2024 BENEFITS
MAKING THE MOST OF YOUR BENEFITS

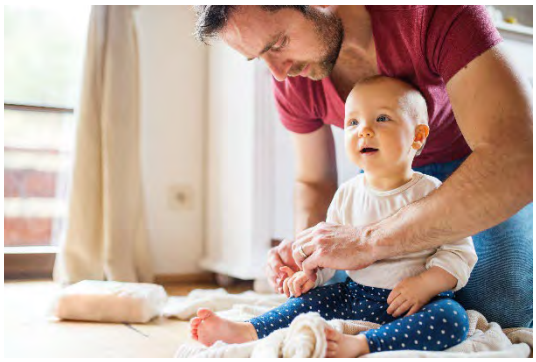
ENLOE MEDICAL CENTER

CONTENTS

MEDICARE PART D NOTICE

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 Plan Information section for more details.

WHO'S ELIGIBLE FOR BENEFITS?



IMPORTANT!

Please be prepared to upload originals or copies of original documents and social security numbers for you and your covered dependents even if you have previously provided these documents to Human Resources. Official documents of birth, marriage and death certificates may be obtained through www.vitalchek.com or by calling 800.255.2414, 5:00 am – 5:00 pm PST. State document fees and courier fees will apply.

Employees

You are eligible if you are an active, full-time, or part-time benefit eligible employee, and regularly scheduled to work 48 hours or more per pay period.

Eligible dependents

- Legally married spouse or registered domestic partner (see the full Summary Plan Description (SPD) to see if you meet the qualifications)
- Natural, adopted or stepchildren under the age of 26
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO).
- Children whom you have legal guardianship of

For additional information, please refer to the benefit booklets or Summary Plan Descriptions (SPD) for each benefit.

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the first of the month following the date of hire as long as you enroll on or before the first of the month following date of hire. If you miss the enrollment deadline, you'll need to wait until either the next open enrollment period (the one time each year that you can make changes to your benefits for any reason) or unless you experience a midyear qualifying event, such as a loss of other employer coverage (for more on qualifying events, refer to the "Changing Your Benefits" section.)

REQUIRED DEPENDENT VERIFICATION DOCUMENTS

When enrolling a dependent, you are required to provide supporting documentation to substantiate the relationship. You must supply originals or copies of the original documents to ADP when first enrolling, when changing benefit selections or during a Dependent Verification Audit. This can be done via upload, mail or fax. If adding a dependent, the social security number or tax identification number (TIN) of the dependent must be provided. Refer to the chart below for a detailed list of the most commonly required supporting documentation for different types of dependent coverage.

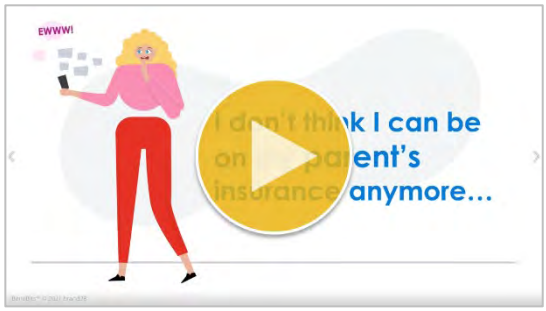
Covered Dependent	Required Verification Documents
Married Partner A legally married spouse	Original Marriage Certificate AND Current proof of common residency (such as utility bill with both of your names on it)
Domestic Partner A registered Domestic Partner of the employee	State Domestic Partner Affidavit AND Current proof of common residency (such as a utility bill with both of your names on it)
Natural Birth Child Birth to age 26*	Copy or Original Birth Certificate naming employee as child's biological parent
Stepchild Birth to age 26*	Copy or Original Birth Certificate naming the employee's spouse as the child's biological parent and applicable spouse documentation (see above)
Domestic Partner's Child Birth to age 26*	Copy or Original Birth Certificate naming the employee's domestic partner as the child's biological parent and applicable domestic partner documentation (see above)
Adopted Child Birth to age 26*	Court documents naming the employee as legal guardian OR adoption record
Disabled Adult Child Over age 26*	Most recent IRS 1040** AND Birth Certificate AND Social Security Disability Verification Form AND Physicians Certification Form
Legal Guardianship/Custody Birth to age 26*	Court documents naming employee as Legal Guardian/Custodian

*Age 26 applies to Medical, Dental, Vision and Optional Child Life

**First page of the IRS 1040 document listing family members with income information redacted. Please note that in accordance with IRS rules, filing Head of Household is considered a single status.

CHANGING YOUR BENEFITS

Click to play video



LIFE HAPPENS

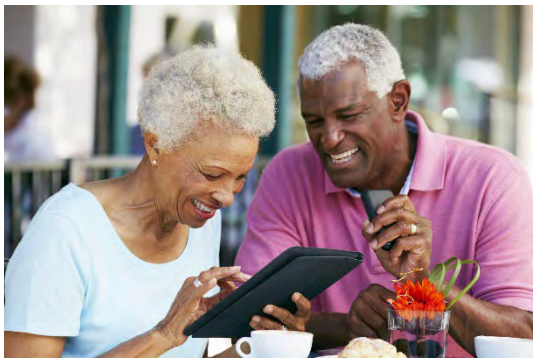
A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers (Value Plan only)
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 30 days of the qualifying event.

ENROLLING FOR BENEFITS



ADP Enrollment Presentation

You can refer to the ADP Presentation for detailed step-by-step instructions on how to enroll by scanning the QR code below or by clicking HERE.

Welcome to ADP!

All employees will utilize the ADP system to enroll in benefits. ADP will allow you to make all your benefit decisions in one place. Here are some tips to help you get started.

Before you enroll

- Know the date of birth, social security number and address for each dependent you will cover.
- PLEASE NOTE: If you are adding a dependent to the Medical, Dental, Vision or Voluntary Life and AD&D, please refer to the “Required Dependent Verification Documents” for more information on what documents are required.
- Review your enrollment materials to understand your benefit options and costs for the coming year.
- Review any benefits offered through your spouse’s/domestic partner’s employer to avoid costly duplicate coverage.

Getting started

- Log in to My.ADP.com
- ENTER your Username and Password
- ADD your personal and dependent information
- SELECT your benefit plans for the coming year
- REVIEW your choices and costs before finalizing

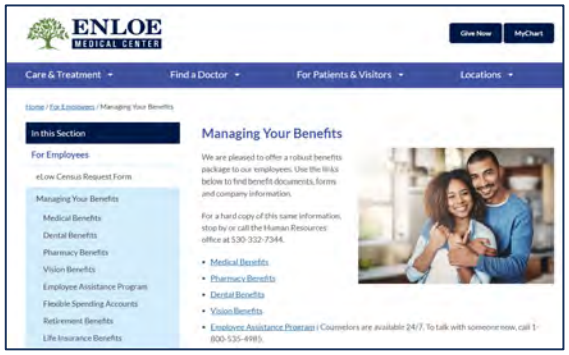
If you are a new user and need to register, registration codes are available on Inside Enloe.

EMPLOYEE BENEFITS WEBSITE

Welcome to your Employee Benefits Website!

Enloe Medical Center has a great Employee Benefits Website to give you an easy and convenient way to access benefits information and offers immediate answers to potential benefit questions.

This can be accessed at www.enloe.org/benefits or by scanning the QR code on the left.



The following is a summary of the information and resources available on the website:

Benefits information, such as:

- Medical, Dental, Vision and Pharmacy information
- Employee Assistance Program
- Flexible Spending Accounts
- Retirement Benefits
- Life Insurance Benefits
- All Benefit Forms
- Benefit Plan Documents and Summaries

Enloe Contact Information

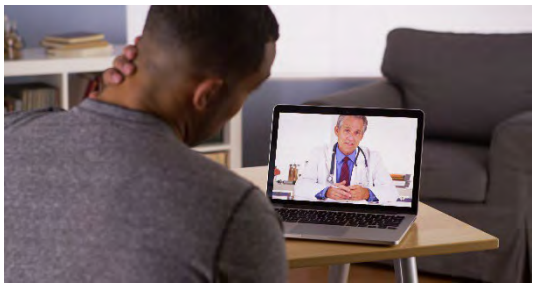
Address: Enloe Medical Center

1531 Esplanade

Chico, CA 95926

Phone: 530.332.7344

TELADOC



GET THE CARE YOU NEED

Teladoc Health doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Sinus problems
- Urinary tract infection
- Respiratory infection
- Skin problems
- And more!

Talk to a doctor anytime

Teladoc Health gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone, video or mobile app visits. It's an affordable alternative to costly urgent care and ER visits when you need care now.

Meet our doctors

Teladoc Health is simply a new way to access qualified doctors.

All Teladoc Health doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 20 years' experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

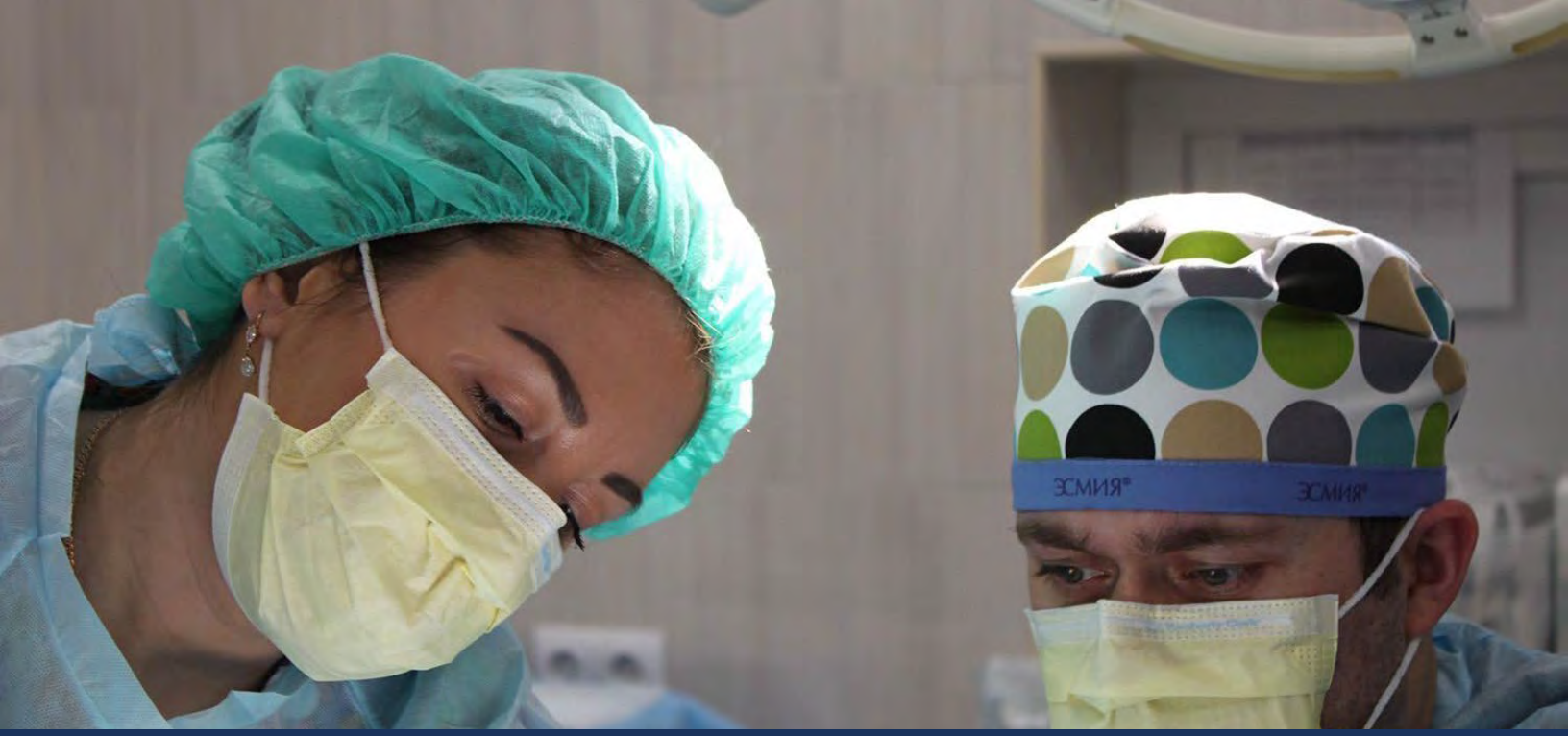
When should you use Teladoc Health?

Teladoc Health does not replace your primary physician. It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care for a non-emergency
- When on vacation, a business trip or away from home
- For short-term prescription refills

Teladoc Health is just a call or click away!

Teladoc.com | 800-Teladoc



MEDICAL: CLASSIC PLAN VS VALUE PLAN

Classic Plan

The Classic Plan provides employees with (3) tiers of healthcare services to choose from including: Enloe Medical Center (Tier I), a Blue Shield Network Provider (Tier II), or an Out-of-Network Provider (Tier III).

Tier I: Enloe Medical Center	This tier provides employees with lower out-of-pocket costs on average than the other two tiers of providers.
Tier II: Blue Shield Network Providers	Within this tier, employees have access to providers participating in the Blue Shield network. These providers have agreed to provide services at negotiated rates in exchange for being a part of the Blue Shield network, resulting in lower out-of-pocket costs for the employee.
Tier III: Out-of-Network Providers (Classic Plan only)	Employees are responsible to pay the difference between what the Classic Plan pays and the amount billed by the out-of-network provider.

Value Plan

All employees enrolled in the Value Plan must use Enloe Medical Center whenever services are available. **The Tier II and Tier III may only be used in the case that services are not provided at Enloe or out of town medical care is required – prior to receiving services from a Tier II or Tier III provider, you must receive a referral authorization.** Employees are responsible for all costs acquired using Tier II or Tier III services that are available at Enloe. These expenses will not be covered under the Value Plan.

MEDICAL – CLASSIC PPO

	CLASSIC PPO PLAN		
	Tier 1 **Enloe Medical Network**	**Tier 2** **Blue Shield Network**	**Tier 3** **Out-of-Network**
Annual Deductible	$0 per individual $0 family limit	$250 per individual $750 family limit	$250 per individual $750 family limit
Annual Out-of-Pocket Maximum[1]	$2,000 per individual $6,000 family limit	$2,000 per individual $6,000 family limit	No limit
Primary provider office visit	$20 copay then Plan pays 100%	$20 copay then Plan pays 100%	Plan pays 80%*
Specialist office visit	$20 copay then Plan pays 100%	$20 copay then Plan pays 100%	Plan pays 80%*
Other Physician Services	Plan pays 80%	Plan pays 80%	Plan pays 80%
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 80%
Teladoc (virtual visit)	$10 copay		
Diagnostic Lab and X-ray[2]	Plan pays 100%	Plan pays 80%*	Plan pays 80%*
Urgent Care	$20 copay then Plan pays 100%	$20 copay then Plan pays 100%	$20 copay then Plan pays 100%
Emergency Room	$50 copay then Plan pays 100% (copay waived if admitted)		
Inpatient Hospitalization Facility charge Physician charge	 Plan pays 100% Plan pays 80%*	 Plan pays 70%* Plan pays 80%*	 Plan pays 60%* Plan pays 80%*
Outpatient Surgery Facility charge Physician charge	 Plan pays 100% Plan pays 80%*	 Plan pays 70%* Plan pays 80%*	 Plan pays 60%* Plan pays 80%*
PRESCRIPTION DRUGS	Enloe Outpatient Pharmacy	MedImpact	Out-of-Network
Annual Out-of-Pocket Maximum	$2,000 per individual; $4,000 family unit		
Generic	**Pharmacy:** $5 copay then Plan pays 100%	**Pharmacy:** $15 copay then Plan pays 100% **Mail order:** $15 copay then Plan pays 100%	Not Available
Preferred brand	**Pharmacy:** $15 copay then Plan pays 100%	**Pharmacy:** $25 copay then Plan pays 100% **Mail order:** $30 copay then Plan pays 100%	Not Available
Number of days' supply	**Pharmacy:** 30 – 90 days (2x copay for 60, 3x copay for 90)	**Pharmacy:** 30 days **Mail order:** 90 days	Not Available

1. Annual out-of-pocket maximums do not apply in all situations. Please call 877.365.6399 to determine whether out-of-pocket maximums will apply.
2. If lab/cultures are taken at Enloe and sent to a non-Enloe lab for processing, the covered person must call 877.365.6399 if s/he would like the expense to be paid at the Enloe benefit level.

* After deductible

MEDICAL – VALUE PPO

	VALUE PLAN		
	Tier 1 **Enloe Medical Network**	**Tier 2** **Blue Shield Network**	**Tier 3** **Out-of-Network**
Annual Deductible	$0 per individual $0 family limit	$250 per individual $750 family limit	$250 per individual $750 family limit
Annual Out-of-Pocket Maximum	$2,500 per individual $7,500 family unit	$2,500 per individual $7,500 family unit	No limit
Primary provider office visit	$25 copay then Plan pays 100%	$25 copay then Plan pays 100%	Plan pays 80%*
Specialist office visit	$25 copay then Plan pays 100%	$25 copay then Plan pays 100%	Plan pays 80%*
Other Physician Services	Plan pays 80%	Plan pays 80%	Plan pays 80%
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 80%*
Teladoc (virtual visit)	$10 copay		
Diagnostic Lab and X-ray[1]	Plan pays 100%	Not Covered	Not Covered
Urgent Care [2]	$25 copay then Plan pays 100%	$25 copay then Plan pays 100% (only if outside Chico)	$25 copay then Plan pays 100% (only if outside Chico)
Emergency Room	$75 copay then Plan pays 100% (copay waived if admitted)		
Inpatient Hospitalization Facility charge Physician charge	Plan pays 90% Plan pays 80%*	Not Covered Plan pays 80%*	Not Covered Plan pays 80%*
Outpatient Surgery Facility charge Physician charge	Plan pays 90% Plan pays 80%*	Not Covered Plan pays 80%*	Not Covered Plan pays 80%*
PRESCRIPTION DRUGS	Enloe Outpatient Pharmacy	MedImpact	Out-of-Network
Generic	**Pharmacy:** $10 copay then Plan pays 100%	**Pharmacy:** $15 copay then Plan pays 100% (only available for immediate need drugs when Enloe Pharmacy is closed) **Mail order:** Not covered	Not Available
Preferred brand	**Pharmacy:** $25 copay then Plan pays 100%	**Pharmacy:** $25 copay then Plan pays 100% (only available for immediate need drugs when Enloe Pharmacy is closed) **Mail order:** Not covered	Not Available
Number of days' supply	**Pharmacy:** 30 – 90 days (2x copay for 60, 3x copay for 90)	**Pharmacy:** 30 days **Mail order: Not applicable**	Not Available

1. If lab/cultures are taken at Enloe and sent to a non-Enloe lab for processing, the Covered person must call the Contract Administrator if s/he would like the expense to be paid at the Enloe benefit level. Lab and radiology services obtained at a non-Enloe facility will only be covered by the plan if services were urgent in nature.
2. Value Plan enrollees must use Enloe PromptCare Clinics for urgent care office visits.

*Copay or coinsurance listed is after deductible is met.

PRESCRIPTION PLAN

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

The formulary is reviewed regularly for quality and efficacy, and it is designed to offer drugs in the majority of drug classes. If you wish to save money, often a generic drug is available for a brand name prescription your physician may prescribe. The full formulary is available on the Enloe website, www.enloe.org/benefits or scan the QR code below.

Bring the formulary to your doctor's appointment when you may be receiving a new prescription. If you would like a paper copy, one is available to you at no charge in the HR Department.

FIND A PROVIDER

Find a Provider – Blue Shield of California

By creating an account on the myhnas.com website, you will have direct access to the www.blueshieldca.com/networkppo. Please see below for additional information.

Blue Shield of California (CA providers only)

- Go to www.blueshieldca.com/networkppo
- Under "What are you looking for?" select the type of provider you are seeking, such as doctors, facilities, or equipment and supplies.
- Once you choose the type of provider, advanced searches are available, if you'd like to further narrow your searches.
- In the "Where are you located?" field, enter your city and state or zip code, then click on Continue.

Blue Shield Participating Providers (outside of California)

- Go to www.blueshieldca.com/networkppo
- Select the "Providers outside of CA" link at the bottom left of the page, under Accessing Care Outside CA.
- Click the "Leave Blue Shield Website" button.
- In the "Your Location" field, type in your city and state then click the "Prefix: AAA" link and enter XEL. Click GO.
- Using the "Search All" dropdown menu, choose your search criteria, e.g., Doctor by name or Doctors by specialty.
- Follow the prompt to continue your search.

PRIOR VS REFERRAL AUTHORIZATIONS

How to request prior authorization

1. Provider calls HNAS at 877.629.1500. Provider will be advised if an authorization may be required for certain services.

2. If the service required preauthorization, the customer service representative will fax the Preauthorization Review Request Form to the provider.

3. The provider should fax the Preauthorization Review Request Form to HealthNow Administrative Services.

4. The Preauthorization Department will place calls (as well as send a letter) to both the provider and the member.
The turnaround time is about 5 business days.

Prior Authorization – Classic and Value Plans

Prior Authorization is needed before certain medical treatments are started. It is a program that is designed to determine whether or not a proposed setting and course of treatment is medically necessary and appropriate. It minimizes the risk of reduced benefits. Please have your doctor call HealthNow Administrative Services (HNAS) to go through the necessary process of obtaining a prior authorization. If you have questions on a particular medical benefit, please contact HNAS at 877.629.1500 or hnas.enloe@hnas.com.

How the Prior Authorization Works

- The member and provider should contact HNAS to determine prior authorization requirements for the service being covered.
- If prior authorization is required, the provider will fax the review request in to the HNAS Comprehensive Care team and include clinical information in support of the request for medical necessity review.

If the submitted information meets clinical and medical necessity, the case request will be approved. The member and provider will receive a notification call and approval letter.

If the submitted information does NOT meet criteria required for medical necessity, the case request will be denied. The member and provider will receive a notification call and denial determination letter with appeal rights. The provider may then initiate an appeal for the decision and supply any additional supporting information for an appeal review.

Referral Authorization – Value Plan ONLY

If you elect the Enloe Value Plan, you are required to use Enloe whenever services are available. You can only seek care outside of Enloe if the services are not provided at Enloe or out-of-town medical care and/or emergency care is required. In this case, prior to receiving services from a Tier II or Tier III provider, you must receive a referral authorization. No benefit will be payable if a non-emergency service is incurred outside of Enloe before obtaining an approved referral authorization.

PREVENTIVE VS DIAGNOSTIC

Know the difference

You benefit both financially and health-wise when you get annual medical checkups. Preventive care helps you avoid more serious and costly health problems down the road. Plus, it is fully covered when obtained in-network.

Did you know? Depending on the situation, the same test or service can be considered preventive (100% covered) or diagnostic (shared cost)?

Preventive Care Services

- Helps you stay healthy by checking for diseases before you have symptoms or feel sick
- Can include flu shots and other vaccinations, physical exams, lab test and prescriptions
- 100% covered when delivered by an in-network provider

Diagnostic Services

- Check for diseases after you have symptoms or because of a known health issue
- Can also include physical exams, lab tests and prescriptions
- You pay your share of the cost

Examples

PREVENTIVE: As part of her well woman exam, Vanessa receives a mammogram to make sure there have been no changes since last time.

DIAGNOSTIC: Darla visits her doctor because she found a lump. Her doctor schedules a mammogram and a biopsy to check for cancer.

PREVENTIVE: Oscar's doctor orders lab work during his annual physical, including a cholesterol check.

DIAGNOSTIC: Hector was diagnosed with high cholesterol two years ago. He has blood tests twice a year to check his cholesterol levels and make sure his medication is the right dose.

If you are unsure why a test was ordered, ask your doctor. Don't forget to schedule your preventive care visits.

CASE MANAGEMENT

HealthNow Administrative Services (HNAS) Case Management

Experiencing a major health event can be difficult. HealthNow Administrative Services (HNAS) understands this and are here to empower and guide you through your path to recovery. Case management, through HNAS, is a free and confidential service that Enloe Medical Center makes available to its employees and their family members covered through our benefits.

Our case management is prepared to step in to help you through traumatic or other serious health care issues. It will provide assistance every step of the way.

The skilled team includes:

- Registered nurses
- Dieticians
- Social works who collaborate with doctors and hospitals to coordinate your care

Areas of assistance

- General care support
- Complex conditions
- Transplants
- Behavioral health
- High-risk pregnancies
- Emergency room use

To get started, call HNAS at 877.229.1002.

DENTAL

Dental coverage provides periodic preventive care, and if there's a problem, helps with the cost of dental work. Enloe Medical Center provides its employees with the Delta Dental Preferred Dentist Program (PPO). The DPPO has a larger network of participating dentists that have agreed to reduce their fees so that they are able to partake in the PPO network. You will have less out-of-pocket expenses by choosing to visit a Delta Dental Preferred Dentist.

To locate a network dentist, please visit www.deltadentalins.com.

	Delta Dental PPO		
	In-Network	**Premier[1]**	**Out-of-Network**
Annual Deductible Individual Family		$25 $75	
Annual Plan Maximum		$1,500 per individual	
Diagnostic & Preventive		Plan pays 80%	
Basic Services Fillings Root Canals Periodontics	 Plan pays 70%* Plan pays 70%* Plan pays 70%*	 Plan pays 70* Plan pays 70%* Plan pays 70%*	 Plan pays 70%* Plan pays 70%* Plan pays 70%*
Major Services Prosthodontics	 Plan pays 60%*; all other: Plan pays 65%*	 Plan pays 60%*; all other: Plan pays 65%*	 Plan pays 60%*; all other: Plan pays 65%*
Orthodontia Services (Dependent Children to age 19) Lifetime Maximum		Plan pays 50% $1,500	

[1]Reimbursement is based on PPO contracted fees for PPO dentists. Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.
* Copay or coinsurance listed is after deductible is met.

TOOTHPIC APP[2]

The Toothpic App is a photo-based app, ideal for members looking for a quick exam and a full diagnostic report from a Delta Dental dentist. You can answer a few questions and take photos of your mouth from a computer, smartphone or tablet to receive a personalized dental report in under 24 hours.

VIRTUAL CONSULT[2]

Virtual Consult connects Delta Dental members and dentists for real-time video appointments. It's secure and HIPAA-compliant, and it's available for free[1] with your existing Dela Dental PPO™ Plan. When you have an urgent issue, even if it's after hours, Virtual Consult makes getting a dentist's advice simple.

Scan the QR code to visit Quip and access both services.

[2]These services will count toward one of your two oral examinations, per member, covered under the PPO plan for the calendar year.

VISION

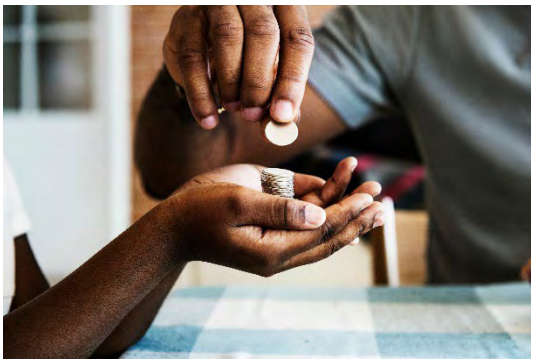
The VSP Vision plan provides participants with access to a large network of vision care providers. To locate a network provider, please visit www.vsp.com. If you decide not to see a VSP doctor, the Out-of-Network copay will apply. Your VSP benefits are a tremendous part of your overall benefits package. There are no ID cards necessary for this plan.

If you enroll in a medical plan, you will automatically be enrolled into the Basic Vision plan, at no additional cost.
You will also have the option to enroll in the Optional Plus plan, at an additional cost. If you waive medical coverage, you can only elect to enroll in the Optional Plus plan, at an affordable bi-weekly premium.

	VSP VISION- BASIC		VSP VISION- OPTIONAL PLUS	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Frequency				
Examination	1x every 12 months		1x every 12 months	
Frames	1x every 24 months		1x every 12 months	
Eyeglass lenses	1x every 24 months		1x every 12 months	
Contacts (elective)	1x every 24 months		1x every 12 months	
Benefit				
Examination	$10 copay	Plan pays up to $45	$10 copay	Plan pays up to $45
Frames	$120 allowance, plus 20% discount on remaining balance	Plan pays up to $47	$175 allowance, plus 20% discount on remaining balance	Plan pays up to $47
Lenses	Plan pays 100% of basic lens ($10 materials copay applies)	Plan pays up to $45	Plan pays 100% of basic lens	Plan pays up to $45
Contacts (elective)*	Fitting & eval exam: up to $10 copay then Plan pays 100%; contact lenses reimbursed up to $120*; 15% discount on contact lens exam ($10 materials copay applies)	Plan pays up to $105	Fitting and Eval: up to $10 copay then Plan pays 100%; contact lenses reimbursed up to $175	Plan pays up to $105
Enhancements				
Anti-Reflective Coating	$37 - $75 copay		$30 copay	
Polycarbonate Lenses	Covered for dependent children Adults: $33 copay		Covered (dependent children and adults)	
Standard Progressives	$50 copay		Covered	

*in lieu of eyeglasses

FLEXIBLE SPENDING ACCOUNTS (FSA)



FIND OUT MORE

- Administered by:
  WEX, Inc.
- Eligible Expenses – now include more over-the-counter items!
- Ineligible Expenses

Healthcare Flexible Spending Account

Set aside healthcare dollars for the coming year.

A Healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. WEX, Inc. administers this benefit.

For 2024, you may contribute up to $3,200 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 care for your convenience.

USE IT OR LOSE IT

Be sure to plan carefully. All unused funds, over the amount of $640, will be forfeited at the end of the plan year.

The deadline to incur expenses is December 31, 2024 and you have until March 1, 2025 to submit receipts or explanations of benefits for reimbursements for money in your 2024 accounts.

Dependent Care Flexible Spending Account (Daycare/After School Care/Adult Daycare)

For 2024, 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 at the time of enrollment is not available right away – funds are available as they are deducted from your paycheck.**

Eligible dependent care expenses are those that enable an individual or married couple to remain gainfully employed or look for work. If married, your spouse must be working, looking for work, or be a full-time student. Some examples of eligible dependent care expenses are:

- Care of a dependent child under the age of 13 by babysitter, nannies, nursery schools, pre-school, daycare centers, summer day camp and after school programs.
- Care for any member of your household who is physically or mentally incapable of caring for him/herself and qualifies as a federal tax dependent.

LIFE and AD&D

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) listed on the ADP system— receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

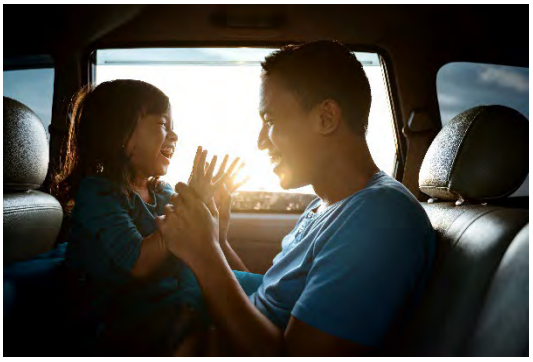
Is your family protected?

Life and AD&D insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

LIFE AND AD&D INSURANCE



Basic Life and AD&D

Life insurance can fill a number of financial gaps for a family recovering from a death of a loved one. Without enough life insurance, many families may have to reduce their standard of living after the loss of an income.

Consider your current and future financial needs when evaluating how much coverage you need. The most common short and long-term financial needs include:

- Medical bills and funeral expenses
- Living expenses for the surviving family (housing, food, clothing, utilities, etc.)
- Large expenses (college education, home mortgage, etc.)
- Taxes and debts that need to be settled

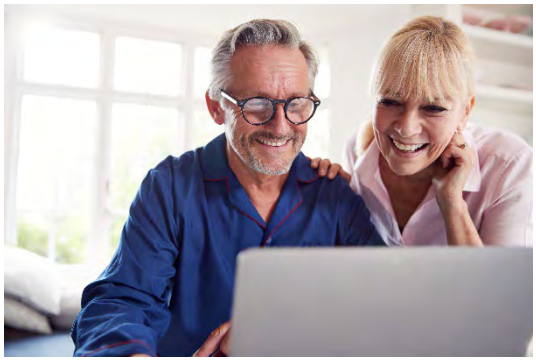
Make sure that you have named a beneficiary for your life insurance and update it if your family or marital status changes. Basic Life and AD&D is covered by your employer. You are automatically enrolled in this coverage. This benefit is administered by UNUM.

UNUM Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight or hearing, or if you have a fatal accident. The cost of coverage is paid in full by the company. You do not need to be enrolled in the medical, dental or vision plans to be enrolled in this benefit.

Basic Life-Employees working 24 hours or more	**1 x covered annual earnings up to a maximum of $350,000**
Basic AD&D-Employees working 24 hours or more	**Equal to the amount of your basic group term life amount**

VOLUNTARY LIFE AND AD&D INSURANCE



Voluntary Life and AD&D

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is available for your spouse and/or child(ren) if you purchase coverage for yourself.

UNUM Voluntary Life

Employee	**Increments of $10,000 up the lesser of 5x covered annual earnings or $750,000. Guaranteed issue: lesser of 3x covered annual earnings or $150,000**
Spouse	**Increments of $5,000 up to $500,000 Guaranteed issue: $25,000 not to exceed 100% of the employee's benefit amount**
Child(ren)	**Increments of $2,000 (child coverage begins on the 15th day following birth and terminates at age 26) up to $10,000, not to exceed 50% of the employee's benefit amount Guaranteed issue: $10,000**

If you select coverage above the guaranteed issue amount, you will need to submit an Evidence of Insurability (EOI) form with additional information about your health for the insurance company to approve this higher amount of coverage.

Voluntary AD&D

Voluntary AD&D Insurance allows you to purchase additional accidental death and dismemberment insurance to protect your family's financial security in case you suffer from loss of a limb, speech, sight or hearing, or if you have a fatal accident. Coverage is available for your spouse and/or child(ren) if you purchase coverage for yourself.

Voluntary AD&D is automatically provided to all employees who elect Voluntary Life.

UNUM Voluntary AD&D

Employee	**Increments of $10,000, up the lesser of 5x covered annual earnings or $750,000**
Spouse	**Increments of $5,000 up to $500,000**
Child(ren)	**Increments of $2,000 up the lesser of $10,000**

ADDITIONAL BENEFITS

ADDITIONAL BENEFITS

- Employee Assistance Program (EAP)
- LifeBalance
- Mental Health Resources

Additional benefits to meet your needs

Enloe Medical Center is proud to offer additional benefits to help meet your needs.

In addition to the core benefits, we also offer a no-cost Employee Assistance Program (EAP) to give you a lending hand when you need it.

Enloe Medical Center also offers LifeBalance, a discount program available year-round for you and your family members.

MENTAL HEALTH RESOURCES

These are challenging times, and we understand that you or people close to you may also be faced with additional work and family stresses. Feelings of isolation, depression or despair should never be taken lightly. This is a reminder that our medical plans include coverage for mental health care. And through our telemedicine provider, you can connect to a mental health provider within minutes, from any location, at any time.

In-Network Mental Health Services*			
	Tier 1	**Tier 2**	**Tier 3**
Classic Plan* Inpatient	No Charge. Deductible does not apply.	20% coinsurance	20% coinsurance
Value Plan* Inpatient	10% coinsurance. Deductible does not apply.	20% coinsurance	20% coinsurance

*Precertification required. Certain behavioral health services are not covered. Coverage is only available outside of Enloe in the event of an emergency or for services that are not provided at Enloe. Please refer to the benefits summaries located in your Mental Health Toolkit to see all levels of mental & behavioral health services coverage for the Classic and Value Plan.

Self Care by AbleTo, through your Optum EAP

Through your EAP administrator, Optum, you have access to Self Care. Self Care by AbleTo offers the latest self-care techniques, coping tools, meditations and more. You can access it online or with the app. Self Care offers a variety of mental health tools and personalized activities to help create your self-guided journey to better mental health. To get started, you will be asked a couple of questions to better understand the goal you're trying to reach.

Visit the site at www.ableto.com or by scanning the QR code.

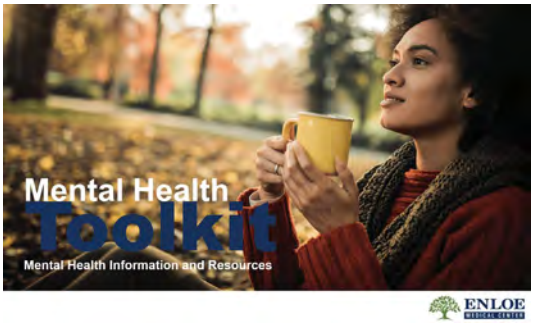
"Mental health is as important as physical health.
That's why we're making high-quality care accessible."

- Steve Bewley, AbleTo CEO

Your Mental Health Toolkit

Be sure to check out your Mental Health Toolkit. You can get a chance to learn more about the importance of mental health, understanding the different mental health conditions, and what resources are available to you through your Enloe Medical Center benefits.

Click to view your Mental Health Toolkit.



EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT THE EAP

Phone

866.248.4096

Website

Visit www.Liveandworkwell.com or scan the QR code below.

Company access code: enloe

Help for you and your household members

There are times when everyone needs a little help, advice, or assistance with a serious concern.

Your Employee Assistance (EAP) and WorkLife Services are available to you at no cost as part of your benefits with Enloe. This includes 24/7 access to your EAP over the phone and online. You can call to speak with master's-level employee assistance specialists who provide consultation, risk screening advocacy, referrals and educational materials. Their website is available in English and Spanish.

You have access to 3 free face-to-face counseling sessions, per member, per issue, per year.

ADULT & ELDERCARE SUPPORT

- Grief/loss
- Retirement planning
- Adult daycare programs
- Financial and legal issues
- In-home/nurse care options

CHILD AND FAMILY SUPPORT

- Childcare options
- Adoption resources
- Day/summer camps
- Emergency/sick-child care
- Parent/family support groups

CHRONIC ILLNESS AND CONDITION SUPPORT

- Respite services
- Caregiving services
- Assistive technology
- Affordable housing resources
- Meal and transportation resources

CONVENIENCE SERVICES

- Pet services
- Traveling needs (business and leisure)
- Car and home repair maintenance
- Shopping, dining and recreation recommendations

EDUCATIONAL RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

Talkspace

Through Optum EAP, you also have access to Talkspace, an alternative to face-to-face counseling sessions, where you can obtain online therapy with a licensed therapist. You can start therapy within hours of choosing your EAP provider, message your EAP provider at your convenience and choose real-time face-to-face video visits by appointment, when needed.

LIFEBALANCE PROGRAM

"LifeBalance connects me with events, locations, services, and adventures that I would have otherwise been unaware of"

-Olivia Ramos, LifeBalance member

Health. Happiness. Savings.

LifeBalance specializes in offering savings where you work, live, and play. The program's discount network is constantly growing with new local and regional savings options, making it easy to provide meaningful employee discounts. They offer employee savings and benefits at more than 20,000 recreational, cultural, well-being, and travel related businesses. LifeBalance's unrivaled focus ensures that meaningful savings are available in your community.

Make your LifeBalance with savings on:

- **Fitness** – Health club memberships, yoga, cycling, running, and more
- **Travel** – Lodging, car rentals, cruises, vacation packages, and tours
- **Attractions** – Admission to theme parks, water parks, zoos, and museums
- **Spa & Relaxation** – Massages, meditation, gardening, and more
- **Movie Tickets** – Tickets to theaters nationwide
- **Performing Arts Tickets** – Plays, musicals, family shows, symphonies, and more.
- **Sports** – Sporting event tickets, sports camps, gear, and classes
- **Eating Well** – Weight management, meal delivery, supplements, and more

Create an account today.

1. Visit Enloe.LifeBalanceProgram.com/login on any device.
2. Enter your preferred email address, then click "Let's Get Started."
3. If prompted, enter your activation code*:
4. Enter your first and last name, and your zip code. If prompted, select your city from a drop-down menu of locations.
5. Enter a password for your account, set your preferences using the checkboxes, and click "Submit."

*Codes available on Inside Enloe.

PLAN CONTACTS

Provider	Plan	Phone Number	Website
Medical			
HealthNow Administrative Services (HNAS)	Classic PPO Value PPO	877.629.1500 Email: hnas.enloe@hnas.com	www.myhnas.com
Pharmacy			
MedImpact	MedImpact	888.265.7422	www.medimpact.com
Enloe Outpatient Pharmacy (Monday – Friday 8am – 8pm)	Enloe Outpatient Pharmacy	530.332.6470	
Dental			
Delta Dental of California	Dental PPO	800.765.6003	www.deltadentalins.com
Vision			
VSP	Vision Service Plan	800.877.7195	www.vsp.com
Life and AD&D			
UNUM	Basic Life and AD&D Voluntary Life and AD&D	866.679.3054	www.unum.com/employees
Flexible Spending Account			
WEX, Inc.	Healthcare FSA Dependent Care FSA	866.451.3399	www.wexinc.com
Additional Benefits			
Optum	Employee Assistance Program	866.248.4096	www.liveandworkwell.com Access code: enloe
LifeBalance	EE Discount Program	888.754.5433	Enloe.LifeBalanceProgram.com

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Note: Beginning January 1, 2022 the "No Surprises Act" provides protections against surprise billing for emergency services, air ambulance services, and certain services provided by a non-participating provider at a participating facility. For these services, the member's cost are generally limited to what the charge would have been if received in-network, leaving any balance to be settled between the insurer and the out-of-network provider. Consult your health plan documents for details.

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

GLOSSARY

High Deductible Health Plan (HDHP)
A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more, or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

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 care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

REQUIRED PLAN NOTICES

AVAILABILITY OF PRIVACY PRACTICES NOTICE

We maintain the HIPAA Notice of Privacy Practices for Enloe Medical Center describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Human Resources.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in an Enloe Medical Center plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in an Enloe Medical Center plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in an Enloe Medical Center plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law. **Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.**

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

AVAILABILITY OF SUMMARY INFORMATION

As an employee, the health benefits provided by Enloe Medical Center represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Enloe Medical Center offers a variety of benefit plans to eligible employees. The federal health care reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered by Enloe Medical Center are available on our website.

MEDICARE PART D NOTICE

Important Notice from Enloe Medical Center 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 Enloe Medical Center and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage.
All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Enloe Medical Center has determined that the prescription drug coverage offered by Enloe Medical Center is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your Enloe Medical Center coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Important Note for Retiree Plans: Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed. Since the existing prescription drug coverage under Enloe Medical Center is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage. If you do decide to join a Medicare drug plan and drop your Enloe Medical Center prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 Enloe Medical Center and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact the Benefits Department listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Enloe Medical Center changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 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).

Date:	January 2024
Name of Entity/Sender:	Enloe Medical Center
Contact-Position/Office:	MedImpact Healthcare Systems, Inc.
Address:	10181 Scripps Gateway Ct. San Diego, CA 92131
Phone Number:	888.265.7422

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 you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Part A: General Information

This notice provides you with information about Enloe Medical Center 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, contact the Health Insurance Marketplace directly at www.Healthcare.gov.

What Is The Health Insurance Marketplace?

The Marketplace offers "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.

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 9.86% (for 2019) and 9.78% (for 2020) 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.

Employer name: Enloe Medical Center
Employer Identification Number (EIN): 94-1603784
Employer address: 1531 Esplanade Chico, CA 95926
Employer phone number: 530.332.7344
Who can we contact about employee health coverage at this job?
Ann Welch, HR Benefits Coordinator
Phone number (if different from above): 530.332.7090
Email address: ann.welch@enloe.org

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility—

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

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov | KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 | Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 617-886-8102
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: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
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: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

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

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

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, 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 approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2024)

NOTICE INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS AND NONDISCRIMINATION STATEMENT:

Discrimination is Against the Law

Enloe Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Enloe Medical Center does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Enloe Medical Center

- Provides free aids and services with disabilities to communicate effective with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- 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 Shannon Smith. If you believe that Enloe Medical Center 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:

Shannon Smith, VP of Human Resources
1531 Esplanade Chico, CA 95926
Telephone Number: 530.332.7091
Email: Shannon.Smith@enloe.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Carol Linscheid 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 https://www.hhs.gov/ocr.

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-301-5522.
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 1 – 855-301-5522
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-301-5522.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-301-5522번으로 전화해 주십시오.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-301-5522.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-301-5522.
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-301-5522 (رقم هاتف الصم والبكم: 1-xxx-xxx-xxxx).
French Creole (Haitian Creole)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-301-5522.
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-301-5522.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-301-5522.
Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-301-5522.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-301-5522.
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。1-855-301-5522 まで、お電話にてご連絡ください。
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-301-5522.
Persian (Farsi)	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-301-5522 تماس بگیرید.

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 under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally 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 his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or,
- You become divorced or legally separated from your spouse.

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

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

When Is COBRA Continuation Coverage Available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee; 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.

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, no later than the date specified in the election form, and properly addressed 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 the 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.

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.

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, 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.

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.

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), has jurisdiction with respect to the COBRA continuation coverage requirements of the Public Health Service Act (PHSA) that apply to state and local government employers, including counties, municipalities, public school districts, and the group health plans that they sponsor (Public Sector COBRA). COBRA can be a daunting and complex area of federal law. If you have any questions or issues regarding Public Sector COBRA, you may contact the Plan Administrator or email HHS at phig@cms.hhs.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.

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.

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), has jurisdiction with respect to the COBRA continuation coverage requirements of the Public Health Service Act (PHSA) that apply to state and local government employers, including counties, municipalities, public school districts, and the group health plans that they sponsor (Public Sector COBRA). COBRA can be a daunting and complex area of federal law. If you have any questions or issues regarding Public Sector COBRA, you may contact the Plan Administrator or email HHS at phig@cms.hhs.gov.

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.

DETERMINING ELIGIBILITY

Employee Eligibility: Look-Back Measurement Period

The information below explains in detail how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA).

Look-Back Measurement Method

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee who works on average 130 hours per month. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. Enloe Medical Center uses the look-back measurement method to determine group health plan eligibility.

New employees hired to work full-time. If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for group health plan coverage as of .

New employees hired to work a part-time, variable hour or seasonal schedule. If you are hired into a part-time position, a position where your hours vary and Enloe Medical Center is unable to determine — as of your date of hire — whether you will be a full-time employee, or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of 12 Months. Your IMP will begin on 1st of the month following Date of Hire. If, during your IMP, you average 130 or more hours a month, you will become full-time and, if otherwise eligible for benefits, you will be offered coverage January 1. Your full-time status will remain in effect during an associated stability period that will last 12 Months. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

Ongoing employees. An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12 Months period during which Enloe Medical Center counts employee hours to determine which employees work full-time. Those employees who average 130 or more hours a month over the standard measurement period will be deemed full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect during an associated stability period for 12 Months. If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

Enloe Medical Center uses the standard measurement period and associated stability period annual cycle set forth below:

Measurement Period: Time to determine if you work 130+ hours per month on average – used to establish if you are "full-time" or "part-time" for medical eligibility	October 1 to October 1
Stability Period: Time during which you will be considered "full-time" or "part-time" for medical plan eligibility - based on hours worked during preceding Measurement Period	January 1 to January 1

NOTES

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