Lehigh Regional Medical Center

Employee Benefits Guide | 2022

Prime

Live Well. Work Well. Be Well.

EXCEPTIONAL CARE
EXCLUSIVE BENEFITS

Member of Prime Healthcare

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While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For detailed information, please refer to the Summary Plan Description (SPD).

Medicare Part D Notice and AGA Medicare Options

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Notices on page 47 for more details. For additional information on AGA Medicare Options please refer to page 38.

Welcome to Prime Healthcare - Your Benefits

Lehigh Regional Medical Center is proud to offer you a comprehensive variety of benefits and programs to enrich your life.

We want you to be healthy and cared for in the same way you care for our patients, families and the communities we serve. It is a unique privilege to provide care to each other through our Prime network of hospitals and providers. Don't miss out on this opportunity to enroll in these important benefits.

As a member of the Prime Healthcare family, we are pleased to offer three valuable medical options for you to consider. These options include 1) our very own Prime EPO (Exclusive Provider Organization) plan which provides the greatest value to you and your family through Prime's network, 2) the MERP (Medical Expense Reimbursement Plan) for those employees who have eligible coverage and can have your costs of care paid for by Prime and receive credit paid to you every pay period, and 3) the Prime Value Plan.

1) PRIME EPO PLAN

Tier 1 Prime Healthcare Network

Staying within the Tier 1 Prime Healthcare Network, you will receive quality, compassionate award-winning care with better benefits, less cost, easier access and an expanded Tier 1 Prime Healthcare Network. Find your local Tier 1 Prime Provider Directory at ehp.primehealthcare.com/find-a-provider.

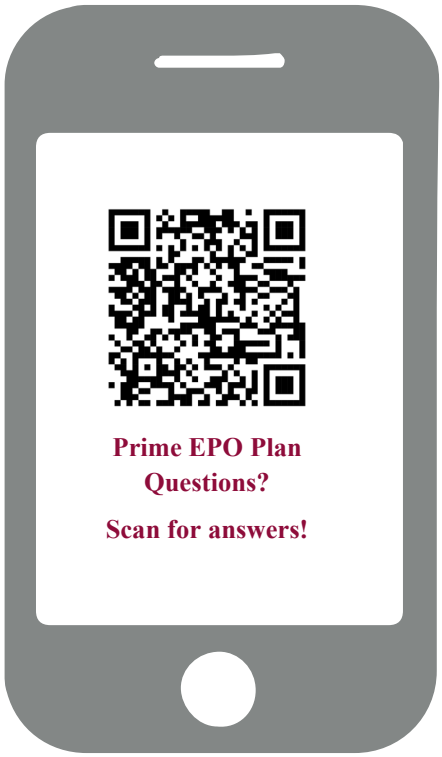
Advantages of the Tier 1 Prime Healthcare Network include:

- No annual deductible
- Minimal or no copays or coinsurance
- Easy access to the Tier 1 Prime Healthcare Network
- One of the best plans in the nation for quality, value and the least cost to members
- Award winning hospitals for quality
- Board certified physicians dedicated to your care, with more joining the Network every week
- Open access to any Prime inpatient or outpatient facility across the nation with no need for prior authorization for covered services
- All covered services provided at any Prime facility are 100% covered at no cost to the member
- No prior authorization is required to see a Tier 1 Prime Healthcare Network Specialist for the initial office visit or for any of the covered services (list available on company website https://www.primehealthcare.com/EHP)

Tier 2 BCBS BlueCard Network

When services are not available in the Tier 1 Prime Healthcare Network, with Prime Utilization Management (UM) Department authorization, the Tier 2 BCBS BlueCard Network of services and providers can be used. If you obtain a service through a Tier 2 BCBS BlueCard Network facility or provider for a service that Prime Healthcare can provide, there will be no benefit coverage for the service unless prior approval is obtained from the Prime Healthcare UM Department. Prior approval is required and must be obtained by your Provider.

If a covered person requires care for an emergency medical condition and must use the services of a Non-Prime and Non-BCBS BlueCard Network Provider, such expenses will be paid at the Tier 2 BCBS BlueCard Network allowable amount as shown in the schedule of benefits. Once stable, the covered person must be transferred to an in-network provider for care. The patient may be responsible for any amount over the Non-Network rate.



Your Benefits (continued)

2) MEDICAL EXPENSE REIMBURSEMENT PLAN

MERP is a voluntary plan available to employees who have access to alternate group medical and prescription drug coverage through a spouse or other source. This excellent benefit, with credits paid to you every pay period, can be a powerful way to avoid the impact of unexpected medical costs. For more information, please refer to page 4.

3) PRIME VALUE PLAN

The Prime Value Plan members have access to Tier 2 BCBS BlueCard Network Providers in addition to Tier 1 Prime Healthcare Network facilities and providers. **No authorization** is required for Tier 1 and Tier 2 Primary Care Provider (PCP). Initial consult to a Tier 1 Specialist doesn't need an authorization but all follow up needs an authorization to be submitted by your provider. All Tier 2 Specialist will need an authorization submitted by the provider on your behalf.

- Forms are available on our website: https://www.primehealthcare.com/Careers/Employee-Health-Plan.aspx
- Tier1 Providers can be located at: https://ehp.primehealthcare.com/find-a-provider/ (Note: Clear filters before searching)
- Tier 2 Providers can be located at: http://www.bcbs.com/find-a-doctor

The Prime Value Plan offers essential health benefits as specified under the Affordable Care Act.

MAKING YOUR MEDICAL PLAN DECISIONS

As you review the medical plans, ask yourself these questions when deciding what's best for you this year:

- Do you expect to have high medical bills?
- Who else in your family will need health care coverage?
- Are you offered medical coverage from another source (your spouse's employer, for example) that better meets your needs? The MERP described on page 4 may be a great option for you.

EMPLOYEE BENEFITS THIRD PARTY ADMINISTRATOR

Prime Healthcare has selected Keenan EBTPA to help administer benefits for our Medical Plans. Keenan EBTPA handles member eligibility, plan benefits, claim inquiries and claims payments for the Medical Plan. For example, a member would call Keenan if he/she has questions about member responsibility for payment, how to file an appeal or need a new medical ID card.

Keenan's dedicated customer service number for Prime Healthcare is 888-773-7218. This number is printed on the back of your ID card. Keenan's Customer Service Department is available from 5:00 am to 5:00 pm PST, Monday through Friday.

Keenan provides an online resource for your Benefit, Eligibility & Claims Status needs. Members can now request an email reminder when a new Explanation of Benefits is available to view. Register at https://keenan-mesa.javelinaweb.com.

PRESCRIPTION DRUG COVERAGE

Express Scripts administers our prescription drug plan. For your convenience, members can create an online account by logging onto http://www.express-scripts.com.

Prescription drugs can play a vital role in maintaining or regaining your health. Lehigh Regional Medical Center offers lower copays for a 90-day supply of maintenance drugs that help manage certain chronic conditions.

The Prime EPO plan offers lower copays for a 90-day supply of Maintenance Drugs for the following chronic conditions:

- Asthma
- Diabetes
- High Blood Pressure
- Heart Disease
- High Cholesterol

PHARMACY BENEFITS

DISPENSE AS WRITTEN (DAW)

Brand medications will automatically be substituted with generic medications of equal clinical efficacy and safety providing greater value to you. If a brand medication is necessary, a member and physician can request an authorization.

ADVANCED UTILIZATION MANAGEMENT (AUM)

Certain prescriptions will require a review before they are covered by your prescription plan.

During the review, your doctor can provide us with more detailed information about your prescription so we can make sure its use falls within your plan's rules. These rules are based on the product information approved by the Food and Drug Administration (FDA) as well as published clinical trials and guidelines. We want to make sure you get the safest, most effective medication available.

Your Benefits (continued)

DIABETES REMOTE MONITORING PROGRAM

Members who choose to join will be enrolled in a virtual program that encourages a healthier lifestyle. The program will last at least 12 months and will have access to multiple resources to assist with living healthy lifestyle.

KPCM & US-RX

Keenan Pharmacy Care Management (KPCM), administered by US-Rx, is a care management service offered to ensure the best possible drug therapies are prescribed, based on their clinical effectiveness and overall cost to patients and the Plan.

SaveOnSP

SaveOnSP will provide members with the opportunity to have a zero-dollar ($0) cost on select specialty medications. You will be contacted directly if you are taking one of the targeted medications. The Prime EPO and Prime Value Plans include this valuable benefit.

For additional information regarding Pharmacy Benefits, please refer to page 22.

DENTAL, VISION, LIFE, DISABILITY AND OTHER VALUABLE PROGRAMS

Lehigh Regional Medical Center is proud to offer many benefit programs to you and your eligible family members. Lehigh Regional Medical Center will continue to offer the following valuable coverages:

- Delta Dental PPO Plan
- Vision Service Plan (VSP)
- Life and AD&D
- Optional Life/Voluntary Disability
- MetLife Legal Plans
- Trustmark Voluntary Plans – *only offered during Open Enrollment*

Medical Expense Reimbursement Plan (MERP)

MERP is a plan available to employees who have access to alternate group medical and prescription drug coverage through a spouse or other source. It can be a powerful way to avoid the impact of unexpected medical costs. MERP is an excellent benefit that covers medical expenses plus you can take advantage of the per pay period credit received when waiving the medical plan. For more information, please contact the plan administrator, Catilize Health, at 877-872-4232.

MERP members are reimbursed for copays, coinsurance, and deductibles incurred under their alternate group plan up to a maximum amount of **$8,150/Single or $16,300/Family**.

There is **NO COST** to join the MERP program for eligible employees and their dependents. However, there may be a cost associated with enrolling in an alternate group insurance plan, like your spouse's employer plan.

Eligibility Requirements:

- New hires or newly eligible Full-Time and Part-Time employees and dependent(s) are eligible.
- Existing Full-Time / Part-Time employees and their dependent(s) currently enrolled in a Prime Healthcare medical plan are eligible.
- Employees already enrolled in MERP in 2021 are eligible for the plan. You will need to complete a new Attestation form.

HELPFUL DEFINITIONS

Medical Expense Reimbursement Plan (MERP): Reimburses employees and dependents for eligible out-of-pocket medical care expenses incurred under an alternate group medical coverage.

Medical Care Expenses: Deductibles, copays and coinsurance for eligible expenses incurred under the alternate group medical plan.

Alternate Group Medical Plan: Any Non-Prime Healthcare group medical coverage available to an employee, such as coverage through the spouse's employer, another employer of the employee, or group coverage available to the employee from any other source.

Alternate coverage in the following types of medical plans do not meet MERP eligibility requirements:

- High Deductible Health Plan (HDHP) with an active Health Savings Account (HSA)
- Medicaid, Medicare or TRICARE
- Healthcare Exchange Policy made available through the Affordable Care Act
- Individual Policy
- Limited Benefit Health Plan

1 ENROLL

- Enroll in your eligible alternate group medical plan.
- Complete your MERP Enrollment Form.
- Complete the Attestation Form.

Please submit the completed enrollment and attestation forms to your HR Department.

2 PAYMENT METHODS

- Present your alternate medical plan ID Card.
- And present your MERP ID Card for Copays, Deductibles, Coinsurance and Rx.
- Your provider may file claims with your alternate Medical Plan and the MERP. (Mail Order will not accept the MERP ID Card and will require you to file a paper claim.)

3 TYPES OF REIMBURSEMENT

- Most claims will be paid directly to the provider through use of the ID card.

OR

- If you pay for an eligible expense out of pocket, you may submit a paper claim for reimbursement.

Who Can You Cover?

WHO IS ELIGIBLE?

Eligible Employee

Full-Time employees regularly scheduled to work 60 hours per pay period are eligible for medical benefits the first of the month following or coinciding with two months from the date of hire. Eligibility for other coverage will remain 72 hours per pay period.

Part-Time employees regularly scheduled to work 40 hours per pay period are eligible for benefits the first of the month following or coinciding with two months from the date of hire.

Plan	Full-Time	Part-Time
Medical Expense Reimbursement Plan (MERP)	X	X
Prime EPO Plan	X	X
Prime Value Plan	X	X
Delta Dental PPO	X	X
VSP Plan B - Basic	X	X
VSP Plan C - Premium	X	X
Life/AD&D	X	
Optional Life	X	X
Voluntary Long-Term Disability	X	X
Voluntary Short-Term Disability	X	X
Employee Assistance Program	X	X
Flexible Spending Account	X	X
MetLife Legal Plans	X	X

Dependents

You can enroll the following family members in our medical, dental, vision and dependent life plans.

Your spouse:

- Married Spouse

Your children:

- Under the age of 26 are eligible to enroll. 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. The onset of the disability had to occur prior to age 26.
- Dependent children (under age 26) employed with Prime Healthcare are eligible to enroll as either dependent under a parent's medical plan, if the parent also works for Prime Healthcare, or under their own Prime Healthcare plan as an employee, but not both.

Please refer to the Dependent Eligibility Chart page in this Benefits Guide or the Summary Plan Description for complete details on how benefits eligibility is determined.

WHO IS NOT ELIGIBLE?

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

- Parents, grandparents, grandchildren, and siblings
- Ex-spouse
- Married Spouse who are eligible for medical coverage under their own employer's plan are not eligible to enroll in the Lehigh Regional Medical Center medical plan. However, they can enroll in the dental, vision and dependent life plans.

OPT-OUT CREDIT

Employees selecting the Opt-Out credit must annually waive the medical benefit and elect the Opt-Out credit through the online enrollment portal and provide the alternate insurance carrier's name and policy number.

Enrollment in another Prime Healthcare medical plan does not qualify as other coverage.

WHEN CAN I ENROLL?

Employees must complete the enrollment process as soon as possible to ensure timely benefits upon the Benefits Effective Date. If you do not enroll within 31 days from your Benefits Effective Date, you will not be allowed to change your plan selections or add dependents until the next Annual Open Enrollment generally held in October/November (starting January 1), unless you have a qualified change in status. Qualified changes in status typically follow a life event such as marriage, divorce, birth or adoption.

WHEN DOES MY BENEFIT BECOME EFFECTIVE?

Date of Hire	Benefits Start
First day of the month (e.g., June 1st)	**August 1st**
Second day of the month (e.g., June 2nd)	**September 1st**
Middle or End of the month (e.g., June 15th - June 30th)	**September 1st**

Dependent Eligibility: Document Requirements

IMPORTANT REMINDER: **If you are enrolling dependents**, you must complete the **Dependent Data Collection Form** and provide the required **supporting documents** to Human Resources **prior** to enrolling in any of the benefit plans.

- New benefit eligible employees or those with a recent Qualified Life Event must see Human Resources to complete the verification process. Proof of the dependent relationship is required before a dependent is eligible for enrollment.
- All verification documents must be presented to Human Resources.
- A Passport and/or Social Security Card will not be accepted as proof of a dependent relationship.
- Prime Healthcare follows IRS rules and guidelines of Dependent Eligibility.

Lost or Misplaced Documents

- Order lost or misplaced official U.S. documents of birth, marriage and/or death certificates, through VitalChek at www.vitalchek.com or call 800-255-2414.
- A 30-day grace period will be provided with copy of receipt showing documentation order is provided to HR.
- An IRS transcript will be accepted for providing proof of dependent relationship. You may download a copy of your transcript by going to https://www.irs.gov/individuals/get-transcript.

Birth Certificates

- Government Issued Birth Certificate listing the employee as child's parent.
- Hospital certificate listing the employee as the parent, if birth occurred in the last six months.
- Stepchild; a birth certificate and current Federal Tax Return or IRS transcript listing child to substantiate the relationship.

Federal Tax Filing

- Only the first page of your Federal Tax Return (1040) needs to be provided for review. You may black out Social Security numbers or monetary amounts on the documents.
- Handwritten tax returns are not acceptable.
- Dependent(s) must be listed on the first page as proof of relationship.
- A State Tax Return will **not** be accepted as proof of dependent eligibility.

Proof of Marriage

- Current year Federal Tax Return (1040) showing married filing "jointly". Both the employee and spouse names must be listed.
- Current year Federal Tax Return (1040) showing married filing "separately". The employee must present **both tax** records, each one reflecting "Married Filing Separately" status and includes the name and SSN of each spouse.
- In accordance with IRS Guidelines, you may claim Head of Household if you are unmarried and provide a home to qualified dependents.
- Government Issued Marriage Certificate showing date of marriage will be accepted only if marriage occurred within the last 12 months.

Legal Guardianship/Legal Custody

- Current Federal Tax Return (1040) (not required if named as guardian in the last 12 months) and official Court Document naming you/your spouse as Legal Guardian or Custodian.
- Applies to children from birth to 18 years of age.

Permanently Disabled Adult Children

Current year Federal Tax Return (1040), Birth Certificate, and Physician documented incapacity of self-support (document must show onset of disability was prior to turning age 26).

Dependent Eligibility Chart

Employees are required to substantiate their dependents before applying for benefits each year. This is to ensure that our plans are compliant with the law. The eligibility criteria outlined below is defined by dependent type for your reference. Employees must present the appropriate **document**(s) to Human Resources, and your information will remain protected and confidential. Approved dependents will then be entered into the enrollment system. Prime Healthcare reserves the right to request original documents. Tip: To verify dependent(s) download your IRS transcript at https://www.irs.gov/individuals/get-transcript.

Dependent Type	Eligibility	Supporting Documents
Spouse	**Married Spouse** **NOTE**: A Federal Tax Return filed as "**Head of Household**" does **NOT** meet the eligibility guidelines. If presented to HR your Spouse will be considered ineligible to enroll as your dependent.	**One of the following documents will be accepted:** • Federal Tax Return (1040), current filing period[1] • IRS Transcript, current filing period • If **Married and filing separately**, Employee is required to present **both** Federal Tax Returns[1]. Each return **must** indicate "Married Filing Separately" status **and** include the name and SSN of the Spouse. • If newly Married, within the **last 12 months** you may present a Government Issued Marriage Certificate.
Natural Birth Child Birth to Age 26[2]	**Biological Child**	**One of the following documents will be accepted:** • Federal Tax Return (1040), current filing period[1] • IRS Transcript, current filing period • Birth Certificate • Qualified Medical Child Support Order (QMCSO)
Stepchild Birth to Age 26[2]	**Child of current Spouse**	**One of the following three documents will be accepted PLUS the Birth Certificate[3]:** • Federal Tax Return (1040), current filing period[1] • IRS Transcript, current filing period **NOTE**: Birth certificate alone will not validate the stepchild's eligibility. Employee/Spouse relationship must also be substantiated.
Adopted Child Birth to Age 26[2]	**Adopted Child** Eligible at the time of placement	**One of the following documents will be accepted:** • Federal Tax Return (1040), current filing period[1] • IRS Transcript, current filing period • Court Documents naming Employee/Spouse as Guardian • Adoption Record • Qualified Medical Child Support Order (QMCSO)
Legal Guardianship/ Legal Custody Birth to Age 18	**Child is in the custody of the Employee/Spouse or under the protection of**	Federal Tax Return (1040), current filing period[1] *(not required if named as guardian in the last 12 months)* **AND** Court Documents naming Employee/Spouse as Legal Guardian/Custodian
Permanently Disabled Adult Child[4]	**Adult Dependent Child Overage 26**	Federal Tax Return (1040), current filing period[1] **AND** Birth Certificate **AND** Physician documented incapacity of self-support letter

1. Handwritten tax returns are not acceptable.
2. Age 26 limit applies to Medical, Dental, Vision and Dependent Child Life Coverage.
3. The birth certificate must include the employee's spouse's name as parent.
4. Onset of disability must be prior to attaining age 26.

Making Benefit Changes During the Year

Other than during annual Open Enrollment, you may only make changes to your benefit elections if you experience a qualifying event or qualify for a "special enrollment." If you qualify for a mid-year benefit change, you may be required to submit proof of the change or evidence of prior coverage.

QUALIFYING EVENTS INCLUDE:

- **Change in legal marital status,** including marriage, divorce, legal separation, annulment, and death of a spouse.
- **Change in number of dependents**, including birth, adoption, placement for adoption, or death of a dependent child.
- **Change in employment status that affects benefit eligibility**, including the start or termination of employment by you, your spouse, or your dependent child.
- **Change in work schedule**, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between Part-Time and Full-Time employment that affects eligibility for benefits.
- **Change in a child's dependent status**, either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- **Change in place of residence or worksite**, including a change that affects the accessibility of network providers.
- **Change in your health coverage or your spouse's coverage** attributable to your spouse's employment (including MERP).

- **Change in an individual's eligibility for Medicare or Medicaid.**
- **A court order** resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child.
- **An event that is a "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA)** including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan.
- **An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act.** Under provisions of the Act, employees have **60 days** after the following events to request enrollment:
  - Employee or dependent loses eligibility for Medicaid (known as Medi-Cal in CA) or CHIP (known as Healthy Families in CA).
  - Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP.

If you must make mid-year changes to your insurance (adding/dropping dependents), contact Human Resources and provide supporting documents within 31 days of the change in status.

How to Enroll in Benefits using Lawson

ACCESSING EMPLOYEE SPACE IN LAWSON

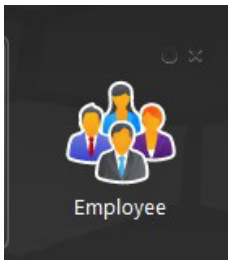
Enter User Name and Password in the login page:

EMPLOYEE SPACE DASHBOARD EMPLOYEE

Employee Space will display.

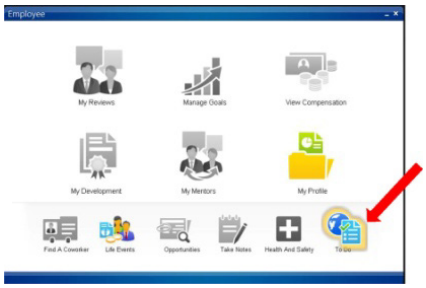
EMPLOYEE ICON

Double click on Employee icon to launch employee information

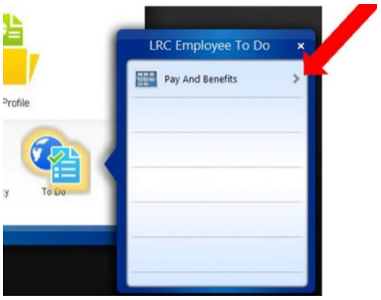


ACCESS TO DO OPTIONS

Place your cursor on the "To Do" icon and the To Do Menu will display.



Click on the arrow next to the Pay and Benefits option to display menu items



Menu items are displayed

Click on the New Hire Benefits Enrollment or Annual Open Enrollment option to start the enrollment process

WELCOME PAGE

The Welcome Page will be displayed.

SOCIAL SECURITY IDENTIFICATION

Please Note: In order to meet IRS requirements mandated by the Affordable Care Act (ACA), the enrollee's name and social security number entered into the enrollment system must match exactly as stated on the Social Security Identification card, including hyphenated names.

Prime Healthcare's Personal Choices and Tier 1 Provider Directory

We are pleased to share these valuable resources you can access anytime from anywhere.

PERSONAL CHOICES

Personal Choices is a web-based benefit forum where employees and plan members can locate benefit information and access a multitude of decision support tools. View or download information on the Prime Healthcare benefit plans. **Access Personal Choices 24/7 from any internet ready computer, tablet, or mobile device**.

From Home or Work

Enter app.strivebenefits.com/PHS

Log In: PHS

Password: Benefits

Resources on Personal Choices

- **Benefit Plan Information**: This section lists benefit plans offered to employees and their eligible dependents. View important information such as the Medical-Rx Summary Plan Document and Amendments, Evidence of Coverage, Prescription Formulary, Dental Plans and other detailed plan descriptions. This section can be used to compare and contrast eligible plan options.

- **Tier 1 Prime Provider Directory**: Access your local Tier 1 Prime Provider Directory on Personal Choices as well, or at www.PrimeHealthcare.com/EHP.

- **Resources**: Contains useful links to program websites, state and federal programs, instructions to network navigation systems and links to Prime Healthcare forms. The State and Federal Programs tab provides information and links to a variety of governmental programs including Consolidated Omnibus Budget Reconciliation Act (COBRA), Children's Health Insurance Program (CHIP), Health Insurance Portability and Accountability Act (HIPAA), U.S. Department of Labor, Preventive Care Services and the Health Insurance Marketplace.

- **Life Events**: Provides employees with information on what constitutes specific life events and reminds you to contact Human Resources within 31 days of a life event if changes need to be made.

Prime EPO Plan Costs

Members have access to our own valued providers in the Tier 1 Prime Healthcare Network. Take advantage and receive the maximum benefit by using a Prime Healthcare facility and network of Physicians. Establishing a primary care physician ensures you have a physician dedicated to coordinating your medical care. To view a list of services that do not require prior authorization when rendered at or by a Tier 1 contracted provider, visit www.PrimeHealthcare.com/EHP. **Better benefits, less cost and easier access.**

Tier 1 Prime Healthcare Network	
Annual Deductible	None
Annual Out-of-Pocket Maximum	$1,350 Individual / $2,700 Family
Office Visit • Primary Care Physician (PCP) • Pediatrician • Specialist	 $10 copay $10 copay $20 copay
Preventive Care Service	No charge
Chiropractic[1] (20 visit limit per calendar year)	$20 copay
Lab and X-ray	No charge
Inpatient Hospital Services / **Outpatient Hospital Services**, Surgical Service	No charge
Urgent Care	$20 copay
Emergency Room	$25 copay (copay waived if admitted)
Ambulance	$250 copay per trip
Rehab Therapy[1] Physical, Occupational, Speech (30 visit combined limit per calendar year)	No Charge at a Prime Hospital or Facility; or $10 copay
Dialysis[1]**:** 39 lifetime visits	No charge
Home Health Care[1] (100 visit limit per calendar year)	20% coinsurance
Durable Medical Equipment	20% coinsurance
Bariatric Procedure • Prime Facility / Physician Care	Facility: $500 copay plus 20% coinsurance / Physician: 50% coinsurance
Sleep Study • Home Study / Prime Sleep Lab • DME Supplies	$100 copay / $250 copay 20% coinsurance

1. Visit limits are combined with Tier 1 Prime Healthcare Network and Tier 2 BCBS BlueCard Network.

For detailed plan information, please refer to the Summary Plan Description (SPD) in SharePoint.

And remember ... as a member of the Prime Healthcare family, by staying within the Prime Healthcare Network, you will receive your care from our award-winning Prime Healthcare hospitals and physicians ... at little or no cost to you!

Prime EPO Plan Costs (continued)

The Tier 2 BCBS BlueCard Network is used when a service is not available in the Tier 1 Prime Healthcare Network. Your treating Provider must submit a referral for services and receive prior authorization from Prime UM. Services obtained without prior authorization may not be covered and may become your responsibility to pay in full.

Contact Prime Employee Health Plan (EHP) Customer Service at 877-234-5227 with any questions on the referral and authorization requirement.

Tier 2 BCBS BlueCard Network	
Annual Deductible	$1,500 Individual / $3,000 Family
Annual Out-of-Pocket Maximum	$6,800 Individual / $13,600 Family
Office Visit • Primary Care Physician (PCP) • Pediatrician • Specialist	 $40 copay $10 copay $60 copay
Preventive Care Service	No charge
Chiropractic[1] (20 visit limit per calendar year)	$40 copay
Lab and X-ray	Deductible plus 20% coinsurance
Inpatient Hospital Services / **Outpatient Hospital Services**, Surgical Service	$500 copay plus Deductible and 20% coinsurance $250 copay plus Deductible and 20% coinsurance
Urgent Care	$40 copay
Emergency Room	$200 copay plus 20% coinsurance, No Deductible (copay waived if admitted)
Ambulance	$250 copay per trip, No Deductible
Rehab Therapy[1] Physical, Occupational, Speech (30 visit combined limit per calendar year)	$40 copay
Dialysis[1]**:** 39 lifetime visits	20% coinsurance, No Deductible
Home Health Care[1] (100 visit limit per calendar year)	Deductible plus 20% coinsurance
Durable Medical Equipment	20% coinsurance, No Deductible
Bariatric Procedure	Not covered
Sleep Study • Home Study / BlueCard Sleep Lab • DME Supplies	 $200 copay / $500 copay 20% coinsurance, No Deductible

1. Visit limits are combined with Tier 1 Prime Healthcare Network and Tier 2 BCBS BlueCard Network.

Note: 1.5 benefit may be available at a Tier 2 BCBS BlueCard Network provider for services not available in the Tier 1 Prime Healthcare Network within a 50-mile radius of the employee's hospital. Prior authorization is required to receive this 1.5 benefit for Tier 2 coverage at Tier 1 cost to apply. Please refer to the following page for additional information.

For detailed plan information, please refer to the Summary Plan Description (SPD) in SharePoint.

1.5 Benefit FAQs

What is the 1.5 Benefit?

The 1.5 Benefit was created to ensure that you and your covered dependents have access to comprehensive medical care at minimal out of pocket costs when available. If a Tier 1 Prime Facility or Tier 1 Prime Provider is not available in the Prime Network within a predetermined geographical distance (listed in your benefits guide) of the Prime hospital/facility where you are employed, you and your covered dependents may be eligible for the 1.5 Benefit with **Prime UM authorization**. This means the applicable copay, coinsurance, or deductible would be the same as if you were receiving services at a Tier 1 facility or provider.

When does the 1.5 Benefit apply?

The 1.5 Benefit would apply when a service is unavailable in the Tier 1 Prime Healthcare Network within a predetermined geographical distance (listed in your benefits guide) of the Prime hospital/facility at which a member is employed. Prime UM must provide approval for the 1.5 Benefit to apply. If approved for the 1.5 Benefit, the member's out of pocket cost is based on the Tier 1 costs, instead of the higher amounts listed in Tier 2.

What if a service is not available in the Prime Tier 1 Network?

Prime UM will review each referral during the utilization determination process. If the service requested is determined unavailable within the Tier 1 Prime Healthcare Network, the member will be directed to a contracted Tier 2 Provider. The UM authorization will reflect approval of the 1.5 Benefit, and you will receive that authorization in the mail.

What if the care I need is not offered at a Tier 1 Prime Healthcare Facility?

Prime UM will arrange services with a contracted Tier 2 Facility once the referral is received and approved. We will make every effort to make this process as seamless as possible. You will receive an authorization in the mail.

To receive the 1.5 Benefit, do my provider or I need to request this benefit?

No. Prime UM will review referral requests and make this determination. If it is determined that the 1.5 Benefit applies, this will be noted on the authorization that is sent to the provider and mailed to the member. It is not the member's or provider's responsibility to request this level of coverage at the time of referral.

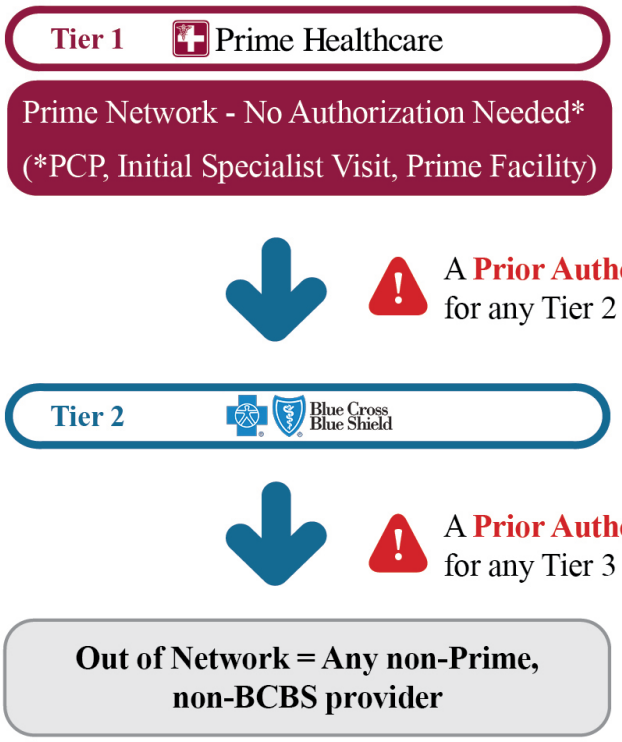
If my child needs emergency care and I choose to go to the nearest hospital, will the 1.5 benefit apply?

Always go to the nearest emergency room for medical emergencies. If a member is taken by ambulance to the emergency room, 1.5 benefits may apply. Keep in mind that Prime hospital emergency departments can provide emergency medical services for all pediatric patients. If transferred to another facility for admission or higher level of care, the emergency department will facilitate the transfer to ensure that quality of care is received. All emergency departments and emergency physicians are qualified to care for pediatric patients.

If a member elects to go to a non-network hospital emergency room because of personal preference, then Tier 2 out of pocket costs will apply and may be subject to additional costs, above the usual and customary billed amount.

For detailed plan information, please refer to the Summary Plan Description (SPD) in SharePoint.

Our Network: Defining the "Tiers" and EPO Flow



ANY service that can be provided in Tier 1 will be provided or re-directed in Tier 1

A **Prior Authorization** is needed for any Tier 2 services*

Tier 2 services in BCBS network are approved when Tier 1 services are not available and will be at Tier 1 copays/ deductibles only with **Prior Authorization**

A **Prior Authorization** is needed for any Tier 3 services*

Out of network services are usually NOT covered and only approved when Tier 1 or Tier 2 services are not available. Tier 1 rates only apply if no Tier 1 OR Tier 2 services available.

Providers and facilities in our network are categorized into two "Tiers" based on their contracted agreements with Prime Healthcare, Blue Shield of California and for those outside of California the Blue Cross Blue Shield BlueCard Network. The amount members pay out of pocket for services will depend on the network "Tier" providers are in.

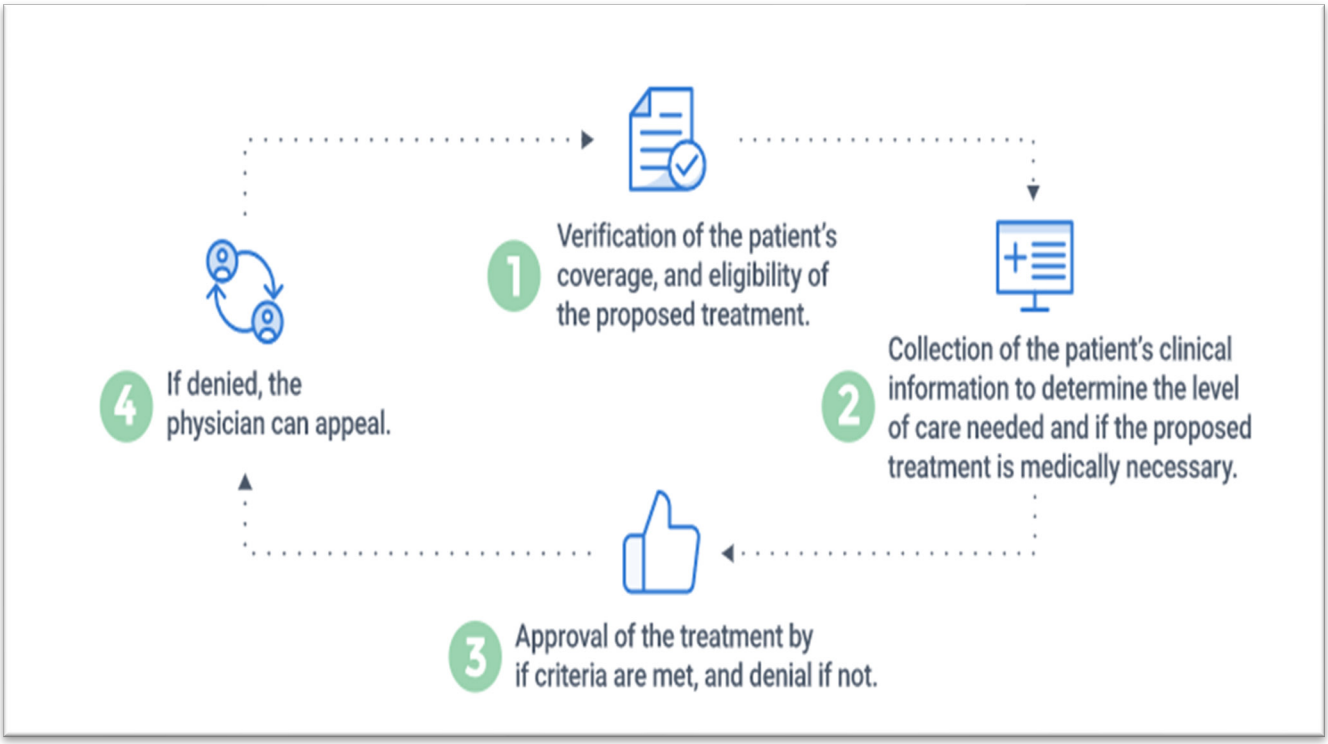
Tier 1 provides the maximum benefit, at little or no cost to members and consists of Prime Healthcare providers and locations.

Tier 2 consists of the Blue Cross Blue Shield Network. Prior authorization is required to access provider services in Tier 2.

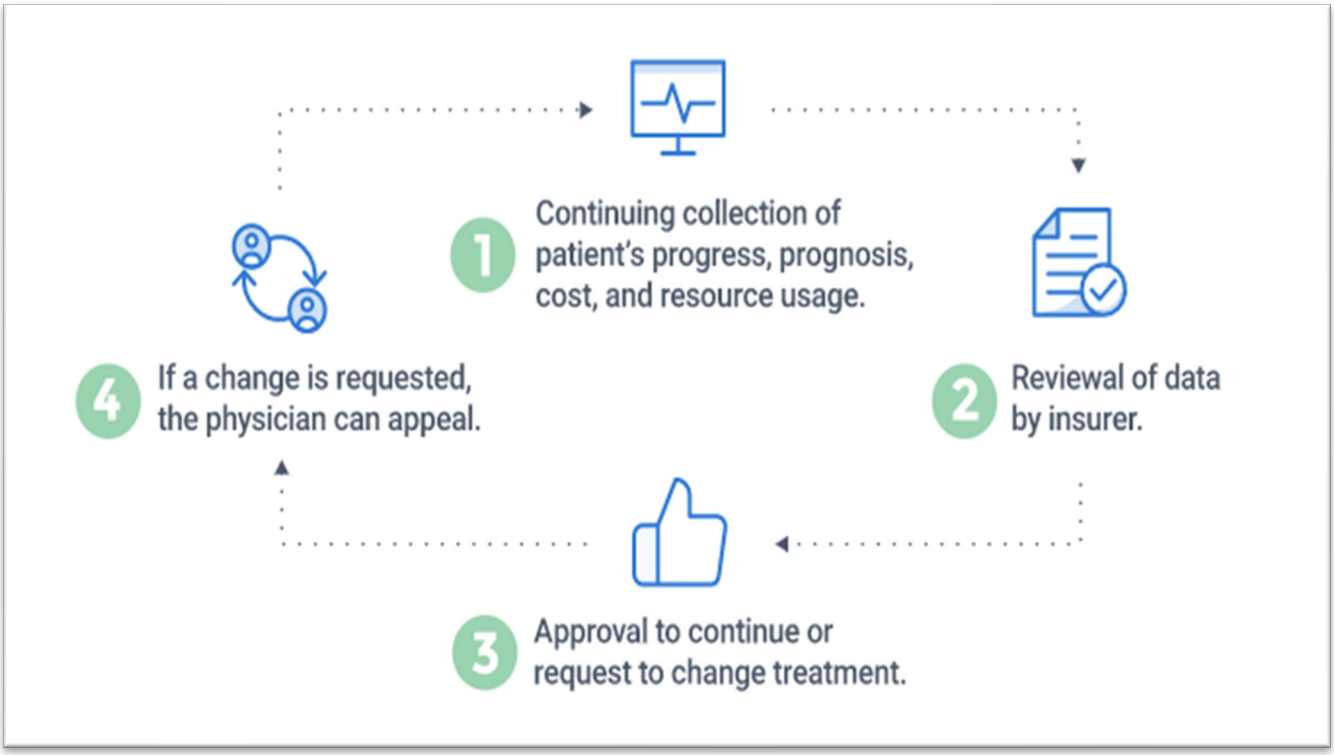
Should members choose to visit a physician who is not part of the Prime Healthcare network, the visit may not be covered by our plan. So, remember, look for Tier 1 Providers and Prime Healthcare facilities to ensure members receive the maximum benefits!

Authorization Review

PRIOR AUTHORIZATION REVIEW



CONCURRENT REVIEW



Referral / Prior Authorization Form

Prime Healthcare

Self-funded Employee Medical Plan

Prior-Authorization *–The Plan Sponsor requires pre-service review for all services with exception of: PCP visits, diagnostic testing performed at a Prime Facility, Annual Well Care, Urgent Care and Emergency Room visits. PCP should initiate requests however Specialists should submit requests for further care after initial visit.*

Note: *Without filling out the fields that are marked with asterisk (*), Fax numbers to fax the decision back and Clinicals/ physician notes , the decision for the requested Authorization will be delayed exceeded the expected turnaround time.*

*Patient Name	Hospital of Employment *(Subscriber)*
*Home Address	*Phone
*Date of Birth	*Member ID Number
*Referring Physician & Phone	Primary Care Physician & Phone
*Referred to	
**Referral place of service, phone/address	***Referred to Fax#

Expected Date of Service *(valid for 90 days from authorization)* Date: _____

*ICD-10 Code _____

*Diagnosis

*CPT Code & QTY _____

*Description of Service & QTY _____

*Inpatient? Yes No Retro Active Request? Yes No

Referring physician's notes Return Fax # _____

_____

_____

_____

Please include recent labs, pertinent imaging reports, problem list, allergies and relevant clinical notes

X _____

(Referring Physician Signature) *(Date)*

Prime UR Department use only

☐ Approved ☐ Denied ☐ Pending *(additional information required)*

UR Director's Notes

Referral Tracking Number *(valid as authorization number, if approved)* _____

PROVIDERS – Fax Referrals and any supporting documentation to:
Prime Healthcare Utilization Review Department
Primary Fax: 1-909-235-4414 Alternate Fax1: 1-909-235-4404 Alternate Fax2: 1-909-235-4427
Referral Questions: call toll free 1-877-234-5227
Member Eligibility and Benefit Summary: call toll free 1-888-773-7218
*Mandatory Field

01/2022

All fields are required to be completed.

- If they are not filled in, authorization **will not be granted**
- Will all referral /authorization requests eventually be granted? **NO**
  - ✓ Patient needs to be currently eligible
  - ✓ Requests need to be for covered benefits
  - ✓ Request meets Medical Necessity

Referral vs. Authorization for PCP/Specialty Services

PHYSICIAN ORDER/ PRESCRIPTION:
An order given by a provider for a service/ medication.

VS.

REFERRAL:
Request by a provider to refer member to another provider. Referrals to Prime employed or Tier 1 physicians do not need authorization by Prime UM.

VS.

AUTHORIZATION:
The Approval for services given by Prime EHP UM.

Required	Tier 1 Prime Employed		Tier 1 Network Prime Healthcare		Tier 2 Network Blue Shield of CA/BCBS BlueCard	
Service	**Referral**	**Authorization**	**Referral**	**Authorization**	**Referral**	**Authorization**
Primary Care Office Visit General Practice, Family Practice, OB/GYN, Internal Medicine	N/A	No	N/A	No	N/A	**Yes**[3]
Pediatrician Office Visit	N/A	No	N/A	No	N/A	No
Specialist Office Visit[1] Initial Visit/Consult and Follow up visits	No	No	**Yes**	No[2]	**Yes**	**Yes**[3]
PCP Lab Work In-Office Preventive/Routine	No	No	N/A	No	N/A	No[4]
PCP Lab Work In-Office Non-Preventive	No	No	N/A	**Yes**	N/A	**Yes**
Auto-Approved Services Visit www.primehealthcare.com/EHP for a list of these services	No	No	No	No	No[4]	No[4]

1. **SPECIALIST OFFICE VISITS**
   - Initial consults with Tier 1 specialists require a PCP referral, but do **not** require authorization or Prime UM Review.
2. **TIER 1 PRIOR-AUTHORIZATION NOT REQUIRED**
   - Office visits (evaluation and management codes)*
   - Auto-approved codes (www.primehealthcare.com/EHP)*
   - US Prevention Task Force Preventive screening services (www.uspreventiveservicestaskforce.org/uspstf)
   - Facility-based services provided at a Prime facility*
   - * All Other specialty services not listed above will require Prior Authorization.
   - * Please verify benefits & review for services with a limited benefit.
3. **TIER 2 AUTHORIZATION**
   If authorization to a Tier 2 provider is approved and Tier 1.5 benefits are applied:
   - Three follow-up visits are approved within 365 days following the initial approved authorization date.
   - A new authorization is required for follow-up visits after 365 days of initial approved authorization.
   - All other services require prior authorization for each follow-up visit.
   - Benefits may differ based on location with some locations not requiring authorization for Tier 2 PCP visits.
4. **TIER 2 LAB WORK**
   - All labs should be sent to a Prime facility or Prime-contracted LabCorp. All other labs require an authorization.

REMEMBER: Benefits can vary by Location. Please refer to the Summary Plan Description (SPD) for specific details.

Referral vs. Authorization for Facility Services

PHYSICIAN ORDER/ PRESCRIPTION: An order given by a provider for a service/ medication.

VS.

REFERRAL: Request by a provider to refer member to another provider. Referrals to Prime employed or Tier 1 physicians do not need authorization by Prime UM.

VS.

AUTHORIZATION: The Approval for services given by Prime EHP UM.

Required	Prime Owned Hospitals/Facilities			Non-Prime Facilities		
Service	**PCP Order or Prescription**	**Referral**	**Authorization**	**PCP Order or Prescription**	**Referral**	**Authorization**
Imaging: MRI / CT / MRA/ PET scan / DEXA / Hospital Imaging	**Yes**	No	No	**Yes**	**Yes**	**Yes**
Inpatient Hospitalization	**Yes**	No	No	**Yes**	**Yes**	**Yes**[1]
Outpatient Surgery	**Yes**	No	No	**Yes**	**Yes**	**Yes**
Bariatric Services	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Sleep Studies	**Yes**	**Yes**	No	**Yes**	**Yes**	**Yes**
Emergency Room Services	N/A	No	No[2]	N/A	No	No[2]
Urgent Care	N/A	No	No[3]	N/A	No	No[3]
Labs[4]	**Yes**	No	No	**Yes**	**Yes**	**Yes**
Auto-Approved Services Visit www.primehealthcare.com/EHP for a list of these services	**Yes**	No	No	**Yes**	**Yes**	**Yes**

1. **INPATIENT HOSPITALIZATION:** Prime UM must be notified and authorization is required for post stabilization care and inpatient hospitalization.
2. **EMERGENCY DEPARTMENT SERVICES:** are to be provided at a Prime facility whenever possible, if rendered at a non-Prime facility Tier 2 rates may apply.
3. **URGENT CARE:** should be provided at a Prime facility ER or contracted urgent care facility whenever possible, if rendered at a non-Prime facility Tier 2 rates may apply.
4. **LABS:** Any Lab Services should be sent to Prime Facility Lab or Prime Contracted Lab Corp.

REMEMBER: Benefits can vary by Location. Please refer to the Summary Plan Description (SPD) for specific details.

Prime Value Plan Costs

The Prime Value Plan members have access to Tier 2 BCBS BlueCard Network Providers in addition to Tier 1 Prime Healthcare Network facilities and providers. **No authorization** is required for Tier 1 and Tier 2 Primary Care Physician (PCP). Initial consult to a Tier 1 Specialist doesn't need an authorization but all follow up needs an authorization to be submitted by your provider. All Tier 2 Specialist will need an authorization submitted by the provider on your behalf.

Forms are available on our website: https://www.primehealthcare.com/Careers/Employee-Health-Plan.aspx

Tier 1 Providers can be located at: https://ehp.primehealthcare.com/find-a-provider/ (Note: Clear filters before searching)

Tier 2 Providers can be located at: http://www.bcbs.com/find-a-doctor

The Prime Value Plan offers essential health benefits as specified under the Affordable Care Act.

Tier 1 Prime Healthcare Network	
Annual Deductible	$2,500 Individual / $5,000 Family
Annual Out-of-Pocket Maximum	$3,000 Individual / $6,000 Family
Office Visit • Primary Care Physician (PCP) • Specialist	 $20 copay $40 copay
Preventive Care Service	No charge
Chiropractic[1] (20 visits limit per calendar year)	20% coinsurance, No Deductible
Lab and X-ray	20% coinsurance, No Deductible
Inpatient Hospital Services	Deductible plus 20% coinsurance
Outpatient Hospital Services – Surgical	Deductible plus 20% coinsurance **Ambulatory Surgical Center:** $250 copay plus Deductible and 20% coinsurance
Urgent Care	$40 copay, No Deductible
Emergency Room	$300 copay (copay waived if admitted)
Ambulance	$300 copay plus Deductible and 30% coinsurance per trip
Rehab Therapy[1] Physical, Occupational, Speech (24 visit combined limit per calendar year)	20% coinsurance, No Deductible
Dialysis[1]**:** 39 lifetime visits	20% coinsurance, No Deductible
Home Health Care[1] (24 visit limit per calendar year)	20% coinsurance, No Deductible
Durable Medical Equipment	20% coinsurance, No Deductible

1. Visit limits are combined with Tier 1 Prime Healthcare Network and Tier 2 BCBS BlueCard Network.

For detailed plan information, please refer to the Summary Plan Description (SPD) in SharePoint.

And remember ... as a member of the Prime Healthcare family, by staying within the Prime Healthcare Network, you will receive your care from our award-winning Prime Healthcare hospitals and physicians ... at little or no cost to you!

Prime Value Plan Costs (continued)

The Prime Value Plan provides access to the Tier 2 BCBS BlueCard Network of facilities and providers. Prime UM will review if requested services are a covered benefit.

Contact Prime Customer Service at 877-234-5227 with any questions on the referral and authorization requirement.

Tier 2 BCBS BlueCard Network	
Annual Deductible	$5,000 Individual / $10,000 Family
Annual Out-of-Pocket Maximum	$5,700 Individual / $11,400 Family
Office Visit • Primary Care Physician (PCP) • Specialist	 $60 copay, No Deductible $100 copay plus 20% coinsurance
Preventive Care Service	No charge
Chiropractic[1] (20 visit limit per calendar year)	Deductible plus 60% coinsurance
Lab and X-ray	Deductible plus 60% coinsurance
Inpatient Hospital Services	$500 copay plus Deductible and 60% coinsurance
Outpatient Hospital Services – Surgical	Deductible plus 60% coinsurance **Ambulatory Surgical Center:** $750 copay plus Deductible and 60% coinsurance
Urgent Care	$100 copay plus Deductible and 60% coinsurance
Emergency Room	$300 copay plus Deductible and 60% coinsurance (copay waived if admitted)
Ambulance	$300 copay plus Deductible and 30% coinsurance per trip
Rehab Therapy[1] Physical, Occupational, Speech (24 visit combined limit per calendar year)	Deductible plus 60% coinsurance
Dialysis[1]**:** 39 lifetime visits	Deductible plus 60% coinsurance
Home Health Care[1] (24 visit limit per calendar year)	Deductible plus 60% coinsurance
Durable Medical Equipment	Deductible plus 60% coinsurance

1. Visit limits are combined with Tier 1 Prime Healthcare Network and Tier 2 BCBS BlueCard Network.

For detailed plan information, please refer to the Summary Plan Description (SPD) in SharePoint.

Your Prescription Drug Benefits

Prescription drugs coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. If you enroll in medical coverage, you will automatically receive coverage for prescription drugs. Express Scripts is the Pharmacy Benefits Manager.

PRIME EPO PLAN

Express Scripts	
Annual Out-of-Pocket Maximum	Combined with Tier 2 Medical Out-of-Pocket Maximum
Retail Pharmacy • Generic • Formulary Brand	**Up to 30-day Supply** $10 copay $30 copay
Maintenance Drugs (After 2nd refill at a Retail Pharmacy) • Generic • Formulary Brand	**Up to 30-day Supply** $20 copay $60 copay
Specialty Drugs (Available through Accredo) • Generic • Formulary Brand	**Up to 30-day Supply** $200 copay $300 copay
Mail Order • Generic • Formulary Brand	**Up to 90-day Supply** $20 copay $60 copay
Maintenance Drugs for the following conditions: • Asthma • Diabetes • High Blood Pressure • Heart Disease • High Cholesterol	**Up to 90-day Supply** Generic: $10 copay Formulary Brand: $30 copay

PRIME VALUE PLAN

Express Scripts	
Annual Out-of-Pocket Maximum	Combined with Tier 2 Medical Out-of-Pocket Maximum
Retail Pharmacy • Generic • Formulary Brand	**Up to 30-day Supply** $25 copay $100 copay
Specialty Drugs (Available through Accredo) • Generic • Formulary Brand	**Up to 30-day Supply** $200 copay $300 copay
Mail Order • Generic • Formulary Brand	**Up to 90-day Supply** $50 copay $200 copay

For detailed plan information, please refer to the Summary Plan Description (SPD) in SharePoint.

Pharmacy Benefits

DISPENSE AS WRITTEN (DAW)

Brand medications will automatically be substituted with generic medications of equal clinical efficacy and safety providing greater value to you. If a brand medication is necessary, a member and physician can request an authorization.

Prescription orders will be filled based on this policy therefore a generic will be substituted, and the least cost will be incurred. Please note that a brand medication may require prior authorization to avoid higher copays and costs. Non-formulary medications may also incur greater costs when clinically equal formulary medications are available. If you have noticed an increase in the cost of some of the medications you are taking, it may be because there is a generic equivalent available to you at less cost or the medication is not on formulary and there is an equivalent formulary medication available to you.

ADVANCED UTILIZATION MANAGEMENT (AUM) PROGRAM

Certain prescriptions will require a review before they are covered by your prescription plan.

During the review, your doctor can provide us with more detailed information about your prescription so we can make sure its use falls within your plan's rules. These rules are based on the product information approved by the Food and Drug Administration (FDA) as well as published clinical trials and guidelines. We want to make sure you get the safest, most effective medication available.

DIABETES REMOTE MONITORING PROGRAM

Members who choose to join will be enrolled in a virtual program that encourages a healthier lifestyle. The program will last at least 12 months and resources will include:

- Dedicated, personalized coaching from registered dieticians, nutritionists and exercise physiologists
- New free glucose meter that syncs with an app on your smartphone
- Test strips
- Access to a comprehensive, evidence-based lifestyle change curriculum that includes the following:
  - Content certified by the American Diabetes Association and American Association of Diabetes Educators.
  - Content from the American Heart Association.
  - Content approved by the Centers for Disease Control for Diabetes Prevention Programs.
  - A cellular-connected scale that automatically transfers weigh-ins to a coach for review.
  - A personalized, behavior-based weight loss program, approved by the Centers for Disease Control, that delivers actionable, personalized and timely health signals to drive lasting behavior change.
  - Peer support through a virtual community of 15 – 20 individuals on their own journeys to better health: members can challenge and encourage each other through in-app messaging.
  - These members will also have access to our Therapeutic Resource Center℠ specialized care team.

WHAT IS THE KEENAN PHARMACY CARE MANAGEMENT PROGRAM (KPCM)?

The KPCM offers an independent, unbiased review of prescription medications by engaging physicians and members directly to ensure that the best possible drug therapies are chosen, based on their clinical effectiveness and overall cost to patients and the plan. In most cases, this program will help you reduce your out-of-pocket costs for prescription medications. The KPCM program is provided in partnership with US-Rx Care.

FAQ

How does the KPCM program work?

1. KPCM completes a review of claims data through an automated care management system to assess all prescriptions written and identify appropriate therapeutic alternatives.
2. When KPCM identifies a better drug therapy based on clinical effectiveness and overall cost, they recommend the drug alternative to the prescribing physician.
3. If the physician approves the drug alternative, a new prescription is issued.

How am I notified if my prescription is changed?

If an alternative is approved by your physician, the new prescription will be sent directly to your pharmacy. KPCM will contact you by phone to let you know about the doctor-approved alternative.

What if I don't want to take the new prescription or want to go back to my original prescription?

Then you simply contact your physician and let them know that you want to stay on the original prescription.

Pharmacy Benefits (continued)

How will prescribers know to contact KPCM if a Prior Authorization review is required?

If a member brings a specialty prescription to their pharmacy or checks coverage through Express Scripts, they will receive electronic messaging that provides KPCM contact instructions to initiate the prior authorization process. If a provider contacts Express Scripts to initiate a prior authorization review, Express Scripts will direct the provider to contact KPCM by phone via the website.

Will KPCM manage the prior authorization (PA) for specialty drugs?

The specialty PA process will be managed by KPCM. All other non-specialty drugs requiring a prior authorization will continue to be managed by Express Scripts.

ACCREDO PHARMACY

Specialty Drugs, such as Injectables, have to be obtained through Accredo an Express Scripts Specialty Pharmacy. Members can contact Accredo by calling 800-803-2523. US-RX Care will coordinate fills with Accredo on all specialty medications they review and approve.

SaveOnSP

This program provides you with the opportunity to have zero-dollar ($0) cost on select specialty medications.

You are eligible to participate in the SaveOnSP Program if you are currently taking a medication on the SaveOnSP Drug List. This list can be found at www.saveonsp.com/Primehealth. To participate call SaveOnSP at 800-683-1074.

Go Green Initiative

HOW TO OBTAIN YOUR EXPLANATION OF BENEFITS (EOB)

Obtaining your EOBs for your medical plan is easy! Although they will be mailed to you on a monthly basis, you can obtain your EOBs online through MESA, Keenan's Online Resource for Benefits, Eligibility & Claims Status.

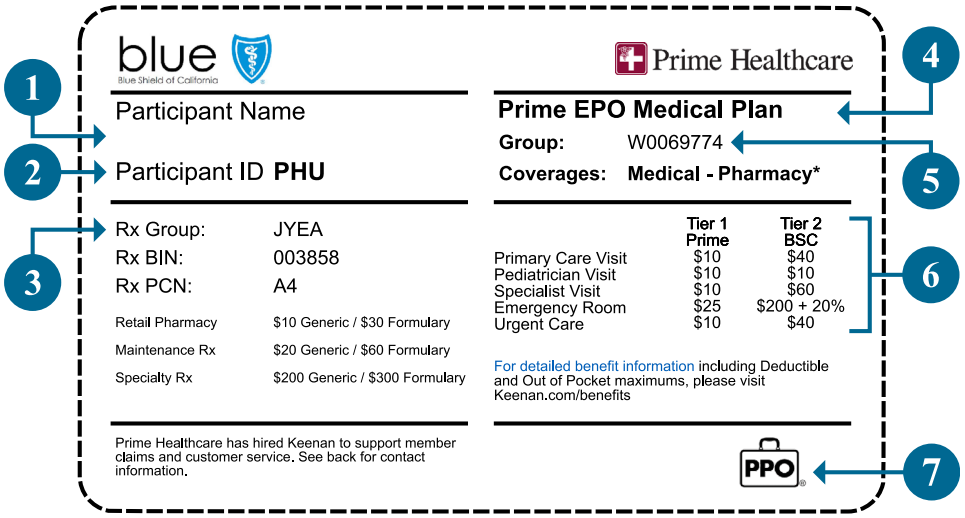
Register now at keenan.com/benefits **to access the following at any time:**

- Claim Status
- Plan Information
- Coverage Summary
- Eligibility Status
- Request an ID Card

Registration is easy and will give you instantaneous access to your information. Additionally, you may opt-out of receiving paper copies in the mail or request an email notification when a new EOB is available to view on MESA.

How to Read Your ID Card

FRONT



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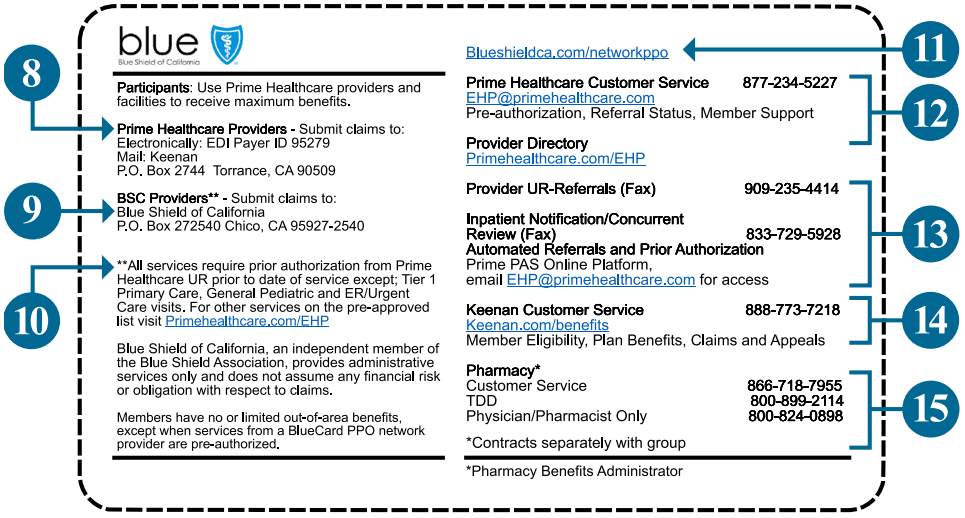

GLOSSARY

1. Covered Member Name
2. Member ID Number
3. Prescription Benefits
4. Plan Name
5. Plan Group Number
6. Copayments
7. PPO Logo: Please ensure your providers are aware, although the PPO logo appears here, you are enrolled in a Prime EPO plan with Prime UM prior-authorization requirements.
8. Billing Information for Tier 1 Provider
9. Billing Information for Tier 2 Provider
10. Services Requiring Prior Authorization
11. Websites for Provider Lookup
12. Contact Information for Prime Healthcare Customer Service
13. Contact Information for Referrals
14. Keenan Customer Service
15. Prescription Contact Numbers

How to Read Your Explanation of Benefits (EOB) Statement

20150309T07
1165 7834

J105 [1] 1 of 1

Page 1 of 2

Keenan
PO Box 2744
Torrance CA 90509-2744

Forwarding Service Requested

Keenan
HealthCare

Explanation of Benefits

RETAIN FOR TAX PURPOSES

THIS IS NOT A BILL

1 → EMPLOYEE OR PROVIDER NAME
ADDRESS
CITY, STATE ZIP

Go Green
Receive EOB's Via Email
Sign up at https://keenan-mesa.javelinaweb.com

Customer Service

2 → If you have questions regarding this statement, please write to:
Employee Benefits TPA
PO Box 2744
Torrance, CA 90509-2744

Or call us at: (888) 773-7218
Or visit us at: www.keenan.com/benefits

Statement Date: 3
Subscriber: 4
Group: 5

Patient: 6
Claim #: 7

Provider: 8
Patient #: 9

Dates of Service	Type Of Service	Billed Amount	Ineligible Amount	Reason Code	Contract Discount	Copay	Deductible	Co-Ins	% Paid	Payment
10	11	12	13	14	15	16	17	18	19	20
Totals:										

COB Credits and Adjustments	21
Patient Responsibility	22
Payment	23

Type Of Service

24

Reason Code Description

25

Additional Information

免費語言服務。如需中文翻譯的服務,可致電要求,電話號碼位於此表格右上角。如需要另外的服務,請電CA Department of Insurance(加州保險局),電話是(800) 927-4357。

Servicios Liguisticos Sin Costo. Servicios de Intérprete, o relacionados, en tu idioma pueden ser obtenidos llamando al teléfono localizado en la esquina superior derecha de este formulario. Para ayuda adicional, llame al Departamento de Seguros de California al teléfono (800) 927-4357.

How to Read Your EOB Statement (continued)

GLOSSARY

1. Employee or Provider's name and address
2. Customer Service contact information
3. Date of this notice
4. Employee's name
5. Group name
6. Patient's name
7. Claim number
8. Name of the provider who provided services
9. Patient account number
10. Dates of service
11. Code for the type of service; described in box 24
12. Charges from the provider
13. Amounts not covered by the plan
14. Messages on this claim line; described in box 25
15. Contract discount shows savings reduced from provider contract
16. Copay amounts separate from deductibles and coinsurance appear here
17. Deductible amounts applied separate from copays and coinsurance appear here
18. Coinsurance amounts separate from copays and deductibles appear here
19. Percentage paid shows at what level the allowable charge (less patient responsibility) was calculated for benefits
20. Payment is the amount paid by the plan to your provider
21. COB Credits and Adjustments show what amounts were subtracted from the Plan's regular benefit.
22. Patient responsibility summarizes the amount you need to the pay the provider.
23. Payment is the total amount paid by the plan to your provider
24. Type of service is the detailed description for the code in box 11
25. Reason code description is the detailed description for the code in box 14

Your Dental Benefits

Regular visits to your dentist 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.

Lehigh Regional Medical Center provides you with comprehensive coverage through Delta Dental of California. To locate a network provider, visit www.deltadentalins.com.

Plan Benefits	Delta Dental PPO	
	In-Network*	Out-of-Network*
Calendar Year Maximum	$2,000	$1,000
Calendar Year Deductible • Individual • Family	 $25 $75	 $50 $150
Diagnostic and Preventative	No charge	20%
Basic Services • Fillings	20%	
Endodontics • Root Canals	20%	
Periodontics • Gum Treatment	20%	
Major Services • Crowns, inlays, onlays & cast restorations	50%	
Prosthodontics • Bridges, dentures and implants	50%	
Orthodontic Benefits • Orthodontia (Child and Adult) • Lifetime Maximum	 50% $1,500	

* Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

For detailed plan information, please refer to the Summary Plan Description (SPD) in SharePoint.

Your Vision Benefits

Routine vision exams are important, not only for correcting vision, but because they can detect other serious health conditions. Vision Service Plan (VSP) provides members with access to a large network of vision care providers. To locate a network provider, visit www.vsp.com. Your vision benefit can now be used at a VSP participating retail location. To access this benefit, simply inform the retail provider that you have VSP and they will handle the rest. The benefits received at a retail location will be at the same coverage level as a VSP network doctor's office, with the exception of Walmart and Costco.

Plan Benefits	Choice Plan B – Basic Plan	Choice Plan C – Premium Plan
	In-Network*	In-Network*
Examination	$20 copay	$10 copay
Materials	$20 copay	$20 copay
Frames	$170 allowance 20% savings on the amount over your allowance $95 Walmart/Costco frame allowance**	**$180** allowance 20% savings on the amount over your allowance **$100** Walmart/Costco frame allowance**
Eyeglass Lenses • Single Vision Lenses • Lined Bifocal Lenses • Lined Trifocal Lenses • Polycarbonate Lenses for dependent children	Covered in full	Covered in full
Lens Enhancements • Standard Progressive Lenses • Premium Progressive Lenses • Custom Progressive Lenses • Anti-Reflective Coating • Scratch-Resistant Coating	Covered in full $95 to $105 copay $150 to $175 copay Not Covered Not Covered	Covered in full $95 to $105 copay $150 to $175 copay $30 copay Covered in full
Contacts (in lieu of lenses and frames) • Contacts • Contact Lens Exam	Up to $150 allowance Up to $60 copay	Up to $150 allowance Up to $60 copay
Frequency • Eye Exam • Lenses or Contact Lenses • Frames	Once **every** calendar year Once **every** calendar year Once **every other** calendar year	Once **every** calendar year Once **every** calendar year Once **every** calendar year

* For additional information on Out-of-Network benefits, please refer to VSP's Benefit Summary.
** Since Walmart and Costco already discount its pricing, the plan discounts will not apply (i.e., lens options and additional pair of glasses).

For detailed plan information, please refer to the Summary Plan Description (SPD) in SharePoint.

Cost of Coverage

Full-Time Employees

For employees that enroll in MERP - there is no cost to the employee! Prime pays for out-of-pocket costs, and you can take advantage of the per pay period credit received when waiving the medical plan.

The amount the Employee pays and the amount Prime pays is shown by pay period. There are 26 pay periods in the year.

Prime EPO Plan	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Amount You Pay	$25.00	$66.60	$54.48	$136.21
Amount Prime Pays	$264.79	$541.99	$493.24	$776.67
Total Per Pay Period	$289.79	$608.59	$547.72	$912.88

Refer to the Quit for Life program in the 2022 Benefits Guide or on SharePoint to learn about the definitions of "Tobacco Free" and "Tobacco User" information and how to qualify for the Tobacco Free rate by completing a tobacco cessation program. Tobacco Users pay a surcharge of $13.85 per pay period.

Prime Value Plan	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Amount You Pay	$47.61	$111.22	$92.87	$185.35
Amount Prime Pays	$153.62	$291.24	$269.34	$418.34
Total Per Pay Period	$201.23	$402.46	$362.21	$603.69

Delta Dental PPO Plan	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Amount You Pay	$13.00	$32.50	$39.00	$52.00
Amount Prime Pays	$3.51	$0.24	$0.82	$3.47
Total Per Pay Period	$16.51	$32.74	$39.82	$55.47

Voluntary Vision	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
VSP Plan B – You Pay	$3.50	$5.61	$5.73	$9.43
VSP Plan C – You Pay	$4.19	$6.71	$6.85	$11.05

Cost of Coverage (continued)

Part-Time Employees

For employees that enroll in MERP - there is no cost to the employee! Prime pays for out-of-pocket costs, and you can take advantage of the per pay period credit received when waiving the medical plan.

The amount the Employee pays and the amount Prime pays is shown by pay period. There are 26 pay periods in the year.

Prime EPO Plan	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Amount You Pay	$90.59	$199.78	$166.46	$332.95
Amount Prime Pays	$199.20	$408.81	$381.26	$579.93
Total Per Pay Period	$289.79	$608.59	$547.72	$912.88

Refer to the Quit for Life program in the 2022 Benefits Guide or on SharePoint to learn about the definitions of "Tobacco Free" and "Tobacco User" information and how to qualify for the Tobacco Free rate by completing a tobacco cessation program. Tobacco Users pay a surcharge of $13.85 per pay period.

Prime Value Plan	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Amount You Pay	$47.61	$111.22	$92.87	$185.35
Amount Prime Pays	$153.62	$291.24	$269.34	$418.34
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Delta Dental PPO Plan	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Amount You Pay	$13.00	$32.50	$39.00	$52.00
Amount Prime Pays	$3.51	$0.24	$0.82	$3.47
Total Per Pay Period	$16.51	$32.74	$39.82	$55.47

Voluntary Vision	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
VSP Plan B – You Pay	$3.50	$5.61	$5.73	$9.43
VSP Plan C – You Pay	$4.19	$6.71	$6.85	$11.05

Quit for Life® Tobacco Cessation Program

The Quit For Life® Program is the nation's leading nicotine dependence coaching program. Quit For Life helps participants create a personalized plan to quit using nicotine, provides support as they execute that plan, and re-engages those who relapse. The program uses a structured, evidence-based approach to quitting, paired with engaging tools and resources developed with the member in mind. A mix of digital tools and behavior change content, expert one-on-one and group coaching led by highly trained Coaches, and nicotine replacement therapy (NRT) supports participants when they need it and how they want it provided.

With Quit For Life, participants receive the following:

Convenient Tools

- Our proprietary, interactive website and mobile app, which offers online support tools that complement coaching sessions and enable for further exploration
- A course of NRT (patch or gum) mailed in conjunction with each participant's established quit date

Access to Coaches and Expert-led Online Education

- Expert-led online tobacco cessation and stress management content that provide participants with additional education and support between sessions
- One-on-one coaching sessions with a Quit Coach staff to support and guide participants through the quitting process; unlimited inbound phone support is available
- Online Group coaching sessions to create a sense of community and facilitate peer learning
- Unlimited inbound Quit Coach support for up to one year using toll-free phone, live chat and text

Engaging Experience

- Tailored motivational emails throughout the quitting process
- Text messaging service that provides personalized, interactive messages, urge management support as well as planning and motivational support
- Personalized, digital dashboard that tracks program progress

Quit for Life offers a personalized, yet structured approach with each member.

If you are ready to quit, please call 866-784-8454, or visit www.quitnow.net.

TOBACCO USER SURCHARGE

If you select the Tobacco Free rate for your employee medical plan (refer to rate sheet), you are declaring that you are tobacco free and are attesting to the following:

1. You have not used any tobacco products during the past 30 days, you are currently tobacco free, and you will not use tobacco products during the 2022 benefits year;
2. You understand that tobacco products include cigarettes, cigars, chewing or pipe tobacco, any other tobacco products, and electronic cigarettes or "vapes" that include nicotine, regardless of the frequency or method of use;
3. You understand that misrepresentation of your tobacco use status may result in the imposition of the Tobacco User surcharge for the entire year.

If you select the **Tobacco User** rate for your employee medical plan (refer to rate sheet), you are declaring that you are a current Tobacco User of one or more of the tobacco products previously mentioned. Please note that you have the alternative option of qualifying for the Tobacco Free rate by completing the Quit For Life tobacco cessation program during the 2022 benefit plan year, offered at no cost to employees.

If you are a current tobacco user and want to receive a waiver of the Tobacco User surcharge, you must:

1. Contact the Quit for Life Tobacco Cessation Program and sign up for the program, and
2. Once you have successfully completed five (5) phone-based coaching sessions, confirmation will be sent to your employer from Quit for Life. You will then receive the Tobacco Free medical premium rate for the remainder of the plan year.

A reasonable alternative option for meeting the requirements for waiver of the Tobacco Use surcharge is available to any employee for whom it is unreasonably difficult to satisfy the requirement, or for whom it is medically inadvisable to attempt to satisfy the requirement.

Flexible Spending Accounts (FSAs)

A Flexible Spending Account (FSA) lets you set aside money before it is taxed through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. You must re-enroll in this program each year. HR Simplified administers this program.

HEALTH CARE FSA

For 2022, you may contribute up to **$2,750** in pre-tax dollars to cover eligible health care expenses. The entire amount you set aside is available to you on your coverage effective date. This plan offers a benefit debit card for your convenience.

The Health Care FSA allows you to pay for a variety of health care expenses incurred by you, your spouse, and your children up to age 26. Some examples of the expenses you could pay with your Health Care FSA:

- Medical and dental deductibles and copays
- Orthodontia
- Vision exams, eye glasses and laser vision surgery
- Hearing aids
- Other services not considered cosmetic and aren't covered by your medical, dental or vision benefit plans.

DEPENDENT CARE FSA

For 2022, you may contribute up to **$5,000** in pre-tax dollars to cover eligible dependent care expenses. If you and your spouse file separate tax returns, your maximum contribution is **$2,500.**

The entire amount you set aside is not available right away - Funds are available as they are deducted from your paycheck.

Eligible dependent care expenses include nursery schools and day care centers for your children under age 13, or for an adult tax dependent. Refer to IRS Publication 503 on www.irs.gov under the "Forms & Instructions" link for information regarding eligible Dependent Care FSA expenses.

Note: Employees with an annual salary of $110,000 or more will not be able to enroll in the Dependent Care FSA plan

How FSAs Work

1. **PLAN** – You estimate how much your health care and/or dependent care expenses might be for the 2022 calendar year (or portion thereof depending on your coverage effective date). Then you decide how much you want to put into your account(s), subject to the plan limit.

2. **CONTRIBUTE** – The amount you set aside will automatically be deducted from your paychecks in equal amounts throughout the year.

3. **COLLECT** – As you incur your eligible expenses, the amount you owe can be reimbursed by completing a claim form and submitting it with the required documentation to HR Simplified.

   Claims can be submitted **online**, through the HR Simplified mobile app (free and available for both Apple and Android devices), by **mail** or **fax**.

   - **FSA Debit Card** – You can also pay for eligible expenses using your FSA Debit Card. If you use your FSA Debit Card, you may be asked to submit your receipt to HR Simplified as proof of an eligible expense, so be sure to keep all your receipts.

Important!

The **FSA Grace Period** is an extended period of coverage at the end of every plan year that allows you extra time to incur expenses to use your remaining Flexible Spending Account balance after the close of the plan year. The Grace Period is 2 ½ months (through March 15th of the following year). If you do not use your remaining balance in the account, you will lose it at the end of the Grace Period.

Important Dates	
Plan Starts	First day of Eligibility
Plan Ends	December 31st
Last Day for Spending	March 15th of the following year
Last Day to Submit Claims	June 15th of the following year

Life Insurance

LIFE AND AD&D

Life and Accidental Death & Dismemberment (AD&D) Insurance is an important part of your comprehensive benefits package. For peace of mind, and the financial protection for you and your family in the event of death or a serious accident, benefit eligible employees are automatically enrolled in the Life and AD&D Insurance program through Sun Life Financial.

Employee Life Amount	**1 x Base Annual Earnings** up to a maximum of $500,000
Employee AD&D Amount	**1 x Base Annual Earnings** up to a maximum of $500,000

Taxes: Due to IRS regulations, an employer paid life insurance benefit of more than $50,000 is considered a taxable benefit. You will see the value of the benefit included in your W-2.

Employee benefits reduce to 67% at age 70, 50% at age 75 and terminate at retirement.

OPTIONAL LIFE

Optional Life Insurance provides you additional life insurance to protect your family's financial security. Coverage is provided by Sun Life Financial at affordable group rates.

Employee Optional Life Amount	**Increments of $10,000** up to lesser of 5 x Base Annual Earnings or $1,000,000
Spouse Optional Life Amount	**Increments of $5,000** up to a maximum of $150,000 not to exceed 50% of employee benefit
Child(ren) Optional Life Amount	**Increments of $2,500** up to a maximum of $10,000 not to exceed 50% of employee benefit

Employee benefits reduce to 67% at age 70, 50% at age 75 and terminate at retirement.

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.

Evidence of Insurability (EOI), also called "proof of good health", is required if you decline coverage during your initial eligibility period and then want coverage at a later date.

All late entrants and increases of coverage require Evidence of Insurability.

Sun Life Financial will advise you if you need to submit an Evidence of Insurability application. If so, Sun Life Financial may arrange for you to take a medical exam (at Sun Life Financials' expense) and/or complete a questionnaire. Coverage will not go into effect until Sun Life Financial approves the application.

Guarantee Issue: When newly eligible, you can elect Optional Life coverage up to the Guarantee Issue amounts without having to provide Evidence of Insurability (EOI).

The initial Guarantee Issue amounts are as follows:

- Employee*:
  - $250,000 if under age 65
  - $100,000 if age 65-69
  - $20,000 if age 70-79
  - $1,000 if age 80 or older
- Spouse**: $50,000
- Child(ren):
  - $10,000 (12 months up to 26 years of age)
  - $500 (birth up to 12 months of age)

* Based on employee age as of January 1, 2022.
** Spouse benefits terminate at Spouse age 70.

Disability Insurance

VOLUNTARY SHORT-TERM DISABILITY INSURANCE

Short-Term Disability coverage pays you a benefit if you temporarily can't work because of an injury, illness, or maternity leave. Benefits may be reduced by income from other income sources such as Workers' Compensation, Social Security and Sick Pay. Vacation hours are not considered to be another source of income. Your doctor and the insurance company will work together to determine how long benefits are payable, based on your condition.

Coverage is provided by Sun Life Financial. No Evidence of Insurability is required; however, a Pre-Existing Condition exclusion applies.

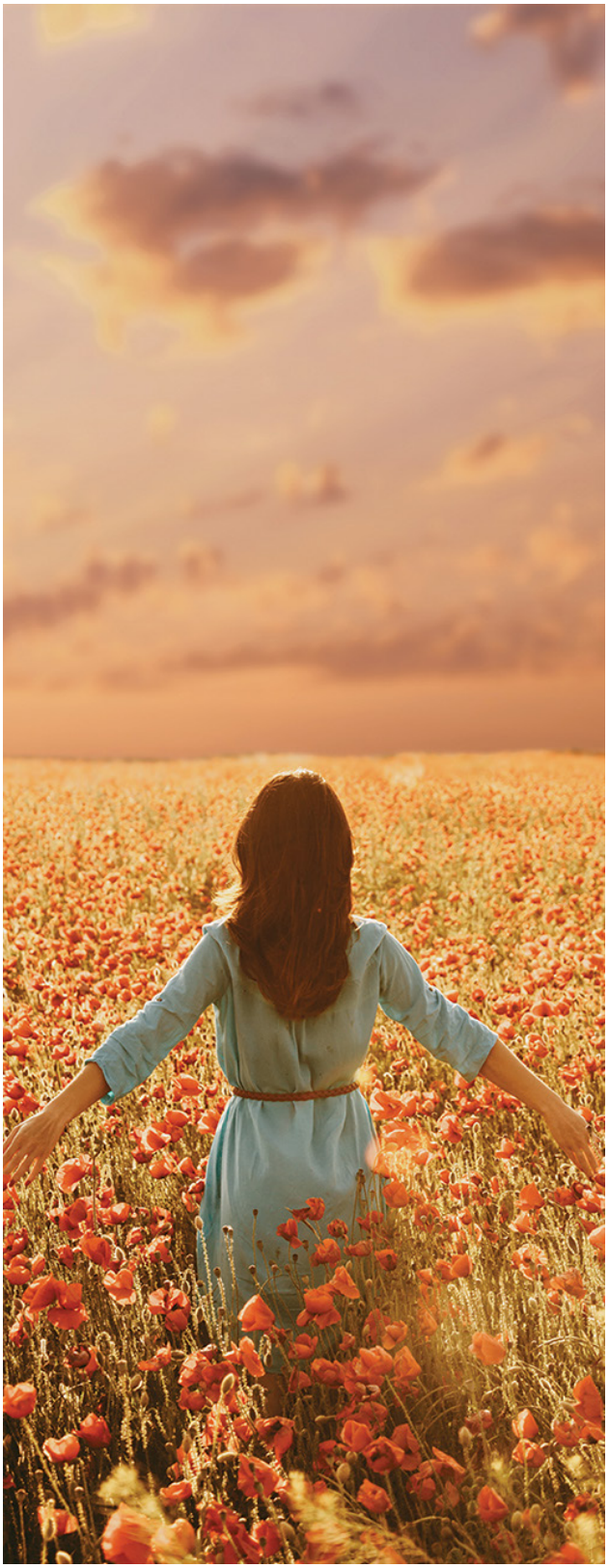
Weekly Benefit Amount	Plan pays 60% of covered weekly earnings
Maximum Weekly Benefit	$2,500
Benefits Begin After:	
• Accident	7 days of disability
• Sickness	7 days of disability
Maximum Payment Period	25 weeks

VOLUNTARY LONG-TERM DISABILITY INSURANCE

Long-Term Disability coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like Workers' Compensation, Social Security and Sick Pay. Vacation hours are not considered to be another source of income.

Coverage is provided by Sun Life Financial. No Evidence of Insurability is required; however, a Pre-Existing Condition exclusion applies.

Monthly Benefit Amount	Plan pays 60% of covered monthly earnings
Maximum Monthly Benefit	$5,000
Benefits Begin After:	
• Accident	180 days of disability
• Sickness	180 days of disability
Maximum Payment Period	To age 65 or Social Security Normal Retirement Age



Voluntary Programs

Voluntary benefits are available through Trustmark. These benefits are optional and do not replace any of your other benefit coverages. The following information is provided to help you make an informed decision on what coverages suit your situation when it is time to enroll. **Please note: You are only able to make elections during the Open Enrollment period.**

Voluntary Benefit Plans are not subject to ERISA and are offered to employees as a convenience only and are not endorsed by Prime Healthcare.

TRUSTMARK HOSPITAL STAYPAY INSURANCE®

Hospital StayPay insurance pays cash directly to you for days you spend in the hospital due to covered sickness or accident, normal childbirth or mental wellness/addiction recovery. It pays regardless of other coverage you have and there are no restrictions on how you use the money. The First Day Stay benefit pays you when you're first admitted to a hospital. For each day your stay continues after that, you'll receive a smaller amount. Days spent in an intensive care unit pay double the daily benefit. With Hospital StayPay, you can worry less about your bills and focus on recovering.

- First Day Stay pays $1,000 for hospital admission, pays once per person per calendar year
- Wellness Checks pays $50 for one routine test per year as well as another $50 if follow-up test if recommended by a physician
- Immediate care benefit of $100 for emergency room visits up to 3 times per person per year, whether or not it leads to an admission
- Rehabilitation services benefit for inpatient rehabilitation services including those for mental wellness and addiction recovery

UNIVERSAL LIFE INSURANCE WITH LONG-TERM CARE BENEFIT

Trustmark's Universal Life insurance can supplement existing life insurance coverage you may already have. Group term life insurance costs increase with age and reduce or disappear at retirement. Universal Life is permanent insurance with premiums that do not increase as you get older. Universal Life insurance not only offers benefits if you die, it also builds cash value you can use while you are alive. Another important feature is that you can continue the policy if you change jobs or retire. This plan provides permanent coverage designed to last to age 100 at a level premium and level benefit.

Your Universal Life Insurance Policy is Flexible:

- You can apply for coverage for yourself, your spouse, children and grandchildren. You can only insure your dependents if you elect coverage on yourself.
- You can select the coverage amount that makes sense for you and you can adjust your coverage as your needs change.

This Plan Provides Many Other Advantages Such As:

- Accrues tax-deferred interest on the accumulated cash value at competitive rates
- Can advance the death benefit up to 75% upon diagnosis of a terminal illness
- Long Term Care Rider can double the value of your life insurance by paying a monthly benefit of 4% of your death benefit for 25 months for home healthcare, assisted living, adult day care, hospice or nursing services
- Restoration of Death Benefit
- Optional Benefit Rider - All employee and dependent children premiums are waived if you (the Plan's insured) are totally disabled. Spouse premium is only waived if the spouse is disabled.

To protect against inflation, this policy also gives you the option to purchase guaranteed automatic increases in coverage amounts at certain policy anniversaries.

UNIVERSAL LIFEEVENTS® INSURANCE WITH LONG-TERM CARE BENEFITS

This is permanent life insurance designed to take care of your needs throughout your lifetime. LifeEvents* pays a higher death benefit during your working years. The death benefit reduces to one-third the original amount at age 70 or the policy's 15th anniversary, whichever is greater. This age reduction does not reduce the benefit amount available for Long Term Care services. You can continue the policy if you change jobs or retire.

**Issue age is 18-64 for employee and spouse*

Benefits Include Coverage For:

- Benefit amounts available up to $300,000
- Can advance the death benefit up to 75% upon diagnosis of a terminal illness
- Long Term Care Rider can double the value of your insurance by paying a monthly benefit of 4% of your death benefit for up to 25 months for home healthcare, assisted living, adult day care, hospice or nursing services.
- Restoration of Death Benefits
- Waiver of Premium (optional)

Voluntary Programs (continued)

Key Components:

- Guaranteed Annual Benefit Increases with $1 increases in weekly premium (optional)
- Family coverage including grandchildren
- Guaranteed Renewable to age 100

ACCIDENT INSURANCE

This benefit helps pay for the unexpected expenses that result from accidents above and beyond what health insurance pays. Benefits can be used how the employee chooses, from medical insurance deductibles to the cost of driving to a doctor appointment or child care expenses.

Benefits Include Coverage For:

- Initial care benefits: physician visit, ambulance, emergency room treatment, hospital benefits, lodging, blood, surgery, emergency dental
- Injury benefits: burn; concussion; dislocation; eye injury; fracture; herniated disc; laceration; loss of finger, toe, hand, foot, or sight; tendon ligament; rotator cuff injury; torn knee cartilage

Key Components:

- Annual $100 health screening benefit
- Benefits up to $100,000 for Catastrophic Accident for employee
- 24-hour coverage
- Organized sports are covered (except if being paid)
- Family coverage if elected
- No coordination with other insurance
- Benefit is paid to the employee
- Guaranteed Renewable to age 100
- Accidental Death Benefit

Please refer to schedule of benefits for benefit amounts.

CRITICAL ILLNESS INSURANCE

This coverage provides a substantial cash benefit upon the first diagnosis of a covered condition. It helps pay for expenses not covered by medical insurance. Benefits can be used however the employee chooses allowing you to focus on your health.

Covered Conditions Include:

- Invasive Cancer
- Carcinoma in situ (25% benefit)
- Stroke
- Major Organ Transplant
- Occupational HIV Infection
- Coronary Artery By-Pass (25% benefit)
- Heart Attack
- Renal Failure
- Paralysis of at least 2 limbs
- Blindness
- ALS

Key Components:

- Benefit amounts available up to $100,000
- Double Benefit can pay a second benefit for a separate and different covered condition
- Guaranteed Annual Benefit Increases with $1 increases in weekly premium (optional)
- Annual Health Screening Benefit – $100
- Family coverage if elected
- No coordination with other insurance
- Benefit is paid to the employee
- Guaranteed Renewable to age 100

Most insurance policies contain exclusions, limitations and terms for keeping them in force. Your representative will be glad to provide you with costs and complete details.

Plan forms GUL.205/IUL.205, CACI-82001, A-607, HII 119 and applicable riders are underwritten by Trustmark Insurance Company, Lake Forest, Illinois. Underwriting conditions may vary and determine eligibility for the offer of insurance. Benefits, availability, exclusions and limitations may vary by state and may be named differently. Your policy/certificate will contain complete information. Trustmark®, LifeEvents® and Trustmark Hospital StayPay® are registered trademarks of Trustmark Insurance Company.

Other Benefits and Programs

We are pleased to offer other valuable programs for you and your family.

AGA MEDICARE OPTIONS

Have Medicare questions?

Learn about the different Medicare plan choices from licensed and certified AGA Medicare Options agents in the comfort of your home.

AGA Medicare Options independent agents are dedicated to providing objective Medicare information and recommendations to help you make the right choice for you and your family. They can discuss topics that include:

AGA Medicare Option...

- Determining your eligibility
- Benefits, timeframes, and enrollment periods
- Assessing your healthcare needs
- Assuring that your plan covers your medications at the lowest cost
- Finding plans that are accepted by your physicians and hospitals of choice
- Simplifying the enrollment process

Common question:

What are Medical Advantage Plans?

Medicare Advantage Plans is an option worth learning before selecting a medical plan. Benefits can include:

- Expanded provider networks
- Office visits closer to home
- Specialty pharmacy benefits
- Possible $0 copay
- Possible 100% in-patient hospital coverage

About AGA Medicare Options

AGA agents specialize in the Medicare market and have been helping Medicare beneficiaries find the most suitable plan selection for their needs since 1993. They are licensed and certified and abide all state and CMS regulations.

Call today to get in touch with an independent agent at 800-549-1880, TTY 711. Monday – Friday, 8:30am-5pm (PST). By calling the number, you will be directed to a licensed insurance agent.

EMPLOYEE ASSISTANCE PROGRAM

ComPsych provides you with an Employee Assistance Program (EAP) that is designed to help you manage life's challenges. Everyone needs a helping hand once in a while, and your EAP can provide confidential access 24/7. It can refer you to professional counselors and services that can help you resolve emotional health, family and work issues. This benefit is provided at no cost to you and is available to all household members.

EAP Services include:

Employee Assistance Program (EAP): Complete referral assistance to in-person emotional counseling support, helping you and your family members address an array of personal difficulties, including stress, anxiety, depression, family/marital relationships, substance use disorder, difficulties at work, etc.

FamilySource®: Can help you sort out issues like being a new parent, locating a quality caregiver for an elder, sending your child to college, choosing a contractor, finding pet care, and more. FamilySource will provide expert information and identify specific resources and referrals to help you make your decision.

LegalConnect®: Provides telephone access to licensed attorneys for information about any legal concern you may be facing, whether it is regarding a home purchase, estate issues, or any legal issue. If your legal matter requires in-person assistance, you are eligible to receive a free half-hour consultation with the ComPsych selected, in-network attorney, in your area. After the consultation, you are eligible to receive a 25% discount on his or her customary legal fees thereafter.

FinancialConnect®: Allows you to consult directly with a financial professional by telephone. Call anytime for tools and information regarding your specific financial questions on: budgeting, tax issues, credit cards and loans, investment resources and other money matters.

EstateGuidance®: Now with EstateGuidance, you have the opportunity to create a Will at no cost. This benefit offers you the ease and simplicity of online Will preparation right on your PC! By creating an online Will you can name a guardian for your children, name an executor(s) to settle your estate, and specify funeral and burial wishes.

GuidanceResources® Online: Are you seeking counseling, work-life or other assistance through your employer-provided GuidanceResources program?

Other Benefits and Programs (continued)

- GuidanceResources Online is an award-winning, comprehensive, interactive service that provides expert content and unique tools to assist you in every aspect of your life, all in a secure, easy-to-use, personalized environment.

IDENTITY THEFT PROTECTION

With your Sun Life coverage, you receive an ID-theft protection services provided by Assist America, at no cost to you. Identity theft is a serious crime. Each year, millions of Americans have their personal financial information stolen and must spend a significant amount of time and money to restore their records. If you ever become a victim of identity theft, you don't have to face it alone.

You have the support of a powerful Identity Theft Protection program through Assist America's SecurAssist® Identity Protection program. It provides:

- 24/7 telephone support and step-by-step guidance by anti-fraud experts
- an expert case worker who is assigned to you and will help you notify your credit bureaus and file paperwork to correct your credit reports
- help canceling stolen cards and reissuing new cards
- help notifying police, financial institutions, and government agencies.
- Internet fraud monitoring

To activate these identity protection services, visit: www.assistamerica.com/sunlife

You can help stop identity theft before it happens:

- You can securely register up to 10 credit or debit cards for 24/7 surveillance.
- Registered cards are monitored using sophisticated web crawling technology that watches underground chat rooms where thieves are selling, and trading stolen personal information.
- You receive early warning of potential threats and are notified if your identity has been misused.

EMERGENCY TRAVEL ASSISTANCE

With your Sun Life coverage, you receive an emergency travel assistance program services provided by Assist America, at no cost to you. If you have a medical emergency while you are more than 100 miles away from home, you don't have to face it alone. With one simple phone call, you can be connected to Assist America's staff of medically trained, multilingual professionals who can advise you in a medical emergency, 24/7. You have immediate access to:

- pre-qualified, multilingual doctors, hospitals,
- pharmacies, and dentists anywhere in the world
- medical consultation, evaluation, and referral
- hospital admission guarantee
- emergency medical evacuation
- lost prescription assistance
- legal and interpreter services and more

You or your family (whether traveling together or separately) can activate Assist America's emergency services with one call to the number on your Assist America ID card, whether you are on vacation or on a business trip (spouse business travel excluded).

GLOBAL EMERGENCY SERVICES

assist america®

Reference # 01-AA-SUL-100101

If you require assistance when traveling 100 miles from your permanent residence, or in another country, call Assist America's Operations Center at:

+1 609 986 1234 (outside USA - Collect Call)

+1 800 872 1414 (inside USA - Toll Free)

Or email at: medservices@assistamerica.com

Please provide the following information when you call:

- **Your name, phone number and relationship to the patient**
- **Patient's name, age, gender**
- **The Assist America reference number**
- **Name, location and phone number of hospital or treating doctor if applicable**

Attention: This card is not a medical insurance card. All services must be provided by Assist America. No claims for reimbursement will be accepted. The holder of this card is a member of Assist America and is entitled to its medical and personal services.

METLIFE LEGAL PLANS

With MetLife Legal Plans, you'll have access to legal services and representation on a wide range of matters including wills and estate planning, financial matters, real estate, traffic offenses (no DUI) and more. Once enrolled, you will be required to remain in the plan for the full the benefit year. Premiums are deducted through payroll.

NATIONWIDE PET INSURANCE

My Pet Protection® and My Pet Protection with Wellness® from Nationwide® helps you provide your pets with the best care possible by reimbursing you for vet bills. You receive cash back for accidents, illnesses, hereditary conditions and more. Choose 70% or 50% reimbursement for the level of coverage that fits your needs*. Both plans have a $250 annual deductible and $7,500 maximum annual benefit.

Other Benefits and Programs (continued)

You're free to use any vet and will get additional benefits for emergency boarding, lost pet advertising and more. Nationwide's 24/7 vethelpline® is available as a free service to all pet insurance members.

You can enroll at https://benefits.petinsurance.com/primehealthcare or by calling 877-738-7874. Your premium payment is arranged directly with Nationwide.

*Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions. Reimbursement options may not be available in all states.

AUTO AND HOME INSURANCE

Farmers GroupSelect Auto & Home offers a voluntary group auto and home program that provides you with access to insurance coverage for your personal insurance needs. With Farmers GroupSelect Auto & Home you can take advantage of valuable features and benefits:

- You can receive up to a 15% employee group discount
- Save more with multi-policy discounts when you insure both your home and auto
- Choose from a variety of insurance policies to meet your coverage needs including: condo, renters, boat, personal excess liability, personal property, motorcycle, and recreational vehicle insurance
- You may apply for group auto and home insurance at any time. Take advantage of these savings today and call 800-438-6381 and mention your discount code BSK or by visiting www.myautohome.farmers.com.

Your premium payment is arranged directly with Farmers Insurance.

Summary Annual Report

FOR PRIME HEALTHCARE SERVICES, INC. WELFARE BENEFITS PLAN

This is a summary of the annual report of the Prime Healthcare Welfare Benefits Plan (Employer Identification Number 33-0943449, Plan Number 501) for the plan year January 1, 2020 through December 31, 2020. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Prime Healthcare Services, Inc. has committed itself to pay certain medical, dental and vision claims incurred under the terms of the plan.

INSURANCE INFORMATION

The plan has insurance contracts with Delta Dental of California, Metropolitan Life Insurance Company, SafeGuard Health Plans, Inc., Sun Life Assurance Company of Canada, Vision Service Plan, HM Life Insurance Company and Aetna Life Insurance Co. to pay certain life, accidental death & dismemberment, medical, dental, vision, temporary disability, long-term disability and employee assistance claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2020 were $23,333,057.

YOUR RIGHTS TO ADDITIONAL INFORMATION

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- Insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the plan administrator, at 3480 E. Guasti Road Attention - Employee Health Plan, Ontario, CA 91761 and phone number, 909-235-4400.

You also have the legally protected right to examine the annual report at the main office of the plan: 3480 E. Guasti Road Attention - Employee Health Plan, Ontario, CA 91761, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

PAPERWORK REDUCTION ACT STATEMENT

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

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). 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, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 06/30/2022)

Important Notices

DISCRIMINATION IS AGAINST THE LAW

Prime Healthcare (Prime) complies with the applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Prime does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Prime:

- Provides free aids and services to people with disabilities to communicate effectively with it, such as:
  - Qualified sign language interpreters
  - Written information in other formats (e.g., large print, audio, accessible electronic formats, etc.)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Joel Richlin, Vice President & General Counsel.

If you believe that Prime has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Joel Richlin, Vice President & General Counsel, 3480 E. Guasti Road, Ontario, CA 91761, 909-235-4235, fax 909-235-4316, jrichlin@primehealthcare.com. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Joel Richlin, Vice President & General Counsel is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at:

http://www.hhs.gov/ocr/office/file/index.html

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 844-203-2025, Acct # 501025769, Pin 0679 (TTY: 711).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 844-203-2025, Acct # 501025769, Pin 0679 (TTY: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 844-203-2025, Acct # 501025769, Pin 0679 (TTY: 711).

Filipino

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 844-203-2025, Acct # 501025769, Pin 0679 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 844-203-2025, Acct # 501025769, Pin 0679 (TTY: 711) 번으로 전화해 주십시오.

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 844-203-2025, Acct # 501025769, Pin 0679 (TTY (հեռատիպ)՝ 711):

Persian

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم تماس بگیرید.844-203-2025, Acct # 501025769, Pin 0679 (TTY: 711)با می باشد.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 844-203-2025, Acct # 501025769, Pin 0679 (телетайп: 711).

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。844-203-2025, Acct # 501025769, Pin 0679 （TTY: 711）まで、お電話にてご連絡ください

Important Notices (continued)

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 844-203-2025, Acct # 501025769, Pin 0679 (رقم هاتف الصم والبكم: 711).

Punjabi

ਧਿਆਨ ਦਿਓ :ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ ,ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 844-203-2025, Acct # 501025769, Pin 0679 (TTY: 711)' ਤੇ ਕਾਲ ਕਰੋ।

Mon-Khmer Cambodian

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 844-203-2025, Acct # 501025769, Pin 0679 (TTY: 711) ។

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 844-203-2025, Acct # 501025769, Pin 0679 (TTY: 711).

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 844-203-2025, Acct # 501025769, Pin 0679 (TTY: 711) पर कॉल करें।

Thai

เรียน :ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 844-203-2025, Acct # 501025769, Pin 0679 (TTY: 711)

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

Benefits for pregnancy hospital stay (for delivery) for a mother and her newborn generally may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) ANNUAL NOTICE

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 909-235-4400.

PATIENT PROTECTIONS

The medical plan requires 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. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers visit https://ehp.primehealthcare.com/find-a-provider/.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the plan or 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 visit https://ehp.primehealthcare.com/find-a-provider/.

Important Notices (continued)

NETWORKS/CLAIMS/APPEALS

The major medical plans described in this booklet have provider networks. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims, and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

COBRA CONTINUATION COVERAGE

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

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

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

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

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. The employer must notify the Plan Administrator of the following Qualifying Events:

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

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if part of the employer's plan), are not eligible for continuation under COBRA.

Important Notices (continued)

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, or as otherwise permitted by the COBRA administrator, no later than the date specified in the election form, and properly submitted to the Plan Administrator.

Each notice must include all of the following items: the covered employee's full name, address, phone number and Social Security Number; the full name, address, phone number and Social Security Number of each affected dependent, as well as each dependent's relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred; a copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the employer or Plan Administrator.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their dependent children.

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

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

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

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

Important Notices (continued)

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

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

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

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

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

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

IF YOU HAVE QUESTIONS

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans subject to ERISA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

For more information about the Marketplace, visit www.healthcare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the employer for non-COBRA beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period greater than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description or contact the Plan Administrator for more information.

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

Important Notices (continued)

FLEXIBLE SPENDING ACCOUNTS (FSAS) – TERMINATION AND CLAIMS SUBMISSION DEADLINES

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health Care FSA no later than 90 days after the date your eligibility terminates. You must submit claims for reimbursement from your Dependent Care FSA no later than the end of the plan year (or grace period if applicable). Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

SPECIAL ENROLLMENT RIGHTS NOTICE

CHANGES TO YOUR HEALTH PLAN ELECTIONS

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

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 there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or the Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and/or your dependents into this plan. However, you must request enrollment no later than 60 days after the determination for eligibility for such assistance.

If you have a change in family status such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death, or Qualified Medical Child Support Order, you may be able to enroll yourself and / or your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption or placement for adoption or divorce (including legal separation and annulment).

For information about Special Enrollment Rights, please contact:

Title	Corporate Benefits Manager
Contact Information	909-235-4400

MEDICARE PART D – IMPORTANT NOTICE 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 Prime 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:

- **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.**
- **Prime has determined that the prescription drug coverage offered by Prime Medical Plans are, 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 Prime coverage will not be affected. If you keep this coverage and elect Medicare, the Prime coverage will coordinate with Part D coverage.

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

Important Notices (continued)

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 Prime 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 (i.e., 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 will 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 Prime 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 will 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 your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY users should call 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 800-772-1213 (TTY 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:	October 2021
Name of Entity / Sender:	Prime Healthcare
Contact:	Corporate Benefits Manager
Address:	3480 East Guasti Road
	Ontario, CA 91761
Phone:	909-235-4400

AVAILABILITY OF HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) NOTICE OF PRIVACY PRACTICES

Prime Healthcare Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact the Corporate Benefits Manager at 909-235-4400.

WELLNESS – ALTERNATIVE STANDARDS

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all participating employees. If you think you might be unable to meet a standard for a reward under the wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 877-234-5227 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you with regard to your health status.

Important Notices (continued)

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

This notice provides you with information about Prime in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through Covered California will begin November 1, 2021 and is anticipated to end on January 31, 2022. Open Enrollment for other states will begin on November 1 and close on December 15 of each year. Some states have expanded the open enrollment period beyond December 15, 2021 for coverage to begin in 2022. Notably, Covered California continues its special enrollment period for coverage beginning in 2021 to December 31, 2021.

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 you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.61% (for 2022) of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's medical plan.

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 medical 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.

PART B: EXCHANGE APPLICATION INFORMATION

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com.

1. Employer name Prime Healthcare	**2. Employer Identification Number (EIN)** 33-0943449 (Prime Healthcare Services) 20-8065139 (Prime Healthcare Foundation)	
3. Employer address 3480 E. Guasti Road	**4. Employer phone number** 909-235-4400	
5. City Ontario	**6. State** CA	**7. ZIP code** 91761
8. Who can we contact about employee health coverage at this job? Corporate Benefits Manager		
9. Phone number (if different from above) 909-235-4400	**10. Email address** EHP@primehealthcare.com	

Important Notices (continued)

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 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 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, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado
Colorado's Medicaid Program & Child Health Plan Plus (CHIP+)
Healthy First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 800-221-3943
TTY: Colorado relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 800-359-1991
TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 855-692-6442

FLORIDA – Medicaid
Website:
http://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 877-357-3268

GEORGIA – Medicaid
Website: http://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp/
Phone: 678-564-1162, ext. 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800-338-8366
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 800-792-4884

Important Notices (continued)

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 888-342-6207 (Medicaid hotline) or
855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 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

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 800-657-3739

MISSOURI – Medicaid
Website:
https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov/
Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218
Toll-Free for the HIPP program: 800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
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: 800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888-365-3742

OREGON – Medicaid
Websites: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 800-699-9075

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877-543-7669

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp/
Medicaid Phone: 800-432-5924
CHIP Phone: 800-432-5924

Important Notices (continued)

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800-562-3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 855-MyWVHIPP (855-699-8447)

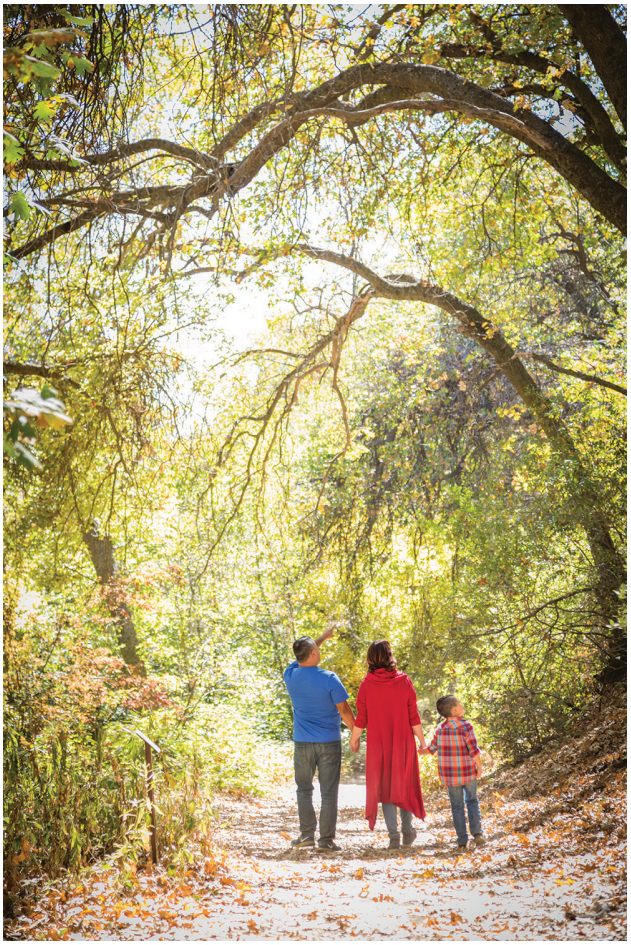
WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

WYOMING – Medicaid
Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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



Glossary of Terms

This glossary of commonly used terms was put together with you in mind to help you throughout the year as you utilize your benefits.

MEDICAL / GENERAL TERMS

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal: A request for your health plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

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

Coinsurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

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

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

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

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

Deductible: The amount you owe for health care services your health plan covers before your health plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

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

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. Emergency Medical Transportation Ambulance services for an emergency medical condition.

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

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your health plan doesn't pay for or cover.

Glossary of Terms (continued)

Explanation of Benefits (EOB): The statement you receive from the Keenan EBTPA 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

Grievance: A complaint that you communicate to your health plan.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Home Health Care: Health care services a person receives at home.

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

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

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

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

In-network Coinsurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

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

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

Marketplace: A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange." The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Network: The facilities, providers and suppliers your health plan has contracted with to provide health care services.

Non-Network Provider: A provider who doesn't have a contract with your health plan to provide services to you. You'll pay more to see a non-network provider. Check your policy to see if you can go to all providers who have contracted with your health plan, or if your health plan has a "tiered" network and you must pay extra to see some providers. Out-of-Network Coinsurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Coinsurance: Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health plan. Out-of-network coinsurance usually costs you more than in- network coinsurance.

Out-of-Network Copayment: A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-Pocket Maximum: The most you pay during policy period (usually a year) before your health plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health plan doesn't cover. Some health plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

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

Glossary of Terms (continued)

Plan: A benefit your employer, provides to you to pay for your health care services.

Premium Tax Credits: Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level.

Advance payments of the tax credit can be used right away to lower your monthly premium costs.

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

Network Provider: A provider who has a contract with your health plan to provide services to you at a discount. Check your policy to see if you can see all network providers or if your health plan has a "tiered" network and you must pay extra to see some providers. Your health plan may have network providers who are also "participating" providers. Participating providers also contract with your health plan, but the discount may not be as great, and you may have to pay more.

Premium: The amount that must be paid for your health plan. You and or your employer usually pay it yearly.

Prescription Drug Coverage: Health plan that helps pay for prescription drugs and medications.

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

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

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Prime Healthcare Network: The Prime Healthcare Network is comprised of Prime Healthcare Providers (physicians and hospitals). Seeking services under the Prime Healthcare Network provides you with the best option to reduce your out-of-pocket medical expense.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

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

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

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

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

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

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

Glossary of Terms (continued)

PRESCRIPTION DRUG TERMS

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

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

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.

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-Formulary 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-formulary brand drug.

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.

For Assistance

Plan Type	Plan Providers	Phone Number	Website
Medical Prime Healthcare Employee Health Plan (EHP) • Referrals & Prior Authorization • PCP Elections and Changes • Claims • Tier 1 Prime Provider Directory	EHP Customer Service	877-234-5227	www.primehealthcare.com/EHP **Email a general inquiry:** EHP@primehealthcare.com
Keenan Third Party Administrator (TPA) • Member Eligibility / Plan Design • Medical ID Cards • Explanation of Benefits	TPA Customer Service	888-773-7218	www.keenan.com/benefits
Prescription Drugs	Express Scripts	866-718-7955	www.express-scripts.com
MERP (Medical Expense Reimbursement Plan)	Catilize Health	877-872-4232	www.catilize.com
Dental	Delta Dental	800-765-6003	www.deltadentalins.com
Vision	Vision Service Plan	800-877-7195	www.vsp.com
Life/AD&D & Voluntary Disability • Life/AD&D • Optional Life • Voluntary STD • Voluntary LTD	Sun Life Financial	800-247-6875	login.sunlifeconnect.com/commonlogin/#/login/10
Emergency Travel Assistance	Sun Life Financial	**Within U.S.** 800-872-1414 **Outside U.S.** 609-986-1234	www.assistamerica.com
Identity Theft	Sun Life Financial	877-409-9597	www.assistamerica.com
EAP (Employee Assistance Program)	ComPsych	877-595-5284	www.guidanceresources.com
FSA and COBRA	HR Simplified	888-318-7472	www.mypretax.com
Voluntary Insurance • Universal Life/LTC • Universal LifeEvents®/LTC • Accident Insurance • Critical Illness Insurance • Hospital StayPay	Trustmark Voluntary Benefits	800-918-8877	www.trustmarkbenefits.com/Voluntary-Benefits
• MetLife Legal Plans	MetLife	800-821-6400	www.legalplans.com
• Auto & Home	Farmers Insurance	800-438-6381	www.myautohome.farmers.com
• Pet Insurance	Nationwide	**Member Services** 800-540-2016 **Enrollment** 877-738-7874	my.petinsurance.com/login benefits.petinsurance.com/primehealthcare
Personal Choices	https://app.strivebenefits.com/PHS **User ID:** PHS **Password:** Benefits		