SAN YSIDRO HEALTH

SYHealth Benefits Information Guide

May 1, 2024-April 30, 2025

Your Experience, Your Rewards

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Welcome To Your 2024-2025 Benefits

At San Ysidro Health, we value our employees and the dedication provided on a daily basis to serve the 145,000 patients under our care. In turn, we know how important good health benefits are to you and the organization to attract and retain the best talent. This is why offering innovative high-quality benefit programs remain among our highest priorities at San Ysidro Health.

We are pleased to provide a benefits package that gives you flexibility, protection, and security that best meet your needs. Take advantage of the tools and resources that Sharp and SIMNSA provide. Through this open enrollment period, I encourage you to thoroughly review all benefit options available to you. As we work to prioritize the health above all. Keep this guide available for future reference and utilize the many benefits that are offered as a member of Team San Ysidro Health.

Thank you for your many contributions to San Ysidro Health.

Sincerely,
Kevin Mattson
President and CEO

In 2024-2025, San Ysidro Health employees will have access to the following benefits:

Medical:

- Sharp + Nonstop Health
- SIMNSA medical plan

Acupuncture and chiropractic care (*Sharp Health Plan members only*):

- Landmark
- SYHealth Chiro + Acupuncture

Dental:

- UMR dental plans
- SIMNSA dental plan

Vision: EyeMed

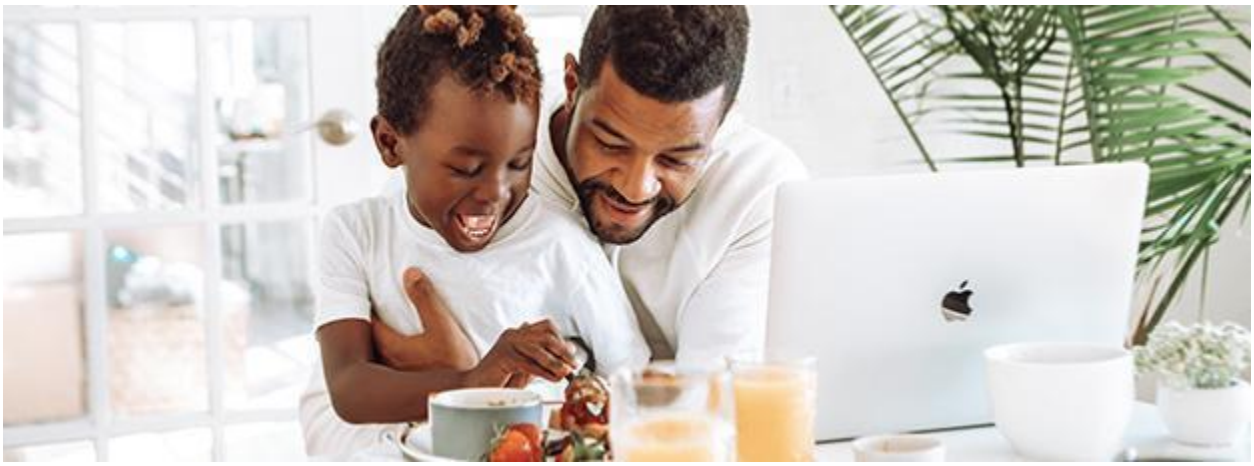
Supplemental:

- **Life/Accidental Death & Dismemberment**: Reliance Standard
- **Long Term Disability**: Reliance Standard
- **Emergency Travel:** Reliance Standard
- **Employee Assistance Program (EAP)**: Aetna Resources for Living
- **Flexible Spending Account**
- **Voluntary benefits** via Colonial Life: (accident, disability, cancer assist, critical illness, whole life, term life)
- **Additional benefits**: LegalShield, FunExpress, TicketsatWork
- **Wellness Plan**

Retirement:

- 162-Bonus plan
- 403(b)

This guide contains information about all your benefits. You can also view each benefit individually or watch videos about each benefit by visiting syhealth.nonstophealth.com or by using the QR code.



Eligibility

Benefit Eligible Employees

Employees working **20** hours or more per week are eligible to participate in the benefit program.

Eligible Dependents

Your eligible dependents include:

- Your spouse (unless you are legally separated)
- Your registered domestic partner
- Your dependent children, up to age 26 regardless of their student or marital status
- Adopted, foster or domestic partner's children
- Your dependent children, if they are incapable of self-support due to physical or mental disability

Coverage may be available for a mentally or physically disabled child who is age 26 or older. Requirements for such coverage and documentation of disability depend on the insurance carrier. Please contact benefits@syhealth.org if you believe this applies to your family.

When You Can Enroll

New Hires/Newly Eligible for Benefits

You are eligible for benefits on the first day of the month after 30 days worked. **You have 30 days from the date of your hire to enroll in benefits.** After your initial enrollment, you will have the opportunity to re-enroll in the benefits program each year during the Annual Open Enrollment period, unless you have a Qualifying Life Event. Be prepared to show documentation for qualifying event, such as marriage license, birth certificate or divorce decree.

Qualifying Life Event Change

During the annual open enrollment period, you will have the opportunity to make any changes in your coverage(s) for the next plan year.

Please keep in mind that you will have 30 days from the event date to make any changes and notify the Benefits Team of any changes.

Plan year begins May 1, 2024 and is in effect through April 30, 2025.

After the annual enrollment period, you will only be able to change your coverage if you have a qualifying life event. Qualifying life events include, but are not limited to:

- Change in your employment status (commencement, termination, reduction in hours from full-time of 20 hours/week to part-time 19 hours or less or vice versa) or change to per diem employment
- Change in marital status (marriage, death of spouse, divorce, legal separation)
- Change in dependents (birth, death, adoption, and child support order)
- Special enrollment rights under Health Insurance Portability Accountability Act (“HIPAA”)
- Medicare or Medicaid entitlement for you, your spouse, or dependent (60 days)

When Coverage Ends

If your employment at San Ysidro Health ends, your medical, dental, and vision coverage will end on the last day of the month of your termination date. Other circumstances which may result in termination of coverage for you and/or your dependents include: reduction in regular hours, divorce/legal separation, and dependent children who reach age 26. Your FSA will terminate on the date of termination.

Your Medical Plan Options

San Ysidro Health recognizes that you have different needs when it comes to your medical coverage. Each plan provides a different level of affordability and flexibility, allowing you the opportunity to select the one that best fits your lifestyle and provides the protection you need. We offer the following medical plans services:

- Sharp HDHP HMO Plan with Nonstop Health *(Nonstop Health only works with the Sharp HDHP HMO Plan)*
- SIMNSA Cross Border HMO

Using the Sharp HDHP HMO Plan with Nonstop Health

Sharp is a medical carrier that coordinates all of your care as far as doctor visits, prescriptions, surgeries and emergency services. San Ysidro Health is proud to offer the Sharp plan + Nonstop Health as an option for your healthcare coverage. Nonstop Health is a type of high deductible healthcare program that allows San Ysidro Health to fund a portion of our employees' healthcare premiums and out-of-pocket expenses while also saving on premium expenses annually. The Nonstop Health program provides you, the member, with a pre-loaded Visa card to pay for in-network, carrier-approved medical expenses through Sharp only. **If you are referred out of the Sharp network, please contact Nonstop Health at 877-626-6057.**

Please note that Nonstop Health only works with the Sharp HDHP HMO Plan. It does not work with the SIMNSA Health Plan and cannot coordinate with any other health plans.

Using the SIMNSA HMO Plan

For those who prefer to receive their quality health care services and coverage in Mexico, SIMNSA's plan may be best for you. SIMNSA requires that only Mexican Nationals (a person born in Mexico, a person born in another country with a Mexican father or a Mexican mother, or both, a foreign woman or man who marries a Mexican man or woman and lives in Mexico, or a foreigner who becomes a naturalized citizen in Mexico) enroll in the Plans. When you select the SIMNSA Health

Maintenance Organization (HMO) plan, you must receive all of your care in Mexico by SIMNSA providers. Generally, the SIMNSA HMO will function as follows:

- A Primary Care Physician (PCP) will direct the majority of your health care needs, and is responsible for referring you to Specialists
- Services may require a fixed-dollar payment up front, referred to as a copayment
- You do not have to submit claim forms to your insurance company
- The only services that may be covered in the U.S. are true medical emergencies and urgent care, as described in your plan documents

A summary of covered services under the SIMNSA HMO plan is listed on page 22. For a complete listing of covered services for the plan, please refer to your Evidence of Coverage (EOC) document in the Member Documents section of the Nonstop Exchange.

Plan Guidelines and Summary of Benefits

The benefit summaries listed on the following pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, including your Summary of Benefits Coverage (SBC) and Summary Plan Description (SPD), please refer to the HR Intranet. The Summary Plan Description (SPD) is the binding document between the elected health plan and the member.

Sharp Provider Network

To best serve your unique needs, we'd like to explain two of the most commonly chosen Sharp medical group options you have available. **You are free to change this selection at any point in the future.**

Here's a handy overview of the two most common medical networks:

Sharp Rees-Steely

- Operates under a clinic model
- Physicians are employees of Sharp Rees-Steely
- Most specialists, clinics, prescriptions, and labs are located in a single building

Sharp Community Medical Group

- Operates under a medical group model
- Physicians are independently employed
- Labs, prescriptions, specialists, and medical offices are often in different locations

Remember: If you choose to utilize the Sharp Rees-Steely provider group, you will not have access to the Sharp Community Medical Group and vice versa.

How To Select Your Medical Network

When you first enroll, if you choose a Primary Care Provider (PCP), you will need to list their National Provider Identifier (NPI) number in Dayforce. You can find the NPI through the Sharp website. As a San Ysidro Health employee, you are on the Sharp "Performance" network. If you do not select a PCP at the time of enrollment one will be assigned to you based on your home address. You can change this PCP choice anytime by contacting Sharp.

No matter which provider group you choose, using the Nonstop Health program is simple and straightforward! Just remember our three golden rules:

- Stay in-network and in your provider group for all services and prescriptions
- Use your Nonstop Visa card to help pay for in-network, carrier-approved expenses
- Give us a call if you have any questions or run into any issues

To learn more about the networks available to you, please visit www.sharphealthplan.com.

Sharp + Nonstop Health Summary

The Sharp HDHP HMO Plan is your underlying medical plan. The table below is an overview of services covered by the Nonstop Health (NSH) Visa card; please see full Summary of Benefits Coverage (SBC) from Sharp on the HR Intranet. Preauthorization is required for some services. **As a reminder, use your Nonstop Visa card to pay for in-network, carrier approved medical services and prescriptions.** There is a $100 Nonstop Health copay for all Emergency Room visits (which is waived if admitted) and this copay is NOT covered under the Nonstop Health program. It will be your responsibility to pay.

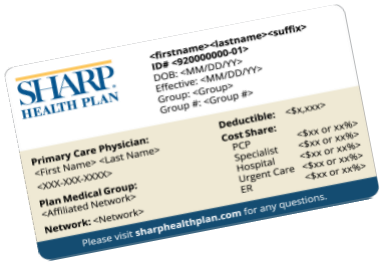
Plan Highlights	In-Network	Out-of-Network
Calendar Year Annual Deductible		
Individual / Family	Covered by Nonstop Visa card ($4,500 / $9,000)	Not covered
Calendar Year Out-of-Pocket Maximum		
Individual / Family	Covered by Nonstop Visa card ($6,350 / $12,700)	Not covered
Lifetime Maximum		
Individual	None	None
Professional Services	**You Pay**	
Primary Care Physician (PCP)	Covered by Nonstop Visa card	Not covered
Specialist	Covered by Nonstop Visa card	Not covered
Preventive Care Exam	Covered by Nonstop Visa card	Not covered
Maternity Services	Covered by Nonstop Visa card	Not covered
Diagnostic X-ray and Lab	Covered by Nonstop Visa card	Not covered
Complex Diagnostics (MRI / CT Scan)	Covered by Nonstop Visa card	Not covered
Therapy, including Physical, Occupational & Speech	Covered by Nonstop Visa card	Not covered
Hospital Services		Not covered
Inpatient*	Covered by Nonstop Visa card	Not covered
Outpatient Surgery	Covered by Nonstop Visa card	Not covered
Emergency Room (if not admitted to hospital)	$100 copay by member	$100 copay
Urgent Care	Covered by Nonstop Visa card	Not covered
Mental Health & Substance Abuse		
Inpatient	Covered by Nonstop Visa card	Not covered
Outpatient – Individual	Covered by Nonstop Visa card	Not covered
Outpatient – Group	Covered by Nonstop Visa card	Not covered
Prescription Drugs		
Preferred generic	Covered by Nonstop Visa card	Not covered
Preferred brand	Covered by Nonstop Visa card	Not covered
Non-preferred brand	Covered by Nonstop Visa card	Not covered

Information about Nonstop Health

With Nonstop Health, you will receive two cards in the mail after you enroll: your carrier identification card from Sharp Health Plan and your Nonstop Visa card from Nonstop Administration and Insurance Services, Inc. (Nonstop). Cards should be received within 7–10 business days after enrollment. During heavy enrollment periods, cards may take up to 4 weeks to be processed and delivered.

How to Use Your Health Plan Card vs. the Nonstop Visa Card

Sharp Health Plan ID Card



The carrier card comes from Sharp Health Plan, and includes information relevant to the HDHP.

You must present the carrier ID card from Sharp Health Plan during every doctor visit and for prescription purchases. This is important to ensure that Sharp Health Plan is apprised of the charge and properly credits your services towards your in-network deductible/out-of-pocket maximum.

Nonstop Visa Card

The Nonstop Visa card comes from Nonstop and can be used to pay for in-network, carrier approved medical services and prescriptions, up to the allowed amount for your plan.

You cannot use the Nonstop Visa card to purchase over the counter drugs.

You will receive two Nonstop Visa cards and they will both only be in your name. If you need additional cards, please call us at 1-877-626-6057.

We recommend that you DO NOT set up a PIN as this will only allow you to use the card as a debit card and not a credit card.

How Do I Use Nonstop Health at My Provider or Pharmacy?

If/when you receive a bill for in-network services, please pay that bill with your Nonstop Visa card.

Please note!

- The Nonstop Visa card works with digital wallets such as Apple Pay, Google Pay, and Samsung Pay. With just four quick steps you can connect your Nonstop Visa card to any of these services. So even if you forget your card at home, you don't need to worry! You can simply tap your phone or mobile device and be on your way.
- Nonstop Health is only designed for medical services and prescriptions. As such, you cannot use the Nonstop Visa card for dental or vision payments.
- You will be responsible for any out-of-network or unapproved charges on the card.
- If you receive a reimbursement check from your carrier or a provider, please know that money needs to be re-deposited back into your employer's account with Nonstop. We request that you endorse the check and mail it to Nonstop at 1800 Sutter St. Suite 730, Concord, CA 94520
- There is a $100 Nonstop Health copay for all Emergency Room visits (which is waived if admitted) and this copay is NOT covered under the Nonstop Health program. It will be your responsibility to pay out of pocket. To make a payment to Nonstop Health please contact us at clientsupport@nonstophealth.com or by phone (877)626-6057

What are some good tips and tricks I should know about?

Make sure any <u>provider, facility, prescription, and/or service</u> you use is considered in-network for your medical plan; it is better to call ahead and check on this before receiving services or filling a prescription.

Don't go out-of-network for services or prescriptions <u>unless</u> you have written permission from Sharp Health Plan and confirmation that those expenses will be counted towards your in-network deductible.

Medical discount or coupon programs may not allow prescription/service costs to be applied towards your plan's in-network deductible, which means that these expenses would not qualify for Nonstop Health. If this happens, you will be responsible for covering those costs. We recommend checking in with Sharp Health Plan before accessing a discount/coupon program.

If you have to prepay for a service, **please do not pay more than $1,000**; if the provider requires a larger prepayment, call Nonstop and we will pay the provider directly.

Cosmetic surgery <u>is not covered</u> unless Sharp Health Plan deems it medically necessary.

If you are having surgery or a procedure that involves multiple providers, **please confirm with your doctor and/or Sharp Health Plan that everyone on the team is an in-network provider**. If anyone is out-of-network, please require your provider to find an in-network alternative before proceeding with the surgery/procedure.

If you require **medically-necessary ophthalmology or dental procedures** and Sharp Health Plan has approved it as part of your medical plan, please know that you will not be able to use your Nonstop Visa card to pay for services as they will be coded for vision or dental. Please call Nonstop before your procedure and we will help pay the provider directly.

There are times your provider may prescribe you durable medical equipment (DME), such as a CPAP machine or wheelchair. As long as your prescribing doctor is in-network and the DME being prescribed is covered under your medical plan, you can use Nonstop Health to pay for it. However, Nonstop recognizes that some carriers may take longer to process DME items and we don't want you to have to wait to fill your prescriptions. As such, we offer a pre-approval process for DME items, which will allow you to access prescribed and approved DME items when you need them. To learn more, please contact Nonstop's Member Support Team at 877.626.6057 or clientsupport@nonstophealth.com.

Coverage Under the Nonstop Health Plan

The Nonstop Health program only works with in-network providers/facilities and covered services and prescriptions. But what exactly does this mean?

Key Terms

Let's start by reviewing key terms that you'll read, see or hear about with Nonstop Health.

In-network: Providers that are in-network are those that have a contract with Sharp Health Plan, and have set up a pre-negotiated rate for different services. As such, the provider can only charge Sharp Health Plan – and you – a set price for the services you receive. This results in lower costs, as in-network providers almost always charge less than an out-of-network provider.

Covered services: A covered service is one that Sharp Health Plan has agreed to pay for under your medical plan. Not all services are covered by every plan, so before receiving a new service please check with your carrier first. Sharp Health Plan may have a cost or visit limit for specified services, or other limitations.

Covered prescriptions: Your carrier will set a "formulary" or drug list at the beginning of each plan year, which lists what prescriptions will be covered under your medical plan. Just because a doctor prescribes you a medication doesn't mean it's automatically covered by Sharp Health Plan! So before paying for a new prescription, be sure to call Sharp Health Plan or ask your pharmacist if it's covered.

Carrier-approved: A carrier-approved service or prescription is one that Sharp Health Plan has agreed to cover as part of your underlying medical plan. This includes covered services and prescriptions. However, it also can indicate that Sharp Health Plan has given you explicit/written permission to see an out-of-network provider for services and agreed that those costs will be considered in-network and covered under your plan.

Examples of What Nonstop Health Covers – And What It Doesn't

COVERED EXPENSES

Nonstop Health can be used to pay for all services and prescriptions that are covered under your medical plan. In essence this means that if Sharp Health Plan has agreed to pay for a medical service or prescription as part of your medical coverage, then you can use your Nonstop Visa card to pay for it. If Sharp Health Plan does not cover a service or prescription, then you will be responsible for 100% of those costs. If you're not sure if a service or prescription is covered, check your Summary of Benefits and Coverage (SBC) or contact Sharp Health Plan before receiving care.

NON-COVERED EXPENSES

Because medical plans cover services and prescriptions differently, there's not an exhaustive list of where you can/can't use your Nonstop Visa card. **But below are a few examples of services/providers/ facilities that are never covered by Nonstop Health.** This is only a sample – if you are not sure if a service or prescription is covered, please check with Sharp Health Plan.

• Amazon.com or FSA/HSA store • BetterHelp • Weight Loss Programs • FullScripts	• FreeSpira • Massage Envy • Carex • HSAStore.com	• PeopleCare • TalkSpace • Hero Health

As a general rule the Nonstop Visa card cannot be used for the following:

- Over the counter medication, vitamins or supplements
- Dental services
- Vision services
- Services and medications not approved by Sharp Health Plan
- Durable Medical Equipment (DME) that is not approved by Sharp Health Plan
- Alternative care that is not approved by Sharp Health Plan
- Mental health services not approved by Sharp Health Plan
- Feminine hygiene products

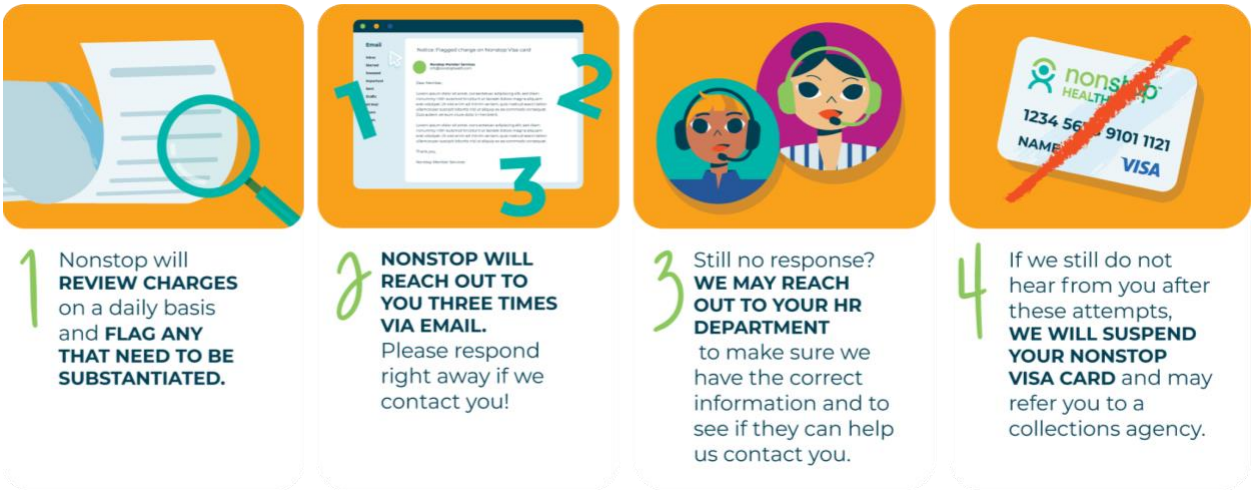
Nonstop Visa Card Substantiation Policy

You may use the Nonstop Visa card for carrier-approved, in-network services and prescriptions, up to the allowed amount for your plan. The card may not be used for out-of-network or elective procedures or anything that Sharp Health Plan would not apply towards your in-network deductible and out-of-pocket tracking. In addition, the Nonstop Health program does not cover dental or vision costs so you cannot use your Nonstop Visa card to pay for these services.

Charges on your card may need to be substantiated to ensure they are in-network and carrier-approved. Substantiation simply means that we are confirming acceptable use of your Nonstop Visa card. **Nonstop reserves the right to ask you for documentation to confirm that the charges on the card were allowed and approved by Sharp Health Plan, and counted towards your deductible and out-of-pocket tracking.** Documentation typically includes an Explanation of Benefits (EOB). For a detailed breakdown of how to read your Sharp Explanation of Benefits (EOB), please click here.

If charges on your Nonstop Visa card cannot be substantiated and/or have not been approved by Sharp Health Plan, we may request that you repay the amount that does not qualify for the Nonstop Health program back into your employer's healthcare plan. If we do not receive documentation or repayment, your card may be suspended and you may be referred to a collections agency. However, before this happens we want to work directly with you to investigate the charge and determine what, if any, errors may have occurred.

THE PROCESS IS AS FOLLOWS:



Please note: in our message, we cannot include personal health information due to HIPAA compliance regulations. We will simply ask you to call us back or respond to our email.

Key Dates and Deadlines

When using the Nonstop Health program there are some key dates and deadlines that apply to the Nonstop Visa card as well as the Nonstop claims process. Please read this information carefully so you don't miss any critical deadlines for reimbursement! If you need to submit a claim manually, please visit www.nonstophealth.com/claims.

	**The Nonstop Visa card begins upon enrollment:** The Nonstop Visa card cannot be used for claims prior to your enrollment in the Nonstop Health program. In other words, if you first enrolled in the Nonstop Health plan on May 1, 2024, you cannot use the card to pay for claims with dates-of-service prior to this date (e.g., April 14, 2024).
	**The Nonstop Visa card can only be used within the current calendar year:** The Nonstop Visa card should not be used to pay for outstanding claims from the prior calendar year, as the Nonstop Visa card can only be used in the same year as the services were rendered. For example, 2024 medical services must be paid for using the Nonstop Visa card in 2024; once the date turns to January 1, 2025, you cannot pay for 2024 expenses with the Nonstop Visa card. Instead, any outstanding claims/costs from the prior calendar year should be submitted manually to Nonstop.
	**Claims submission deadlines while enrolled in Nonstop Health:** All Nonstop Health claims must be submitted no later than 90 days after the end of the calendar year. As such, all 2024 claims are due by or **before March 31, 2025**.
	**January 1 resets out-of-pocket maximums (OOPM) and deductibles amounts:** All carrier plan deductible and OOPM maximum calculations are based on a calendar year and reset to $0 every January 1. So, if your renewal date is May 1, your deductible still runs January to December. The Nonstop Visa card also resets on January 1.
	**Claims deadlines when benefits and/or employment is terminated:** If you leave your employer or are no longer benefits eligible, you are required to submit all past claims to the Nonstop Health office within **90 days** of your last day of coverage. Your Nonstop Visa card will be cancelled on your last day of coverage and all services performed before the last day of coverage should be submitted manually.

Using the Nonstop Exchange Member Portal

Once you are enrolled with Nonstop Health, you will be able to access your plan information via the Nonstop Exchange member portal (members.nonstophealth.com). When you log into the system all your information will be available, allowing you to:

- View available card balances
- View demographic information
- View documents about your plan (e.g. summary plan description, benefits summary)
- Navigate to our member help site through the HELP button, where you can find fast answers to questions
- File and view claims submissions

As a reminder, please refer to the Member Documents tab in the Nonstop Exchange (NSE) member portal to access and view all complete plan summaries for your medical benefits. All legal and compliance-related notices will also be located under the Member Documents tab in NSE.

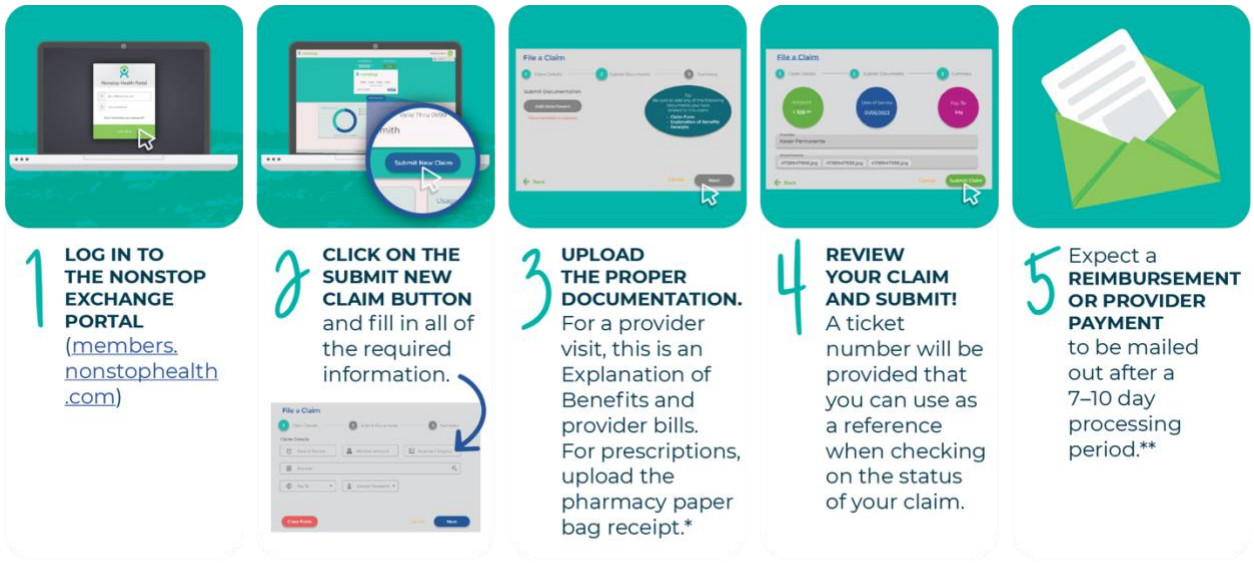
Logging into the NSE for the first time

1. Using the Chrome internet browser, go to members.nonstophealth.com. Click on "Don't Remember Your Password?" on the login page and enter your email address (If you're unsure about what email to use, contact Nonstop). You will be emailed a link to set a personal and private password.
2. Then come back to members.nonstophealth.com and re-enter your email and new password.
3. When you log in for the first time you must go through our two-factor authentication process. You will be asked to enter your mobile phone number, and then a six-digit code will be texted to you. Enter that code to log into NSE. A second "backup" code will be provided when you log in and we recommend writing down or taking a picture of this backup code. If you're using a trusted computer/browser, you can click "Remember This Browser" to bypass two-factor authentication for 30 days. If you don't have a mobile phone number, please contact us!

Submitting a Claim to Nonstop

While the Nonstop Health program is set up to help you pay for a portion of your medical expenses, there may be times when you'll need to pay up front and be reimbursed later. If needed, the claims submission process is quick and easy with reimbursement checks typically processed within 7 to 10 days of submission.

SUBMITTING A CLAIM AT-A-GLANCE



* For a claim to be processed, the service date you enter on the first page must match the date stated on the uploaded documentation.
** During the peak claims season of December 1–April 1, it may take 14–20 days for Nonstop to process your claim.

Alternatively, you can submit a claim manually by filling out a claims form and emailing it or faxing it to Nonstop. Please visit www.nonstophealth.com/claims for a claims form.

What If My Reimbursement Check Doesn't Arrive?

In the rare instance that a payment or reimbursement check is lost, Nonstop will re-issue a check after 30 days and confirmation from the service provider that they have not received payment.

How Can I Track A Claim or Reimbursement?

If the claim is submitted via Nonstop Exchange, it will appear as a pending claim on your dashboard. When you submit a claim via email, a ticket number will be assigned to that claim and you'll receive a confirmation response. If claims were submitted via fax or through the US Postal System, you will need to contact Nonstop Health at 877-626-6057 or via email at claims@nonstophealth.com for details on if the claim was received or has been paid.

What Happens If Nonstop Pays My Provider Directly?

When a bill has been paid by Nonstop, you will not receive a notification from Nonstop that payment has been made. If you continue to receive bills from providers after a claims submission to Nonstop Health, it is recommended that you follow up with the Nonstop Health team directly. The bill has likely been paid, but has not been credited to your account with your provider yet.

Chiropractic/Acupuncture Benefits – Landmark Healthplan

San Ysidro Health has contracted with Landmark Healthplan of California, Inc. (Landmark) to provide you with a combined chiropractic and acupuncture benefit that requires the use of participating Chiropractors and Acupuncturists. As such, you must use a Landmark contracted provider to access this benefit. Landmark will not pay for services accessed through an out of network provider and you would be responsible to pay the amount due.

TO FIND A LANDMARK CONTRACTED PROVIDER:

1. Visit www.LHP-CA.com and select "Find a Provider" (plan name is Landmark Healthplan) or call Landmark Customer Service at 1-800-298-4875
2. **Let the provider know you are enrolled in Landmark Expanded benefits** and provide them with your name, date of birth, and your group number so they can verify eligibility with Landmark
3. **If the provider asks you for a copay, please have them contact Landmark directly** as you do not have a copay for these services; we recommend you clarify this with the provider before your appointment

Summary of Chiropractic and Acupuncture Benefits

Please note that you can only use your Nonstop Visa card to pay for x-ray, DME, and herbal therapy costs that are covered under the Sharp Health Plan and received at in-network providers and facilities.

Coverage Type	Benefits snapshot (in-network coverage)
Office Visit	$0 copay
Maximum Annual Visits	30 visits per enrollee
X-ray Services*	$75 annual maximum benefit
Emergency Care**	Same copayment as office visit
Durable Medical Equipment (DME) Purchase or Rental***	$50 annual maximum benefit
Acupuncture Herbal Therapies******	$5 copayment per bottle / $500 annual max benefit

* X-ray Services must be prescribed by a Participating Chiropractor

** Services provided by Non-Participating Practitioners are covered for Emergency Services only

*** Durable Medical Equipment must be prescribed by a Participating Chiropractor

**** Herbal therapies must be prescribed by a Participating Acupuncturist

SYHealth Chiropractor and Acupuncture

As an additional company paid benefit, SYHealth employees with the Sharp Medical Plan may receive a total of up to 30 (combined) Chiropractic and Acupuncture visits from SYHealth providers, at a $0 co-pay, per plan year, which is May 1, 2024, through April 30, 2025. This benefit applies to the employee only and does not extend to covered dependents and is **completely separate** from the Landmark Health Plan benefit.

Employees should contact the SYHealth Call Center at (619) 662-4100 to schedule appointments.

Summary of Chiropractic and Acupuncture Benefits

Coverage Type	Benefits snapshot (in-network coverage)
Office Visit	$0 copay
Maximum Annual Visits	30 visits per SYHealth employee enrolled with Sharp

SIMNSA HMO Plan

Please note that this plan is not covered by Nonstop Health. Below is an overview of services covered; please see full Summary of Benefits Coverage (SBC) from SIMNSA on the HR Intranet.

Plan Highlights	SIMNSA HMO In-Network Only
Annual Calendar Year Deductible	
Individual / Family	None
Maximum Calendar Year Out-of-pocket[(1)]	
Individual	$6,350 / $12,700
Lifetime Maximum	
Individual	Unlimited
Professional Services	
Primary Care Physician (PCP)	$5 Copay
Specialist	$5 Copay
Preventive Care Exam	No Charge
Well-baby Care	No Charge
Diagnostic X-ray and Lab	No Charge
Complex Diagnostics (MRI / CT Scan)	No Charge
Therapy, including Physical, Occupational and Speech	$10 Copay
Hospital Services	
Inpatient	No Charge
Outpatient Surgery	No Charge
Emergency Room	$250 Copay
Urgent Care	USA: $50 Copay; Mexico: $25 Copay
Maternity Care	
Physician Services (prenatal or postnatal)	$5 Copay
Hospital Services	No Charge
Mental Health & Substance Abuse	
Inpatient	No Charge
Outpatient	$5 Copay
Retail Prescription Drugs (30-day supply)	
Medically Necessary, obtained at participating pharmacy	$10 Copay
Mail Order Prescription Drugs (90-day supply)	
Medically Necessary, obtained at participating pharmacy	Not Covered

[(1)] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider. The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Dental Benefits – UMR and SIMNSA

You have three options for dental coverage:

- UMR Basic Dental PPO Plan
- UMR Premier Dental PPO Plan
- SIMNSA Cross Border Dental HMO

The Basic UMR Dental PPO Plan requires that you only receive care from a San Ysidro Health Dental provider. Services from non-San Ysidro providers will not be covered. Contact San Ysidro Health to make an appointment by calling our customer service line at 619-662-4100.

The Premier UMR Dental PPO Plan allows you access to two tiers of providers: San Ysidro Health Dental providers and UMR and non-network providers. You will receive greater benefits when seeing a San Ysidro Health dentist. To find a provider within the UMR network, you may visit their website at www.umr.com. Be sure to select the "UnitedHealthcare Dental PPO" Network and follow the website instructions to access a list of contracted providers.

UMR Plan Overview

Below is an overview of both UMR dental plans. The below is an overview of services covered; please see full Summary of Benefits Coverage (SBC) from UMR on the HR Intranet.

UMR Basic Dental Plan			UMR Premier Dental Plan	
	San Ysidro Health Dental Providers Only	**Out-of-Network (With Referral ONLY) (1)**	**San Ysidro Health Dental Providers Only**	**UHC and Non-Network Providers**
Calendar Year Deductible				
Per Person	None	$50	None	$50
Family Maximum	None	$150	None	$150
Annual Plan Maximum				
Annual Maximum Benefit	$1,500	$1,500	$2,500	$2,500
Covered Services				**After Deductible**
Class 1 (preventive care)	100%	80%	100%	100%
Class 2 (repair & restoration)	100%	80%	100%	80%
Class 3 (major services)	100%	80%	100%	50%
Orthodontia Services				**1 Year Waiting Period**
Child(ren) to Age 26 & Adults	N/A	N/A	N/A	50%
Calendar Year Deductible	N/A	N/A	N/A	$50 per person
Orthodontic Maximum				$2,500 Lifetime Maximum

The **SIMNSA Dental HMO** plan requires that you receive care from a primary care dentist who participates in the SIMNSA network. If you receive services from a provider outside of the approved

network, you will be responsible for paying the entire dental bill yourself. When seeking care, you will be charged a copayment for each service received.

Refer to your SIMNSA plan documents for a detailed listing of copayments. To find a contracted provider, go to www.simnsa.com or call 800.424.4652. SIMNSA requires that only Mexican Nationals enroll in the plan. Mexican nationals by birth are: people born on Mexican territory regardless of their parent's nationality, people born abroad to at least one parent who is a national of Mexico. people born on Mexican vessels or aircraft that are either for war or merchant

SIMNSA Plan Overview

The below is an overview of services covered; please see full Summary of Benefits Coverage (SBC) from SIMNSA on the HR Intranet.

Plan Highlights	SIMNSA Dental HMO In-Network Only
Calendar Year Deductible / Annual Maximum	None
Preventive (1)	
Examinations	No Copay
X-rays	No Copay
Cleanings	No Copay
Basic Services	
Amalgam Fillings (only)	$5 – $15 Copay
Oral Surgery (2)	$8 – $50 Copay
Root Canal – Molar	$30 – $50 Copay
Major Services	
Bridges (3)	$10 – $70 Copay
Complete Dentures (upper / lower)	$63 Copay
Crown - Full Cast Porcelain / Acrylic / Non-Precious Metal (3)	$15 – $50 Copay
Orthodontia Services (4)	
Children to age 26 & Adults	$50 Copay per Visit

(1) Age & Frequency Limits may apply; see your DHMO Schedule of Benefits for details

(2) Surgery involving multiple teeth may result in additional costs

(3) The use of noble metal is an additional cost

(4) SIMNSA DHMO orthodontic benefits cover consultation, all necessary appliances, banding and monthly office visits for 24 months. The treatment must be provided by a SIMNSA Panel Orthodontist. Orthodontic referrals must be submitted by the member's assigned dental provider and approved by SIMNSA dental. Additional start up fees may apply

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Vision Benefits – EyeMed

Vision coverage is offered through EyeMed as a Preferred Provider Organization (PPO) plan.

As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service.

However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount. Any questions pertaining to your vision coverage can be directed to EyeMed by calling 866.804.0982 or visiting their website, www.eyemed.com (choose INSIGHT Network).

Summary of Benefits

The below is an overview of services covered; please see the full Summary of Benefits Coverage (SBC) from EyeMed on the HR Intranet.

Plan Highlights	EyeMed Vision PPO – Insight Network	
	In-Network	Out-of-Network
Frequency		
Exam / Lenses / Contacts / Frames	Once Every 12 Months	
Exam		
Per Exam	$10 Copay	Up to $40 Reimbursement
Lenses		
Single	$25 Copay	Up to $30 Reimbursement
Bifocal	$25 Copay	Up to $50 Reimbursement
Trifocal	$25 Copay	Up to $70 Reimbursement
Frames		
Per Pair	Up to $130 Allowance + 20% off over allowance	Up to $91 Retail Reimbursement
Contacts (instead of glasses)		
Medically Necessary (not common)	No Copay	Up to $210 Reimbursement
Conventional / Cosmetic (hard contacts)	Up to $130 Allowance + 15% off over allowance	Up to $130 Reimbursement

SYHealth

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$10 copay	Up to $40
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $130 allowance	Up to $91
STANDARD PLASTIC LENSES		
Single Vision	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal	$25 copay	Up to $70
Lenticular	$25 copay	Up to $70
Progressive - Standard	$90 copay	Up to $50
Progressive - Premium Tier 1 - 3	$110 - 135 copay	Up to $50
Progressive - Premium Tier 4	$90 copay; 20% off retail price less $120 allowance	Up to $50
LENS OPTIONS		
Anti Reflective Coating - Standard	$45	Not covered
Anti Reflective Coating - Premium Tier 1 - 2	$57 - 68	Not covered
Anti Reflective Coating - Premium Tier 3	20% off retail price	Not covered
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$40	Not covered
Polycarbonate - Standard < 19 years of age	$40	Not covered
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid or Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $130 allowance	Up to $130
Contacts - Disposable	$0 copay; 100% of balance over $130 allowance	Up to $130
Contacts - Medically Necessary	$0 copay; paid in full	Up to $210
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing exam and aids; call 1.877.203.0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Exam	Once every 12 months from the date of service	Once every 12 months from the date of service
Frame	Once every 12 months from the date of service	Once every 12 months from the date of service
Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service
Contact Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service

(Plan allows member to receive either contacts and frame, or frames and lens services)

Employer Paid Benefits

(for employees working 20+ hours/week)

RELIANCE STANDARD
LIFE INSURANCE COMPANY

Long Term Disability (LTD) – Provided by Reliance Standard

If your disability extends beyond 60 days, Reliance Standard can replace 60% of your earnings, up to a maximum of $20,000 per month. Your benefits may continue to be paid until you reach age 65 as long as you continue to meet the definition of disability.

- **Defining Disability Coverage – Provided by Reliance Standard**
  - Benefit Period: Maximum amount of time you may receive proceeds for a continuous disability.
  - Commencement Date: The first day your disability is covered, which immediately follows the completion of the waiting period.
  - Waiting Period: The time you must wait before you are eligible to receive benefit payments.
- **Taxation Of Disability Coverage – Provided by Reliance Standard**
  - Because disability coverage is an employer-paid benefit and is available for employees at no cost, any disability payments made to you will be taxable.

Basic Life/Accidental Death & Dismemberment – Provided by Reliance Standard

The benefits outlined below are provided by Reliance Standard:

- Basic Life Insurance: 1.5 times annual earnings, up to $200,000
- AD&D: Equal to employee's Basic Life coverage amount

Note: An age reduction schedule applies to employees once they reach the age of 70.

IRS regulation: Employees can receive employer-paid life insurance up to $50,000 on a tax-free basis, and do not have to report the payment as income. However, an amount in excess of $50,000 will trigger taxable income for the "economic value" of the coverage provided to you.

Emergency Travel Assistance – Provided by Reliance Standard

Emergency Travel Assistance is provided by Reliance Standard, via an agreement with On Call International (On Call). On Call is a 24-hour, toll-free service that provides a comprehensive range of information, referral, coordination, and arrangement services designed to respond to most medical care situations and many other emergencies you may encounter while traveling. On Call also offers pre-trip assistance including passport/visa requirements, foreign currency, and weather information. The following is an outline of the On Call emergency travel assistance service program.

Covered Services

When traveling more than 100 miles from home or in a foreign country, On Call offers you and your dependents the following services:

- Pre-Trip Assistance
  - Inoculation requirements information
  - Passport/visa requirements
  - Currency exchange rates
  - Consulate/embassy referral
  - Health hazard advisory
  - Weather information
  - Emergency Medical Transportation*
  - Emergency evacuation
  - Medically necessary repatriation
  - Visit by family member or friend
  - Return of traveling companion
  - Return of dependent children
  - Return of vehicle
  - Return of mortal remains
- Emergency Personal Services
  - Urgent message relay
  - Interpretation/translation services
  - Emergency travel arrangements
  - Recovery of lost or stolen luggage/personal possessions
  - Legal assistance and/or bail bond
- Medical Services Include:
  - Medical referrals for local physicians/dentists
  - Medical case monitoring
  - Prescription assistance and eyeglasses replacement
  - Convalescence arrangements

* The services listed above are subject to a maximum combined single limit of $250,000. Return of vehicle is subject to $2,500 maximum limit.

How It Works

At any time before or during a trip, you may contact On Call for emergency assistance services. It is recommended that you keep a copy of this summary with your travel documents. Simply detach the wallet card below to ensure convenient access to the On Call phone numbers.

- **TO REACH ON CALL VIA INTERNATIONAL CALLING:** Go to www.att.com/esupport/traveler.jsp?group=tips for complete dialing instructions. It is recommended that you do this prior to departing the US, find the access code from the country you will be visiting, and note it on the cut-out card below so you will have the information readily available in case of an emergency. (AT&T provides English-speaking operators and the ability to place collect calls to On Call, whereas local providers may encounter difficulty placing collect calls to the US.)
- You can reach the 24-Hour Travel Assistance in the US by calling 800.456.3893.
- For international callers, please call 603.328.1966.

Employer Paid Benefits

Employee Assistance Program – Provided by Aetna

Aetna Resources For Living (ARFL) is available for you and your family. It's designed for anyone who could use a little help managing issues and life events, big and small. ARFL helps you save time and effort because the resources are in one place. Best of all, you have confidential access to the program, which you can use at no cost to you.

Benefits:

From the stress of everyday life to relationship issues or even work-related concerns, ARFL can help with any issue affecting overall health, well-being and life management.

- Six professional counseling sessions per person per issue per year
- Access to Talkspace: you can send unlimited text, audio and video messages to your dedicated therapist.
- Access to ARFL website with resources and live and on-demand webinars
- myStrength™ — a unique emotional wellness portal
- Child and elder care support
- Help with parenting and relationships
- Worklife and daily life assistance
- Legal and financial services
- ID theft and online will assistance
- Discount center, including fitness discounts
- Crisis support

ARFL benefits are free of charge, 100% confidential, and available to all family members regardless of location. ARFL representatives and resources are easily accessible through 800.342.8111 or www.resourcesforliving.com (username: SYH; password: EAP).

Best Health

- Challenges & prizes
- Website offers Wellness Assessment, Health Trackers, Education, etc.
- Free 30 min/6x Health Coaching (National Board Certified)
- Wellness discounts on gym memberships, virtual workouts, & wellness products

Flexible Spending Account

Flexible Spending Accounts (FSA) are provided through WEX. Medical FSA's can be used to cover copays/coinsurance, prescriptions, dental, vision, and over-the-counter medications. However, you should not use your FSA card to pay for in-network, carrier approved qualifying medical expenses as the Nonstop Visa card will cover all of these costs up to the out-of-pocket maximum.

Paying for medical expenses using both your Nonstop Visa card and the FSA card would be considered "double dipping" so you want to make sure the amount you select to contribute towards your FSA is for Dental, Vision and out-of-network expenses which are all not covered under the Nonstop program. The maximum contribution for FSA for 2024 is $3,200.00. You are allowed to roll over $640 at the end of your plan year. Lastly, if you terminate from your position, keep in mind that you can only file for claims for as much as you have contributed up to that date

Savings

You save between 15-40% by not having to pay federal and most state and local taxes, as well as social security and Medicare taxes for every dollar elected for the FSA. The savings really add up!

Without an FSA		With an FSA	
Gross taxable wage	$500.00	Gross taxable wage	$500.00
Federal, FICA & State Tax	-113.25	Group Insurance premium contribution	-40.00
Group Insurance premium contribution	-40.00	Average weekly out-of-pocket medical expenses	-50.00
Take home pay	$346.75	Taxable wage	$410.00
Average weekly out-of-pocket medical expenses	-50.00	Federal, FICA & State Tax	-92.86
Amount left to spend	$296.75	Amount left to spend	$317.14
FSA Tax Savings per week			$20.39

• *Assuming 15% Federal tax, 7.65% FICA Tax (Social Security and Medicare)*

For more details on the FSA benefit please visit: https://www.fsafeds.com/explore/hcfsa/expenses

Voluntary Supplemental Insurance Plans
(Only Offered at Open Enrollment)

Colonial Life
Making benefits count.

Accident – Colonial Life

Accidents can happen to anyone. You never know when you or someone you love could get hurt in an accident. And accidents come with costs, such as emergency room fees, doctor's bills and lost income from missing work. Even if you have good health insurance, deductibles and copays can really add up. With accident insurance from Colonial Life, you can receive benefits to help with the expenses of a covered accident. This financial protection can help you focus on what really matters: healing.

With this coverage:

- A set amount is payable based on the injury you suffer and the treatment you receive.
- You do not need to answer medical questions or have a physical exam to get basic coverage.
- Unlike workers' compensation, which only covers on-the-job injuries, accident insurance covers injuries that happen on-the-job or off-the-job.
- Coverage is available for you, your spouse, and eligible dependent children.

Disability – Colonial Life

Help protect your income. You never know when a disability could impact your way of life. Fortunately, there's a way to help protect your income. If a covered accident or sickness prevents you from earning a paycheck, disability insurance from Colonial Life can provide a monthly benefit to help you cover your ongoing expenses. Disability insurance from Colonial Life helps protect your income, so you can receive help paying the bills while you recover from a covered accident or sickness.

With this coverage:

- You can choose the amount of your disability benefits, subject to income.
- You're paid regardless of any insurance you may have with other companies.
- Benefits are paid directly to you, and you can use the funds however you choose.

Cancer Assist – Colonial Life

Would you be financially prepared for cancer? If you were diagnosed with cancer, you could have expenses that medical insurance doesn't cover. In addition to your regular, ongoing bills, you could have to pay for out-of-network treatment, childcare, home health care services, and other indirect treatment and recovery costs. Hopefully, you and your family will never face cancer. If you do, cancer insurance from Colonial Life can help protect the lifestyle you've worked so hard to build.

With this coverage:

- Coverage options are available for you, your spouse, and your eligible dependent children.
- You're paid regardless of any insurance you may have with other companies.
- You can use benefits to help pay for travel to and from treatment centers, lodging and meals, deductibles – or any other way you choose.
- You may have the option of purchasing additional riders for even more financial protection against cancer.

Critical Illness – Colonial Life

You can't predict an illness, but you can be prepared. No matter where you are in life, you never know when you or a loved one could experience a critical illness, such as a heart attack or stroke. Medical advancements and early detection are helping many people survive critical illnesses. However, preventive tests and treatment can lead to increased medical expenses, and your health insurance may not cover these costs. Critical illness insurance helps supplement your major medical coverage by providing a lump-sum benefit that you can use to pay the direct and indirect costs related to a covered critical illness.

With this coverage:

- Benefits are paid directly to you, unless you specify otherwise.
- You may receive additional benefits if you're diagnosed with more than one critical illness.
- Coverage options are available for you, your spouse, and eligible dependent children.

Term Life – Colonial Life

Life insurance protection when you need it most. Life insurance needs change as life circumstances change. You may need more coverage if you're getting married, buying a home, or having a child.

Term life insurance from Colonial Life provides protection for a specified period of time, typically offering the greatest amount of coverage for the lowest initial premium. This fact makes term life insurance a good choice for supplementing cash value coverage during life stages when obligations are higher, such as while children are young. It's also a good option for families on a tight budget – especially since you can convert it to a permanent cash value plan later.

With this coverage:

- A beneficiary can receive a benefit that is typically free from income tax.
- The policy's accelerated death benefit can pay a percentage of the death benefit if the covered person is diagnosed with a terminal illness.
- You can convert it to a Colonial Life cash value insurance plan, with no proof of good health, to age 75.

Whole Life – Colonial Life

Life insurance that comes with guarantees – because life doesn't. You can't predict the future, but you can rest easier knowing you have life insurance with lifelong guarantees. Whole life insurance from Colonial Life provides guaranteed cash value accumulation, level premium and a death benefit (minus any loans and loan interest). This coverage can help protect your family's way of life.

With this coverage:

- Life insurance benefits for the beneficiary are typically free from income tax.
- You have three opportunities to purchase additional coverage with no proof of good health required if you are 55 or younger when you initially purchase coverage.
- The policy's accelerated death benefit can pay a percentage of the death benefit if the covered individual is diagnosed with a terminal illness.
- A $3,000 immediate claim payment can be paid to the designated beneficiary as an advance of the death benefit.

For more details on the Colonial Life plans, please contact Susie Estrada at Colonial Life at 949.702.4159 or Susie.estrada@coloniallife.com.

Additional Plans

LegalShield – Provided By IDShield/LegalShield

LegalShield provides employees, spouses and dependents convenient access to legal services, including a network of attorneys with telephonic advice and office consultations. No deductible, copay or coinsurance will apply. LegalShield's Identity Theft Plan is also available, combined with the LegalShield plan or as a separate plan. Services may include:

- Will Preparation
- Legal Document Review, up to 15 pages each
- Trial defense hours
- Access to Video Law Library and Forms Service Center
- Advice on an unlimited number of topics, including Family Matters, Estate Issues, Finance and Real Estate

Discount Programs

As an added benefit to our employees, we offer discounted tickets through Fun Express and TicketsatWork.

Fun Express

To take advantage of great entertainment savings on tickets for Universal Studios, Six Flags Magic Mountain, Sea World, LegoLand, Knott's Berry Farm, AMC movies and more, check out www.FunEx.com. Register using the following Employee Activity Code (EAC): 11-3861.

TicketsatWork

Through TicketsatWork, you will receive discounts and special access to theme parks and attractions including the Walt Disney World® Resort, Universal Studios®, Las Vegas and New York City shows and performances, Disneyland®, SeaWorld®, Six Flags, and Cirque du Soleil! Also check with TicketsatWork.com for savings on car rentals, hotels, tours and attractions across the US. If you're staying local, save on movie tickets, sporting events, and other special events. To register, visit ticketsatwork.com, click on "Become a Member" and use the company code "San Ysidro Health."

AT&T Information

https://www.att.com/verification/signaturehub/

Foundation Account Number (FAN) **3277212**

Retirements Benefits

Employer Paid – 162 Bonus Plan

San Ysidro Health's Leadership Team is proud to be able to offer the 162 Bonus Plan for employees who are the heart of the organization. SYHealth is committed to your financial well-being. One way we want to support you is through helping you prepare for your retirement. We offer the SYHealth 162 Bonus Life Insurance & Supplemental Retirement Plan ("the plan") which is completely funded by SYHealth and can provide you with a tax advantage way to supplement your retirement savings and provide you additional life insurance benefits. The Life Insurance and retirement account are provided through Pacific Life.

SYHealth is engaged with The Hebets Company, an NFP company, and the "Plan Manager" to design, implement, communicate, record keep and manage The Plan.

The plan has two main benefits:

- Additional Life Insurance Protection (for those that qualify)
- Supplemental Retirement Fund (Cash value in the policy)

Eligibility Information:
This plan is offered to eligible San Ysidro Health's employees on January following one full year of service. The HR Benefits team will inform employees of enrollment period once eligible.

Life Insurance Qualification:
Age 70 & Younger (generally no medical background information required)
Age 71 & Older (You must qualify medically for the coverage)

All the contributions to this plan are made by San Ysidro Health on the employee's behalf as long as the employee continues to participate in the plan and is actively working at San Ysidro Health at the eligibility level.

San Ysidro Health will provide a percent by annual bonus in pay. The bonus will be automatically set aside as a budget towards your income tax on the overall bonus. An amount will be deducted from your paycheck and credited as a contribution to a plan that will provide you with the two main components (Additional Life Insurance and Supplemental Retirement Funds). As the owner of the life insurance policy, the employee can access the cash value available in their plan at any age, for any reason, with no IRS early withdrawal penalties. Because employees own the life insurance contract, at termination of employment, the employee will be able to keep their policy in force for as long as they want to. Depending on how long the employee has been participating in the plan, they may or may not need to continue paying premiums to maintain their policy. The employee will continue to have access to the cash available in their policy.

Voluntary – 403(b) Retirement Plan

San Ysidro Health has established a secondary retirement vehicle to help you prepare you to your financial future. Employees may enroll and change pre-tax contributions throughout the year. Plan Member Services has certified financial planners available to help you enroll. In addition, they are available to review your accounts on an annual basis. Contact DeGrazier and Associates for more information.

Contributions are made by you from your paycheck on a pretax basis resulting in automatic tax savings on the money you have invested. This is a long-term investment plan meant to prepare you for your retirement. It is not a savings plan, and you are not able to withdraw the money once it is in the plan unless you meet one of the qualifying IRS definitions for hardship withdrawals. You will be required to pay a 10% penalty on money withdrawn before your retirement. In addition, you would be required to pay any applicable taxes.

The maximum contribution for 2024 is $23,000 for those 50 and younger. For those over 50, the maximum contribution is $30,500.

Vacation and Sick Leave Policy

Vacation Policy

Eligibility: Regular full time and part time employees scheduled to work 20 or more hours per week are eligible for vacation accruals.

Non-Eligible: Employees who are temporary, per diem or work less than 20 hours per week are not eligible for vacation accruals. Physicians who work less than 20 hours per week are not eligible for vacation accruals.

Accrual Start Date:

- New hires: Regular full time and part time employees who are eligible for vacation start accruing vacation paid time off from their date of hire. However, they are not eligible to take vacation until they have completed their 90-day introductory period and have their manager's authorization.
- Current Employees Changes in Benefit Eligible Status: An employee may become eligible or ineligible for vacation benefits based on changes in his/her official scheduled hours. Employees who become benefit eligible will begin their vacation accrual the first day of the pay period following the date they become benefit eligible and have completed 520 hours of worked hours. Employees who become ineligible for benefits will stop accruing at the end of the pay period of the date in which they became ineligible for benefits.

Accrual Hours: Vacation will only be accrued during straight work time; it will not be accrued while working overtime. Vacation does not accrue while employees are on unpaid status by San Ysidro Health. Employees will continue to accrue vacation hours while they are on paid San Ysidro Health status only. **Employees working 39 hours or less per week accrue on a pro-rated amount.**

Accrual Schedule: Full time employees who are scheduled to work 40 hours per week are eligible for vacation according to the following schedule:

FULL TIME EMPLOYEES ONLY (Eligible part time employee accruals are prorated)			
Continuous Employment	**Vacation Accrual Rate**	**Annual Vacation**	**Maximum Accrual**
1 to 5 years	3.34 hours per pay period	80 hours	160 hours
5 to 15 years	5.00 hours per pay period	120 hours	240 hours
15 years or more	6.66 hours per pay period	160 hours	320 hours

Maximum Accrual: Employees are allowed to accrue up to 2 times their annual vacation allowance. Once the maximum accrual has been reached, employees will no longer continue accruing vacation hours. Employees may be asked to take vacation in order not to exceed their maximum accrual.

Holiday Pay: If a company-paid holiday falls during an employee's vacation, the holiday will not be counted as vacation taken. Each supervisor will maintain a department schedule and the record of the vacation time taken by each employee must be recorded and approved through San Ysidro Health's HCM (Dayforce) system.

Employment Termination: Employees will be paid for all vacation time and floating holidays earned at the time of their termination from employment. Pay will be computed based on the rate earned upon separation.

Sick Leave Policy

To help prevent loss of earnings that may be caused by accident or illness, SYHealth provides paid sick leave (PSL) to all employees in compliance with applicable state and local law, including the San Diego Paid Sick Leave Ordinance. Beginning January 1, 2024, all employees who have worked 30 continuous days in the previous year will receive a total of 40 hours/five workdays of paid sick leave (PSL) per year. New employees who have worked 30 continuous days in the same year will receive a total of 40 hours/five workdays of paid sick leave (PSL) per year, to be used after an employee's 90th day of employment. The maximum cap on usage per year is 40 hours/five workdays per year. Once all PSL has been used, employees will receive no more PSL under this policy until the following calendar year. PSL can be used after an employee's 90th day of employment, and the available balance shall appear on the employee's wage statement. Any time taken before PSL eligibility has been met or after PSL has been exhausted, is not covered by this policy and shall be unpaid, except as provided in SYHealth's other policies providing for paid time off. PSL pay will be calculated based on the employee's regular rate of pay **at the time of absence. Sick time cannot be used to augment wages such as overtime or any special forms of compensation such as incentives or shift differentials.**

The amount of PSL available at any time will appear on the payroll earnings statements. Employees who voluntarily or involuntarily separate from the company will not be paid their unused sick time. Following the exhaustion of PSL, employees may use their FAPSL (if available). However, if no PSL is available under the current policy or accrued under FAPSL, employees may take paid sick time off under VWL (if available), or any accrued and unused vacation time (if appropriate and approved), to recover from an illness or help their immediate family recover from illness.

An employee may take PSL to care for themselves or a family member, for preventive care or diagnosis, care, or treatment of an existing health condition, or for specified purposes if they are a victim of domestic violence, sexual assault, or stalking. Family members include the employee's parent, child, spouse, registered domestic partner, grandparent, grandchild, sibling, or designated person. Although PSL cannot be used towards "personal" absences, time off for healthcare, medical, dental, and vaccination appointments can be treated as sick time. PSL can be used in increments of 1 hour or more.

The State of California also provides both disability and paid family leave benefits to eligible employees, which may augment and/or supplement California Paid Sick Leave. Learn more at http://www.edd.ca.gov.

Sick Leave Policy Definitions

Paid Sick Leave (PSL): Beginning January 1, 2024, all employees who have worked 30 continuous days in the previous year will receive a total of 40 hours/five workdays of paid sick leave (PSL) per year. New employees who have worked 30 continuous days in the same year will receive a total of 40 hours/five workdays of paid sick leave (PSL) per year, to be used after an employee's 90th day of

employment The maximum cap on usage per year is 40 hours/five workdays per year. PSL pay will be calculated based on the employee's regular rate of pay at the time of absence. Sick time cannot be used to augment wages such as overtime or any special forms of compensation such as incentives or shift differentials.

Formerly Accrued Paid Sick Leave (FAPSL): Paid sick leave hours accrued prior to 2024 which are unused and displayed on the final wage statement in 2023. These hours carry-over each year until they are exhausted. These hours cannot be used to augment wages such as overtime or any special forms of compensation such as incentives or shift differentials.

Voluntary Wellness Leave (VWL): Accrued paid time off provided voluntarily by SYHealth starting January 1, 2024, to provide additional paid time off for employees to care for themselves and/or an immediate family member. Eligible employees may accrue up to 32 hours of VWL each calendar year. VWL accrues based on hours worked at a rate of 1 hour for every 65 hours worked. There is no accrual while the employee is on any time off, including leave of absence, sick time, floating holiday or vacation time. This leave is not available to use until the employee has exhausted all available PSL and FAPSL.

The complete Sick Leave Policy is made available to all employees and is posted on the *HR Intranet*.

Holiday Policy

Regular full-time employees receive a total of nine paid holidays on an annual basis. Each year, a new holiday schedule is published based on organizational needs. Some holidays may be fixed while others may be floating. An annual holiday schedule is made available to all employees and is posted on the *HR Intranet*. Observed holiday schedules may vary due to clinic service operations. From the date of hire, regular employees scheduled for a minimum of 20 hours per week are eligible for holiday pay on a prorated basis. Employees will be compensated for the average daily hours configured on the employee's record.

Our annual floating holiday(s) provides SYHealth employees the opportunity to take paid time off to honor important and meaningful events and dates or to celebrate personal events or dates that may be special to them. If a holiday falls on a weekend date, then it may be observed as a Floating Holiday. Please refer to the holiday schedule. Please note that Urgent Care employees have a different holiday schedule. For more information please visit the HR Intranet.

The Cost of Coverage for Employees Working 20+ Hours per Week

The rates below are effective May 1, 2024 – April 30, 2025

Coverage	Total Monthly Cost	San Ysidro Health Monthly Contribution	Employee Monthly Cost	Payroll Deductions (24 pay periods/yr)
Sharp HDHP NG5L HMO + Nonstop Health Plan				
Employee Only	$676.00	$653.47	$22.21	$11.11
Employee and Spouse / DP	$1,481.00	$1,183.74	$297.40	$148.70
Employee and Child(ren)	$1,052.00	$900.86	$150.77	$75.39
Employee and Family	$1,993.00	$1,520.47	$472.58	$236.29
SIMNSA HMO (Cross Border)				
Employee Only	$178.97	$178.97	$0	$0
Employee and Spouse / DP	$365.90	$365.90	$0	$0
Employee and Child(ren)	$414.59	$414.59	$0	$0
Employee and Family	$526.04	$526.04	$0	$0
UMR Basic Dental PPO				
Employee Only	$21.21	$21.21	$0.00	$0.00
Employee and Spouse / DP	$40.29	$22.59	$17.70	$8.85
Employee and Child(ren)	$42.42	$22.76	$19.66	$9.83
Employee and Family	$68.94	$24.70	$44.24	$22.12
UMR Premier Dental PPO				
Employee Only	$48.18	$25.37	$22.81	$11.41
Employee and Spouse / DP	$81.80	$29.27	$52.53	$26.27
Employee and Child(ren)	$91.54	$30.50	$61.04	$30.52
Employee and Family	$173.43	$40.20	$133.23	$66.62
SIMNSA Dental DHMO (Cross Border)				
Employee Only	$18.30	$18.30	$0.00	$0.00
Employee and Spouse / DP	$30.42	$19.00	$11.42	$5.71
Employee and Child(ren)	$41.05	$19.61	$21.44	$10.72
Employee and Family	$50.50	$20.15	$30.35	$15.18
EyeMed Vision PPO				
Employee Only	$6.95	$6.95	$0.00	$0.00
Employee and Spouse / DP	$13.21	$7.57	$5.64	$2.82
Employee and Child(ren)	$13.91	$7.64	$6.27	$3.14
Employee and Family	$20.45	$8.29	$12.16	$6.08

Appendix A: Directory and Resources

CARRIER	PHONE/FAX/EMAIL	WEBSITE
Nonstop Administration & Insurance Services, Inc. (Member Support/Concierge Services)	**General Phone:** 877.626.6057 **Email:** clientsupport@nonstophealth.com **Verification Fax:** 719.270.9845 **Verification Email:** eob@nonstophealth.com **Claims Fax:** 877.463.1175 **Claims Email:** claims@nonstophealth.com	www.nonstophealth.com Information: help.nonstophealth.com Nonstop Exchange: members.nonstophealth.com
Sharp Health Plan (Medical) *Group #: 1001876*	800.359.2002	customer.service@sharp.com
Landmark Healthplan *Group #: NS0025E-000*	800.298.4875	www.LHP-CA.com
San Ysidro Health Chiropractors & Acupuncture	619-662-4100	www.syhealth.org
SIMNSA (Medical) *Group #: 324*	619.407.4082	www.simnsa.com
UMR Benefits (Dental) *Group #: 76-415484*	800.826.9781	www.umr.com
SIMNSA (Dental) *Group #: 324*	619.407.4082	www.simnsa.com
EyeMed (Vision) *Group #: 1000083*	800.988.4221	www.eyemed.com
Aetna Resources for Living (EAP)	800.342.8111	www.resourcesforliving.com Username: SYH/Password: EAP
Reliance Standard (Basic Life, AD&D, LTD) *Group #: San Ysidro Health*	**Life/AD&D:** 800.351.7500 **LTD:** 800.351.7500 **Travel Assistance:** U.S.: 800.456.3893 WW: 603.328.1966	http://www.reliancestandard.com
Wex	**Phone:** 866.451.3399 **Fax**: 866.451.3245 **Email:** customerservice@wexhealth.com	Benefitslogin.wexhealth.com
Colonial (BCN) E3200706	Susie Estrada – 949.702.4159 susie.estrada@coloniallife.com	www.visityouville.com/en/SYH
LegalShield *Policy #: 102507*	David Quackenbush – 720.785.0102 david@quackenbushagency.com	www.legalshield.com/info/syhc
162 Bonus Retirement Plan	P: 602.840.7505 E: hcadmindept@nfp.com	https://www.hebetsco.com/
403(b) Retirement Plan	DeGrazier & Associates P: 858.558.2300 sdegrazier@planmembersec.com	www.planmember.com
Benefits broker for all benefits except medical: Marsh & McLennan Insurance Agency, LLC	Alicia Phan / alicia.phan@marshmma.com Julia Wood / Julia.Wood@marshmma.com Catherine Botello/ catherine.botello@marshmma.com	www.mma-west.com
San Ysidro Health HR Contact: Benefit Team	P: 619.662.4100 Email: benefits@syhealth.org	HR Intranet

Appendix B: Health/Benefits Notices

Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits 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. Your plan complies with these requirements.

Newborn's 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. The law allows the mother or newborn to be released earlier than 48 hours (or 96 hours as applicable) only if the attending provider decides, after consulting with the mother, that the mother or newborn is ready for discharge. 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).

Health Insurance Portability & Accountability Act Non-Discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

HIPAA Privacy Notice When Using SYHealth Medical Services

Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). One of its primary purposes is to make certain that information about your health is handled with special respect for your privacy. HIPAA includes numerous provisions designed to maintain the privacy and confidentiality of your protected health information (PHI). PHI is health information that contains identifiers, such as your name, address, social security number, or other information that identifies you.

Our Pledge Regarding Health Information

- We understand that health information about you and your health is personal.
- We are committed to protecting health information about you.
- This notice will tell you the ways in which we may use and disclose health information about you.
- We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are Required by Law to

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you;
- Follow the terms of the notice that are currently in effect.

The Plan will Use Your Health Information for

- **Treatment:** The plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.
- **Regular Operations:** We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees.
- **Business Associates:** There are some services provided in our organization through contracts with business associates. Business associate agreements are maintained with insurance carriers. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy and security rules.
- **As Required by Law:** We will disclose health information about you when required to do so by federal, state or local law.
- **Workers' Compensation:** We may release health information about you for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Law Enforcement:** We may disclose your health information for law enforcement purposes, or in response to a valid subpoena or other judicial or administrative request.

- **Public Health:** We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation).

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information, where concerning a service already paid for;
- Obtain a paper copy of the Notice of Health Information Practices by requesting it from the plan privacy officer; Inspect and obtain a copy of your health information;
- Request an amendment to your health information;
- Obtain an accounting of disclosures of your health information;
- Request communications of your health information be sent in a different way or to a different place than usual (for example, you could request that the envelope be marked "Confidential" or that we send it to your work address rather than your home address);
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.

The Plan's Responsibilities

The plan is required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction, amendment or other request;
- Notify you of any breaches of your personal health information within 60 days or 5 days if conducting business in California;
- Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice.

The plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you.

For More Information or to Report a Problem

- If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the plan privacy officer. All requests must be submitted in writing.
- If you believe your privacy rights have been violated, you can file a formal complaint with the plan privacy officer; or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you authorize us to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the payment activities that we provided to you.

Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

- For certain health information, you can tell us your choices about what we share.
- If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
- In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization
We can use and disclose your information to run our organization and contact you when necessary.

We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or CHIP) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

"HIPAA Special Enrollment Opportunities" include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage (1)
- Acquisition of a new spouse or dependent through marriage (1), adoption (1), placement for adoption (1) or birth (1)
- Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) (1)
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

"Change in Status" Permitted Midyear Election Changes

Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved "change in status" as defined by the IRS.

Examples of permitted "change in status" events include:

- Change in legal marital status (e.g., marriage (2), divorce or legal separation)
- Change in number of dependents (e.g., birth (2), adoption (2) or death)
- Change in eligibility of a child
- Change in your / your spouse's employment status (e.g., reduction in hours affecting eligibility or change in employment)
- A substantial change in your / your spouse's benefits coverage
- A relocation that impacts network access
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment
- Qualified Medical Child Support Order or other judicial decree
- A dependent's eligibility ceases resulting in a loss of coverage (3)

- Loss of other coverage (2)
- Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage • You enroll, or intend to enroll, in a Qualified health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

You must notify Human Resources within 30 days of the above change in status, with the exception of the following which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

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(1) Indicates that this event is also a qualified "Change in Status"
(2) Indicates this event is also a HIPAA Special Enrollment Right
(3) Indicates that this event is also a COBRA Qualifying Event

Employee Rights & Responsibilities Under the Family Medical Leave Act

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or

illness (1); or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. (1)

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months (2), and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing

The functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or chronic condition. Other conditions may meet the definition of continuing treatment.

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(1) The FMLA definitions of “serious injury or illness” for current service members and veterans are distinct from the FMLA definition of “serious health condition”

(2) Special hours of service eligibility requirements apply to airline flight crew employee

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities.

If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TYY: (877) 889-5627
www.wagehour.dol.gov

Mental Health Parity

The Plan will provide parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with the Plan, as required by section 9812 of the Internal Revenue Code (the Code) and section 712 of the Employee Retirement Income Security Act (ERISA), and the regulations thereunder, as follows: Lifetime or Annual Dollar Limits. The Plan will not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits. Financial Requirement or Treatment Limitations. The Plan will not apply any financial requirement or treatment limitation (whether quantitative or nonquantitative) to mental health or substance use disorder benefits in any classification (as determined by the Plan Administrator in accordance with applicable regulations) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Criteria for Medical Necessity Determinations. The criteria for making medical necessity determinations relative to claims involving mental health or substance use disorder benefits will be made available by the Plan Administrator to any current or potential Participant, beneficiary, or in-network provider upon request. The manner in which these restrictions apply to the Plan will be determined by the Plan Administrator in its sole discretion in light of applicable regulations and other guidance.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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	Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
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	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health- care/health-care-programs/programs-and-services/other- insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
MedicaidWebsite: http://www.coverva.org/programs_premium_assistance. cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistan. cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration

www.dol.gov/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

MEDICARE PART D

2024 Medicare Part D Notice for San Ysidro Health

Important Notice about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your

current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

Your employer has determined that the prescription drug coverage offered by your employer-sponsored medical plan is expected to pay, on average, 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 15 to December 7. 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 prescription drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

Individuals who are eligible for Medicare should compare their current coverage (your medical benefits brochure contains a description of your current prescription drug benefits), including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area. (See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D).

If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact Human Resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

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 your employer and don't join a Medicare prescription 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 your Human Resources Department for further information NOTE: You will receive this notice each year, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For More Information about Your Options Under Medicare Prescription Drug Coverage

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

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

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

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

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

** Continuation Coverage Rights Under COBRA**

You're getting this notice because you recently gained coverage under a group health plan (the Plan). 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 a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more

information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA Continuation Coverage?

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

Once coverage has been elected, full premiums must be paid on a timely basis for coverage to remain in effect. Please refer to the premium schedule on the coverage election form for instructions on how to make premium payments and the specific premium amount(s). The premiums shown include a 2.0000% fee to cover the additional administrative expenses associated with COBRA continuation. If you're maximum coverage period is extended solely because of a disability determination (explained below), then the administrative fee will increase to 2.0000% of the premium when the coverage includes the disabled person. The basic rates may change annually, usually following open enrollment.

Premium payments are considered paid on the date you mail them (as evidenced by your postmark date). If your premium payment is made by check, and your check is returned because of insufficient funds, your premium is treated as unpaid. You must make full payment by immediately available funds within the required time period, including the grace period, to prevent cancellation. If your coverage is canceled for non-payment of premium, you cannot reinstate it for COBRA.

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

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

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

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

When is COBRA Continuation Coverage Available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: ACT Benefits Administrator, Talent Strategy, ACT Inc., PO Box 168, Iowa City, IA, 52243. Your failure to give such notice within the 60-day period will result in the loss of the right to elect to continue coverage under the plan.

How is COBRA Continuation Coverage Provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must provide this notice to Employee Benefits Systems, 214 N. Main Street, PO Box 1053, Burlington, IA, 52601. The disability notice must be provided within 60 days after the SSA's determination and the failure to give such notice will result in the inability to obtain this extension.

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Your failure to give such notice within the 60-day period will result in the loss of the right to elect to continue coverage under the plan. The Employer ceases to provide any group health plan for its employees

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, 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.

For example:

Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both), after electing continuation coverage;
- There was a disability extension of the 18-month continuation coverage period and the SSA determines that the qualified beneficiary is no longer disabled; or
- The Employer ceases to provide any group health plan for its employees.

What About Enrolling in Medicare Instead of COBRA Continuation Coverage?

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of (i) the month after your employment ends or (ii) the month after group health plan coverage based on current employment ends. If you do not enroll in Medicare and elect COBRA continuation coverage instead, you may

have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA continuation coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA continuation coverage. If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second (secondary payer). Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information about enrolling in Medicare, visit www.medicare.gov/medicare-and-you.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Your Rights and Protections Against Surprise Medical Bills

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

What is "Balance Billing" (Sometimes Called "Surprise Billing")?

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

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

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

You are protected from balance billing for:

Emergency services

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

California Comprehensive Balance Billing Protections available:

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of costs sharing
- Above protections apply:
  - To HMO and PPO enrollees
  - For (1) emergency services by out-of-network professionals and facilities* and (2) non-emergency services provided by out-of-network professionals at in-network facilities
  - Provided by all or most classes of health care professionals
- State provides a payment standard ***
- Protection do not apply to:
  - Ground ambulance services***
  - Enrollees who consent to non-emergency out of network services****
  - Enrollees in self-funded plans

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

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

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

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

California Comprehensive Balance Billing Protections available:

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of costs sharing
- Above protections apply:
  - To HMO and PPO enrollees

    - For (1) emergency services by out-of-network professionals and facilities* and (2) non-emergency services provided by out-of-network professionals at in-network facilities
    - Provided by all or most classes of health care professionals
- State provides a payment standard ***
- Protection do not apply to:
    - Ground ambulance services***
    - Enrollees who consent to non-emergency out of network services****
    - Enrollees in self-funded plans

When balance billing isn't allowed, you also have the following protections:

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

If you believe you've been wrongly billed, you may contact CMS after January 1, 2022 at 1-800-985-3059. Also, you may go to the website www.cms.gov/nosurprises/consumers for any updates to this law in the future.

Visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under federal law.

Notes:

* Balance-billing protections in the emergency department setting apply only to those plans regulated by the California Department of Managed Care, which includes HMOs and most PPOs.

**For emergency services, insurer must reimburse the reasonable and customary value for health care services based on statistically credible information that is updated at least once a year and which takes into consideration the following factors: (1) provider's training, qualifications and length of time in practice; (2) nature of services provided; (3) fees usually charged by the provider; (4) prevailing provider rates in the same geographic region; (5) other relevant aspects of the economics of the provider's practice; and (6) any unusual circumstances in the case. The state also has a voluntary, non-binding dispute-resolution process for emergency services, but it is rarely used.

For non-emergency services provided by out-of-network providers at in-network facilities, insurers must reimburse the greater of: (1) 125% of Medicare or (2) average contracted rate for that health plan and for that region. The Department of Managed Health Care has developed a methodology to determine the average contracted rate based on the above specifications. The state also has a dispute-resolution process in place for out-of-network care at in-network facilities if the regular process for applying the payment standard fails in some way.

*** State prohibits out-of-network air ambulance providers from billing enrollees more than the in-network cost-sharing amount for their services.

**** Protections do not apply to non-emergency services when enrollee consents in writing. State has certain minimum requirements for this consent:

- has to be acquired at least 24 hours in advance of care;
- has to be obtained in a separate document than one used to obtain consent for the procedure;
- cannot be obtained by the facility or any representative of the facility, and it cannot be obtained at the time of admission or at any time when the enrollee is being prepped for any procedure;
- at time of consent, provider must give enrollee a written estimate of cost. The provider cannot attempt to collect more than the estimate without a separate written consent unless unforeseen circumstances arise that would change the estimate arise during delivery of services;
- has to inform enrollee that they can seek care from an in-network provider for lower out-of-pocket costs;
- has to be provided in language spoken by enrollee; and
- as to include details about the enrollee's full financial responsibility.

Visit https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections for more information about your rights under state law

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name San Ysidro Health	4. Employer Identification Number (EIN) 95-2801772	
5. Employer Address 1601 Precision Park Lane	6. Employer Phone Number 619-662-4100	
7. City San Diego	8. State CA	9. Zip Code 92173
10. Who Can We Contact About Employee Health Coverage at this Job? Nonstop Health		
11. Phone Number (if different from above) 877-626-6057	12. Email Address clientsupport@nonstophealth.com	

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

- As your employer, we offer a health plan to:
  - ☒ All employees. Eligible employees are:
    Employees working 20+ hours per week at regular FT, regular PT and Temporary status.
  - ☐ Some employees. Eligible employees are:

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    Spouse/Registered Domestic Partners and son/daughter (step children) or adopted children up to 26 years of age. Disable dependents over age 26 need to have a provider's certificate.
  - ☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

- ☐ **Yes** (Continue)

  13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)

- ☐ **No** (STOP and return this form to employee)

14. Does the employee offer a health plan that meets the minimum value standard*?

☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☒ Every 2 week's ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

- ☐ Employer won't offer health coverage

- ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)