Arrest (1 maximum per lifetime)	25% of benefit amount above	
Invasive Cancer	100% of benefit amount above	
Skin Cancer	$1,000	
Major Organ Failure	100% of benefit amount above	
Stroke	100% of benefit amount above	
End-Stage Renal Failure	100% of benefit amount above	
Re-Occurrence Benefit (180 days between diagnosis)	Included	
Wellness Benefit (employee and enrolled spouse)	$50	
Pre-Existing Limitation	None—however, initial diagnosis must occur on or after your initial effective date of coverage	
Portability	Included	

aetna™

Cost of Coverage – Medical, Dental and Vision

NYSC helps to subsidize the benefit plans and pays for a portion of your Medical coverage. Dental and Vision coverage is voluntary and paid for in full by the employee.

Aetna Medical Basic Plan—for those who earn less than $13.25/hr.	Bi-Weekly	Weekly	Annual
Employee Only	$51.72	$25.86	$1,344.72
Employee + 1	$107.49	$53.74	$2,794.74
Family	$167.25	$83.63	$4,348.50

Aetna Medical Basic Plan—for those who earn $13.25/hr. or more	Bi-Weekly	Weekly	Annual
Employee Only	$81.16	$40.58	$2,110.16
Employee + 1	$182.15	$91.07	$4,735.90
Family	$283.46	$141.73	$7,369.96

Aetna Medical Buy-Up Plan	Bi-Weekly	Weekly	Annual
Employee Only	$104.73	$52.37	$2,722.98
Employee + 1	$219.71	$109.86	$5,712.72
Family	$340.38	$170.19	$8,849.88

Aetna Dental DMO Plan	Bi-Weekly	Weekly	Annual
Employee Only	$7.03	$3.52	$182.78
Employee + 1	$12.54	$6.27	$326.04
Family	$21.19	$10.59	$550.94

Aetna Dental Basic PPO Plan	Bi-Weekly	Weekly	Annual
Employee Only	$14.76	$7.38	$383.76
Employee + 1	$28.13	$14.06	$731.38
Family	$41.92	$20.96	$1,089.92

Aetna Dental Buy-Up PPO Plan	Bi-Weekly	Weekly	Annual
Employee Only	$20.26	$10.13	$526.76
Employee + 1	$38.62	$19.31	$1,004.12
Family	$57.56	$28.78	$1,496.56

Vision Plan	Bi-Weekly	Weekly	Annual
Employee Only	$2.69	$1.35	$69.94
Employee + 1	$5.40	$2.70	$140.40
Family	$8.69	$4.34	$225.94

Cost of Coverage – Supplemental Health Plans

Aetna Accident Plan	Bi-Weekly	Weekly	Annual
Employee Only	$3.05	$1.52	$79.20
Employee + Spouse	$5.11	$2.56	$132.96
Employee + Child(ren)	$5.60	$2.80	$145.56
Employee + Spouse + Child(ren)Family	$7.80	$3.90	$202.68

Aetna Hospital Indemnity Plan	Bi-Weekly	Weekly	Annual
Employee Only	$5.18	$2.59	$134.76
Employee + Spouse	$11.61	$5.80	$301.80
Employee + Child(ren)	$8.76	$4.38	$227.88
Employee + Spouse + Child(ren)Family	$14.57	$7.29	$378.84

Aetna Critical Illness Plan – Bi-Weekly Premiums								
EE Age	EE: $10,000 – SP: $5,000 – CH: $5,000 Bi-Weekly Deductions				EE: $20,000 – SP: $10,000 – CH: $10,000 Bi-Weekly Deductions			
	EE Only	EE + SP	EE + CH	EE+SP+CH	EE Only	EE + SP	EE + CH	EE+SP+CH
<25	$0.89	$1.70	$0.89	$1.70	$1.36	$2.49	$1.36	$2.49
25-29	$1.17	$2.12	$1.17	$2.12	$1.92	$3.32	$1.92	$3.32
30-34	$1.72	$2.94	$1.72	$2.94	$2.98	$4.92	$2.98	$4.92
35-39	$2.52	$4.15	$2.52	$4.15	$4.58	$7.32	$4.58	$7.32
40-44	$3.74	$5.97	$3.74	$5.97	$6.99	$10.94	$6.99	$10.94
45-49	$5.15	$8.10	$5.15	$8.10	$9.80	$15.16	$9.80	$15.16
50-54	$7.61	$11.80	$7.61	$11.80	$14.68	$22.50	$14.68	$22.50
55-59	$10.71	$16.46	$10.71	$16.46	$20.82	$31.73	$20.82	$31.73
60-64	$15.59	$23.79	$15.59	$23.79	$30.50	$46.28	$30.50	$46.28
65-69	$21.17	$32.17	$21.17	$32.17	$41.57	$62.91	$41.57	$62.91
70+	$28.39	$43.03	$28.39	$43.03	$55.93	$84.49	$55.93	$84.49

Aetna Critical Illness Plan – Weekly Premiums								
EE Age	EE: $10,000 – SP: $5,000 – CH: $5,000 Weekly Deductions				EE: $20,000 – SP: $10,000 – CH: $10,000 Weekly Deductions			
	EE Only	EE + SP	EE + CH	EE+SP+CH	EE Only	EE + SP	EE + CH	EE+SP+CH
<25	$0.45	$0.85	$0.45	$0.85	$0.68	$1.25	$0.68	$1.25
25-29	$0.59	$1.06	$0.59	$1.06	$0.96	$1.66	$0.96	$1.66
30-34	$0.86	$1.47	$0.86	$1.47	$1.49	$2.46	$1.49	$2.46
35-39	$1.26	$2.07	$1.26	$2.07	$2.29	$3.66	$2.29	$3.66
40-44	$1.87	$2.99	$1.87	$2.99	$3.50	$5.47	$3.50	$5.47
45-49	$2.58	$4.05	$2.58	$4.05	$4.90	$7.58	$4.90	$7.58
50-54	$3.81	$5.90	$3.81	$5.90	$7.34	$11.25	$7.34	$11.25
55-59	$5.35	$8.23	$5.35	$8.23	$10.41	$15.87	$10.41	$15.87
60-64	$7.79	$11.89	$7.79	$11.89	$15.25	$23.14	$15.25	$23.14
65-69	$10.58	$16.08	$10.58	$16.08	$20.79	$31.46	$20.79	$31.46
70+	$14.20	$21.51	$14.20	$21.51	$27.97	$42.24	$27.97	$42.24

Employee Assistance Program – EAP

EMPLOYEE ASSISTANCE PROGRAM - EAP

NYSC provides an invaluable program for you to take advantage of, especially in times of emotional stress and financial worries. The EAP program provided through Aetna's Informed Health Line is available to all employees, dependents and members of your household, absolutely free, 24 hours a day and 365 days a year. It is strictly confidential. The phone number is 1-888-238-6232 and the website is www.resourcesforliving.com (username NYSC, password EAP).

Aetna has a professional staff of counselors that will guide you and help you deal with stress, addiction, financial counseling, daycare issues, eldercare, anger management or just to provide you with resource information for health and wellness just to name a few.

LifeMart
Employee Discount Program

Our EAP program also offers access to LifeMart, a member savings platform that provides discounts on everyday products and services that add up to a lifetime of saving. As part of Aetna's EAP program, LifeMart is available to all employees, dependents, and members of your household, absolutely free, 24 hours a day and 365 days a year.

Register to create your LifeMart account – by visiting - https://discountmember.lifecare.com - then download the mobile app and start accessing your discounts.

LifeMart App

Download Now

Saving big with LifeMart just got even easier!

Now you can access discounts anywhere, anytime, with the new **LifeMart App**. Simply download the app and get your savings to go.*

The LifeMart App is the fast and easy way to:

- Get immediate discounts from brands you know
- Save your favorite offers in "My Deals"
- Browse deals on everything from cars to travel to day-to-day essentials
- Find thousands of local deals near you

Download the LifeMart App from the Google Play Store or iTunes Store and start saving today!

In order to access the LifeMart app, you will need to create a LifeMart account on desktop or laptop.

Download on the App Store

GET IT ON Google Play

Call: (800) 873-4636

LifeMart® App

Add to Favorites

Resources

BENEFIT RESOURCE CENTER (BRC)

NYSC is excited to offer access to the USI Benefit Resource Center (BRC), which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals, and their primary responsibility is to assist you.

The Specialists in the Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time at 855-874-0835 or via e-mail at BRCSouth@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or e-mail message by the end of the following business day.

USI MYBENEFITS2GO MOBILE APP

USI's mobile benefits app provides a quick and simple way for you and your family to access benefit summaries and other important information about your group plans. The app also offers the ability to take photos of ID cards to store on the phone, as well as a way to easily locate carrier and HR contact information all in one place, 24/7 and on the go. The app is free, available for iPhone and Android and the benefits include:

Benefit Information

- The app gives employees access to all of their benefit plan information and ID cards—all in one place.

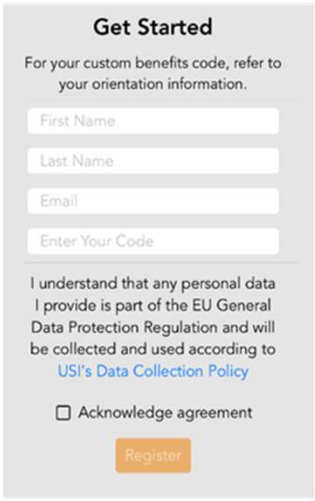
Access ID Cards

- The app allows you to take and access images of your ID cards. Images are stored on the phone itself; no personal health information is transmitted or saved.

In Touch

- The app provides you with a single location to find contact information for your Human Resources team and the Benefit Resource Center as well as insurance carriers.

Search for "MyBenefits2GO" and download the free app. Enter the below code when prompted:
W22703



401(k) and Contacts

401(k) SAVINGS PLAN

The NYSC 401(k) Plan helps eligible employees save and invest for retirement while receiving certain tax advantages. You can defer between 1-100% of your pay up to an annual maximum of $22,500. The catch-up limit for employees aged 50 and older is $7,500 per year. You can choose how your contributions are invested and a Roth (after-tax) option is available as well. Administrative and recordkeeping services for the 401(k) Savings Plan are provided by Principal Financial Group.

You must be at least 21 years of age to participate in the 401(k) Plan. All employees are eligible to participate in the 401(k) plan on the first of the month following 90 days of employment unless they are under age 21 or reside in Puerto Rico.

To enroll or make changes to your 401(k) contribution, visit www.principal.com or call 1-800-547-7754.

For Assistance

If you need to reach our plan providers, here is their contact information:

Benefit Plan	CARRIER	PHONE	WEBSITE
Medical	Aetna	800-962-6842	www.aetna.com
Teladoc	Aetna	855-835-2362	www.teladoc.com/Aetna
Dental	Aetna	877-238-6200	www.aetna.com
Vision	VSP	800-877-7195	www.vsp.com
Life and AD&D	Metlife	800-638-6420	www.metlife.com
Flexible Spending Accounts	Benefit Resource, Inc.	800-473-9595	www.briweb.com
Commuter Benefits	Benefit Resource, Inc.	800-473-9595	www.briweb.com
Short-Term Disability (STD)	ShelterPoint	800-365-4999	www.shelterpoint.com
Accident Hospital Indemnity Critical Illness	Aetna	800-607-3366	www.myaetnasupplemental.com
Employee Assistance Plan	Aetna	888-238-6232	www.resourcesforliving.com Username: Town Sports; Password: EAP
Leaves of Absence	Sedgwick	888-436-9530	https://timeoff.sedgwick.com
Enrollment System	Benefit Plan Manager	800-788-7558	www.benefitplanmanager.com

Key Terms

MEDICAL/GENERAL TERMS

Allowable Charge – The most that an in-network provider can charge you for an office visit or service.

Balance Billing – Non-network providers are allowed to charge you more than the plan's allowable charge. This is called Balance Billing.

Coinsurance – The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70%, you are responsible for paying the remaining 30% of the cost.

Copay – The fee you pay to a provider at the time of service.

Deductible – The amount you have to pay out-of-pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).

Explanation of Benefits (EOB) – The statement you receive from the insurance carrier that explains how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay a bill from your provider until you have received and reviewed your EOB (except for copays).

Family Deductible – The maximum dollar amount any one family will pay out in individual deductibles in a year.

Individual Deductible – The dollar amount a member must pay each year before the plan will pay benefits for covered services.

In-Network – Services received from providers (doctors, hospitals, etc.) who are a part of your health plan's network. In-network services generally cost you less than out-of-network services.

Out-of-Network – Services received from providers (doctors, hospitals, etc.) who are not a part of your health plan's network. Out-of-network services generally cost you more than in-network services.

Out-of-Pocket Maximum – The most you would pay out-of-pocket for covered services in a year. Once you reach your out-of-pocket maximum, the plan covers 100% of eligible expenses.

Preventive Care – A routine exam, usually yearly, that may include a physical exam, immunizations and tests for certain health conditions.

PRESCRIPTION DRUG TERMS

Brand Name Drug – A drug sold under its trademarked name. A generic version of the drug may be available.

Generic Drug – A drug that has the same active ingredients as a brand name drug, but is sold under a different name. Generics only become available after the patent expires on a brand name drug. For example, Tylenol is a brand name pain reliever commonly sold under its generic name, Acetaminophen.

PRESCRIPTION DRUG TERMS (continued)

Dispense as Written (DAW) – A prescription that does not allow for substitution of an equivalent generic or similar brand drug.

Maintenance Medications – Medications taken on a regular basis for an ongoing condition such as high cholesterol, high blood pressure, asthma, etc. Oral contraceptives are also considered a maintenance medication.

Non-Preferred Brand Drug – A brand name drug for which alternatives are available from either the plan's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.

Preferred Brand Drug – A brand name drug that the plan has selected for its preferred drug list. Preferred drugs are generally chosen based on a combination of clinical effectiveness and cost.

Specialty Pharmacy – Provides special drugs for complex conditions such as multiple sclerosis, cancer and HIV/AIDS.

Step Therapy – The practice of starting to treat a medical condition with the most cost effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

DENTAL TERMS

Basic Services – Generally include coverage for fillings and oral surgery.

Diagnostic and Preventive Services – Generally include routine cleanings, oral exams, x-rays, sealants and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Endodontics – Commonly known as root canal therapy.

Implants – An artificial tooth root that is surgically placed into your jaw to hold a replacement tooth or bridge. Many dental plans do not cover implants.

Major Services – Generally include restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Orthodontia – Some dental plans offer Orthodontia services for children (and sometimes adults too) to treat alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.

Periodontics – Diagnosis and treatment of gum disease.

Pre-Treatment Estimate – An estimate of how much the plan will pay for treatment. A pre-treatment estimate is not a guarantee of payment

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 6-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November 2022 for coverage starting as early as January 1, 2023.

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact: Benefit Resource Center at 855-874-0835. 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 Offered by Your Employer

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

3. Employer name: New TSI Holdings, Inc.	4. Employer Identification Number (EIN): 85-3482599	
5. Employer address: 100 Duffy Avenue	6. Employer phone number: 914-347-4009	
7. City: Hicksville	8. State: NY	9. ZIP code: 11801
10. Who can we contact about employee health coverage at this job? Benefits Department		
11. Phone number (if different from above)	12. Email address: benefits@nysc.com	

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

X Eligible employees are: All regular full-time employees working 30 hours or more each week.
With respect to dependents:

X We do offer coverage. Eligible dependents are: Spouse and children to the end of the calendar year the child reaches age 30.

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

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

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

Important Legal Notices Affecting Your Health Plan Coverage

The Women's Health Cancer Rights Act of 1998 (WHRCA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Newborns Act Disclosure – Federal

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

Notice of Special Enrollment Rights

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

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

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 30 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

PATIENT PROTECTION MODEL DISCLOSURE

Aetna generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Aetna at: 800-962-6842.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Aetna at 800-962-6842.

Statement of ERISA Rights

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants. No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $152 per day (up to a $1,527 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Contact Information
New TSI Holdings, Inc.
Benefits Department
914-347-4009 ext. 1477
benefits@nysc.com

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

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights
You have the right to:
- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:
- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures
We may use and share your information as we:
- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records
- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases we never share your information unless you give us written permission:
    - Marketing purposes
    - Sale of your information

Our Uses and Disclosures
How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Medicare Part D

Important Notice from Headlands Research About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current New TSI Holdings, Inc coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current New TSI Holdings, Inc coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with New TSI Holdings, Inc 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 New TSI Holdings, Inc changes. You also may request a copy of this notice at any time.

For More Information About 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:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web 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).

Date:	1/1/2023
Name of Entity/Sender:	New TSI Holdings, Inc
Contact--Position/Office:	Benefits Department
Address:	100 Duffy Avenue, Hicksville, NY 11801
Email:	benefits@nysc.com

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, 2022. Contact your State for more information on eligibility –

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

GEORGIA-Medicaid	MAINE-Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1GA CHIPRA Website:https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-Medicaid**
Medicaid Website:https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website:https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website:http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA-Medicaid	**SOUTH CAROLINA-Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345,ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493

NEW YORK-Medicaid	UTAH-Medicaid and CHIP
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone:1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	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)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website:https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website:https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	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, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You **can’t** be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can’t** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can’t** balance bill you, unless you give written consent and give up your protections.

If you get other types of services at these in-network facilities, out-of-network providers can’t balance bill you, unless you give written consent and give up your protections. If your insurance ID card says “fully insured coverage,” you can’t give up your protections for these other services if they are a surprise bill. Surprise bills are when you’re at an in-network hospital or ambulatory surgical facility and a participating doctor was not available, a non-participating doctor provided services without your knowledge, or unforeseen medical services were provided.

If you get other services at these in-network facilities, out-of-network providers **can’t** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

<u>When balance billing isn't allowed, you also have the following protections:</u>

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Aetna - at 1-800-962-6842 or visit their website - www.aetna.com .

Visit the Centers for Medicare and Medicaid Services at CMS at www.cms.gov for more information about your rights under federal law.

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2023 Employee Benefits Guide