Saint Michael's Medical Center

*Per Diem*

# Employee Benefits Guide | 2022

Prime

Live Well. Work Well. Be Well.

EXCEPTIONAL CARE
EXCLUSIVE BENEFITS

Member of Prime Healthcare

# Table of Contents


Who Can You Cover? ..... 1

Dependent Eligibility Chart ..... 2

Dependent Eligibility: Document Requirements ..... 3

Prime Healthcare's Personal Choices and Tier 1 Provider Directory ..... 4

How to Enroll in Benefits using Lawson ..... 5

Prime Value Plan Costs ..... 6

Your Prescription Drugs Benefits ..... 8

Pharmacy Benefits ..... 9

Cost of Coverage ..... 11

Making Benefit Changes During the Year ..... 12

Other Programs ..... 13

Summary Annual Report ..... 14

Important Notices ..... 15

Glossary of Terms ..... 26

For Assistance ..... 30


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

**Medicare Part D Notice and AGA Medicare Options**

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. You can find the Medicare Part D Notice on page 20, under Important Notices. For additional information on AGA Medicare Options please refer to page 13.

# Who Can You Cover?

## WHO IS ELIGIBLE?

### Eligible Employee

The Prime Value Plan is available to all employees.

Per Diem Employees are eligible the first of the month following the date of hire.

## PRIME VALUE PLAN

The Prime Value Plan provides access to the Tier 1 Prime Healthcare Network facilities and providers. It also provides access to the Tier 2 BCBS BlueCard Network of facilities and providers. When services are available in the Tier 1 Prime Healthcare Network, members will be notified and can take advantage of the lower cost option available by utilizing a Tier 1 provider or facility.

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

### Dependents

**Your Spouse:**

- Married Spouse
- Civil Union Partner
- Registered Domestic Partner (Domestic Partners must be same sex or opposite sex couples who are both 62 years of age or older.)

**Your children:**

- Under the age of 26 are eligible to enroll. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
- Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support. The onset of the disability had to occur prior to age 26.
- Dependent children (under age 26) employed with Prime Healthcare are eligible to enroll as either a dependent under a parent's medical plan, if the parent also works for Prime Healthcare or under their own Prime Healthcare plan as an employee, but not both.

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

## WHO IS NOT ELIGIBLE?

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

- Parents, grandparents, grandchildren, and siblings
- Ex-Spouse

## WHEN CAN I ENROLL?

Open Enrollment for current Per Diem employees is generally held in October/November. Open Enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

# Dependent Eligibility Chart

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

| Dependent Type | Eligibility | Supporting Documents |
|---|---|---|
| **Spouse** | **Married Spouse**<br><br>**NOTE**: A Federal Tax Return filed as "**Head of Household**" does **NOT** meet the eligibility guidelines. If presented to HR your Spouse will be considered ineligible to enroll as your dependent. | **One of the following documents will be accepted:**<br>• Federal Tax Return (1040), current filing period[1]<br>• IRS Transcript, current filing period<br>• If **Married and filing separately**, Employee is required to present **both** Federal Tax Returns[1]. Each return **must** indicate "Married Filing Separately" status **and** include the name and SSN of the Spouse.<br>• If newly Married, within the **last 12 months** you may present a Government Issued Marriage Certificate. |
| **Civil Union Partner (CUP)** | **As recognized by law** | **One of the following documents will be accepted:**<br>• Federal Tax Return (1040), current filing period[1]<br>• IRS Transcript, current filing period<br>• New Jersey Civil Union Certificate if obtained in the current year |
| **Domestic Partner** | **Registered Domestic Partner (RDP)**<br><br>**NOTE**: RDP can be same sex or opposite sex. Both partners must be age 62 or older to register as RDP. | **State Domestic Partner Affidavit** |
| **Natural Birth Child**<br>Birth to Age 26[2] | **Biological Child** | **One of the following documents will be accepted:**<br>• Federal Tax Return (1040), current filing period[1]<br>• IRS Transcript, current filing period<br>• Birth Certificate<br>• Qualified Medical Child Support Order (QMCSO) |
| **Stepchild**<br>Birth to Age 26[2] | **Child of current Spouse, Civil Union Partner or Registered Domestic Partner** | **One of the following three documents will be accepted PLUS the Birth Certificate[3]:**<br>• Federal Tax Return (1040), current filing period[1]<br>• IRS Transcript, current filing period<br>• State Domestic Partner Affidavit<br>**NOTE**: Birth certificate alone will not validate the stepchild's eligibility. Employee/Spouse-RDP-CUP relationship must also be substantiated. |
| **Adopted Child**<br>Birth to Age 26[2] | **Adopted Child**<br>Eligible at the time of placement | **One of the following documents will be accepted:**<br>• Federal Tax Return (1040), current filing period[1]<br>• IRS Transcript, current filing period<br>• Court Documents naming Employee/Spouse as Guardian<br>• Adoption Record<br>• Qualified Medical Child Support Order (QMCSO) |
| **Legal Guardianship/ Legal Custody**<br>Birth to Age 18 | **Child is in the custody of the Employee/Spouse-RDP-CUP or under the protection of** | Federal Tax Return (1040), current filing period[1] *(not required if named as guardian in the last 12 months)* **AND** Court Documents naming Employee/Spouse-RDP-CUP as Legal Guardian/Custodian |
| **Permanently Disabled Adult Child[4]** | **Adult Dependent Child Overage 26** | Federal Tax Return (1040), current filing period[1] **AND** Birth Certificate **AND** Physician documented incapacity of self-support letter |

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

# Dependent Eligibility: Document Requirements

**IMPORTANT REMINDER**: If you plan to add a dependent to your coverage, please locate or order documents in advance. Prime Healthcare reserves the right to request original documents.

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

**Lost or Misplaced Documents**

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

**Birth Certificates**

- Government Issued Birth Certificate listing the employee as child's parent.
- Hospital certificate listing the employee as the parent, if birth occurred in the last six months.
- Stepchild or Child of Civil Union Partner or Registered Domestic Partner; a birth certificate and Federal Tax Return or IRS transcript listing child or New Jersey Civil Union Certificate if obtained in the current year or State Domestic Partner Affidavit to substantiate the relationship.

**Federal Tax Filing**

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

**Proof of Marriage**

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

**Civil Union Partnership**

- Federal Tax Return (1040), current filing period.
- IRS Transcript, current filing period.
- New Jersey Civil Union Certificate if obtained in the current year.

**Registered Domestic Partnership Declaration**

- State Domestic Partner Affidavit.
- Same sex or opposite sex but BOTH partners MUST be age 62 or older to register.

**Legal Guardianship/Legal Custody**

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

**Permanently Disabled Adult Children**

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

# Prime Healthcare's Personal Choices and Tier 1 Provider Directory

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

**PERSONAL CHOICES**


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

**From Home or Work**

**Enter** app.strivebenefits.com/PHSVALUE

**Log In: PHSVALUE**

**Password: Benefits**

### Resources on Personal Choices

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

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

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

- **Life Events**: Provides employees with information on what constitutes specific life events and reminds you to contact Human Resources within 30 days of a life event if changes need to be made.

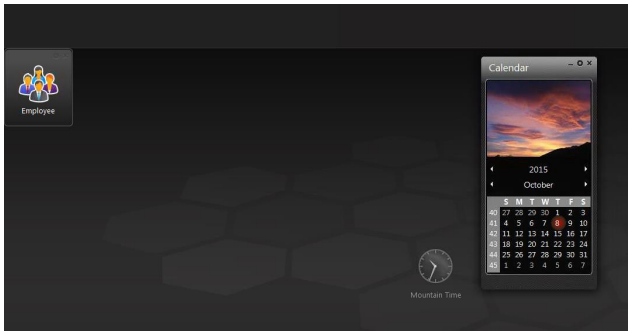
# How to Enroll in Benefits using Lawson

## ACCESSING EMPLOYEE SPACE IN LAWSON

Enter User Name and Password in the login page:

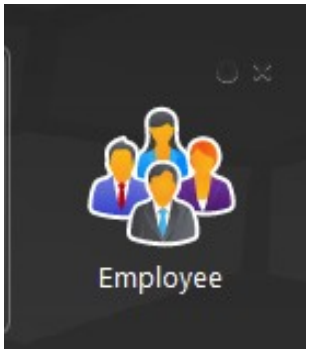

## EMPLOYEE SPACE DASHBOARD EMPLOYEE

Employee Space will display.




## EMPLOYEE ICON

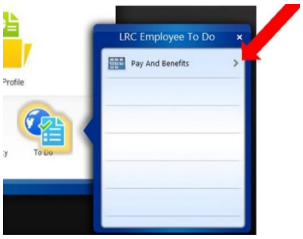
Double click on Employee icon to launch employee information




## ACCESS TO DO OPTIONS

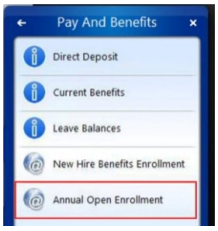
Place your cursor on the "To Do" icon and the To Do Menu will display.

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




Menu items are displayed


Click on the Annual Open Enrollment option to start the enrollment process




## OPEN ENROLLMENT WELCOME PAGE

The Annual Open Enrollment Welcome Page will be displayed.


## SOCIAL SECURITY IDENTIFICATION

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

# Prime Value Plan Costs

The Prime Value Plan provides access to the Tier 1 Prime Healthcare Network of facilities and providers at a lower cost to members. If services are available in the Tier 1 Prime Healthcare Network, Prime UM will notify members of the lower cost option available which provides members with the greatest value for their care.

Prime Value Plan Members have the option to select a primary care physician from the Tier 1 Prime Healthcare Network and Tier 2 BCBS BlueCard Network. Establishing a primary care physician ensures you have a physician dedicated to coordinating your medical care.

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

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

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

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

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

# Prime Value Plan Costs (continued)

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

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

| Tier 2 BCBS BlueCard Network | |
|---|---|
| **Annual Deductible** | $5,000 Individual / $10,000 Family |
| **Annual Out-of-Pocket Maximum** | $5,550 Individual / $11,100 Family |
| **Office Visit**<br>• Primary Care Physician (PCP)<br>• Specialist | <br>$60 copay, No Deductible<br>$100 copay plus 20% coinsurance |
| **Preventive Care Service** | No charge |
| **Chiropractic**[1]<br>(20 visit limit per calendar year) | Deductible plus 60% coinsurance |
| **Lab and X-ray** | Deductible plus 60% coinsurance |
| **Inpatient Hospital Services** | $500 copay plus Deductible and 60% coinsurance |
| **Outpatient Hospital Services** – Surgical | Deductible plus 60% coinsurance<br>**Ambulatory Surgical Center:**<br>$750 copay plus Deductible and 60% coinsurance |
| **Urgent Care** | $100 copay plus Deductible and 60% coinsurance |
| **Emergency Room** | $300 copay plus Deductible and 60% coinsurance<br>(copay waived if admitted) |
| **Ambulance** | $300 copay plus Deductible and 30% coinsurance per trip |
| **Rehab Therapy**[1] Physical, Occupational, Speech<br>(24 visit combined limit per calendar year) | Deductible plus 60% coinsurance |
| **Dialysis**[1]**:** 39 lifetime visits | Deductible plus 60% coinsurance |
| **Home Health Care**[1]<br>(24 visit limit per calendar year) | Deductible plus 60% coinsurance |
| **Durable Medical Equipment** | Deductible plus 60% coinsurance |

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

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

# Your Prescription Drugs Benefits

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

**PRIME VALUE PLAN**

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

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

# Pharmacy Benefits

## DISPENSE AS WRITTEN (DAW)

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

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

## ADVANCED UTILIZATION MANAGEMENT (AUM) PROGRAM

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

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

## DIABETES REMOTE MONITORING PROGRAM

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

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

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

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

## FAQ

**How does the KPCM program work?**

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

**How am I notified if my prescription is changed?**

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

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

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

# Pharmacy Benefits (continued)

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

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

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

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

### ACCREDO PHARMACY

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

### SaveOnSP

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

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

# Cost of Coverage

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

| Prime Value Plan | Employee | Employee + Spouse | Employee + Child(ren) | Employee + Family |
|---|---|---|---|---|
| **Amount You Pay** | $42.64 | $91.20 | $76.15 | $151.98 |
| **Amount Prime Pays** | $158.58 | $311.26 | $286.06 | $451.71 |
| **Total Per Pay Period** | $201.22 | $402.46 | $362.21 | $603.69 |

# Making Benefit Changes During the Year

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

**QUALIFYING EVENTS INCLUDE:**

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

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

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

# Other Programs

## AGA MEDICARE OPTIONS

### Have Medicare questions?

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

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

**AGA Medicare Option...**

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

### Common question:

**What are Medical Advantage Plans?**

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

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

### About AGA Medicare Options

AGA agents specialize in the Medicare market and have been helping Medicare beneficiaries find the most suitable plan selection for their needs since 1993. They are licensed and certified and abide all state and CMS regulations. Call today to get in touch with an independent agent at 800-549-1880, TTY 711. Monday – Friday, 8:30am-5pm (PST). By calling the number, you will be directed to a licensed insurance agent.

# Summary Annual Report

## FOR PRIME HEALTHCARE SERVICES, INC. WELFARE BENEFITS PLAN

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

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

## INSURANCE INFORMATION

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

## YOUR RIGHTS TO ADDITIONAL INFORMATION

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

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

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

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

## PAPERWORK REDUCTION ACT STATEMENT

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

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

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

# Important Notices

## DISCRIMINATION IS AGAINST THE LAW

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

**Prime:**

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

If you need these services, contact Mary Schottmiller, Senior Assistant General Counsel.

If you believe that Prime has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Mary Schottmiller, Senior Assistant General Counsel, 3480 E. Guasti Road, Ontario, CA 91761, 909-235-4255, 909-235-4316, mschottmiller@primehealthcare.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Mary Schottmiller, Senior Assistant General Counsel is available to help you.

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

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

**Complaint forms are available at:**

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

**Spanish**

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

**Chinese**

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

**Vietnamese**

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

**Filipino**

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

**Korean**

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

**Armenian**

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

**Persian**

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

**Russian**

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

**Japanese**

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

# Important Notices (continued)

**Arabic**

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

**Punjabi**

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

**Mon-Khmer Cambodian**

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

**Hmong**

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

**Hindi**

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

**Thai**

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

## NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)

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

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

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

## PATIENT PROTECTIONS

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers visit https://ehp.primehealthcare.com/find-a-provider/.

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

You do not need prior authorization from the plan or any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology visit https://ehp.primehealthcare.com/find-a-provider/.

# Important Notices (continued)

## NETWORKS/CLAIMS/APPEALS

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

## COBRA CONTINUATION COVERAGE

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

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

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

## WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

## WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

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

# Important Notices (continued)

### NOTICE AND ELECTION PROCEDURES

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

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

### ELECTION AND ELECTION PERIOD

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

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

### HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

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

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

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

### OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

# Important Notices (continued)

## ENROLLMENT IN MEDICARE INSTEAD OF COBRA

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

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

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

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

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

## IF YOU HAVE QUESTIONS

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

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

## KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

## EFFECTIVE DATE OF COVERAGE

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

## COST OF CONTINUATION COVERAGE

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

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

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

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

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

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

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

# Important Notices (continued)

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

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

## SPECIAL ENROLLMENT RIGHTS NOTICE

### CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

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

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

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

**For information about Special Enrollment Rights, please contact:**

| | |
|---|---|
| Title | Corporate Benefits Manager |
| Contact Information | 909-235-4400 |

## MEDICARE PART D – IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

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

### WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

### WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Prime coverage will not be affected. If you keep this coverage and elect Medicare, the Prime coverage will coordinate with Part D coverage.

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

# Important Notices (continued)

### WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with Prime and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

### FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

Contact the person listed below for further information.

**Note:** You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Prime changes. You also may request a copy of this notice at any time.

### FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

### FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

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

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

### REMEMBER

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

| | |
|---|---|
| Date: | October 2021 |
| Name of Entity / Sender: | Prime Healthcare |
| Contact: | Corporate Benefits Manager |
| Address: | 3480 East Guasti Road |
| | Ontario, CA 91761 |
| Phone: | 909-235-4400 |

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

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

# Important Notices (continued)

## HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

### PART A: GENERAL INFORMATION

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

### WHAT IS THE HEALTH INSURANCE MARKETPLACE?

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

### CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

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

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

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

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

### PART B: EXCHANGE APPLICATION INFORMATION

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

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

# Important Notices (continue)

## PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility.

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

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

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

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

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

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

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

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

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

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

# Important Notices (continued)

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

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

**MAINE – Medicaid**
Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711

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

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

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

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

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

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

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

**NEW JERSEY – Medicaid and CHIP**
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800-701-0710

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

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

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

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

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

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

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

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

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

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

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

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

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

# Important Notices (continued)

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

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

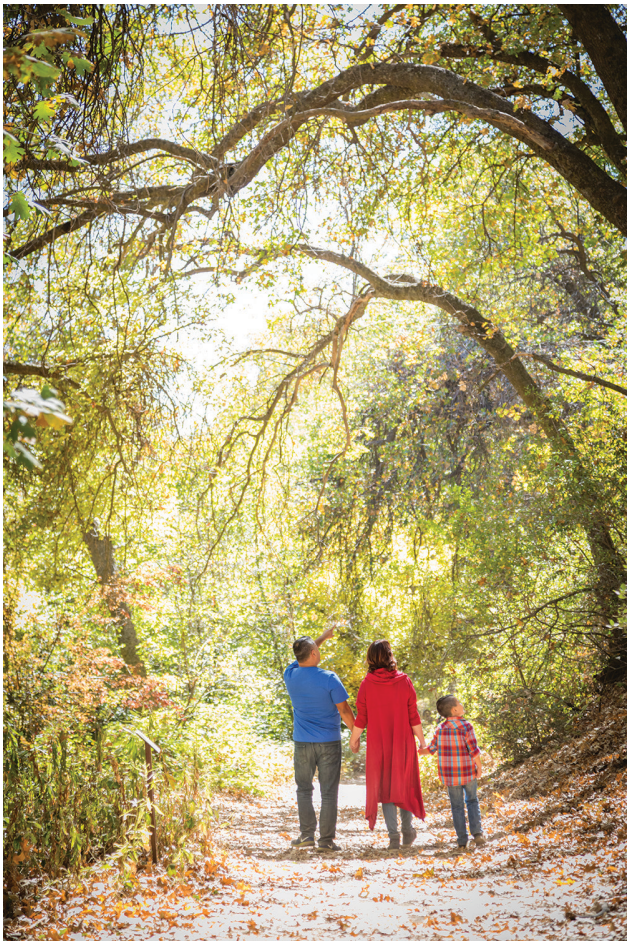
**WISCONSIN – Medicaid and CHIP**
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

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

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

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

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



# Glossary of Terms

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

## MEDICAL / GENERAL TERMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# Glossary of Terms (continued)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# Glossary of Terms (continued)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# Glossary of Terms (continued)

## PRESCRIPTION DRUG TERMS

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

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

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

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

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

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

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

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

# For Assistance

| Plan Type | Plan Providers | Phone Number | Website |
|---|---|---|---|
| **Medical**<br>Prime Healthcare Employee Health Plan (EHP)<br>• Referrals & Prior Authorization<br>• PCP Elections and Changes<br>• Claims<br>• Tier 1 Prime Provider Directory | EHP Customer Service | 877-234-5227 | www.primehealthcare.com/EHP<br><br>**Email a general inquiry:**<br>EHP@primehealthcare.com |
| **Keenan Third Party Administrator (TPA)**<br>• Member Eligibility / Plan Design<br>• Medical ID Cards<br>• Explanation of Benefits | TPA Customer Service | 888-773-7218 | www.keenan.com/benefits |
| **Prescription Drugs** | Express Scripts | 866-718-7955 | www.express-scripts.com |
| **Personal Choices** | https://app.strivebenefits.com/PHSVALUE<br>**User ID:** PHSVALUE<br>**Password:** Benefits | | |