central peninsula
human resources

Benefit Summary Booklet

2024-2025 Plan Year

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Welcome to Central Peninsula Hospital

Welcome to Central Peninsula Hospital. We would like to express our commitment in providing a comprehensive employee benefit program that will meet the overall healthcare needs for you and your family.

Your benefit choices:

- Medical, Dental, Vision, and Prescription
- Health Reimbursement Arrangement (HRA)
- Health Savings Account (HSA)
- Flexible Spending Accounts (FSA)
- Short-Term Disability
- Long-Term Disability
- Life and Accidental Death & Dismemberment (AD&D)
- Employee Assistance Program (EAP)
- Consolidated Leave Program
- Educational Assistance
- Continuing Education (CE)
- Retirement Plan

The CPH benefits program gives you choices about the benefits and coverage amounts that are right for you. This summary booklet highlights some of the main features of our benefits package, so you can make informed decisions about your coverage.

For newly eligible employees, this is your chance to enroll in the CPH Employee Benefits Plan. You must enroll yourself and your dependents within 30 days of becoming eligible for benefits. Enroll eligible dependents at the same time you enroll yourself. If you don't enroll, or if you waive coverage, you'll receive the employer sponsored benefits shown below:

- Basic Short-Term Disability
- Basic Life and Basic AD&D Insurance
- 3% Retirement Contribution Auto-Enrollment
- Employee Assistance Program
- Continuing Education Hours (CE)

Once you're enrolled in benefits, you aren't allowed to make changes until the next annual Open Enrollment period unless you experience a qualifying life event (see below). Open Enrollment usually occurs in May/June and is your one chance each year to review your coverage and make changes to your benefits. It's also your chance to enroll if you previously waived coverage when you first became eligible. If you would like to participate in an FSA, you must re-enroll each year during Open Enrollment. Changes made during Open Enrollment take effect on July 1st each year.

Other than during Open Enrollment, you can make changes to your benefits during the year only if you experience a qualifying life event (QLE), such as birth/adoption of a child, marriage/divorce, death of a dependent, loss of other coverage, gaining other coverage, and if a dependent child ages out (See page 30). Changes must be made in Workday within 60 days of the QLE.

You may change your Health Savings Account (HSA) contribution and beneficiaries in Workday at any time throughout the year. You can also update your retirement contributions at any time throughout the year on the Voya website or app. Contact HR if you need assistance.

Eligible Employees and Dependents

Employee	Dependents	Waiting Period
Full-time employees working at least 72 hours per pay period Part-time employees working at least 32 hours per pay period	-Your legal spouse -Dependent children may be covered until age 26, unless they are incapable of self-support (subject to approval)	Newly hired employees' coverage will begin on the 1st of the month following 30 days of employment

ACA Full Time Definition: In accordance with the Affordable Care Act (ACA), employees who average at least 130 hours per month will be considered full-time. Actual hours worked will be reviewed per the following to determine eligibility:

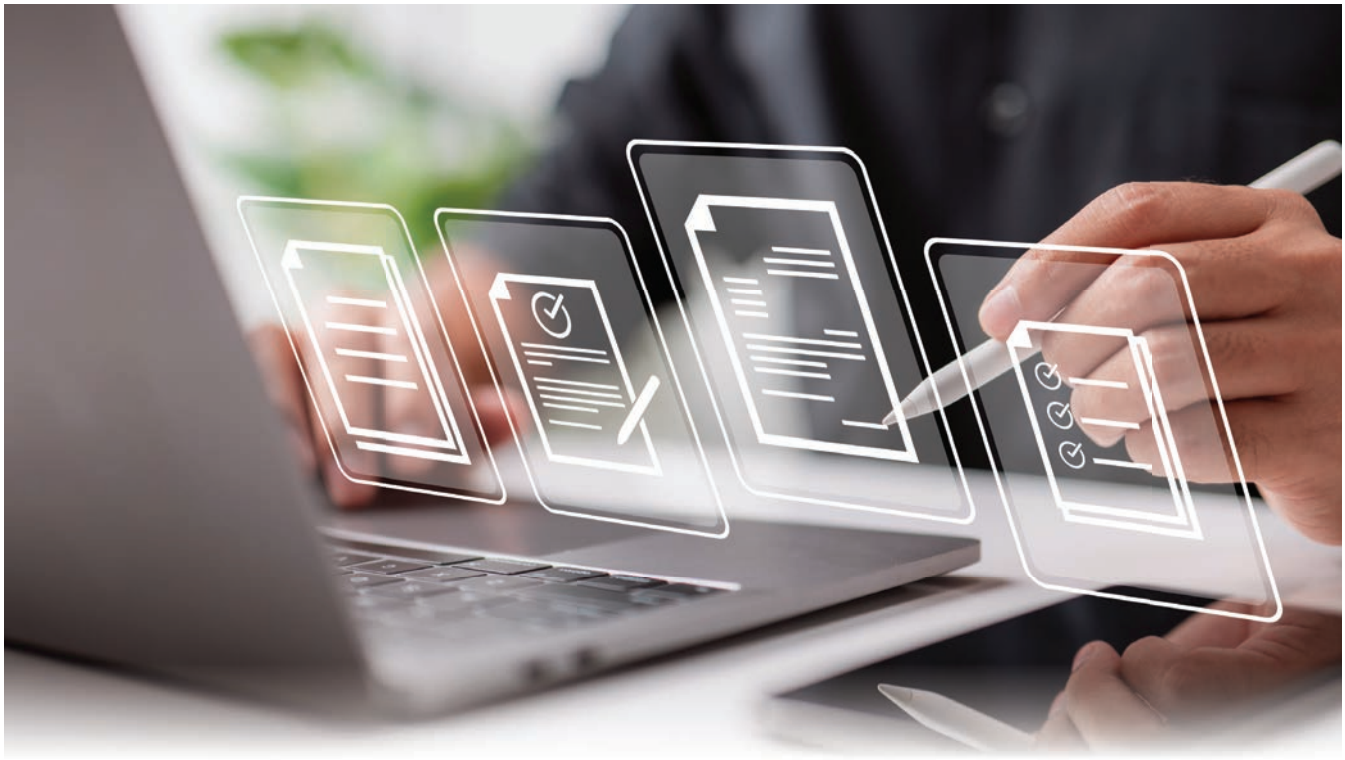
- Per Diem employees who have reached their one-year anniversary.
- A 12 month "look back" period of 5/1-4/30 each year for all employees to determine eligibility for the period of 7/1-6/30 of the next year.

If an employee has averaged at least 130 hours per month during either of the periods identified, they will be able to participate in the health plan at Level 1 premium rates. Per Diem employees who meet this requirement will be offered the following choice:

- CPH health insurance coverage effective the 1st day of the month on or after 30 days post first year anniversary (at level 1 rates) or at Open Enrollment (For July 1) if they qualify at that time; or
- The additional earnings in lieu of benefits normally afforded to Per Diem employees

Employees will be notified upon eligibility and must make their elections in Workday prior to the due date!

Electing Benefits In Workday



ALL BENEFIT ELECTIONS MUST BE COMPLETED IN WORKDAY WITHIN 30 DAYS !

The benefits election process is online through Workday, our HRIS platform. You will receive a task in your Workday inbox to make your benefit elections. You have 30 days from eligibility to enroll in benefits. Even if you decide to waive coverage, you should visit Workday to add your beneficiaries for employer sponsored benefits.

You can access Workday by visiting https://www.myworkday.com/cpgh/login.htmld.

Workday will automatically calculate your monthly benefit premiums based on the elections you make during enrollment. Please review the monthly total prior to submitting your elections.

If you need assistance logging in to Workday, please contact the IS HelpDesk at 714-4701 or helpdesk@cpgh.org .

BENEFIT QUESTIONS?

- See page 29 for customer service numbers and websites for our benefit vendors.
- Contact Human Resources at 907-714-4773 or submit a ticket to HR HelpDesk.

BENEFITS ADVOCACY

- Parker, Smith & Feek, Inc.

CPH has partnered with Parker, Smith & Feek to provide you and your family with individualized assistance with insurance problems you are unable to resolve directly with the carriers. This includes claims issues, eligibility questions, network problems, and general healthcare or insurance questions.

PARKER SMITH & FEEK

Your Account Manager. . . . . Shelly Tuttle
Email . . . . . smtuttle@psfinc.com
Phone 800-457-0220

Benefits are a big part of your total pay and compensation. CPH pays most of the cost (85% for Level 1 and 70% of the premium for Level 2) to provide coverage for employees and their families.

You will have the option to choose between the three health insurance plans: the Denali Plan, Redoubt Plan, and the Iliamna Plan. The Redoubt and Iliamna Plans offer coverage at a reduced employee contribution rate but have higher deductibles. Employees who want a lower deductible have the option to purchase the Denali Plan at a higher employee contribution rate.

The premium rates listed below are effective July 1st, 2024 and include health, vision, dental, and prescription coverages. You cannot purchase these benefits separately. Monthly premiums are divided between the first two paychecks each month. Full-time employees pay Level 1 rates and part-time employees pay Level 2 rates.

Monthly Premiums Level 1	Denali Plan	Redoubt Plan	Iliamna Plan
Employee	$409.21	$187.31	$187.31
Employee and Spouse	$843.96	$386.36	$386.36
Employee and Child(ren)	$791.81	$362.46	$362.46
Employee and Family	$1,247.05	$570.89	$570.89

Monthly Premiums Level 2	Denali Plan	Redoubt Plan	Iliamna Plan
Employee	$818.41	$374.62	$374.62
Employee and Spouse	$1,687.93	$772.71	$772.71
Employee and Child(ren)	$1,583.61	$724.92	$724.92
Employee and Family	$2,494.12	$1,141.78	$1,141.78

Please note:

Your health insurance premiums are taken out of your paycheck on a pre-tax basis as allowed by Section 125 of the Internal Revenue Code. IRS rules state that once you make your enrollment election for the year, you will not be allowed to change that election until the next Open Enrollment period, unless you experience a qualified life event, such as marriage, divorce, birth of a child, or change in employment status. This means you may not drop coverage for a dependent during the year unless there is a qualified change in family status. (See page 3)

Health Insurance Coverage

Central Peninsula Hospital self-insures our health care plan. This means that we assume the financial risk for providing health care benefits, rather than paying an insurance company to assume this risk. Moda Health is the claims administrator for our medical, vision, dental, and prescription drug plans, however the money they use to make payments comes directly from CPH, which is funded by the premiums paid by both the company and you.

Our Value Based Plan features reduced deductibles for Value Based network providers. A $10 copay for Value Based Primary Care for Provider office visits with the deductible waived on the Denali and Redoubt Plans and for those on the Iliamna Plan, the services accrue to your deductible and the $10 copay will apply after the deductible is met. There is also a $2 copay for value tier prescriptions, deductible waived on the Denali and Redoubt Plans, and for those on the Iliamna Plan, the $2 copay will apply after the deductible is met.

You will receive an identification card in the mail. If you have misplaced your card or have dependents on your plan that will need additional cards, you may log in to your dashboard at www.modahealth.com to download or request one.

NETWORK INFORMATION

Value Based Provider Network:
Value based providers have agreed to coordinate care at a reduced rate for CPH Health Plan participants

The plans encourage you to use in-network providers by charging you lower co-pays and co-insurance amounts. In-network providers agree to bill Moda directly and accept a negotiated fee as payment in full. Out-of-Network providers have not, and you may have to pay amounts above Moda's allowable charge (also called balance billing). To find a list of in-network providers, go to www.modahealth.com and search for providers in the **Endeavor Select** Network. The deductible and out-of-pocket maximum are on a calendar-year basis and reset on January 1st each year.

Endeavor Select is the primary network for Alaska. All licensed professional providers (non-facility) in Alaska are covered at the in-network level. All major hospitals (facility) in Alaska are considered in-network with the exception of Providence Hospital in Anchorage. Members searching for providers in Alaska should navigate to: https:www.modahealth.com/ProviderSearch/faces/webpages/providerSearch.xhtml.

First Choice Alaska is the wrap network partnered with the Endeavor Select network in Alaska. First Choice Network is a network of providers in Alaska, inclusive of Providence providers. Members searching for providers should navigate to the First Choice network at https:www.fchn.com/providersearch/moda-ak.

Aetna Signature PPO is the wrap network for the lower 48. Services outside of Alaska are subject to the PPO network, in and out-of-network benefits for providers and facilities applies. Members searching for providers outside of Alaska should navigate to Provider Search – Home (www.aetna.com).

Preauthorization for all hospital admissions should be obtained by you or your attending physician. Failure to preauthorize an admission may result in a reduction of benefits or possible non-payment of the claim. Contact the Moda Health Navigator to obtain preauthorization of hospital admissions, case management services or medical necessity reviews. They may be reached at 855-232-6886.

Summary of Medical Benefits

	Denali Plan	Redoubt Plan	Iliamna Plan
Annual Deductible			
Individual			
Value Based	$1,000	$2,000	$2,000 self only*
All Other Providers	$1,250	$2,500	$2,500 self only
Family			
Value Based	$2,000	$4,000	$4,000
All Other Providers	$2,500	$5,000	$5,000
Out-of-Pocket Maximum			
Individual	$3,000	$4,000	$4,000
Family	$6,000	$8,000	$8,000
Preventive Care Services	100% deductible waived	100% deductible waived	100% deductible waived
OP Physician Services			
Central Peninsula Hospital	$10 copay (ded. waived)	$10 copay (ded. waived)	$10 copay (after ded.)
PPO Network Hospital	covered at 80% (after ded.)	covered at 80% (after ded.)	covered at 80% (after ded.)
Non-PPO Hospital	covered at 60% (after ded.)	covered at 60% (after ded.)	covered at 60% (after ded.)
Facility Services			
Central Peninsula Hospital	90%	90%	90%
PPO Network Hospital	80%	80%	80%
Non-PPO Hospital	60%	60%	60%
	after deductible	after deductible	after deductible
Value Based Diagnostic Testing	90% after deductible	90% after deductible	90% after deductible
Virtual Visits (CirrusMD)	100% after deductible	100% after deductible	100% after deductible
Chiropractic Visits	12 visit limit after deductible	12 visit limit after deductible	12 visit limit after deductible
Tax Savings Account Options	FSA options	$500 employer paid HRA and FSA options	$500 employer paid HSA Employees can also contribute

Please note:

For the Iliamna Plan to be a Qualified High Deductible Health Plan eligible for Health Savings Account (HSA) contributions, the IRS requires that all non-preventive medical and prescription drug expenses be subject to minimum medical deductibles for self-only and family coverage. Therefore, on the Iliamna Plan, you will have to meet the deductible before most prescriptions will be covered. If you are the only person in your family covered on the plan, the self-only deductible will apply. If you have any other family members enrolled on the plan, you must meet the family deductible before the plan covers any non-preventive medical or prescription expenses.

Prescription Coverage

	Denali Plan & Redoubt Plan	Iliamna Plan
Value Based – 30 day supply	$2 copay	$2 copay (after ded.)
Generic/Select– 30 day supply	$10 copay	$10 copay (after ded.)
Formulary Brand/High Cost Generic– 30 day supply	$35 copay	$35 copay (after ded.)
Non-Formulary Brand– 30 day supply	$70 copay	$70 copay (after ded.)
Specialty Preferred– 30 day supply	$150 copay	$150 copay (after ded.)
Specialty Non-Preferred – 30 day supply	$300 copay	$300 copay (after ded.)
Retail (60 or 90 day supply) or Mail Order	2x copay	2x copay (after ded.)
Out-of-Pocket Maximum	$3,100 / individual $5,700 / family	Combined with medical maximum out-of-pocket
Notice regarding Medicare Part D	Our medical plans offer what is called "creditable coverage," which means a Medicare-eligible person will not have to buy a Medicare Part D supplement for prescription drugs and will not be subject to the 1% per month late enrollment charge assessed by Medicare for purchasing Part D at a later date.	

Navitus is the Pharmacy Benefits Manager with a large selection of in-network pharmacies. Navitus Member Portal Mail-Order prescriptions are processed with Costco Mail Order (you don't need to be a Costco member to use the Costco Pharmacy) or Postal Prescription Services. Visit www.Costco.com/pharmacy/home-delivery or www.ppsrx.com to get set up.

In order to encourage the use of low-cost high value medications to treat some chronic conditions, we offer a Value Based prescription tier with a $2 copay per prescription (after deductible for those on the Iliamna Plan). The list of Value Based medications is on the Moda website at https://modahealth.com/pdfs/Prescription-drug-list-large-group.pdf

Your copays are limited by the Annual Out-of-Pocket Maximum each year. If you are on the Iliamna Plan, you must meet your medical deductible first before the plan pays for non-preventive prescriptions.

If a Generic drug equivalent is available and a Covered Person chooses to purchase a Brand Name drug, the Covered Person will be required to pay the Brand Name copayment amount plus the cost difference between the Brand Name drug and the Generic equivalent, unless the Physician's prescription indicates "Dispense as Written" or similar indication.

When you use either option, your claim for benefits will automatically be filed for you with the Claims Administrator.

- If you fail to show your Plan identification card at the pharmacy, or if you use a non-participating pharmacy, you must pay the Brand Name copayment amount plus the cost difference between the Brand Name drug and the Generic equivalent unless the Physician's prescription indicates "Dispense as Written" or similar indication.
- Your reimbursement will be based on the amount the plan would have paid had you used a participating pharmacy.

Local In-Network Pharmacies include: Safeway, Fred Meyer, Walgreens, Walmart, and Soldotna Professional.

Dental Coverage

Dental coverage is included when you enroll in any medical plan through CPH. Contracted providers agree to bill Moda directly and to accept a negotiated fee as payment in full. Allowable charges for out-of-network providers are paid based on allowed amounts, as determined by Moda. You may be responsible for any additional amounts (also called balance billing). The deductible and annual maximum are on a calendar-year basis and reset every January 1st.

	Denali, Redoubt, and Iliamna Plans
Annual Deductible (waived for in-network dentists)	$50 / Individual $150 / Family
Preventive Care (exams, x-rays, etc.)	100%
Basic Services (fillings, extractions, etc.)	80%
Major Services (crowns, bridges, dentures, etc.)	50%
Orthodontia	50% with $50 lifetime deductible
Annual Maximum Benefit	$2,000
Orthodontia Maximum Benefit	$2,000 per person per lifetime

Preventive care does not accumulate towards the annual maximum benefit.

Preventative

- Preventative services do not apply to your maximum benefit under the dental plan
- Oral examinations, limited to two examinations each year
- Diagnostic services, including examinations and diagnostic x-rays
- Topical fluoride application for covered person under the age of 20, limited to two treatments each year
- Sealants for covered person under age 14, limited to use on permanent teeth
- Space maintainers for covered persons under age 14

Basic services

- Extractions
- Filling restoration to restore, diseased or accidentally broken teeth
- Root canal therapy
- Oral surgery performed on teeth or gums

Major services

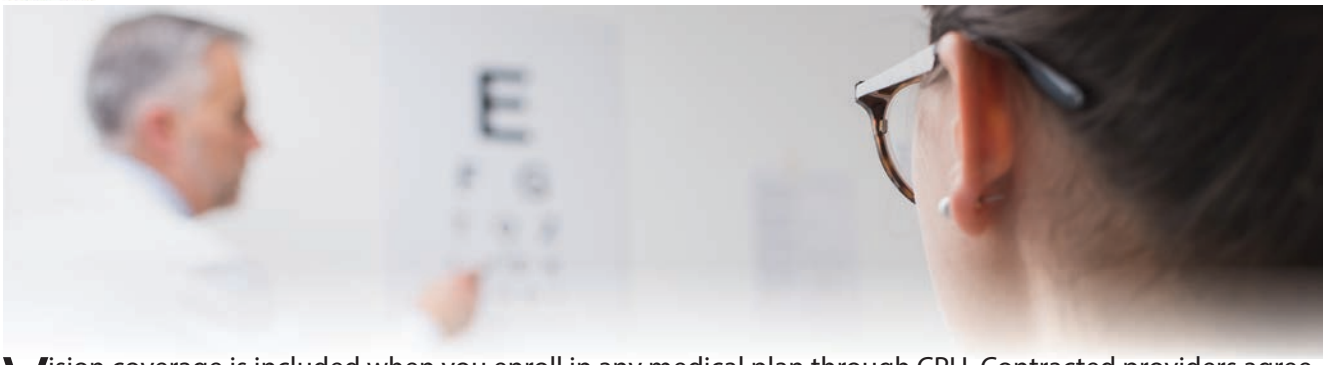
- Inlays, onlays, gold filling and crown restoration to restore, diseased or accidentally broken teeth
- Replacement of an existing partial or full removable, denture, new bridgework, or the addition of teeth to an existing partial or full removable, denture, or bridgework initial install installation of fixed bridgework
- Initial installation of partial or removable dentures

Orthodontia services

- Diagnostic services
- Active treatment, including initial and subsequent necessary appliances
- Retention treatment, including necessary appliances

Delta Dental PPO & Premier is the network of dentists who have agreed to charge set fees and won't balance-bill you. Search for PPO Providers at Moda Find Care | Search as guest (www.modahealth.com) and Search for Premier Providers at Moda Find Care | Search as a guest (www.modahealth.com). The PPO Network offers members the most savings for the lowest cost. Contracted providers agree to bill Moda directly and to accept a negotiated fee as payment in full. Allowable charges for out-of-network providers are paid based on allowed amounts, as determined by Moda. You may be responsible for any additional amounts (also called balance billing).

Vision Coverage



Vision coverage is included when you enroll in any medical plan through CPH. Contracted providers agree to bill Moda directly and to accept a negotiated fee as payment in full. Allowable charges for out-of-network providers are paid based on allowed amounts, as determined by Moda. You may be responsible for any additional amounts (also called balance billing). Local in-network centers include Vista Optical and Eyewear Express. Please note that Kenai Vision is not in-network.

	Denali, Redoubt, and Iliamna Plans
Vision Exam Every year	$25 copay
Eyeglass Lenses Every year	Covered at 100%
Frames Every year	$120 allowance for frames
Contact Lenses Every year	$105 allowance in lieu of glasses

Examinations

Covered routine examination services are:

- Examinations of the outer and inner parts of the eye
- Evaluation of vision sharpness (refraction)
- Binocular balance testing
- Routine tests of color vision, peripheral vision and intraocular pressure
- Case history, recommendations and prescriptions

Lenses

When necessary to improve vision, benefits are available to include eyeglass lenses. Benefits for the following are paid up to the allowable amount for the type of lens prescribed.

- Special features, such as tinting or coating
- Fitting of the eyeglass lenses to frames
- Fitting contact lenses to the eyes

Frames

Benefits are available for the Usual, Customary and Reasonable fee, up to the limits as stated in the Schedule of Benefits. This benefit includes parts of frames and fitting of the frames to the face.

You will be auto-enrolled in an HRA if you elect the Redoubt plan!

A Health Reimbursement Account (HRA) allows CPH to set aside funds on a pre-tax basis for you to spend on any qualified expense that is covered under Section 213(d) of the IRS Code. Money not used in one calendar year can be rolled over from year-to-year with the idea being that you, the participant, can save money to be used in years when you have higher health care expenses. Central Peninsula Hospital will contribute the following amount to each employee's HRA account at the beginning of the plan year on July 1st:

Invidual & Family
$500

The HRA is not available to Denali or Iliamna Plan participants. Please note, when you terminate coverage, you will no longer have access to these funds for future claims, unless you choose to purchase COBRA coverage. Employees who change plans can move funds to a limited purpose HRA (see page 17). You may continue to use the HRA for claims incurred prior to coverage termination, subject to timely filing limits.

Filing A Claim

- Claims can be filed via the mobile app or online via your member portal
- Submit for reimbursement with a completed manual claim form and fax or mail it in
- Benefits Card: The Benefits Card provides direct access to your HRA, allowing you to pay for eligible healthcare expenses at qualified locations wherever Visa is accepted.
- You are responsible for receipts verifying the account was used for qualifying expenses. The IRS can request documentation when you do your taxes, so you will want to track expenditures with your tax paperwork.

BenefitHelp SOLUTIONS

Health Savings Account (HSA)

You must be enrolled in the Iliamna Plan to participate in an HSA

A Health Savings Accounts (HSA) is a tax-advantaged savings account that belongs to you and is designed to help you save money pre-tax for when you have higher health care expenses. Regardless of who puts money into your HSA, HSA dollars are owned by you. Unused money rolls over to the next year and is fully portable. This means you take it with you if you leave CPH.

The maximum amount that may be contributed to your HSA (employer and employee) is determined annually by the IRS and is updated January 1st of each year. The 2024 maximums are listed below:

	2024 Maximums
Individual-only coverage	$4,150
Individual, plus one or more covered family members	$8,300
Additional catch-up contribution for those 55+	+ $1,000

HSA EMPLOYER CONTRIBUTIONS

Central Peninsula Hospital will contribute the following amount to each employee's HSA account at the beginning of the plan year on July 1st:

Invidual & Family
$500

BENEFITS TO YOU:

- Grow funds tax-free. An HSA grows with you. When your HSA balance reaches the minimum balance requirement, your funds may be invested in mutual funds yielding tax-free earnings. Ask your HR Associate for a copy of the BHS Consumer Guide for more details regarding investing your HSA funds.
- After age 65, the funds can be used for any purpose, without penalty.

Please note:

You will only have access to funds that are deposited to your account. Additionally, you may elect to put money from your paycheck into your HSA on a pre-tax basis. The amount you contribute can be changed in Workday at any time throughout the year.

BenefitHelp Solutions will send you Identity Verification information to set up your Health Savings Account. You have 60 days to respond and verify your identity before they close the account.

FILING A CLAIM

- Claims can be filed via the mobile app or online via your member portal
- Submit for reimbursement with a completed manual claim form and fax or mail it in
- Benefits Card: The Benefits Card provides direct access to your HSA, allowing you to pay for eligible healthcare expenses at qualified locations wherever Visa is accepted.

- You are responsible for receipts verifying the account was used for qualifying expenses. The IRS can request documentation when you do your taxes, so you will want to track expenditures with your tax paperwork.

To receive contributions, you must NOT have other health coverage for yourself including:

- Coverage through an individual non-qualified HDHP plan
- Coverage through a spouse's or parent's non-qualified HDHP plan
- Access to a spouse's Flexible Spending Account
- Be a dependent on someone else's tax return
- Coverage through a state or federal program:
  - Tricare/Champva/Veterans Administration
  - Native/Tribal plan
  - Medicare
  - Medicaid

Please note that Health Savings Accounts and employer HSA contributions are not subject to ERISA or COBRA. HSA information is included in this Summary to provide you with a complete overview. It is not our intent to include your account in our ERISA benefits program.

For IHS beneficiaries or Veterans beneficiaries, you cannot contribute to your HSA for 3 months following the month you receive benefits from the Veterans or Native Tribal facilities.

HRA vs. HSA

	HRA	HSA
What is the account?	An HRA is an employer-funded account that reimburses you for out-of-pocket medical expenses that are incurred while on the Redoubt Plan.	An HSA is a tax-advantaged savings account that belongs to you and is designed to help you save money pre-tax for when you have higher health care expenses.
Who is eligible	Employees enrolled on the Redoubt Medical Plan.	Employees enrolled in the Iliamna Medical Plan. (See page 13 for eligibility rules)
Employer Contributions	$500	$500
Funding Availability	100% of your annual funds are available on July 1. Any unused funds are carried over.	Employer contributions are deposited on July 1st. Employee contributions are added biweekly. You can be reimbursed up to your account balance. Any unused funds are carried over.
Maximum Employee Contributions	n/a: An HRA cannot be funded by employee contributions. (See page 15 for Healthcare FSA information on tax-free medical reimbursements)	The maximum amount you can contribute to your HSA (from employer and employee) is determined annually by the IRS. For 2024, those amounts are: 1. Individual only coverage: $4,150 2. Individual, plus one or more covered family members: $8,300 3. Additional catch-up contribution for those aged 55+: $1,000
Eligible Expenses	Your out-of-pocket expenses for any service that is covered under the Redoubt Plan. Includes deductible, coinsurance, and copays.	All qualified medical expenses as allowed under Section 213(d) of the Internal Revenue Code. Includes vision care, dental care, non-covered medical expenses, over-the-counter medicines, and menstrual products.
Non-eligible expenses	Any item that is not covered under the Redoubt Plan. Includes vision care, dental care and non-covered medical expenses.	Any item that is not allowed under Section 213(d).
Interaction with Flexible Spending Account (FSA)	The FSA will reimburse eligible medical expenses until FSA funds are exhausted before using HRA funds.	The Limited Purpose FSA will reimburse eligible dental and vision expenses.

Flexible Spending Accounts

With an FSA, you determine how much out-of-pocket healthcare and/or dependent care expenses you have each year, and then you have that amount (divided by the number of payroll periods) automatically set aside from your paycheck. The money is pulled out before taxes are deducted and held in a special account for you. When you start paying healthcare or dependent care expenses, you are able to use those funds from your FSA account, and that money never gets taxed. The Benefits Card provides direct access to your Flexible Spending Account, allowing you to pay for eligible healthcare expenses at qualified locations wherever Visa is accepted. FSA accounts require re-enrollment each year during Open Enrollment.

HEALTHCARE FSA

This program allows you to set aside up to $3,200 pre-tax per year, so that you can pay for certain IRS-approved medical care expenses not covered by the insurance plan or Health Reimbursement Arrangement (HRA). You cannot contribute to a Healthcare FSA if you elect a Health Savings Account (HSA). You do not need to be enrolled in the medical plan to take advantage of an FSA.

You should only set aside enough money for those expenses you know you will incur during the plan year, as the roll-over provision only allows you to carry forward up to $640 into the next plan year.

IRS rules state that once you make your enrollment election for the year, you will not be allowed to change that election until the next Open Enrollment period, unless you have a change in family status, such as marriage, divorce, birth of a child, or change in employment status. If you elect a Healthcare FSA, you must re-enroll each year during Open Enrollment.

DEPENDENT CARE FSA

Similar to the Healthcare FSA, you may also use pre-tax dollars to pay for qualified dependent care expenses. Expenses can be for your dependent children 12 and under, and in some cases elder care, and must be so you can work. Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

The annual maximum amount you may contribute into the Dependent Care FSA is $5,000 per calendar year (or $2,500 if married and filing separately). This limit is set by the IRS and is a calendar year limit. Refer to the IRS for eligible dependent care expenses. If you elect a Dependent Care FSA, you must re-enroll each year during Open Enrollment.

	Healthcare FSA	Dependent Care FSA
What is the account?	A Healthcare FSA can be used to pay for medical expenses that are not covered by insurance.	A Dependent Care FSA can be used to pay for dependent care expenses (refer to IRS for eligible expenses)
Who is eligible?	Employees enrolled on the Redoubt or Denali plans and those who waive coverage	Employees enrolled in any of the health plans and those who waive coverage
Employer Contributions	n/a	n/a
Funding Availability	100% of funds are available on July 1. Unused funds are carried over (up to $640).	100% of funds are available on July 1. Unused funds cannot be carried over.
Employee Contributions	Employee contributions are deducted on a biweekly basis	Employee contributions are deducted on a biweekly basis
2024 Annual Maximum	$3,200	$5,000/ household $2,500 if married, filing separately
Interaction with HRA and HSA	The FSA will reimburse eligible medical expenses until FSA funds are exhausted before using HRA funds. You cannot elect a Healthcare FSA if you elect an HSA.	n/a

LIMITED PURPOSE FSA AND HRA

If you have funds left in your Healthcare FSA or Health Reimbursement Account (HRA) and wish to enroll in the Iliamna Plan with an HSA during Open Enrollment, your Healthcare FSA and HRA funds will be rolled into limited purpose accounts, so that you can maintain the ability to contribute to a Health Savings Account. The limited purpose FSA or HRA can be used to pay for dental and vision expenses only.

FILING A CLAIM

- Claims can be filed via the mobile app or online via your member portal
- Submit for reimbursement with a completed manual claim form and fax or mail it in
- Benefits Card: The Benefits Card provides direct access to your FSA, allowing you to pay for eligible healthcare expenses at qualified locations wherever Visa is accepted.
- You are responsible for receipts verifying the account was used for qualifying expenses. The IRS can request documentation when you do your taxes, so you will want to track expenditures with your tax paperwork.

CPH's disability coverage through New York Life offers you financial stability and peace of mind if you are unable to perform the material duties of your job due to sickness, injury, or pregnancy.

EMPLOYER PAID

All full-time and part-time employees are auto-enrolled in the Basic Short-Term Disability policy. Benefits are listed below:

	Employer Paid Basic Short-Term Disability
Benefits Begin	On the 30th day of disability, contingent upon satisfying the definition of disability as stated in your policy.
Percentage of Income Replaced	70% of base weekly earnings.
Maximum Benefit Available	Up to $200 per week.
Benefit Duration	Up to 22 weeks. *

OPTIONAL COVERAGE

If you want additional disability coverage, you may purchase additional Short-Term coverage and/or Long-Term disability. through payroll deductions. Deductions occur on the first paycheck each month. Refer to the "Short-Term Disability Insurance" and "Long-Term Disability Insurance" booklets in your benefit folder for more information including the cost of these benefits.

	Voluntary Short-Term Disability	Voluntary Long-Term Disability
Benefits Begin	On the 30th day of disability, contingent upon satisfying the definition of disability as stated in your policy.	On the 181st day of disability, contingent upon satisfying the definition of disability as stated in your policy.
Percentage of Income Replaced	70% of base weekly earnings.	60% of base monthly earnings.
Maximum Benefit Available	Up to $1,000 per week.	Up to $10,000 per month.
Benefit Duration	Up to 22 weeks. *	Up to Social Security Normal Retirement Age.
Who funds this benefit?	The Employee	If elected, CPH shares cost

*Benefits may be reduced or your claim denied if you are eligible to receive payment from other sources including, but not limited to, your accrued PTO/IAP, PTO donations, State Disability, Social Security, and Retirement funds.

Important Information Regarding Short-Term Disability Insurance and Maternity Leave:

Since there is a 29-day elimination period for short-term disability, and basic maternity leave is six weeks, benefits would start after 29 days and run through the remainder of the six weeks less the 29 days.

EMPLOYER PAID

Basic term life insurance is being provided to help you protect your families' financial security. All full-time and part-time employees are auto-enrolled in the Basic Life and Accidental Death & Dismemberment policy offered by New York Life. In the event you should pass away, your beneficiary will receive benefits listed below. AD&D insurance will pay an additional amount for accidental death and scheduled amounts for dismemberment.

	Employee	Spouse	Child
	Basic Term Life Insurance		
Benefit Available	1x annual salary	-	-
	Basic AD&D		
Benefit Available	1x annual salary	-	-

OPTIONAL COVERAGE

If you want additional group life insurance, you may purchase additional amounts through payroll deductions. Deductions occur on the first paycheck each month. You must be enrolled in voluntary life to purchase life insurance for your spouse or child. Spouse coverage cannot exceed employee coverage. If your election exceeds the guaranteed issue, medical underwriting is required. Review the "Term Life and Accident Insurance" booklet in your benefits folder for more information including the cost of these benefits.

	Employee	Spouse	Child
	Voluntary Term Life Insurance		
Benefit Available	Lesser of 7x annual earnings or $750,000	Lesser of 100% of employee election or $500,000	Flat $1,000, $5,000, or $10,000 Under the age of 19
Available in increments of:	$10,000	$5,000	Flat amounts of $1,000, $5,000, or $10,000
Guaranteed Issue	$80,000	$25,000	$10,000
	Voluntary AD&D		
Benefit Available	Up to $500,000	Up to $500,000	Same as Life
Guaranteed Issue	Full Benefit	Full Benefit	Full Benefit
	Age Reduction Schedule		
Reduction schedule applies to Life, AD&D and Supplemental benefits	At age 65, benefit reduces to 65% of original amount At age 70, benefit reduces to 50% of original amount Coverage for a spouse ends at age 70		

Because the premium is based on your age, when you go from one age bracket to the next, monthly deductions will increase to reflect the new age bracket. Age brackets are in 5-year increments (30–34, 35–39, etc.).

Employee Assistance Program *(EAP)*

The Employee Assistance Program (EAP) through Magellan Health is a completely free and confidential counseling program that helps you and/or your family members address life issues, big or small. Access up to 3 free counseling sessions per issue. Benefits are offered to all employees and immediate family members, and can help with:

- Marital and family concerns
- Difficult relationships
- Depression
- Substance abuse
- Grief and loss
- Financial entanglements
- Personal stressors

LifeMart (access via Magellan's website) offers discounts to hotels, flights, rental cars, event tickets, subscriptions, and more!

Visit https://member.magellanhealthcare.com/login or call 800-478-2812 (TTY 711) to:

- Find information about parenting, retirement, finance etc.
- Locate schools, camps, and eldercare/childcare providers
- Lifemart's Discount Center
- Use financial calculators and retirement planners
- Read books, articles, and guides
- Watch videos and listen to audio files

PASSPORT TO HEALTH

CPH offers the Passport to Health program to employees and their dependents who have been identified with health conditions and who may be able to benefit from in-person health coaching. The program is voluntary and free to health plan participants. Participants work with a Moda health coach located in Soldotna. If you are invited into the program, participation incentives may include waiving copays or coinsurance for certain services, although deductibles still apply. Call 855-718-1769 to find out more about eligibility and the program.

BEHAVIORAL HEALTH CHAMPIONS

As you manage all the responsibilities in your life, challenged by all the forces in our world, you may find yourself needing someone to help you find the right mental health balance and support. Behavioral Health Champions bring the support and tools you need for mental wellness right to you. Your Behavioral Health Champion can help you:

- Access a local mental health professional that's right for you
- Get the care and support you need quickly and easily
- Verify provider availability and schedule appointments
- With follow-up connections to make sure you have what you need and are getting the care and support you deserve

To get started, call 833-212-5027 or email bhchampions@modahealth.com.

TELEDOC HEALTH DIABETES MANAGEMENT PROGRAM

When you register for the Teledoc Health Diabetes Management Program, you will receive a welcome kit within 3-5 days. Medical plan participants and their covered dependents can participate in this program at no additional cost. Once you've signed up, you'll receive:

- Connected blood glucose meter
- Unlimited strips
- Personalized insights
- Expert coaching

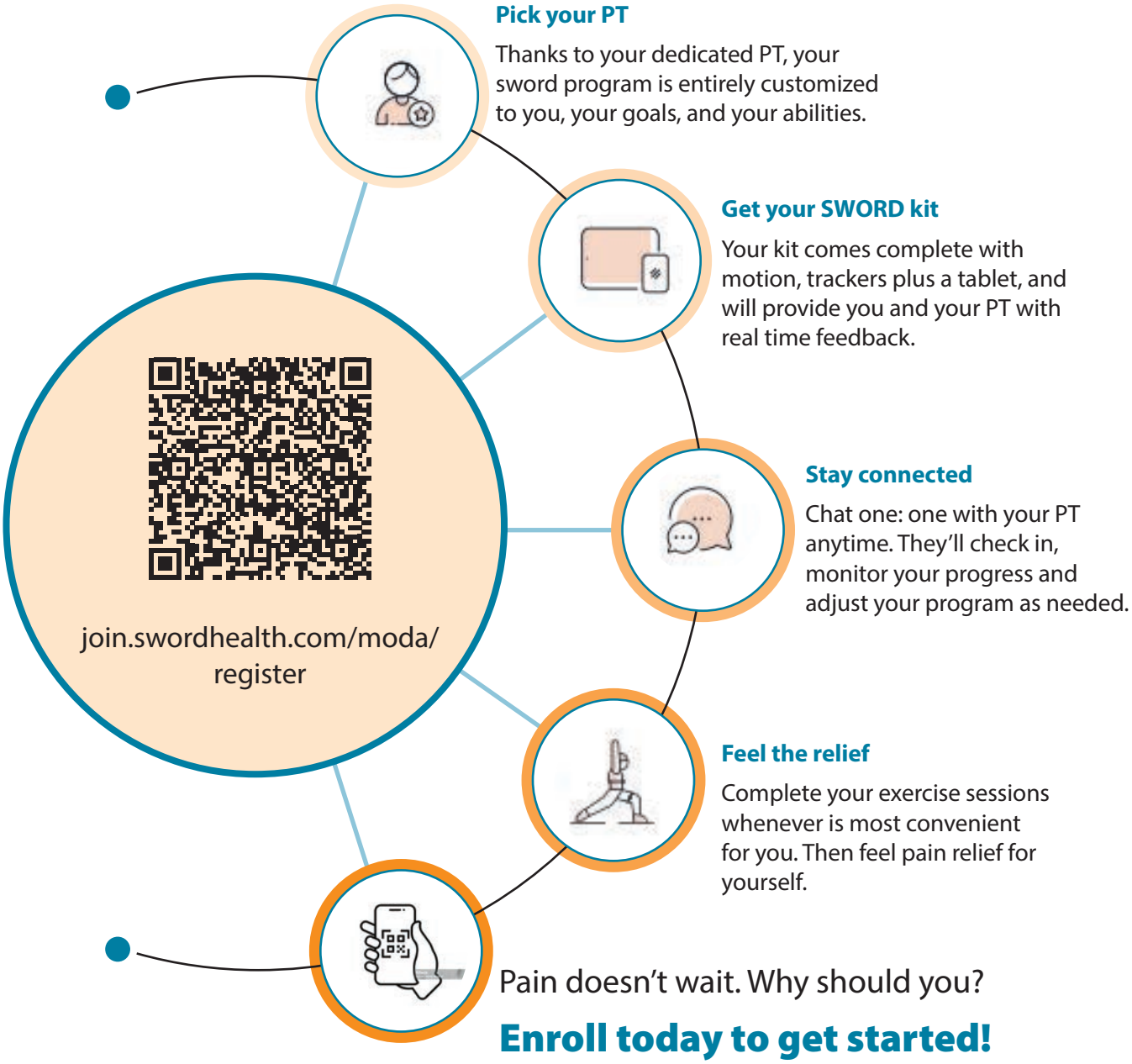
The Diabetes Management program supports people diagnosed with Type 1 or Type 2 diabetes and helps make living with diabetes easier. The program team works with you to provide personalized plans, so you can live your healthiest life possible. If members of the program team see that your glucose levels of out of range, they'll reach out to you within 15 minutes to get you the support you need. You also have the option to work with a certified health coach for more guidance.

Getting registered for the Teledoc Health Diabetes Management program is easy and only takes a few minutes. Call 800-945-4355 or visit **https://www.teladochealth.com/** and use registration code CPH.

SWORD Virtual Physical Therapy

Alleviate your pain by as much as 70% in just eight weeks from the comfort of home. This wellness program is available to Moda Health plan participants and their covered dependents at no additional cost as part of your medical benefits. Receive specialized treatment tailored just for you. SWORD will ship a tablet and motion sensors to guide you and provide real-time feedback during your exercises. Your physical care specialist will be there to support you virtually and is available at any time.

Here's how it works



Pick your PT

Thanks to your dedicated PT, your sword program is entirely customized to you, your goals, and your abilities.

Get your SWORD kit

Your kit comes complete with motion, trackers plus a tablet, and will provide you and your PT with real time feedback.

Stay connected

Chat one: one with your PT anytime. They'll check in, monitor your progress and adjust your program as needed.

Feel the relief

Complete your exercise sessions whenever is most convenient for you. Then feel pain relief for yourself.

Pain doesn't wait. Why should you?

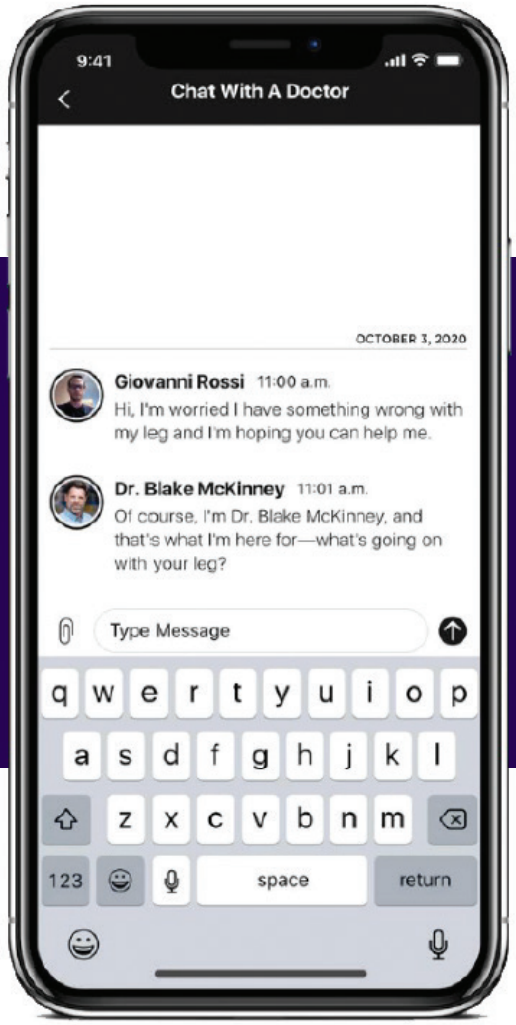
Enroll today to get started!

Cirrus MD - Text A Doctor 24/7

Download the cirrusMD app or connect online at modahealth.com/cirrusMD and see how easy it is to connect to a doctor in seconds!

Download on the App Store

GET IT ON Google Play



Use cirusMD for:

- Cough, fevers, sore throat
- Earaches, stomach, pain,
- Rashes, allergic reactions, animal/insect bites
- Back/abdominal pain
- Sports injuries, Burns, heart – related illness
- Urinary tract in
- General health questions

Doctors are available 24 hours a day, 7 days a week.

Learn more at modahealth.com/cirrusMD.

Please note:

CirrusMD is covered at 100% with no deductible for participants in the Denali and Redoubt plans. The services are subject to the deductible for participants on the Iliamna plan and will be covered at 100% after the deductible is met.

The Consolidated Leave Program is a two-part program, which consolidates and replaces the traditional vacation, holiday, and sick leave benefits. This program is comprised of Paid Time Off (PTO) and the Income Assurance Program (IAP). This program is available to full and part-time employees.

PAID TIME OFF (PTO)

A benefit accrued each period according to the number of hours paid per pay period (up to a maximum of eighty-four (84) hours), and the number of years of service with the hospital. This accrued time may be used for any purpose including holidays, vacations, family needs, personal business, or illness.

Plan in effect upon:	PTO Accrual Per Hour	PTO Accrual Per 80 Hour Pay Period	PTO Accrual For 26 Pay Periods	Maximum Accrual	Maximum Accrual for Director
Hire Date	0.08462	6.77 Hours	176 Hours (22 Days)	264 Hours (33 Days)	344 Hours (43 Days)
1st Anniversary	0.10385	8.31 Hours	216 Hours (27 Days)	324 Hours (40.5 Days)	404 Hours (50.5 Days)
3rd Anniversary	0.11538	9.23 Hours	240 Hours (30 Days)	360 Hours (45 Days)	440 Hours (55 Days)
5th Anniversary	0.12308	9.85 Hours	256 Hours (32 Days)	384 Hours (48 Days)	464 Hours (58 Days)
7th Anniversary	0.13077	10.46 Hours	272 Hours (34 Days)	408 Hours (51 Days)	488 Hours (61 Days)
10th Anniversary	0.13846	11.08 Hours	288 Hours (36 Days)	432 Hours (54 Days)	512 Hours (64 Days)
Executive Level 1	0.123077	9.8462 Hours	256 Hours (32 Days)	464 Hours (58 Days)	N/A
Executive Level 2	0.142308	11.3846 Hours	296 Hours (37 Days)	524 Hours (65.5 Days)	N/A
Executive Level 3	0.161538	12.9230 Hours	336 Hours (42 Days)	584 Hours (73 Days)	N/A

TAKING PTO: PTO, except for illness or emergency, must be requested in advance in accordance with departmental policy and the Collective Bargaining Agreement if applicable. In absence of a departmental policy, at least a two-week (14 day) advance notice is required.

UNSCHEDULED PTO (PTO-U): When using PTO due to illness and/or an unscheduled absence, the employee must contact his/her Director by the required time designated by departmental policy. If the employee is ill at work and must leave, and/or if the Director sends the employee home due to illness, the Director will make

Continued

the determination as to use of accrued PTO or IAP based on prior utilization of hours by the employee. PTO for illness or unscheduled absence will be documented on the time record as PTO-U.

CPH'S OBSERVED HOLIDAYS: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Eve and Christmas Day. If a holiday falls on the day of the week that an employee is normally scheduled to work, the default procedure is to pay the employee PTO equivalent to the number of hours normally worked that shift. If an employee chooses not to be paid PTO for the holiday, they must notify their Director before processing that pay period's payroll.

PTO FOR REGISTERED NURSES: PTO usage for Registered Nurses falls under the Collective Bargaining Agreement, Article 9. Contact Human Resources for a copy of the Collective Bargaining Agreement.

PTO DONATIONS: If an employee is on an approved leave, has exhausted PTO and applicable IAP hours, and experiences a medical or family emergency or some other hardship situation that causes an absence (10 or more days) from work, the employee may request PTO donations. Being approved to receive PTO donations does not guarantee pay.

To donate your hours, staff members may submit a written request to donate accrued, unused PTO hours to the facility-wide Emergency Leave Bank. Donated hours can be designated for the benefit of a specific employee recipient, if desired. Donations of a minimum of one hour, up to a maximum of 120 hours may be donated any one calendar year. The donating employee must retain at least 40 hours of PTO in their own bank. Employees may make donations in response to a specific co-worker's request for donations.

If you need to request additional PTO hours, please submit the request to the Human Resources department. Hours are donated to specifically designated recipients first, with the remaining hours to be equally distributed among other approved recipients, so long as donated PTO hours are available. Donated hours will be paid on the pay period in which the employee falls below status hours. If approved, the employee may receive up to a maximum of 480 donated hours in one calendar year if the hours are available.

ANNUAL VOLUNTARY PTO CASH-OUT: In December of each year, employees may have the option to voluntarily cash out a portion of their PTO balance during the next calendar year. Employees must maintain a minimum balance of PTO in their account. The total number of hours cashed out may not exceed 50% of projected PTO accruals for the year, based on regularly scheduled hours. Voluntary cash-out forms must be completed within the designated time frame to be eligible.

INCOME ASSURANCE PROGRAM (IAP)

A benefit accrued each pay period according to the number of hours paid per pay period (up to a maximum of 80 hours). IAP may be used on the first two shifts missed due to an employee or an employee's child's medical condition during any calendar year. After the first two shifts in any calendar year, IAP may only be used following 32 consecutive hours of absence caused by illness or injury or on the first day of an absence due to hospitalization or non-elective outpatient surgery.

Should an employee return to the use of IAP and find that they cannot complete their scheduled shift due to the same illness, they will return to the use of IAP and provide a physician's release documenting that the absence was due to the continuation of the same illness. If the employee returns to work after the use of IAP and completes their scheduled shift, any additional days absent will be paid as if the employee were encountering a new illness.

IAP Accrual Schedule (Based on Full-Time Employment)				
Length of Service	IAP Accrual Per Hour	Accrual Per 80 Hour Pay Period	Accrual For 26 Pay Periods	Maximum
Date of Hire	0.030768	2.46 Hours	64 Hours (8 Days)	480 Hours (60 Days)

FAMILY MEDICAL LEAVE

The Family Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. Eligible employees are entitled to:

Twelve work weeks of leave in a 12-month period for:

- The birth of a child and to care for the newborn child within one year of birth
- The placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement
- To care for the employee's spouse, child, or parent who has a serious health condition
- A serious health condition that makes the employee unable to perform the essential functions of their job
- Any qualifying exigency arising out of the fact the employee's spouse, child, or parent is a covered military member on "covered active duty," or
- Twenty-six work weeks of leave in a single 12-month period to:
- Care for a covered service member with a serious injury or illness if the eligible employee is the service member's spouse, child, parent, or next-of-kin (military caregiver leave).

For further questions regarding PTO, IAP or Family Medical Leave contact the Human Resources Department

Educational Assistance

CPH encourages employees to develop their skills, knowledge, and job effectiveness through continuing education. Educational Assistance may be granted for courses taken through an accredited college, university, or an approved technical school that is work-related, maintain or improve the skills required by an employee in their employment, or that may make an employee more valuable to the organization. This program allows eligible employees to receive funds to further their education prior to completing the course.

ELIGIBILITY

All full and part-time employees who have completed one year of service are eligible for this benefit. Per Diem and Temporary employees are not eligible for Educational Assistance.

WHAT CAN IT BE USED FOR?

Educational Assistance may be used for the following educational expenses as outlined in the Internal Revenue Code Section 127(c)(1): tuition, books, supplies, and equipment necessary for class.

Educational Assistance may not be used for tools or supplies which employees may keep after the course is completed, education involving sports, games, hobbies (unless job-related), meals, lodging or transportation.

	Maximum Annual Reimbursement	
	Undergraduate Courses	Graduate Courses
Full Time Employee		
2nd Year of Service	$1,500	$1,500
3+ Years of Service	$2,000	$2,500
Part Time Employee		
2nd Year of Service	$750	$750
3+ Years of Service	$1,000	$1,250

HOW TO APPLY:

- Submit your application online, at https://app.smartsheet.com/b/form/135b4b6b441c4979bcc55503bbf44057 .
- Applications will be reviewed and are subject to available funds. If approved, you will receive a check and be requested to sign a promissory agreement.
- At the completion of your course, record of passing grades received ("C" or better, or "Pass" if Pass/Fail grading) and all receipts for educational expenses incurred must be turned into Human Resources no later than 30 days after the end date of the course/semester.

Applications must be submitted prior to class start date.

For More information, contact Human Resources or see policy CPGH.102.520-Educational Assistance.

Continuing Education Hours

It is strongly encouraged for all employees to stay current with the trends and new achievements in their area of employment. All employees at CPH are eligible for compensation for hours spent in educational endeavors that are relevant to their position.

Employees may be provided a minimum of 16 hours per year of continuing education dependent upon their position. To view the number of CEs available to you, please visit Workday. This time will be reimbursed at regular pay rate, and not be, or cause worked time to be eligible for overtime pay. Additional education time will be available to those attending programs that are hospital directed for their position.

ELIGIBILITY

All employees are eligible to participate in this program. (For information pertaining to education benefits for RN staff, please refer to the Collective Bargaining Agreement)

WHAT CAN CE HOURS BE USED FOR?

Certifications, Conferences, or online CE programs approved by your department leadership. Educational offerings are posted on various education boards throughout the hospital and on the Staff Development page on the intranet.

403(b) Retirement

Central Peninsula Hospital's employees have the option to participate in 403(b) Employer Contributory Plan. This plan offers many benefits and investment options making it easy and convenient for you to save for your future.

CONTRIBUTIONS

All employees (Per Diem included) are auto-enrolled at a 3% contribution rate after 60 days of employment. Contributions are pre-tax and are added via payroll deductions. Employees can adjust their contribution amounts or opt out at any time throughout the year in the Voya app or website. In order to bypass auto-enrollment and enroll sooner than 60 days, follow the instructions on the flyer provided in your benefit folder during orientation (it takes approximately one week from date of hire to bypass auto-enrollment).

EMPLOYER MATCH & DISCRETIONARY

In order to receive Employer Discretionary and Matching contributions, you must be full or part-time, have completed one year of service in which you worked 1,000 hours (if not in the first year from your date of hire, it will be measured by calendar year), and be 21 years of age. Once eligibility requirements have been met, employees will be enrolled in the next enrollment period which occur in December and June of each year and are effective January and July of each year. Eligible employees receive an automatic 2% Employer Discretionary contribution based on the employee's annual salary. CPH will match employee contributions up to a maximum of 3% of the employee's salary. Employee contributions cannot exceed the IRS limits of $23,000 for 2024. The annual combined maximum the hospital will contribute is $7,162.

VESTING SCHEDULE

Years of Service Completed	Vested Percentage
1	20
2	40
3	60
4	80
5 or more	100

Please contact Human Resources for more information regarding vesting calculations and requirements.

You have the option to rollover funds from previous employer accounts. Contact Voya to get started! Voya Financial Advisors are available for on-site meetings throughout the year. HR will send emails with appointment instructions prior to the Financial Advisor's visit.

You can reach Voya by calling 800-584-6001 or visiting https://cph.beready2retire.com/

Refer to this list when you need to contact a benefits vendor.

For general information, contact Human Resources.

Medical, Vision, Eligibility, Claims, and Provider Questions	Moda Health Navigator	855-232-6886	www.modahealth.com
Dental	Moda Health	855-232-6863	www.modahealth.com
Prescription Drugs	Moda Health	855-232-6696	Monday through Friday 7:30 a.m. until 5:30 p.m. PST
Virtual Care	CirrusMD		www.modahealth.com/cirrusmd
Behavioral Health	Behavioral Health Champions	833-212-5027	bhchampions@modahealth.com
Virtual Physical Therapy	SWORD		www.Join.swordhealth.com/moda
Diabetes Management Program	Teledoc Health	800-945-4355	Join.Livongo.com/CPH/hi

Provider Information	First Choice Alaska
	Aeta Signature PPO
		Alaska
		Lower 48
			https;//www.fchn.com/providersearch/moda-ak
			aetna.com

Flexible Spending Arrangement (FSA) Health Reimbursement Arrangement (HRA) Health Savings Account (HSA)	BenefitHelp Solutions	800-669-3539	www.benefithelpsolutions.com
Employee Assistance Program (EAP)	Magellan Behavioral Health	800-478-2812	www.magellanascend.com
Life Insurance and Disability	New York Life	800-362-4462	www.newyorklife.com
403(b) and 457(b) Retirement Plan	Voya Financial	800-584-6001	www.voyaretirementplans.com
Benefit Eligibility Enrollment Qualified Family Status Changes Family Medical Leave	Human Resources	907-714-4773	Monday – Friday 8 AM-4:30 PM Or submit a ticket to the HR HelpDesk
Benefits Advocacy	Shelly Tuttle Parker, Smith & Feek	907-865-6833 800-457-0220	smtuttle@psfinc.com

HEALTHCARE REFORM

The Affordable Care Act (ACA) is complex, and you may have questions about how it impacts you, your family and your benefits. There are three items you should know:

First, the individual mandate (the requirement that all individuals have health insurance) remains in place. What has changed is the penalty associated with it. As of January 1, 2019, the ACA tax penalty is repealed and you won't have to pay anything if you don't enroll.

Second, the Health Insurance Marketplace still exists. You can shop for and enroll in insurance plans through the exchange and still apply for income-based subsidies.

Third, for most people, the plans we offer are considered affordable for most employees and you may not be eligible for the federal subsidies available in the Health Insurance Marketplace, even if you choose not to enroll in CPH's plan.

Effective 2023, the IRS updated how eligibility for subsidies are calculated. This means your spouse and/or child(ren) may be eligible for less expensive coverage on the Health Insurance Marketplace as eligibility for a subsidy is now based on your monthly premium contribution to enroll family members in CPH's plan. Be sure to complete a thorough evaluation of the Health Insurance Marketplace's plan benefit designs and networks when comparing insurance coverage.

Please refer to your Notice of Health Insurance Marketplace Coverage for general information. For additional information on Marketplace options in your area and subsidy calculators, go to www.healthcare.gov or call 1-800-318-2596.

ANNUAL REMINDERS

Special Enrollment

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), allows a Special Enrollment period in addition to the regular Open Enrollment period. Only the following individuals may enroll outside the Open Enrollment period:

- Individuals who previously waived coverage under this program because they had other coverage and then involuntarily lost the other coverage. Enrollment must occur within 60 days of the loss of other coverage;
- New dependents due to marriage, birth, adoption or placement for adoption. The eligible employee and other dependents who previously did not elect to be covered under the employer's health care plan may also enroll at the time the new dependent is enrolled. Enrollment must occur within 60 days of date of marriage, or 60 days of a birth, adoption or placement for adoption;
- A court has ordered coverage be provided for a spouse or minor child under this plan and request for enrollment is made within 60 days after issuance of such court order;
- If employee and/or dependent(s) become ineligible for Medicaid or the Children's Health Insurance program and request coverage under our plan within 60 days of termination (Please read the Medicaid and the Children's Health Insurance Program notice for more information); or
- If employee and/or dependent(s) become eligible for the state premium assistance program and request coverage under our plan within 60 days after eligibility is determined.

Notice Regarding the Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

Contact Human Resources for more information.

HIPAA Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) requires employers to adhere to strict privacy guidelines and establishes your rights with regard to your personal health information. You received a copy of the Central Peninsula Hospital Group Health Plan Privacy Notice when you were hired. This notice describes how medical information about you may be used and disclosed, and how you can access that information.

If you have any questions regarding the HIPAA Privacy Notice, or would like another copy, please contact Human Resources.

COBRA

COBRA continuation coverage is a temporary continuation of coverage under our employee benefit plan. Please contact Human Resources for a copy of the General Notice of COBRA Continuation Rights. This notice explains your rights and obligations to receive COBRA benefits.

We are not always aware when a COBRA event takes place, unless notified by you. The most common examples are divorce, or when a child exceeds the maximum age. When such an event occurs, the Notice of Qualifying Event must be postmarked within 60 days of the qualifying event for the affected person to be eligible for COBRA continuation. If you have questions about COBRA please contact Human Resources.

Important Notice about Your Prescription Drug Coverage and Medicare

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

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

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. CPH has determined that the prescription drug coverage offered by the Central Peninsula Hospital Employee Benefit Plan 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?

Plan Participants who also are eligible for Medicare have the following three options concerning prescription drug coverage:

- You may stay in the Plan and not enroll in the Medicare prescription drug coverage at this time. You will be able to enroll in the Medicare prescription drug coverage at a later date without penalty, either (1) during a Medicare prescription drug open enrollment period (October 15–December 7 of each year); or (2) if you lose Plan coverage. This is the best option for most Plan participants who are eligible for Medicare.
- You may stay in the Plan and also enroll in Medicare prescription drug coverage at this time. The Plan will pay prescription drug benefits as the primary payer in most instances. Medicare will pay benefits as a secondary payer, and thus the value of your Medicare prescription drug coverage will be greatly reduced. Your current coverage under the Plan pays for other health benefits as well as prescription drugs and will not change if you choose to enroll in Medicare prescription drug coverage. However, once you enroll in Medicare, you and CPH will not be eligible to make any further contributions to your Health Savings Account. And under the Plan coverage, you must meet the high deductible amounts before the Plan will pay for most prescription drugs.
- You may reject all coverage under the Plan and choose coverage under Medicare as your primary and only payer for all medical and prescription drug expenses. If you do so, you will not be able to receive coverage under the Plan, including prescription drug coverage, unless and until you are eligible to reenroll at the next enrollment period for which you are eligible, if any. Your current coverage pays for other types of health expenses, in addition to prescription drugs, and you will not be eligible to receive any of your current health and prescription drug benefits if you reject coverage under the Plan and choose to enroll in Medicare, including a Medicare prescription drug plan, as your primary and only payer.

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 CPH 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 November to join.

For More Information about this Notice or Your Current Prescription Drug Coverage…

Contact the person 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 CPH 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 Social Security on the web at www.socialsecurity.gov, or call them 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 drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	July 1st, 2024
Name of Entity/Sender:	Central Peninsula Hospital
Contact—Position/Office:	Human Resources
Address:	250 Hospital Place Soldotna, AK 99669
Phone Number:	907-714-4773

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

If you or your children are eligible for Medicaid or the Children's Health Insurance Program (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, 2024. 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: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: *http://myarhipp.com/*
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program Website: *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://hcpf.colorado.gov/child-health-plan-plus*
CHP+ Customer Service:
1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): *https://www.mycohibi.com/*
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: *https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html*
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: *https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp*
Phone: 678-564-1162, Press 1
GA CHIPRA Website: *https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra*
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid: 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
HIPP Phone: 1-800-967-4660

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://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

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.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
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: https://www.hhs.nd.gov/healthcare
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
Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

Continued

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: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
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: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
Or: https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/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/
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, 2024, 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 Service
www.cms.hhs.gov
1-877-267-2323, menu option 4, ext. 61565