PIONEERS
MEMORIAL HEALTHCARE DISTRICT

Affiliate of the
SCRIPPS HEALTH NETWORK

2023 Benefit Guide

This brochure provides a highlight of the plans offered by Pioneers Memorial Healthcare District and in no way serves as the Summary Plan Description or plan document for the plans. If any discrepancies exist between this brochure and the plan documents or Pioneers Memorial Healthcare District policy, the plan documents or policies shall govern. All Summary Plan Descriptions are available through Human Resources. We reserve the right to modify any of these plans at anytime.

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Welcome

At Pioneers Memorial Healthcare District, we strive to offer a robust benefits package that gives you peace of mind in knowing that the most important things in life are protected—your family, your finances, and your future. This benefit summary highlights the many benefit options available to you.

During your initial enrollment period only, you have the opportunity to enroll in certain voluntary benefit plans without being required to answer any medical questions. If you enroll at a later date, you may be asked to answer medical questions before enrolling in coverage.

Eligibility

If you are an employee regularly working a minimum of 32 hours per week, you are eligible to enroll in benefits. Eligible employees may also choose to enroll family members, including a legal spouse/registered domestic partner (as legally defined under state and local law) and/or eligible children.

Your enrollment choices remain in effect through the end of the benefits' plan year, July 1 through June 30. Benefits for eligible new hires will commence on the first of the month following 30-days of hire.

We're here to help! If you have any questions at all, please contact the Human Resources Department at **760.351.3299** or **echavarin@pmhd.org**.

Medical Coverage – *Anthem*

Pioneers Memorial Healthcare District medical plans offer flexibility in managing care for you and your family. You have the option to choose between two plans from **Anthem, our new medical network:** Freedom Medical PPO and Independence Medical PPO. Although you may see any doctor you like, you will receive greater benefits and lower costs when you choose a Pioneers Memorial Healthcare District or in-network provider. Please note that the claims administrator is also changing. **Claims will be submitted through Pinnacle, the new administrator, so make sure you get your new Pinnacle/Anthem ID card before you see your provider.**

Please note, if you have other group medical coverage and waive Pioneers medical plan, you are eligible to receive $100 per month via your paycheck. You must provide a copy (front & back) of your insurance card to HR. If you do not provide a copy of your insurance card, you will be enrolled in the Independence plan as employee only.

The table on the next page provides a general summary of your medical benefits; please refer to your Summary Plan Description (SPD) for additional details.

Prescription Drug Coverage

- Many FDA-approved prescription medications are covered through the benefits program. Important information regarding your prescription drug coverage is outlined below:
- The Anthem plans have 3 tiers of coverage; Tier 1 offers greatest value compared to other drugs that treat the same conditions and are often the lowest cost using Express Scripts, Tier 2 generally are brand name with a moderate copayment, and Tier 3 covering specialty medications or higher cost drugs.
- Tiered prescription drugs plans require varying levels of payment depending on the drug's tier. Your copayment or coinsurance will be higher with a higher tier number.
- Express Scripts has a $50 calendar year prescription deductible. This means that you much first meet your deductible before the plan will pay any benefit.
- A separate annual out-of-pocket maximum for network prescription drugs will apply ($2,600 single / $5,200 family). Once you have met your out-of-pocket maximum, the plan pays 100% coverage for the remainder of the plan year.
- Express Scripts has a closed drug formulary, or list of prescription drugs including both generic and brand-name medications, that are preferred.
- For specialty medications, there is a copay of 10% up to $200 per prescription.
- Be aware that although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company's preferred formulary list and may not be covered. We encourage you to speak to your physician about utilizing the Express Scripts Formulary list.

For a current version of the prescription drug list, go to www.express-scripts.com.

Why pay more?

There are a few ways you can save money when using the Prescription Drug Plan:

Mail Order
Save time and money by utilizing a mail order service for maintenance medications. A 90-day supply of your medication will be shipped to you, instead of purchasing a typical 30-day supply at a walk-in pharmacy.

Shop Around
Some pharmacies, such as those at warehouse clubs or discount stores may offer less expensive prescriptions than others. By calling ahead, you may determine which pharmacy provides the most competitive price.

Explore Over-the-Counter Options
For common ailments, over-the-counter drugs may provide a less expensive option that serve the same purpose as prescription medications.

Your Medical Plans

Below is a comparison of your medical plan options.

	Freedom PPO Plan			Independence PPO Plan		
Benefit	**Tier I: PMHD**	**Tier II: In-Network**	**Tier III: Out-of-Network**	**Tier I: PMHD**	**Tier II: In-Network**	**Tier III: Out-of-Network**
Deductibles and Maximums						
Annual Deductible						
Individual	$250	$1,000	$1,500	$500	$1,500	$2,500
Family	$500	$2,000	$3,000	$1,000	$3,000	$5,000
Annual Out-of-Pocket Maximum *Including Deductible*						
Individual	$1,500	$3,000	$6,000	$2,000	$4,000	$8,000
Family	$3,000	$6,000	$12,000	$4,000	$8,000	$16,000
Covered Services						
Preventive	N/A	No Charge	Not Covered	N/A	No Charge	Not Covered
Physician	$20 Copay*	$20 Copay*	50%	$20 Copay*	$20 Copay*	50%
Specialist	$40 Copay*	$40 Copay*	50%	$40 Copay*	$40 Copay*	50%
X-Ray/Lab	10%*	25%	50%	20%*	40%	50%
Inpatient Hospital	10%	$250/Admit + 25%	$250/Admit + 50%	20%	$250/Admit + 40%	$250/Admit + 50%
Emergency Room	$250/Visit*	$250/Visit*	$250/Visit*	$250/Visit*	$250/Visit*	$250/Visit*
Prescription Benefit ($50 annual deductible for Tier 2 and 3 drugs)						
30-Day Retail Supply						
Tier 1	N/A	$10	Not Covered	N/A	$10	N/A
Tier 2	N/A	$30	Not Covered	N/A	$30	N/A
Tier 3	N/A	10% up to $200	Not Covered	N/A	10% up to $200	N/A
90-Day Mail Order Supply						
Tier 1	N/A	$20	Not Covered	N/A	$20	N/A
Tier 2	N/A	$60	Not Covered	N/A	$60	N/A
Tier 3	N/A	10% up to $400	Not Covered	N/A	10% up to $400	N/A
Bi-Weekly Employee Cost						
Employee		$71.73			$30.30	
Employee + Spouse		$228.59			$153.75	
Employee + Spouse *With Spousal Surcharge***		$251.67**			$176.83**	
Employee + Child		$183.91			$123.53	
Family		$284.66			$205.55	

*Not subject to calendar year deductible.

** An additional charge of $23.08 / bi-weekly will be added for spouse/domestic partner participants if the spouse/domestic partner is eligible for medical coverage through his/her employer and is enrolled in a PMHD medical plan.

Medical PPO - California

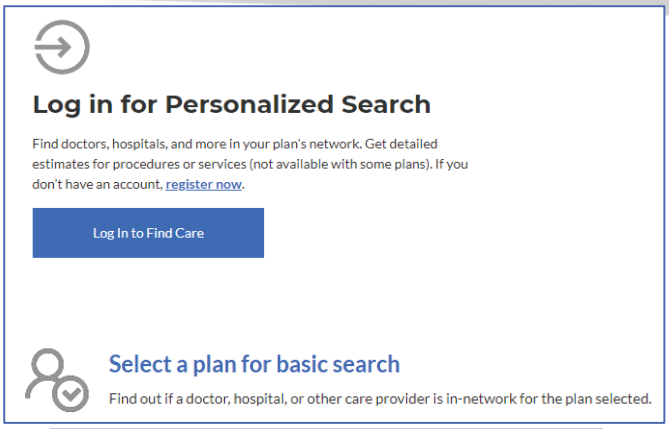
How to Find a Medical Provider Online

Anthem BlueCross

STEP 1

Visit https://www.anthem.com/ca/find-care/.

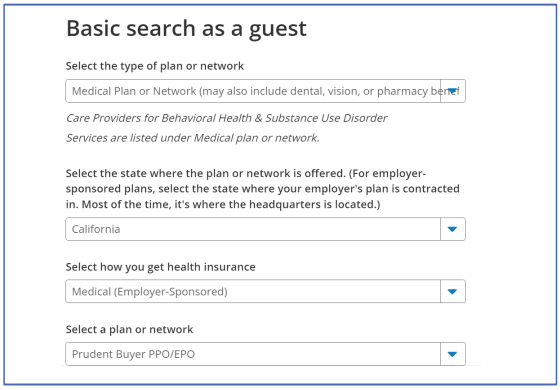
- Click Log in to Find Care box to access your elected plan; OR
- Click Select a plan for basic search box
- Scroll down to answer questions that will help you narrow your search



STEP 2

Scroll down the screen to complete the following fields:

- What type of care are you searching for? Use drop down to select: Medical Plan or Network
- What State do you want to search in?: Use drop down to select your State
- What type of plan do you want to search with? Medical (Employer- Sponsored)
- Select a plan/network: Use drop down to select Prudent Buyer PPO/EPO
- Click Continue button

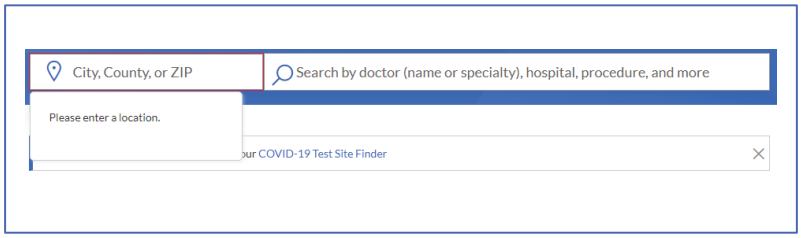


STEP 3

Enter the Zip Code in the far Left box. You now have 2 ways to narrow your search:

- Option 1: Enter in the Physician's Name, Specialty, NPI or license number in the Search Box. The results will appear below the Search Box and you can either click on the name provided or you may click on the View All text.

- Option 2: Scroll down and click one of the Search by Care Provider boxes. The results will appear on a new screen and you can click on the physicians name to obtain additional details.



STEP 4

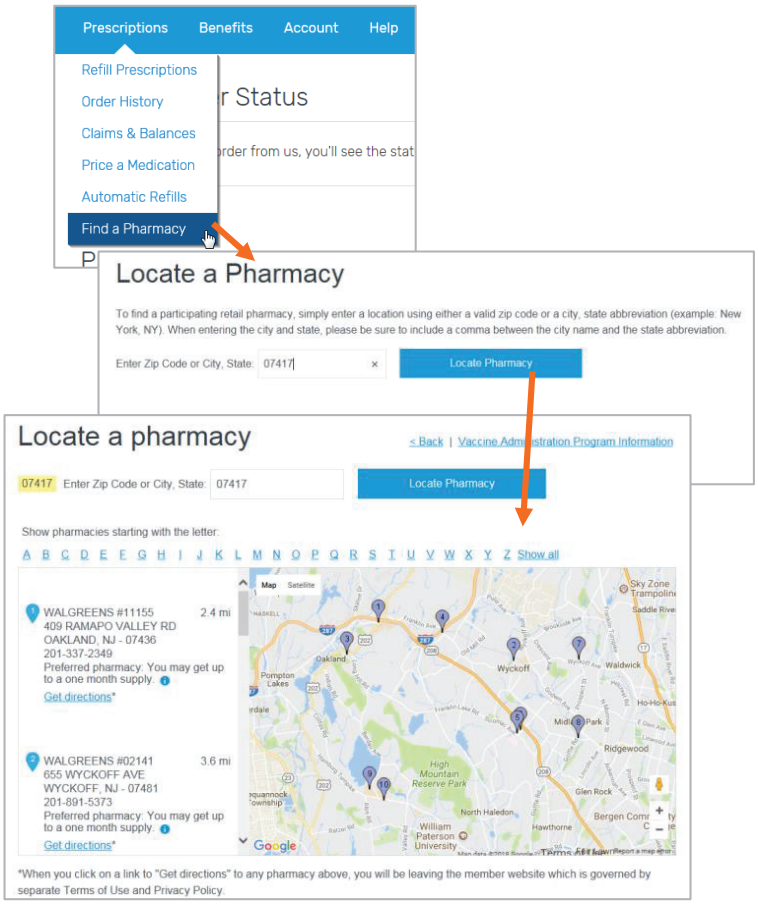
- View your search results.
- Click the printer icon to print the results of your search.
- Click on a provider name to see more details.
- Click the Back to Results button in the upper left hand corner or Back box at the bottom the screen to return to results.

Anthem Blue Cross, Anthem Life Insurance Company y Anthem Blue Cross, Compañía de Seguros de Vida y Salud son los licenciatarios independientes de Blue Cross Association. ANTHEM es una marca registrada de Anthem Insurance Companies, Inc. El nombre de Blue Cross y el símbolo son marcas registradas de la Asociación de Blue Cross.

EXPRESS SCRIPTS®

Find a Pharmacy

Find an in-network pharmacy at express-scripts.com or *on the go* using the Express Scripts mobile app.



From express-scripts.com:

Select "**Find a Pharmacy**" from the menu under **Prescriptions**.

Enter the **ZIP code or City/State** where you wish to find a pharmacy. Click the "Open 24 hours" box to restrict your search to only those pharmacies, if needed. Click "**Locate Pharmacy**."

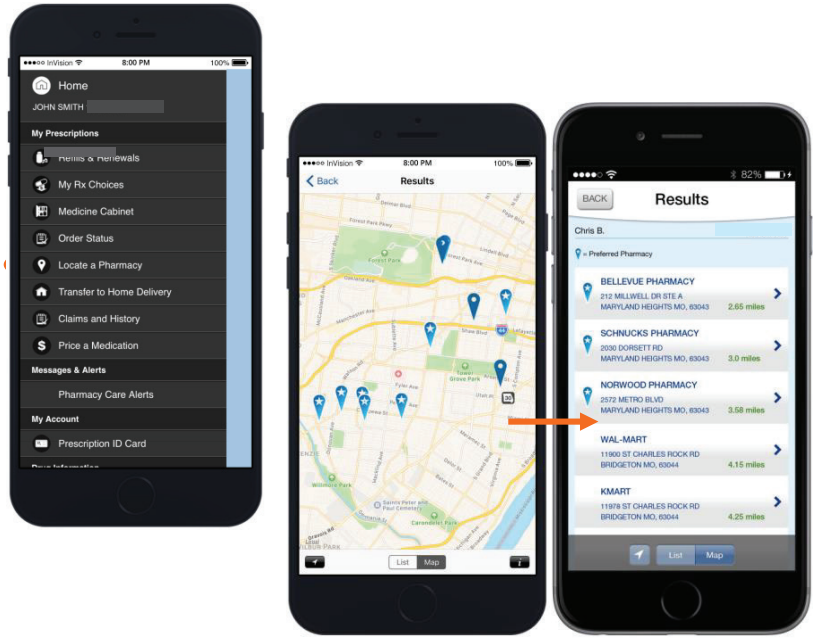
The search results provide a map and list showing nearby pharmacies with address and contact information. You can also "Get directions." Click a letter to find pharmacies alphabetically.

From the Express Scripts mobile app:

Select "**Locate a Pharmacy**" from the main menu. Enter the **ZIP code, City/State**, or "**Current location**."

The search results provide a map showing nearby pharmacies. In-network pharmacies are indicated with a star.

Click on the marker to see the pharmacy name, and click the arrow to view more information. You can also click to call the pharmacy or to get directions from your current location.



Note: The screenshots are a representation of search results and may not be specific to your benefit plan.

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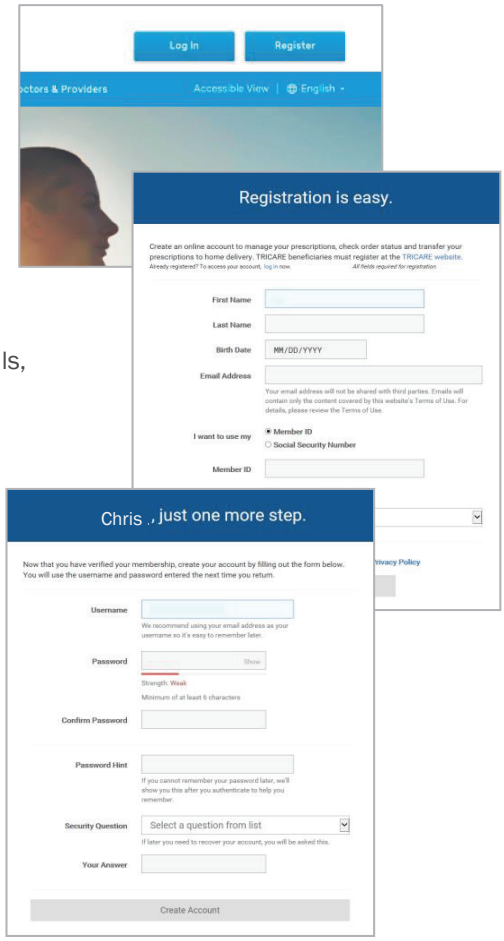
EXPRESS SCRIPTS®

Registering with Express Scripts

Online access to savings and convenience

Manage your medicines anywhere, any time with express-scripts.com and the Express Scripts™ mobile app



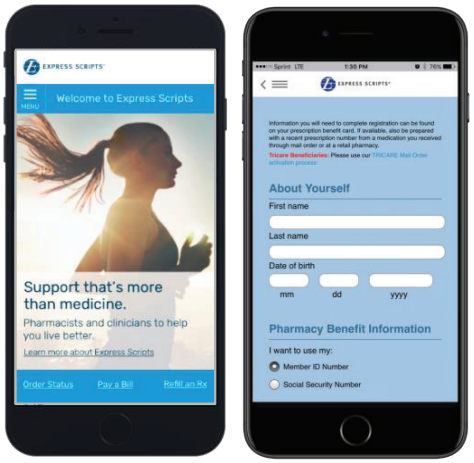
Register now so you can experience:

- **More savings.**
  Compare prices of medicines at multiple pharmacies. Get free standard shipping[1] from the Express Scripts Pharmacy℠.
- **More convenience.**
  Get up to 90-day supplies of your long-term medicine sent to your home. Order refills, check order status, and track shipments. Print forms and ID cards, if needed.
- **More confidence.**
  Talk with a pharmacist from the privacy of your home any time, from anywhere. Find the latest information on your medicine, including possible side effects and interactions.
- **More flexibility.**
  Download the Express Scripts mobile app to manage your medicines, find nearby pharmacies and get directions, and use your virtual ID card while on the go.

Get Started Today!

Registering is safe and simple. Your information is secure and confidential. Please have your member ID number or SSN available.

- Go to express-scripts.com, select **Register** or download the **Express Scripts mobile app** for free from your mobile device's app store and select **Register**
- Complete the information requested, including personal information and member ID number or Social Security Number (SSN), create your username and password, along with security information in case you ever forget your password
- Click **Register now** and you're registered
- To set preferences[2], select **Communication Preferences** from the menu under **Account**, scroll to **Communication** and **Viewing Preferences**. Click **Edit preferences**. Preferences can only be selected via the member website.



Members who have **touch ID authentication** on their mobile devices can enable it to log in to their Express Scripts account on the mobile app, if desired.

[1] Standard shipping costs are included as part of your prescription plan benefit.

[2] Preferences include the option to share your prescription information with other adult members of your household (aged 18+) covered under your prescription drug plan.

- All covered adults (aged 18+) in the household need to register separately.
- When you grant permission to share your prescription information with other registered household members, they can view your information, place orders on your behalf and more.

The Express Scripts mobile app is available for iPhone®, Android™, Windows Phone®, Amazon™, and Blackberry® mobile devices.

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Flexible Spending Accounts (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible health care and dependent care expenses. There are a number of different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse and eligible dependents, as outlined below:

FSA Type	Detail
Health Care FSA	• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance • Maximum contribution for 2023 is $3,050
Dependent Care FSA	• Can be used to pay for qualified child care and/or caregivers for a disabled family member in the household who is unable to care for themselves • Maximum contribution for 2023 is $5,000

What are the benefits?

- Your taxable income is reduced, and your spendable income increases!
- Save money while keeping you and your family healthy

How do I use it?

You must enroll in the FSA program within your initial eligibility window or during annual open enrollment in order to re-enroll. At this time, you must establish an annual contribution amount within the maximum limit. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status and more. Visit www.goigoe.com to access Igoe's online portal.

A few rules you need to know:

Your FSA has a grace period, which allows you to incur and submit claims for an additional 2 ½ months beyond the Plan Year. Below are your deadlines to incur and submit claims for your FSA:

7/1/2022– 6/30/2023 Plan Year		7/1/2023 – 6/30/2024 Plan Year	
Health Care FSA	**Dependent Care FSA**	**Health Care FSA**	**Dependent Care FSA**
Term submittal deadline is 90 days following the date of termination	Term submittal deadline is September 30, 2023	Term submittal deadline is 90 days following the date of termination	Term submittal deadline is September 30, 2024
Grace Period end date is September 15, 2023		Grace Period end date is September 15, 2024	

For more details about using an FSA, contact Igoe's Customer Service at 800.633.8818, Option 1.

How to Use Your Flexible Spending Account

Determine your estimated healthcare usage

Set up (pre-tax) deductions from your paycheck

Use FSA debit card or turn in receipts for eligible expenses

Use it or Lose it! FSA funds don't roll over to the next year

Dental – *MetLife*

You and your eligible dependents have the opportunity to enroll in a Dental Preferred Provider Organization (PPO) plan offered by **MetLife**.

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. This plan offers the same coinsurance rates for in- and out-of-network providers. Although you have the option to see any provider you wish, you will receive the best benefits when you choose an in-network dentist.

To find a provider, go to: **https://metlocator.metlife.com/metlocator/execute/Search**.

MetLife Dental Plan Features

Benefit	In-Network	Out-of-Network
Deductible *Individual / Family*	$50 / $150	$50 / $150
Annual Max	$2,000	$1,000
Preventive	0%	0%
Basic	20%	40%
Major	50%	60%
Ortho	50%	50%
Ortho Max	$3,000	$3,000
Bi-Weekly Employee Cost		
Employee	$4.72	
Employee + Spouse	$9.37	
Employee + Child	$14.24	
Family	$20.86	

Vision – *MetLife*

Vision coverage is offered by **MetLife** as a Preferred Provider Organization (PPO) plan. The MetLife Vision PPO network utilizes the VSP Choice network as a foundation, however they have expanded their network with additional and unique providers. When you visit a Vision Provider, be sure to reference your MetLife vision insurance plan.

You may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount.

To view a complete plan summary, visit **http://mymetlifevision.com/find-eye-doctors.html**.

MetLife Vision Plan Features

Benefit	In-Network	Out-of-Network
Exam *Every 12 months*	$20 Copay*	$45 Copay
Frames *Every 12 months*	$120 + 20% Off Balance $65 at Costco	$55
Lenses *Every 12 months* *Single/Bi-/Tri-Focal*	Covered in full after copay	$30
Contacts	$120 Allowance	Up to $105
Bi-Weekly Employee Cost		
Employee	$1.00	
Employee + Spouse	$1.68	
Employee + Child	$1.72	
Family	$2.77	

*Single copay applicable to exam and materials.

Accident Insurance* – *Aflac*

Since accidents can happen at any time, it's important to be prepared. That is why we are happy to offer a voluntary Accident Insurance program from **Aflac**. You have the option of customizing your coverage by selecting between two plans to best suit you and your family.

This policy can help cover the out-of-pocket costs associated with an off-the-job accident by paying you a benefit depending on the injuries you suffer and the treatment you receive. You can use the money as you see fit, whether to pay for expenses associated with your accident, like an emergency room copay, or to pay for childcare so you can get to the doctor for a follow-up visit. The policy does not coordinate with any other coverage, so you can still receive benefits on top of what your medical plan provides.

Critical Illness Insurance* – *Aflac*

The voluntary Critical Illness program from **Aflac** provides you with a lump sum cash benefit in the event you or a loved one is diagnosed with a covered condition such as cancer, heart attack, or stroke. It can help provide financial protection so you can focus on what's really important — getting better.

You pick the level of coverage that provides the right protection for your family. Plus, the policy will pay you a $50 wellness benefit when you complete a qualified health screening, including a COVID-19 test!

Hospital Indemnity Insurance* – *Aflac*

Even with health insurance, a stay in the hospital can become very costly very quickly as out-of-pocket charges begin to add up. You have the option to enhance your medical plan with additional hospital benefits from **Aflac**. These benefits are designed to provide financial protection by paying you a benefit for hospital admission, hospital confinement, and ICU care. You can use this cash benefit to pay for out-of-pocket expenses that can occur relating to hospitalization, or use the funds however you see fit. The policy will pay you $50 per year per insured for completing a qualified health screening, including a COVID-19 test!

Disability – *Reliance Standard*

Should you experience a non-work related illness or injury that prevents you from working, Disability coverage from **Reliance Standard** acts as income replacement to protect important assets and help you continue with a level of your earnings.

Short Term Disability

Pioneers Memorial Healthcare District provides you with the option of electing Short Term Disability coverage through **Reliance Standard**. The benefit amount is based on 60% of your income, up to a maximum of $2,100 per week. This amount may be offset by other income benefits, including any local or state disability. The plan begins paying these benefits at the time of disability, or after you have been absent from work for 7 consecutive days. This coverage can provide benefits for up to a maximum of 25 weeks if continuously disabled.

Long Term Disability

As an added protection to provide you with financial stability, Pioneers Memorial Healthcare District provides you with the option of Long Term Disability coverage through **Reliance Standard**. If your disability extends beyond 180 days, this coverage can replace 65% of your earnings, up to a maximum of $10,000 per month. Your benefits may continue to be paid until you reach normal retirement age as long as you meet the definition of disability.

*This coverage is only available during each year's open enrollment period.

Life Insurance *– Reliance Standard*

Basic Life Insurance and Accidental Death and Dismemberment Insurance (AD&D)

Basic Life Insurance and AD&D through **Reliance Standard** is available at no cost to you and is paid for by Pioneers Memorial Healthcare District. In the event of your death, this coverage will provide your family members or other beneficiaries with financial protection and security. Eligible employees are covered in the amount of $50,000. The benefits outlined below are provided by Reliance Standard:

- Board Members: $50,000
- Executives, Officers, Managers & Directors: 2x basic annual salary up to $400,000
- All other Employees: $50,000
- Spouse: $2,000
- Dependent Child(ren): birth up to 6 months - $1,000; 6 months up to 26 - $2,000

Voluntary Life Insurance and AD&D

In addition to your employer-paid Basic Life and AD&D Insurance, Voluntary Life and AD&D Insurance is available for purchase through **Reliance Standard**. If you purchase coverage for yourself, you may also purchase coverage for your dependents. You are guaranteed coverage (up to $150,000 for yourself, up to $25,000 for your spouse, and up to $10,000 for your child(ren)) without answering medical questions if you enroll when you are first eligible. All other eligible employees and spouses may be required to submit Evidence of Insurability (EOI) for any new coverage amount or increase in coverage amount:

- For employees: Increments of $10,000 up to the lesser of 5x salary or $500,000
- For your spouse: Increments of $5,000 up to the lesser of 100% of the employee amount or $500,000
- For your child(ren): birth to 6 months of age, $1,000; 6 months of age to age 26, increments of $2,000 up to $10,000

Permanent Life Insurance with Long Term Care

Permanent Life Insurance with Long Term Care through **Chubb** is available to provide you with even greater financial security. This coverage offers protection beyond your working years, potentially for your lifetime. With a guaranteed death benefit that will never decrease, level premiums that will never increase, living benefits, and other options, Permanent Life goes beyond typical term life insurance. This coverage also offers you benefits should you need Long Term Care after becoming chronically ill and confined to a nursing or assisted living facility, or if you need to receive home health or adult day care. This coverage is only available during each year's open enrollment period.

Identity Theft Protection *– Identity Guard*

Identity Guard is a proactive, holistic cyber protection – including ID theft, safe browsing, data privacy, and VPN tools – that empowers individuals with the knowledge and tools necessary to take swift action against cyberthreats to keep themselves and their families protected financially, physically, and digitally.

With two coverage levels available, you can choose the plan that best fits your needs!

- Premier
- Ultimate

Legal Services *– Hyatt Legal Plans*

The MetLaw legal plan from **Hyatt Legal Plans** provides easy, direct access to a national network of attorneys who provide telephone advice and office consultations on personal legal matters. Examples of covered legal services include: preparation of wills and trusts, real estate matters, debt matters, consumer protection, document preparation and review, traffic and juvenile matters, and family law. This coverage is only available during each year's open enrollment period.

Employee Assistance Program (EAP)

Pioneers Memorial Healthcare District understands that you and your family members might experience a variety of personal or work-related challenges. Through the EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

Program Component	Coverage Details
Who Can Utilize	All employees, dependents of employees, and members of your household
Topics May Include	• Childcare • Eldercare • Legal Services • Identity Theft • Marital, relationship, or family problems • Bereavement or grief counseling • Substance abuse and recovery • Financial support • Consumer information
Number of Sessions	6 face-to-face sessions per year per member per incident
How to Access	• By Phone: 877.622.4327 • Online: www.cignabehavioral.com; password: pioneers

Retirement Options

Pioneers Memorial Healthcare District recognizes that saving for retirement is important to its employees. By offering you the opportunity to join its retirement plans, they are giving you an excellent way to save for the future. More detailed information about your plan is available by contacting your OneAmerica plan representative. You can call 800.858.3829.

What type of program is available to me?

Pioneers Memorial Health District's qualified retirement plan may be the easiest and most convenient way to prepare for your retirement. We offer two types of plans; a 401a Plan and a 457b Deferred Compensation program, both funded by a group funding agreement issued by OneAmerica.

All current employees are eligible to immediately participate in the 457b plan. For the 401a plan, all current employees who are at least age 21 and have completed one year of service as defined by the plan may participate.

401a Plan

Under Section 401 of the Internal Revenue Code, employers are permitted to make contributions to the plan for payment to you at a later date. The plans may allow for a variety of different types of contributions. Generally, these contributions, and any investment earnings they may generate, are not subject to current federal and state income taxes.

Contributions made by Pioneers Memorial Healthcare District plus any earnings they generate are subject to a five-year graded vesting schedule.

Years	1	2	3	4	5
Vesting	20%	40%	60%	80%	100%

This match is an amount equal to 3% or more of employee compensation. Pioneers Memorial Healthcare District will make an additional contribution to your plan based on your years of services. See grid for details.

Roth 401(k)

Contributions are on an after-tax basis. The participant's savings will grow without being taxed and you do not pay federal taxes upon withdrawal if the withdrawal is made after the account has been held for at least 5 years and the account owner is at least 59 ½.

Retirement Options (continued)

457b Plan

Under Section 457b of the Internal Revenue Code, deferred compensation plans were established to permit you, on a voluntary basis, to authorize your employer to withhold a portion of your salary and invest it, on a tax-deferred basis, for payment to you at a later date. Neither your contributions nor any investment earnings are subject to current federal and (in most cases) state income taxes. Taxes become payable when your account assets are distributed to you, generally at retirement, when you may be in a lower income tax bracket. As you withdraw assets from the plan, they will be taxed as ordinary income.

Currently, the IRS does not impose a tax penalty on assets withdrawn from a 457b plan regardless of your age, but certain withdrawal restrictions may apply.

Through the convenience of payroll deductions, you can make pre-tax contributions up to the lesser of $12,500 for 2021 or 100% of eligible compensation. Your pre-tax contributions – and any earnings – will accumulate tax deferred until withdrawn (generally at retirement) at which time withdrawals will be taxed as ordinary income. If you have an existing 457b deferred compensation or retirement account with a prior employer or a traditional IRA, you may transfer ("rollover") that account into the plan at any time. However, you are not allowed to transfer after-tax contributions from a traditional IRA into the plan.

Employer Matching Contributions

On behalf of each Participant's elective deferrals (pre-tax and/or Roth) made under the Deferred Compensation Plan, the Employer shall contribute a matching contribution equal to 100% of a Participant's elective deferrals, up to a maximum percentage of such Participant's Compensation as set forth below:

Matching Schedule 401(a) and 457b plans						
Years of Service	1-2	3-5	6-9	10-13	14-17	18+
Percent Match	3%	3.5%	4%	4.5%	5%	5.5%

Benefit Contact Information

Benefit	Provider	Contact
Medical Coverage	Pinnacle (Network: Anthem)	**Provider Finder Search:** www.anthem.com/ca/find-care **Claims:** 800.649.9121;www.pinnacletpa.com
Pharmacy	Express Scripts	www.express-scripts.com
Flexible Spending Account	Igoe Administrative Services	800.633.8818, Option 1; www.goigoe.com
Dental	MetLife	800.638.5433 ; www.metlife.com
Vision	MetLife	800.638.5433 ; www.metlife.com
Accident, Critical Illness, and Hospital Indemnity	Aflac	800.992.3522; www.aflac.com
Disability	Reliance Standard	800.351.7500; www.reliancestandard.com
Life Insurance	Reliance Standard	800.351.7500; www.reliancestandard.com
Permanent Life Insurance	Chubb	866.324.8222; www.chubb.com
Legal Services	Hyatt Legal Plans (A MetLife Company)	800.821.6400; info.legalplans.com
Employee Assistance Program	Cigna	877.622.4327; www.cignabehavioral.com
Retirement Plan	OneAmerica NFP Retirement Advisors	800.858.3829; www.oaretirement.com 800.959.0071; www.nfp.com/retirement
Identity Theft Protection	Identity Guard	888.283.1725; www.identityguard.com

MEDICARE PART D NOTICE

Important Notice about Your Prescription Drug Coverage and Medicare

Individual CREDITABLE Coverage Disclosure

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

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

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. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

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

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area.

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

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

Your medical benefits brochure contains a description of your current prescription drug benefits.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with your employer and don't join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…
Contact your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

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

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

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

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

LEGAL INFORMATION REGARDING YOUR PLANS

Summary of Material Modification

This summary of material modification (SMM) describes changes to the Pioneers Memorial Healthcare District Plan and supplements the Summary Plan Description (SPD) for the plan. The effective date of each of these changes is July 1, 2023. You should read this SMM very carefully and retain this document with your copy of the SPD for future reference.

Required Notices

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

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

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

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).

Special Enrollment Rights

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

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

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

"HIPAA Special Enrollment Opportunities" include:

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

"Change in Status" Permitted Midyear Election Changes

- Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved "change in status" as defined by the IRS.
- Examples of permitted "change in status" events include:
- Change in legal marital status (e.g., marriage (2), divorce or legal separation)
- Change in number of dependents (e.g., birth (2), adoption (2) or death)
- Change in eligibility of a child
- Change in your / your spouse's / your registered domestic partner's employment status (e.g., reduction in hours affecting eligibility or change in employment)
- A substantial change in your / your spouse's / your registered domestic partner's benefits coverage
- A relocation that impacts network access
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment
- Qualified Medical Child Support Order or other judicial decree
- A dependent's eligibility ceases resulting in a loss of coverage (3)
- Loss of other coverage (2)
- Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage
- You enroll, or intend to enroll, in a Qualified health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.
- You must notify Human Resources within 30 days of the above change in status, with the exception of the following which requires notice within 60 days:
- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

Important Information on how Health Care Reform Affects Your Plan

Primary Care Provider Designations

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- Your HMO generally 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Human Resources office

For plans and issuers that require or allow for the designation of a primary care provider for a child:

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

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

- You do not need prior authorization from your insurance provider or from 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, contact your Human Resources office.

Grandfathered Plans

If your group health plan is grandfathered then the following will apply. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator.

Prohibition on Excess waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan. State law may require shorter waiting periods for insured group health plans. California law requires fully-insured plans to comply with the more restrictive waiting period limitation of no more than 60-days.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended

Continuation Coverage Rights under COBRA

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

Continuation Coverage Rights under COBRA (continued)

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

(1) Indicates that this event is also a qualified "Change in Status"

(2) Indicates this event is also a HIPAA Special Enrollment Right

(3) Indicates that this event is also a COBRA Qualifying Event

What is COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan.

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 [choose and enter appropriate information: must pay or aren't required to pay] for COBRA continuation coverage. If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to anyone covered under the Plan who are spouses, dependent children, or anyone else eligible for COBRA continuation coverage under the Plan.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Pioneers Memorial Healthcare District Benefit Department
207 W. Legion Road
Brawley, CA 92227
760.351.3299

For More Information

This notice doesn't fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact your Human Resources Representative.

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, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate

Employee Rights & Responsibilities under the Family Medical Leave Act

Basic Leave Entitlement

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

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

Military Family Leave Entitlements

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

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is:

(1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness (1); or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. (1)

Benefits & Protections

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

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

Eligibility Requirements

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

(1) The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition"

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

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

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

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

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

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

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

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

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

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

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

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

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

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

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

Uniformed Services Employment & Reemployment Rights Act Notice of 1994, Notice of Right to Continued Coverage under USERRA

Right to Continue Coverage
Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage
If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You do not Elect to Continue Coverage?
If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage
The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued
If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Reporting to Work / Applying for Reemployment
Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible
181 days or more	Submit an application for reemployment within 90 days after completion of your service
Any period if for purposes of an examination for fitness to perform uniformed service	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definitions
For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency
- "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

HIPAA Privacy Notice

Notice of Health Information Privacy Practices

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

This notice is EFFECTIVE: 07/01/2017

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to provide information about the legal protections that apply to your health information. HIPAA includes numerous provisions that are designed to maintain the privacy and confidentiality of your Protected Health Information (PHI). PHI is health information that contains identifiers (such as your name, address, social security number, or other information that identifies you) and information related to your past, present or future health condition and treatments.

HIPAA Privacy Notice (continued)

This notice is for participants in the Company Health & Welfare Plan (referred to as the "Plan"), including its component plans.

Required by Law

- The Plan must make sure that health information that identifies you is kept private.
- The Plan must give you this notice of our legal duties and privacy practices with respect to health information about you.
- The Plan must obtain written authorization from you for the use and disclosure of your PHI related to psychotherapy notes; when for purposes of marketing; and/or for disclosures constituting a sale of PHI.
- The Plan must follow the terms of the notice that are currently in effect.

Permitted Plan use of Your Health Information

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact the Plan Privacy Officer.

You have both the right and choice to tell us to: share information with your family, close friends, or others involved in payment for your care; share information in a disaster relief situation; and contact you for fundraising efforts.

If you are not able to tell us your preference, for example if you are unconscious, the Plan may go ahead and share your information if it believes it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety.

The Plan will never share your information unless you give us written permission for: marketing purposes and the sale of your information.

Treatment: The Plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the Plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees. We may also use and disclose your information to run our organization and contact you when necessary. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. The Plan is also not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Payment for Health Services and Administration of the Plan: The Plan can use and disclose your health information when paying for your health services. For example, the Plan may share information about you with your dental plan to coordinate payment for your dental work. The Plan may disclose your health information to your health plan sponsor for plan administration. For example, where your company contracts with an insurer to provide a health plan, and the Plan provides your company with certain statistics to explain the premiums charged.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy rules and HIPAA security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law (this includes the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law).

To Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director: We may share health information about you with organ procurement organizations; and may share health information with a coroner, medical examiner, or funeral director when an individual dies.

Workers' Compensation: We may release health information about you for workers' compensation programs or claims or similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement and other Government Requests: We may disclose your health information for law enforcement purposes or with a law enforcement official, in response to a valid subpoena or other judicial or administrative request/order, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services.

Public Health and Research: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation). Additionally we may share health information about you when: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety or for purposes of health research.

Your Rights Regarding Your Health Information

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

Request a restriction on certain uses and disclosures of your information where concerning a service already paid for.

- Obtain a paper copy of the notice of health information practices promptly (even if you have agreed to receive the notice electronically) by requesting it from the Plan Privacy Officer.
- Ask to see or get a copy of your health and claims records and other health information we have about you. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Inspect and obtain a copy of your PHI contained in a "designated record set." A designated records set includes medical and billing records; enrollment, payment, billing, claims adjudication and case or medical management record systems; or other information used in whole or in part by or for the covered entity to make decisions about individuals. A written request to access your PHI must be submitted to your company Privacy Officer. Requested information will be provided within 30 days if maintained on site or 60 days if maintained off site.
- Request an amendment/correction to your health information: you can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- Obtain an accounting of disclosures of your PHI during the preceding six years, who we shared it with, and why, with the exception of disclosures made for purposes of treatment, payment or health care operations, and certain other disclosures (such as any you asked us to make); made to individuals about their own PHI; or, made through use of an authorization form. A reasonable fee may be charged for more than one request per year.
- Request confidential communications of your health information be sent in a different way (for example, home, office or phone) or to a different place than usual (for example, you could request that the envelope be marked "confidential" or that we send it to your work address rather than your home address). We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.
- Receive notification within 60 days (5 day for California residents) for any breaches of your unsecured PHI.
- Assign someone as your medical power of attorney or your legal guardian, who can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Plan Responsibilities

The Plan is required to maintain the privacy of PHI and to comply with the terms of this notice. The Plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you within 60 days of the effective date of any material change to the rights and duties listed in this notice. The Plan is required to:

• Maintain the privacy and security of your health information.

• Make reasonable efforts not to use, share, disclose or request more than the minimum necessary amount of PHI needed to accomplish the intended purpose, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

• Follow the duties and privacy practices described in this notice with respect to information we collect and maintain about you and provide you a copy of the notice.

• Abide by the terms of this notice.

• Notify you if we are unable to agree to a requested restriction, amendment or other request.

• Notify you of any breaches of your protected health information that may have compromised the privacy or security of your information within 60 days (5 days for California residents).

• Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA. The plan is prohibited from using or disclosing PHI that is genetic information of an individual for any purposes, including underwriting.

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

Your Right to File a Complaint

If you believe your privacy rights have been violated, you can file a formal complaint with the Plan Privacy Officer; or with the U.S. Department of Health and Human Services (by mail or email). We will not retaliate against you and you will not be penalized for filing a complaint.

Changes to the Terms of This Notice

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

Contact Person

If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the Plan Privacy Officer. All requests must be submitted in writing to the address shown below.

Pioneers Memorial Healthcare District
Attention: Human Resources
207 West Legion Road
Brawley, CA 92227
760.351.3299

THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) PREMIUM ASSISTANCE SUBSIDY NOTICE

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, you can 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, 2016. Contact your State for more information on eligibility.

ALABAMA – Medicaid Website: www.myalhipp.com Phone: (855) 692-5447	MASSACHUSETTS – Medicaid and CHIP Website: www.mass.gov/masshealth Phone: (800) 462-1120	OREGON – Medicaid Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: (800) 699-9075
ALASKA – Medicaid Website: http://myakhipp.com/ Phone: 1 (866) 251-4861 Email: customerservice@myakhipp.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/pages/medicaid/default.aspx	MINNESOTA – Medicaid Website: http://mn.gov/dhs/ma/ Click on Healthcare, then Medical Assistance Phone: (800) 657-3739	PENNSYLVANIA – Medicaid Website: http://www.dhs.pa.gov/hipp Phone: (800) 692-7462
ARKANSAS – Medicaid Website: http://myarhipp.com/ Phone: (855) 692-7447	MISSOURI – Medicaid Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: (573) 751-2005	RHODE ISLAND – Medicaid Website: www.eohhs.ri.gov Phone: (401) 462-5300
COLORADO – Medicaid Website: www.colorado.gov/hcpf Medicaid Customer Contact Center: (800) 221-3943	MONTANA– Medicaid Website: http://dphhs.mt.gov/montanahealthcareprograms/hipp Phone: (800) 694-3084	SOUTH CAROLINA – Medicaid Website: www.scdhhs.gov Phone: (888) 549-0820
FLORIDA – Medicaid Website: https://www.flmedicaidtplrecovery.com/hipp/ Phone: (877) 357-3268	NEBRASKA – Medicaid Website: http://dhhs.ne.gov/children_family_services/accessnebraska/pages/accessnebraska_index.aspx Phone: (855) 632-7633	SOUTH DAKOTA – Medicaid Website: http://dss.sd.gov Phone: (888) 828-0059
GEORGIA – Medicaid Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: (404) 656-4507	NEVADA – Medicaid Medicaid Website: dwss.nv.gov/ Medicaid Phone: (800) 992-0900	TEXAS – Medicaid Website: https://www.gethipptexas.com/ Phone: (800) 440-0493
INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: (877) 438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone: (800) 403-0864	NEW HAMPSHIRE – Medicaid Website: www.dhhs.nh.gov/oii/documens/hippapp.pdf Phone: (603) 271-5218	UTAH – Medicaid and CHIP Medicaid Website: health.utah.gov/medicaid CHIP Website: health.utah.gov/chip Phone: (877) 543-7669
IOWA – Medicaid Website: www.dhs.state.ia.us/hipp/ Phone: (888) 346-9562	NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: (609) 631-2392 CHIP Website: www.njfamilycare.org/index.html CHIP Phone: (800) 701-0710	VERMONT– Medicaid Website: www.greenmountaincare.org/ Phone: (800) 250-8427
KANSAS – Medicaid Website: www.kdheks.gov/hcf/ Phone: (785) 296-3512	NEW YORK – Medicaid Website: www.nyhealth.gov/health_care/medicaid/ Phone: (800) 541-2831	VIRGINIA – Medicaid and CHIP Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: (800) 432-5924 CHIP Website: http://www.covera.org/programs_premium_assistance.cfm CHIP Phone: (855) 242-8282
KENTUCKY – Medicaid Website: chfs.ky.gov/dms/default.htm Phone: (800) 635-2570	NORTH CAROLINA – Medicaid Website: http://www.ncdhhs.gov/dma Phone: (919) 855-4100	WASHINGTON – Medicaid Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-programw Phone: (800) 562-3022 ext. 15473
LOUISIANA – Medicaid Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: (888) 695-2447	NORTH DAKOTA – Medicaid Website: www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: (844) 854-4825	WEST VIRGINIA – Medicaid Website: www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: (877) 598-5820, HMS Third Party Liability
MAINE – Medicaid Website: www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: (800) 442-6003 TTY: Maine relay 711	OKLAHOMA – Medicaid and CHIP Website: www.insureoklahoma.org Phone: (888) 365-3742	WISCONSIN – Medicaid & CHIP Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: (800) 362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com
Phone: (307) 777-7531

To see if any other States have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

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