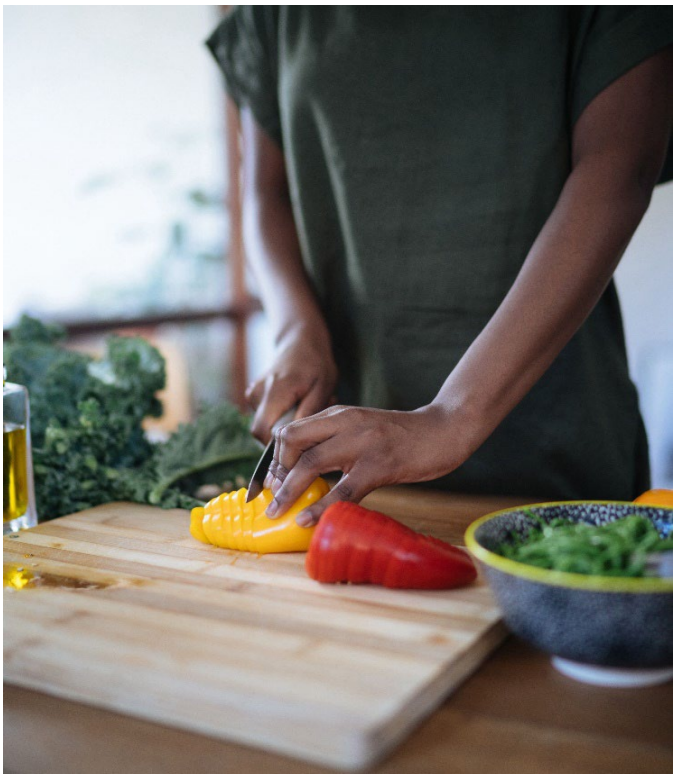
EMANATE HEALTH 2023 BENEFITS

BENEFITTING A BETTER YOU



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This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

WELCOME TO YOUR BENEFITS GUIDE

At Emanate Health, we value your contributions to our success and want to provide you with a benefits package that protects your health and helps you plan for your financial security.

This guide is about your benefits, but it's also about you and how to protect your health, your lifestyle, your future, and the people who are important to you.

You'll find details about your healthcare, life, disability and retirement benefits and tips on how to use your benefits.

You will also discover the programs that Emanate Health provides to help you save time and money and balance your work and home life.

This guide is an overview

The benefits in this summary are effective January 1, 2023, through December 31, 2023.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs).

Your 2022 Core Health Plan Offerings

- HNAS Emanate Health Medical EPO Plan
- HNAS Emanate Health Medical PPO Plan
- OptumRx Pharmacy
- Workterra Flexible Spending Account
- DeltaCare USA HMO
- Delta Dental PPO
- Delta Dental PPO Buy-Up
- VSP Vision
- Employee Assistance Program (EAP)
- Basic Life and Accidental Death & Dismemberment (AD&D) Insurance

Additional Benefits and Voluntary Products:

- Voluntary Life and AD&D Insurance
- Voluntary Long-Term Disability
- UNUM – Voluntary Short-Term Disability, Critical Illness Insurance, Accident Insurance, Hospital Indemnity
- LifeLock Voluntary ID Theft Insurance
- United Pet Care Pet Insurance
- Legal Access Voluntary Legal Assistance
- Additional Benefits – Education Reimbursement, Emanate Health Retirement Plan, Bereavement, Long-Term Sick, Workers' Compensation

WHO'S ELIGIBLE FOR BENEFITS?

Employees

You are eligible if you are a Full-Time or Part-Time Regular employee working 48 hours or more per pay period.

Eligible dependents

- Legally married spouse or domestic partner of the same or opposite sex
- Natural, adopted or stepchildren up to age 26
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the benefit booklets for each benefit.

Spousal Surcharge

If you are covering your spouse/domestic partner in an Emanate Health Medical Plan (under the Employee + Spouse or Employee + Family tier), Emanate Health will be assessing a spousal surcharge of $50 per pay period. The surcharge will only apply if your spouse/domestic partner has access to other group sponsored coverage.

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period.

Coverage begins on the 1st of the month following 30 days of employment, provided you have completed the online enrollment process and have provided any applicable documentation to Human Resources.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

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

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

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

You must submit your change within 31 days of the qualifying event.

Dependent Verification

IMPORTANT: Newly acquired dependents may be added to the plan during the year by submitting the information to HR and providing verification documents within 31 days of their eligibility. See pages 40-41 for dependent verification requirements.

ENROLLING FOR BENEFITS

LOGGING IN

Logging in at Work: You can log into your own PC account or from the Intranet, click the Workday icon for automatic sign-in

Logging in from Home:

- Go to emanatehealth.org or download the Workday app
- At the bottom of the page, click on "Staff and Physician Resources" then click on Workday

  Username: cvhp\domainname (Work PC username)
  Example: John Doe = cvhp\jdoe

  Password: normal PC password

Welcome to Workday!

All employees will utilize the Workday system to enroll in benefits. You will be able to enroll in your benefits from work or home.

Step 1:

Once you log in, search for the "Benefit Change" notification in your inbox located in the upper right hand. Begin selecting desired coverage.

IMPORTANT: If you are covering a spouse or domestic partner under your medical coverage, you must elect to enroll in the "Spousal Surcharge." If no, the surcharge does not apply, and you can select "Not Applicable ($0)" under the Coverage Selection or waive.

Step 2:

Confirm your benefits. Your confirmation statement is a summary of your benefit selections. Review this statement carefully to verify everything is correct, then check "I Agree" at the bottom of the page to the Electronic Signature. Click "Submit" to complete the enrollment process. Print a copy for your records.

Note: Throughout the year, you can go online to Workday to do the following:

- View your Election History (which verifies your coverage)
- Change/Update your beneficiaries
- Initiate Qualifying Event changes
- Download forms and plan summaries

Reminder: Documentation must be submitted via Workday at the time of enrollment by uploading documents in the Attachments box. Please be sure to title your documentation appropriately (i.e., "Marriage Certificate", "Birth Certificate – (child's name)", etc.) Failure to provide documentation verification for newly added dependents will result in no coverage for your dependent. (Important: Please make sure to have the following information for your dependents: date of birth and social security number).

Your dependents will not be enrolled if the required documentation is not received prior to your effective date for benefits. To help you further understand the documentation that is needed, please see page 40 and 41 for the Dependent Eligibility Matrix.

MEDICAL

OUR MEDICAL PLANS

Medical EPO

Medical PPO

All About Medical Plans

- **DEDUCTIBLE:** The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.
- **OUT-OF-POCKET MAXIMUM:** Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most eligible expenses for the rest of the plan year.
- **COINSURANCE:** After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.
- **COPAY:** A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.
- **IN-NETWORK / OUT-OF-NETWORK:** In-network services will always be the lowest cost option. Out-of-network services will cost more or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

MEDICAL EPO PLAN

When covered under the EPO Plan, you must use the services of a participating provider. No specialist referral is required. Certain medical services will require prior authorization. To receive the maximum benefits, use the Tier 1 - Emanate Health Providers. To view a complete listing of all Tier 1 Providers, please visit and log into the HealthNow Administrative Services (HNAS) site at www.hnas.com.

	Tier 1 **Emanate Health Providers**	**Tier 2** **Anthem Blue Cross Participating Providers**
Annual Deductible	$0 Individual $0 Family	$1,000 Individual $2,000 Family
Annual Out-of-Pocket Maximum	$1,000 Individual $2,000 Family	$3,000 Individual $6,000 Family
Lifetime Max	Unlimited	Unlimited
Office Visit Primary Provider Specialist	 $10 copay $20 copay	 $25 copay $60 copay
Preventive Services	**No Charge**	**No Charge**
Chiropractic Care	$10 copay	$25 copay
Acupuncture Care	Not Covered	Not Covered
Lab and X-ray CT, MRI, PET Scans Other lab and x-ray tests	 No Charge No Charge	 20% after deductible $60 copay
Inpatient Hospitalization	No Charge	20% after deductible
Outpatient Surgery	No Charge	20% after deductible
Urgent Care	Not Available	$25 copay
Emergency Room	$150 (waived if admitted)	$150 (waived if admitted)
Ambulance	Not Available	20% after deductible
Mental Health/Substance Abuse Inpatient Admission Outpatient Services	 No Charge $10 copay	 20% after deductible $25 copay

Plan deductibles, plan copayments and pharmacy (Rx) copayments accumulate toward the annual out-of-pocket maximum.

MEDICAL PPO PLAN

The PPO plan allows you and your dependents to seek needed medical care from any hospital, physician or other provider you wish. To receive the maximum benefit, use the Tier 1 – Emanate Health Providers. To view a complete listing of all Tier 1 Providers, please visit and log into the HealthNow Administrative Services (HNAS) site at www.hnas.com.

	Tier 1 **Emanate Health Providers**	**Tier 2** **Anthem Blue Cross** **Participating Providers**	**Tier 3** **Non-Participating Providers**
Annual Deductible	$0 Individual $0 Family	$300 Individual $600 Family	$600 Individual $1,200 Family
Annual Out-of-Pocket Maximum	$1,000 Individual $2,000 Family	$6,000 Individual $12,000 Family	$8,000 Individual $14,000 Family
Lifetime Max	Unlimited	Unlimited	Unlimited
Office Visit Primary Provider Specialist	 $10 copay $20 copay	 $20 copay $35 copay	 40% after deductible 40% after deductible
Preventive Services	**No Charge**	**No Charge**	**Not Covered**
Chiropractic Care	$10 copay	$20 copay	40% after deductible
Acupuncture Care	Not Covered	Not Covered	Not Covered
Lab and X-ray CT, MRI, PET Scans Other lab and x-ray tests	 No Charge No Charge	 20% after deductible 20% after deductible	 40% after deductible 40% after deductible
Home Health Services	No Charge	20% after deductible	Not Covered
Inpatient Hospitalization	No Charge	20% after deductible	50% after deductible
Outpatient Surgery	No Charge	20% after deductible	40% after deductible
Urgent Care	Not Available	20% after deductible	40% after deductible
Emergency Room	$100 copay (waived if admitted)		
Ambulance	Not Available	20% after deductible	20% after deductible
Mental Health/Substance Abuse Inpatient Admission Outpatient Services	 No Charge No Charge	 20% after deductible 20% after deductible	 50% after deductible 40% after deductible

Plan deductibles, plan copayments and pharmacy (Rx) copayments accumulate toward the annual out-of-pocket maximum.

PRESCRIPTION DRUGS

Below are the prescription drug plans that are offered with our Emanate Health Medical EPO and PPO Plan. Your Pharmacy Benefits Manager (PBM) for the 2023 plan year is OptumRx.

EPO PLAN		
	Tier 1 **CVS Pharmacies***	**Tier 2** **OptumRx Participating Providers**
Annual Out-of-Pocket Limit	$1,000 Individual $2,000 Family (combined with Medical)	$3,000 Individual $6,000 Family (Combined with Medical)
Pharmacy		
Generic	$10 copay	$20 copay
Preferred Brand	$25 copay	$45 copay
Non-Preferred Brand	$55 copay	$120 copay
Specialty Drugs	20% up to $150	20% up to $150
Supply Limit	30 days	30 days
Mail Order	**CVS Walk-In Only**	
Generic	$20 copay	$40 copay
Preferred Brand	$50 copay	$90 copay
Non-Preferred Brand	$110 copay	$240 copay
Supply Limit	90 days	90 days

PPO PLAN			
	Tier 1 **CVS Pharmacies***	**Tier 2** **OptumRx Participating Providers**	**Tier 3** **Non-Participating Providers**
Annual Out-of-Pocket Maximum	$1,000 Individual $2,000 Family (Combined with Medical)	$6,000 Individual $12,000 Family (Combined with Medical)	$8,000 Individual $14,000 Family (Combined with Medical)
Pharmacy			
Generic	$10 copay	$20 copay	Not covered
Preferred Brand	$25 copay	$45 copay	Not covered
Non-Preferred Brand	$55 copay	$120 copay	Not covered
Specialty Drugs	20% up to $150	20% up to $150	Not covered
Supply Limit	30 days	30 days	Not applicable
Mail Order	**CVS Walk-In Only**		
Generic	$20 copay	$40 copay	Not covered
Preferred Brand	$50 copay	$90 copay	Not covered
Non-Preferred Brand	$110 copay	$240 copay	Not covered
Supply Limit	90 days	90 days	Not applicable

*Please refer to Page 11 for listing.

PHARMACY (Rx) PLANS

We've partnered with (3) local CVS pharmacies, one near each Emanate Health hospital, to offer Tier 1 pharmacy benefits. These benefits include reduced co-pays, the ability to order a 90-day supply of medications for the cost of two monthly co-pays, extended hours and locations conveniently located near each Emanate Health campus.

Prescription Drugs

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue, such as bronchitis or an ongoing condition, such as high blood pressure.

If you enroll in medical coverage with Emanate Health, you will automatically receive coverage for prescription drugs.

OptumRx is the administrator for your prescription drugs.

Things to know:

- Use your health insurance card sent to you by HNAS when you pick up your prescriptions.
- Your health insurance card is accepted at a wide network of chains and independent pharmacies, as well as a mail order pharmacy that offers convenient delivery of medications directly to your home or office.

Tier 1 Pharmacy Providers

CVS Pharmacy (near Queen of the Valley Hospital)

727 South Glendora Avenue
West Covina, CA 91790
(626) 337-7284
M – F 8am to 9pm, Sat 9am to 6pm, Sun 10am to 6pm

CVS Pharmacy (near Inter-Community Hospital)

206 North Azusa Ave
Covina, CA 91722
(626) 331-9907
M – F 8am to 9pm, Sat 9am to 6pm, Sun 10am to 6pm

CVS Pharmacy (near Foothill Presbyterian Hospital)

130 North Grand Ave
Glendora, CA 91741
(626) 963-0385
M – F 8am to 9pm, Sat 9am to 6pm, Sun 10am to 6pm

LEARN ABOUT TIER 1 PROVIDERS

Emanate Health Tier 1 Providers

Emanate Health Tier 1 Providers are Primary Care and Specialty Physicians specifically selected by Emanate Health for their specialty and relationship with the Emanate Health facilities. Using an Emanate Health Tier 1 Provider will result in a lower copayment and/or coinsurance to you.

Emanate Health Inter-Community Hospital, Emanate Health Queen of the Valley Hospital, Emanate Health Foothill Presbyterian Hospital, Emanate Health Medical Group, Emanate Health Hospice, Emanate Health Home Care and Glendora Surgery Center are considered Tier 1 providers. Employees and covered dependents will have zero copayments/co-insurance or deductibles for facility service(s) obtained at an Emanate Health Hospital including all lab tests, x-rays, and other diagnostic tests.

You can visit www.hnas.com for a full Tier 1 Provider Listing.

Medical Group Liaisons: (626) 483-2150

Emanate Health Outpatient Services

Healthcare needs change throughout your life. Emanate Health's outpatient clinic provides primary and specialty services by highly trained physicians and clinicians to care for individuals and families through every stage of life.

Neurology

Our board-certified neurologists deliver evidence-based, expert-level care with a multidisciplinary and collaborative approach to provide a specialized treatment plan for those who have neurological health issues.

Cardiology

From diagnosis to rehabilitation and prevention, we are committed to helping patients maintain, enhance and take control of their heart health.

Pediatrics

Emanate Health Pediatrics is committed to providing the youngest of patients with the highest quality care. We are passionately dedicated to making each patient feel comfortable while working hard to keep them healthy.

OB/GYN

Whether you need a well-woman exam, a routine mammogram or prenatal care, our expert gynecologists and obstetricians are here to ensure you feel safe, comfortable and empowered as you make decisions about your health.

Family Medicine

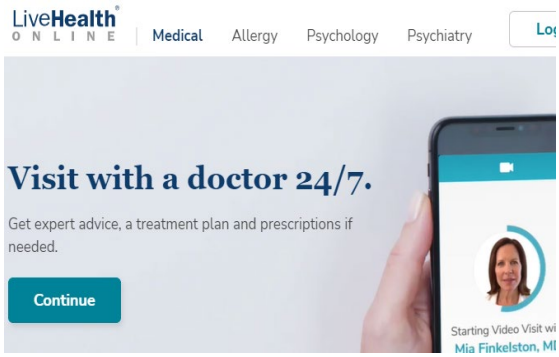
At Emanate Health, we care for people of all ages, offering services from expert physicians who are here to ensure you feel comfortable and empowered to maintain a healthy life.

Orthopedics/Sports Medicine & Rehabilitation

Your body was made to move, but when arthritis or sports injuries occur, even the smallest movements can be painful. Our orthopedic specialists and surgeons treat a wide variety of musculoskeletal conditions, so that you can return to the activities you love!

To learn more about Emanate Health Outpatient Services & to Find a Doctor, visit emanatehealth.org/outpatientservices.

LIVEHEALTH ONLINE



What is LiveHealth Online?

LiveHealth is a service offered through Anthem in which you can have a private and secure video visit with a board-certified doctor on your smartphone, tablet or computer with a webcam. It's a quick and easy way to get the care you need with no appointments or long wait times. You can use LiveHealth Online if you have pinkeye, a cold, the flue, a fever, allergies, a sinus infection, or other common health conditions. A doctor can assess your condition, provide a treatment plan, and even send a prescription to your pharmacy, if needed. You have 24/7 access to this service. LiveHealth Online should not be used for emergency care.

How does LiveHealth Online Work?

When you see a doctor, simply go to www.livehealthonline.com or use the LiveHealth Online mobile app. Pick the state you're in and answer a few questions. Setting up an account allows you to securely store your personal and health information. Plus, you can easily connect with doctors in the future, share your health history and set up online visits at times that fit your schedule. Once connected, you can talk with the doctor as if you were in a private exam room.

How to Get Started

Rather than waiting to sign up when you're not feeling well, register today so you're ready for a visit when you

need one. To sign up, visit livehealthonline.com or download the free LiveHealth Online app to your mobile device.

1. Choose Sign Up to create your LiveHealth Online account. Then enter the required information.

2. Read the Terms of Use and check the box to agree.

3. Choose your location in the drop-down box of states.

4. Enter your birth date and choose your gender.

5. For the question "Do you have insurance?", select Yes. Be sure to have your Anthem member ID card

with you to complete your insurance information. If you choose No, you can still enter the insurance information later.

6. For Health Plan, in the drop-down box, select Anthem.

7. For Subscriber ID, enter your identification number, which is found on your Anthem member ID card.

Select Yes if you are the primary subscriber or No if you are not the primary subscriber.

8. Insert a service key if you have one. If you don't have a service key, that is okay as this is optional and not required to register.

9. Select the green Finish button.

IMPORTANT: There is a $15 copay to use the LIveHealth Online service.

DENTAL

Employees may enroll in the Dental HMO (Health Maintenance Organization) and choose a dentist from the DeltaCare USA Network. The DHMO plan provides you with a list of qualified DeltaCare USA dentists who will deliver you the same services, but at a set of pre-negotiated rates. To locate a dentist, please visit www.deltadentalins.com and click on "Find a Dentist", then click on DeltaCare USA.

The Dental PPO Plan provides you the ability to visit any dentists in the Delta Dental network, making your costs significantly reduced by obtaining your dental care from the Preferred Providers (in-network dentists) over the Non-Preferred Providers (out-of-network providers). To locate a network dentist, please visit www.deltadentalins.com.

	DeltaCare USA DHMO	Delta Dental DPPO		Delta Dental DPPO Buy-Up	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible					
Individual	$0	$0	$50	$0	$50
Family	$0	$0	$100	$0	$100
Annual Plan Maximum	Unlimited	$1,500*		$2,000	
Diagnostic & Preventive	$0 - $25 copay[1]	Deductible Waived		No Charge	
Basic Services					
Fillings	$0 - $90 copay[1]	20%	20%	20%	20%
Root Canals	$0 - $155 copay[1]	20%	20%	20%	20%
Periodontics	$0 - $250 copay[1]	20%	20%	20%	20%
Major Services	$0 - $175 copay[1]	50%	50%	50%	50%
Orthodontia Services					
Children	$1,600 copay[2]	Not Applicable		50%	
Adults	$1,800 copay[2]			50%	
Lifetime Maximum				$1,500	

*Diagnostic & preventive services do not count toward the Base PPO plan's annual maximum
[1]Copays varies by service; see contract for fee schedule
[2]See contract for fee schedule, start-up fee $350

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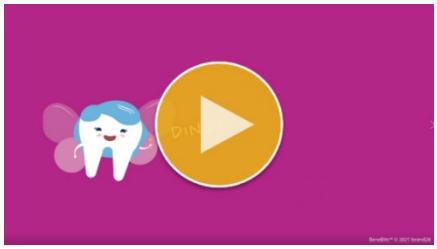


VISION

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

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

	VSP Choice Network	
	In-Network	**Out-of-Network**
Examination Benefit Frequency	 $1o copay 1 x every 12 months	 Up to $45 In-Network limitations apply
Materials	$10 copay	$10 copay
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	 No Charge of basic lens (materials copay applies) No Charge of basic lens (materials copay applies) No Charge of basic lens (materials copay applies) 1 x every 24 months	 Up to $30 Up to $50 Up to $65 In-Network limitations apply
Frames Benefits Frequency	 Up to $150 plan pays (20% discount over allowance) 1 x every 24 months	 Up to $70 In-Network limitations apply
Contacts (Elective) Benefit Frequency	 Up to $150 (15% discount over allowance) 1 x every 24 months	 Up to $105 In-Network limitations apply

Click to play video

FLEXIBLE SPENDING ACCOUNTS (FSA)

Click to play video

FIND OUT MORE

- Administered by: Workterra
- Eligible Expenses – now include more over-the-counter items!
- Ineligible Expenses

Set aside healthcare dollars for the coming year.

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

USE IT OR LOSE IT

If you decide to contribute pre-tax dollars to an FSA and do not use all of the dollars at the end of the plan year, you will lose the remaining balance in the account at the end of the grace period. The "grace period" allows you to continue to incur new claims up to March 15, 2024, with any remaining funds from your 2023 elected amount.

Healthcare Flexible Spending Account

For 2023, you may contribute up to $2,850 in pre-tax dollars to cover eligible health care expenses. **The entire amount you set aside is available to you on your coverage effective date.** This plan offers a benefit debit care for your convenience.

Dependent Care Flexible Spending Account

For 2023, you may contribute up to $5,000 in pre-tax dollars to cover eligible dependent care expenses. If you and your spouse file separate tax returns, your maximum contribution is $2,500. **The entire amount you set aside at the time of enrollment is not available right away – funds are available as they are deducted from your paycheck.**

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

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

LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

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

Is your family protected?

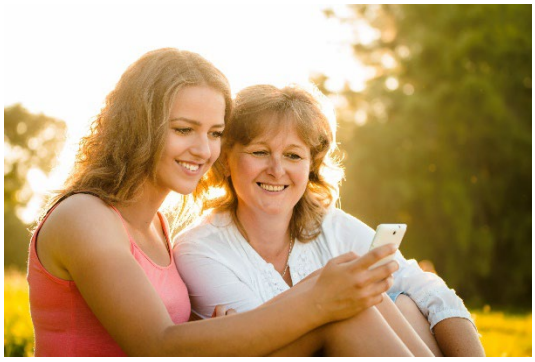
Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large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

We provide short term disability benefits and a base amount of Life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Additional Benefits section for details one some of these voluntary benefits.

LIFE AND AD&D INSURANCE



Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by the company and all eligible employees will be automatically enrolled. Coverage is provided by New York Life.

Basic Life Amount	**1 x covered annual earnings up to a maximum of $800,000**
Basic AD&D Amount	**$3,000**

Guarantee issue: There is a Guarantee Issue (GI) amount of $650,000. Evidence of Insurability (EOI) is required for amounts over $650,000 to a maximum of $800,000.

Taxes: Due to IRS regulations, a life insurance benefit of $50,000 or more is considered a taxable benefit. You will see the value of the benefit included in your taxable income on your paycheck and W-2.

Voluntary Life and AD&D

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

You can purchase Voluntary Life with or without purchasing the AD&D benefit.

Employee Voluntary Life Amount	**Up to the lesser of 3x your salary or $500,000**
Spouse Voluntary Life Amount	**$5,000 or $10,000**
Child(ren) Voluntary Life Amount	**$1,000 or $5,000 for each child**
Employee Voluntary AD&D	**Up to 10x your salary – minimum of $25,000 and maximum of $500,000**

Voluntary AD&D is available for family only when Voluntary Life is elected.

LIFE AND AD&D INSURANCE

Voluntary Life and AD&D (continued)

The plan will pay dismemberment benefits for any of the following losses:

- Both hands
- Both feet
- Sight of both eyes
- One hand and one foot
- One hand and sight of one eye
- One hand
- One foot
- Sight of one eye

Loss of sight means total and irrevocable loss of sight. Loss of hand or foot means loss by severance at or above the wrist and ankle. The total payment for all losses due to any one accident will not be more than your full amount of AD&D insurance.

Evidence of Insurability (EOI): Elections over 2x your salary or $250,000 will require the completion of an EOI form which involves providing the insurance company with additional information about your health. If you elect spouse coverage for the first time at open enrollment or increase spouse coverage at open enrollment, EOI will be required. The EOI form is available through Emanate Health Intranet, Workday or through Human Resources.

DISABILITY INSURANCE

State Disability

Through the state of California, you receive payment for an absence due to non-work-related illness or accident. Benefits begin on the 8th consecutive day of illness or accident. You must apply for benefits if you are eligible.

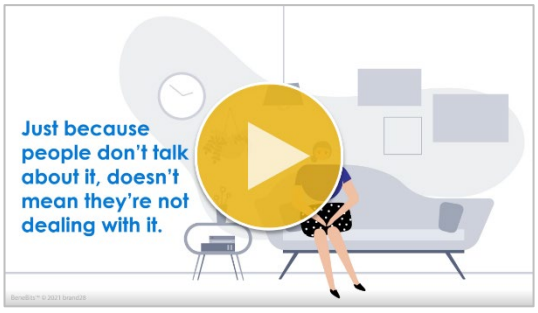
Voluntary Short Term Disability Insurance

Short Term Disability insurance protects your most valuable asset, your income, if you are unable to work due to an illness or off the job injury. You may purchase additional coverage through UNUM. **Benefits will be reduced by any amounts received or entitled to receive from California State Disability or any other sources of income.**

Maximum Weekly Benefit	**67% up to $2,500 per week**
Elimination Period	**Injury: 0 days** **Sickness: 14 days**
Maximum Duration Period	**52 weeks**
Pre-Existing Condition Limitation	**If you have received medical treatment, care or services for a diagnosed condition, or took prescribed medication for that diagnosed condition, in the 3 months immediately prior your effective date of coverage; such condition will not be covered for the first 12 months of the effective date of coverage (credit for prior coverage may apply)**

ADDITIONAL BENEFITS

Click to play video



Accident Insurance

Accident Insurance is designed to help you pay for unexpected costs that result from an accidental injury. Accident Insurance includes benefits for a wide range of common injures such as fractures, dislocations, burns, emergency room or urgent care visits and physical therapy.

If you or a covered family member suffer from an accident, this plan will pay specific benefit amounts. The amount of money you receive depends on the type and severity of your injury and can be used any way you choose. Coverage is available for you, your spouse and your eligible children.

Critical Illness

This benefit provides a lump sum, tax-free benefit upon diagnosis of a covered illness (heart attack, stroke, cancer, etc.). You can cover yourself and your family members if needed.

Hospitalization Insurance

When an accident or illness results in an inpatient hospital stay, the costs can add up. If you or a covered family member have a covered inpatient hospital stay, this plan will pay you a lump sum, tax-free benefit.

Legal Assistance Program

Enrollment in the Legal Assistance Program includes consultation on a variety of common legal matters and simple will preparation. This program provides website access to user-friendly online resources.

Employee Assistance Program

You and your family members have access to professional and confidential assistance for dealing with financial difficulties, marital/family problems, legal concerns, substance abuse, work related issues, etc. Emanate Health pays the full cost of the EAP program. We strongly encourage you to utilize this benefit resource before utilizing your EPO or PPO medical plan. For further information, contact:

The Employee Assistance Program

(800) 266-0510, your supervisor, or Human Resources

ADDITIONAL BENEFITS

ID Theft Protection

Identify theft is one of the fastest growing crimes in the United States. This program provides additional financial security for you and your family and features 24-hour phone access to identity theft recovery counselors.

Education Reimbursement

If you take courses directly related to your present position or advancement in the healthcare field, tuition, registration fees and other related fees may be partially reimbursed by Emanate Health once you meet the eligibility requirements. Reimbursement is 100% of the costs to the following maximum amounts:

- Full-time employees: $3,000 per year
- Part-time employees: $1,500 per year

Prior approval is required.

Emanate Health Retirement Plan

You may choose to set up and account with Lincoln Financial to save for your retirement by making convenient tax-deferred contributions through regular payroll deductions. A Roth account, where you make after tax deductions, is also available. You can direct your contributions to a wide choice of investments.

When you contribute to the Emanate Health Retirement Plan, Emanate Health makes matching contributions each pay period if you meet the eligibility requirements. The match begins at 3% after 1 year of service and 1,000 hours worked in that year. It increases to 4% after 4 years of service and again after 9 years of service to 5%. It is 100% vested after 5 years of service and 1,000 hours worked in each year. To begin contributing to your retirement, please contact Lincoln Financial at (800) 234-3500.

Bereavement

In the event of the death of a designated family member, you will receive pay for bereavement time if you are previously scheduled for work. If you are full-time 8-hour employee, you will receive up to 32 hours of pay. If you are a full-time 12-hour employee, you will receive up to 36 hours of pay. Pay is prorated for a part-time employee.

ADDITIONAL BENEFITS

Long-Term Sick (LTS)

LTS can be used starting on the 8th consecutive day of illness/ accident or the 4th day of workers compensation. You accrue LTS, up to 2.0 hours per pay period, based on regular hours paid. LTS pay is integrated with California State Disability or workers compensation and provides you with income during a period of significant illness.

Workers' Compensation

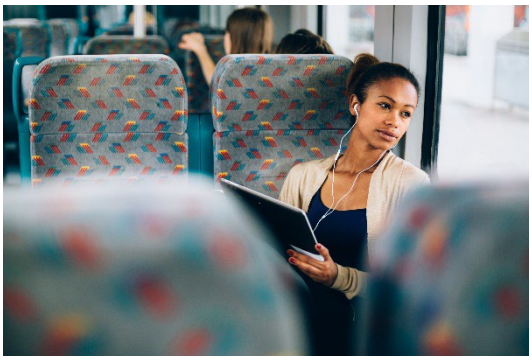
You receive payment for work-related illnesses, accident or conditions, beginning the 1st day of hospitalization or 4th consecutive day of absence.

Paid Time Off (PTO)

You accrue PTO based on your length of employment and the hours you are paid each pay period (excluding Long-Term Sick). PTO can be used for vacations, holidays and personal sick time.

Time of Employment	Accrual Factor	Maximum Accrual Per Pay Period
0-90 days	0.0334 per hour	0.00
90 days – 1 year	0.0850 per hour	6.80
1 – 4 years	0.0887 per hour	7.10
5 – 9 years	0.1076 per hour	8.60
10+ years	0.1275 per hour	10.20

ADDITIONAL BENEFITS



Rideshare Program

Emanate Health is committed to supporting sustainable transportation options for our hospitals in accordance with the annual South Cost Air Quality Management District (AQMD) requirements.

Emanate Health's Rideshare Incentive Program provides subsidy/ incentives to employees who ride the public transportation, carpool with employees, walk, bike or ride their motorcycle to work.

For more information and to see if you are eligible for our Rideshare Incentive Program, please contact your Human Resources or refer to Policy HR-310. Emanate Health's Rideshare Incentive Program saves money, saves time, reduces pollution (fewer emissions) and vehicle maintenance!

Pet Insurance

Emanate Health is pleased to offer our employees the opportunity to save on your veterinary care. Through United Pet Care, you have the chance to a low price, including preventative, accident and sick care. You can join regardless of the pet's age or medical conditions. You can instant savings of 20-50% on every visit. In addition, United Pet Care features no claim forms, no deductibles, no waiting period, no age exclusions and no exclusions due to pre-existing or breed-specific conditions.

IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Your medical, dental and vision benefit contributions for the 2023 plan year
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms
- A Dependent Eligibility Matrix to help you further understand the required documentation when adding a dependent

COST OF COVERAGE

Below you will find the bi-weekly payroll deductions that will become effective January 1, 2023 and will remain in effect through December 31, 2023.

MEDICAL

EPO Plan	Your Cost
Employee Only	$31.02
Employee + Spouse/Domestic Partner	$149.83
Employee + Child(ren)	$128.43
Employee + Family	$214.04

PPO Plan	Your Cost
Employee Only	$89.36
Employee + Spouse/Domestic Partner	$309.06
Employee + Child(ren)	$264.91
Employee + Family	$441.50

VISION

VSP Vision	Your Cost
Employee Only	$0.00
Employee + Spouse/Domestic Partner	$2.60
Employee + Child(ren)	$2.75
Employee + Family	$5.48

DENTAL

DeltaCare USA HMO	Your Cost
Employee Only	$2.90
Employee + Spouse/Domestic Partner	$7.60
Employee + Child(ren)	$6.80
Employee + Family	$10.11

Delta Dental PPO	Your Cost
Employee Only	$10.66
Employee + Spouse/Domestic Partner	$24.78
Employee + Child(ren)	$21.24
Employee + Family	$31.76

Delta Dental PPO Buy-Up	Your Cost
Employee Only	$20.82
Employee + Spouse/Domestic Partner	$46.14
Employee + Child(ren)	$39.54
Employee + Family	$62.26

PLAN CONTACTS

Provider	Plan	Phone Number	Website
Medical			
HealthNow Administrative Services (HNAS)	EPO PPO	855.323.1132	www.myhnas.com
Pharmacy			
OptumRx	Rx	866.795.6556	www.optumrx.com
	Specialty Rx	877.838.2907	
Dental			
Delta Dental	Dental HMO	800.422.4234	www.deltadentalins.com
	Dental PPO	800.765.6003	
Vision			
VSP	Vision Service Plan	800.877.7195	www.vsp.com
Life and AD&D			
New York Life	Basic Life and AD&D Voluntary Life and AD&D	800.362.4462	www.newyorklife.com
Flexible Spending Account			
Workterra	Health Care FSA Dependent Care FSA	888.327.2770	www.workterra.net
Additional Benefits			
United Pet Care	Pet Insurance	888.781.6622	www.unitedpetcare.com/emanatehealth
Lincoln Financial Group	Retirement Plan	800.234.3500	www.lfg.com
Professional Resources	Employee Assistance Program (EAP)	800.266.0510	

PLAN CONTACTS

Provider	Plan	Phone Number	Website
Voluntary Benefits			
UNUM	Critical Illness Insurance Accident Insurance Hospital Indemnity	800.635.5597	www.unum.com
UNUM	Voluntary Short-Term Disability	Claims: 800.858.6843 Plan Questions: 800.421.0344	www.unum.com
LifeLock	Voluntary ID Theft	800.416.0599	https://memberportal.lifelock.com/
Legal Access	Voluntary Legal Assistance	888.416.4313	www.legaleaseplan.com/emanate

GLOSSARY

-A-

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

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

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

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

-B-

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

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

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

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

-C-

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

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

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

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

-D-

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

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

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

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

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

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

-E-

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

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

-F-

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

-G-

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

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

-H-

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

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

GLOSSARY

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

-I-

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

-L-

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

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

-M-

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

-O-

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

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

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

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

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

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

-P-

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

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

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

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

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

-S-

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

-T-

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

-U-

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

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

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

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

REQUIRED PLAN NOTICES

AVAILABILITY OF PRIVACY PRACTICES NOTICE

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

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

AVAILABILITY OF SUMMARY INFORMATION

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

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

MEDICARE PART D NOTICE

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

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

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

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

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

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

Date:	August 2022
Name of Entity/Sender:	Emanate Health
Contact-Position/Office:	Human Resources
Address:	140 W. College St. Covina, CA 91723
Phone Number:	626.858.8515

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

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

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

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 6156

PAPERWORK REDUCTION ACT STATEMENT

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

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

Discrimination is Against the Law

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

Emanate Health:

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

If you need these services, contact Angela Bernacki. If you believe that Emanate Health 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:

Angela Bernacki
140 W College St. 2nd Floor Covina, CA 91722
Telephone Number: 626.858.8515
Fax Number: 626.858.8506
Email: abernacki@emanatehealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Angela Bernacki is available to help you.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr.

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

DEPENDENT ELIGIBILITY MATRIX

Eligible Dependent Type	Eligible Dependent Definition	Required Documentation for Proof of Eligibility
Employee's Child under age 26	Children under the age of 26. Includes any of the following: 1. Natural Child 2. Adopted Child 3. Child for whom the employee is legal guardian Note: The dependent coverage extension to age 26 does not apply to court-ordered non-temporary legal guardianship dependents. Such dependents will be covered only until age 18.	• Birth Certificate: must contain the following information: name of the employee, name of the child and the date of birth (hospital birth records are acceptable only for children under 6 months old and birth certificate is not available); or • Adoption Paperwork: must reflect that the child is the child of the employee and contain the following information: name of the adoptive parent (employee), name of child, and notary signature; or • Court Order: stating that the employee is the child's legal guardian and must contain the following information: name of the legal guardian (employee), name of child and notary signature; or • A divorce decree, court order, or Qualified Medical Child Support Order (QMCSO) declaring the employee is legally responsible for providing health coverage for the child. This must contain name of the parent, name of the child and notary signature.
Stepchild or Domestic Partner's Child under age 26	Children under the age of 26. Includes any of the following: 1. Stepchild 2. Domestic Partner's Child Note: The dependent coverage extension to age 26 does not apply to court-ordered non-temporary legal guardianship dependents. Such dependents will be covered only until age 18.	• Birth certificate showing the child's parent to be your spouse or domestic partner (hospital birth records are acceptable only for children under 6 months old and birth certificate is not available); or • Adoption Paperwork: must reflect that the child is the child of the spouse/domestic partner and contain the following information: name of the adoptive parent (spouse/domestic partner), name of child, and notary signature; or • Court Order: stating that the employee's spouse/domestic partner is the child's legal guardian and must contain the following information: name of the legal guardian (spouse/domestic partner), name of child and notary signature; or • A divorce decree, court order, or Qualified Medical Child Support Order (QMCSO) declaring the spouse/domestic partner is legally responsible for providing health coverage for the child and notary signature. PLUS • Documentation showing your relationship to the stepchild's or domestic partner's child's parent (see above for documentation required for spouse and/or domestic partner)

DEPENDENT ELIGIBILITY MATRIX

Eligible Dependent Type	Eligible Dependent Definition	Required Documentation for Proof of Eligibility
Legal Spouse	A person who is legally married to an employee, so long as he/she is not covered as an employee under an Emanate Health plan.	• Joint tax return, tax return must contain the following information: name of employee and spouse from the most recent tax year, clearly lists names of employee and spouse (married indicated) black out financial information; or • Both spouse's federal tax return if filing separately; or • Copy of tax confirmation notice(s) if filed online; or • Marriage Certificate: must contain name of employee (maiden name acceptable), name of dependent spouse, date of marriage
Domestic Partner	A person of the same or opposite sex with whom you have entered a domestic partnership and reside together in the same principal residence where both of you are 18 years or older and have not married nor have had another domestic partner within the past 6 months.	• Statement of Domestic Partnership that is signed by both partners or Declaration of Domestic Partnership filed with the State of California PLUS • Current proof of joint marriage or joint tenancy on a residential lease. The joint mortgage must include name of employee, name of domestic partner, name of institution; or • Joint bank account or joint liabilities (credit cards). Either of these documents must include name of the employee, name of domestic partner and name of institution; or • Designation or domestic partner as beneficiary for Life Insurance or a legal will or trust.