central peninsula hospital

EMPLOYEE BENEFITS

NEW HIRE ENROLLMENT GUIDE

MAKE THE MOST OF YOUR BENEFITS

2026-2027 Plan Year

If you and/or your dependent have Medicare or will be eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Review our plan's Medicare Part D creditable coverage disclosure included in this brochure in the Important Notices section.

Benefits Overview

At Central Peninsula Hospital, we know our dedicated employees—YOU—are key to our overall success as an organization. We recognize that offering a quality, comprehensive benefit program is an important way to show you how valuable you are to the organization. We understand that navigating the world of employee benefits is challenging and no two employees are alike, which is why we offer this benefits guide to explain the multiple benefit options available to improve your physical, financial, and mental well-being.

Medical, Pharmacy, Dental, and Vision	Moda Health
Virtual Care (when enrolled in the medical plan)	Moda 360 Health Navigators Cirrus MD Teladoc Health Diabetes Management SWORD Virtual Physical Therapy Behavior Health 360 Champions Passport to Health
Health Care Flexible Spending Account (FSA), Dependent Care Flexible Spending Account (DCFSA), Health Savings Account (HSA), or Health Reimbursement Arrangement (HRA)	BenefitHelp Solutions
Short-Term and Long-Term Disability	Lincoln Financial
Life and AD&D	Lincoln Financial
Leave and Education	Consolidated Leave Program Family Medical Leave (FMLA) Sick Leave* Educational Assistance Continuing Education (CE)*
Employee Assistance Program (EAP)*	Magellan Healthcare
Retirement Plan Options*	Voya Financial
Voluntary Pet Insurance*	Multiple plans and carriers available

*Indicates benefits available to all employees.

For more information, including plan documents, summaries, forms, and flyers, please visit:
https://psfinc.egnyte.com/fl/9pkcH8grhvJw/2026_Benefits
Or scan the QR Code!

Your Benefits Eligibility

Understanding your eligibility for benefits is the first step to investing in your total well-being and unlocking the full potential of the total rewards package that Central Peninsula Hospital offers to our employees.

If you are a full-time employee…

You are eligible to enroll in benefits if you work at least 72 hours per pay period.

If you are a part-time employee…

You are eligible to enroll in benefits if you work at least 32 hours per pay period.

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 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 to select one from the following options:

- CPH health insurance coverage will be 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.

When your coverage begins.

Benefits begin 1st of the month following 30 days from your date of hire.

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

Covering your family members

Many of our benefit plans offer coverage for your family members. Eligible family members include:

- **Your legal spouse.**
- **Your dependent children, including your stepchildren, legally adopted children, and children placed with you for adoption.**
  - **Dependent children are eligible for medical, prescription, dental, and vision insurance up to the end of the month in which they turn age 26 (regardless of student or marital status).**
  - **Dependent children of any age may remain eligible if they are physically or mentally incapable of self-support (subject to approval).**

Electing Benefits in Workday

New Employees

Welcome to the Central Peninsula Hospital Team! As a new employee, you must enroll in benefits within 30 days of your date of hire. You will receive a task to make your benefit election in your Workday inbox. If you do not enroll within 30 days, you will need to wait until the next open enrollment period to elect benefits.

This enrollment period is the only time during the year, outside of the annual open enrollment period, that you can change your benefits unless you experience a qualifying life event (see the section to the right for more information on qualifying life events).

If you don't enroll, or choose to waive coverage, you'll receive the employer-sponsored benefits, including:

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

If you decide to waive coverage as a new hire, you need to login to Workday to actively waive coverage and to add your beneficiaries for employer-sponsored benefits.

How to Enroll During

Benefits enrollment is completed online through Workday at 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 before submitting your elections. If you need assistance logging in to Workday, please contact the IS HelpDesk at 907-714-4701 or helpdesk@cpgh.org.

If you need help enrolling in benefits or have questions regarding your benefit options, please reach out to Human Resources.

What is a Qualifying Life Event? Changing Your Benefits During the Year

You cannot change your benefits during the year unless you experience a qualifying life event. The most common qualifying life events are:

- Marriage, legal separation or divorce.
- Birth, adoption or change in legal custody of eligible child(ren).
- Death of your spouse or covered child.
- Loss of other coverage (e.g., child turns 26 and loses coverage through parent's plan).
- Employment status change.

Keep in mind, there are other, less common, life events that will allow you to change your benefit election during the plan year. Please contact Human Resources for a complete list of qualifying life events.

If you experience a qualifying life event and wish to change your benefit elections, you must make the change in Workday within 60 days of the life event. You may be required to provide proof of your life event, such as a birth certificate or marriage license. You may only modify your benefit elections that are directly impacted by the life event. Insurance coverage and any changes to premium rates go into effect based on qualifying event date.

You may change your Health Savings Account (HSA) election and beneficiaries in Workday at any time throughout the year.

You can also change your retirement contributions at any time during the year on the Voya website or app. Contact HR if you need assistance.

Understanding Your Health Plan: Self-Funding Made Simple

What is Self-Funding?

Your health plan is **self-funded**, which means that **Central Peninsula Hospital pays for your healthcare claims as they happen,** instead of paying a fixed premium to an insurance company.
This approach gives CPH more control over plan design and costs—but it also means **how healthcare is used matters more.**

Who Does What?

CPH (Your Employer)

- Pays for employee healthcare claims.
- Responsible for the overall cost of the plan.

Moda as a TPA (Third-Party Administrator)

- Processes claims and handles customer service.
- Helps manage the plan day-to-day.
- Does not FUND claims but pays them on CPH's behalf.

Moda Stop Loss Insurance (plan protection)

- Protects CPH from very high-cost claims.
- Acts like a financial safety net for the plan.

Where Does the Money Go?

Most healthcare costs fall into three areas:

1. **Claims (≈ 94%) — Main Driver of Cost**
   Doctor visits, hospital stays, prescriptions.
   Paid directly by CPH.
   When care is used efficiently across the plan, it helps manage future costs.
2. **Stop Loss Insurance (≈ 4%)**
   Protection against large, unexpected claims.
3. **Administrative Fees (≈ 2%)**
   TPA services (claims processing, support, reporting).

Key Terms

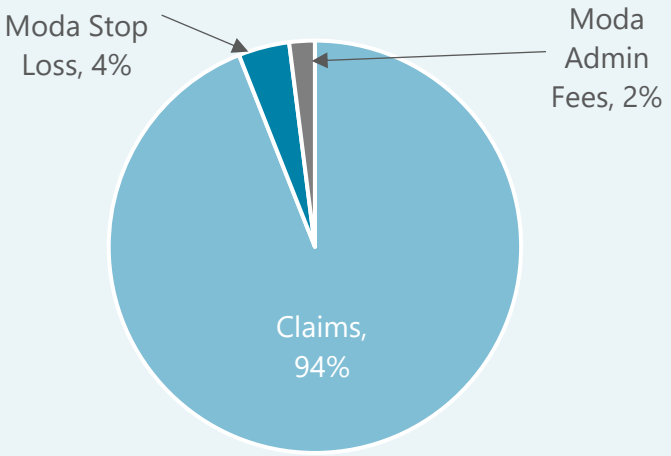
Stop-Loss Insurance: Protects the employer by limiting how much the employer has to pay if medical claims get very large or unusually high in a year.

Claims: The actual cost of medical care (doctor visits, hospital stays, prescriptions).

TPA (Third-Party Administrator): The company that **processes claims and runs the plan**, but does not pay the bills.

Premiums: The set amount you pay each paycheck to have health coverage.

Factors That Make Up Costs



These percentages are approximate and shown for illustration.

Stronger Together

Because CPH funds the plan:

- Every healthcare decision contributes to the overall cost.
- Employees play an important role in keeping the plan sustainable.

Thoughtful use of healthcare helps:

- Maintain strong benefits.
- Manage long-term costs.
- Support the entire CPH employee community.

Know Before You Go

Making informed choices can save you time and money

- **Primary Care** → Best for routine care & ongoing needs.
- **Urgent Care** → Best for minor, same-day issues.
- **Emergency Room (ER)** → For serious or life-threatening conditions only.

Cost difference can be significant—the same issue may cost **hundreds at urgent care vs. thousands at the ER.**

Common Health Plan Terms

The terms below are used throughout this guide to explain how the health plan works and how costs are shared. Knowing what these words mean will help you read through this guide and compare plan options with confidence.

	Definition
Deductible (ded.)	The **amount you pay** for care each year before the plan starts paying.
Deductible Waived	You **do not have to meet the deductible** before the plan pays for that service.
Out-of-Pocket Maximum	The **most you'll pay in a year** for covered **in-network** services. Once you reach this amount, the plan pays 100% of covered costs for the rest of the year.
Individual Deductible – All Plans	The deductible that applies to **one person**. Once that person meets their individual limit, the plan pays according to the benefits for that person—even if the family deductible has not been met. **Important:** On the Iliamna Plan, the individual deductible **only applies if one person is enrolled on the plan.** If any family members are enrolled, the family deductible applies to everyone.
Family Deductible – Denali and Redoubt Plan	**Denali & Redoubt Plans Only:** Each family member has their own individual deductible and out-of-pocket maximum, and there is also a **family total**. • One person alone cannot meet the family deductible. • If **multiple family members'** costs add up to the family limit, the plan then pays for **everyone** in the family.
Family Deductible – Iliamna Plan	**Iliamna Plan Only:** On the Iliamna Plan, if you enroll anyone besides yourself, the plan treats all care as family care—**so the family deductible applies from the start**, even if just one person uses services. There is **no individual deductible** once you add someone else to the plan.
Coinsurance	Your share of the cost **after** you meet the deductible, usually shown as a percentage (for example, you pay 20%, the plan pays 80%).
Copay	A **set dollar amount** you pay for a service, like $10 for a doctor visit.
Annual Limits	The **maximum amount** the plan will pay for certain services in a plan year. (i.e. 12 chiropractic visits per year)
Allowable Charges & Balance Billings	The **maximum amount** the plan recognizes as reasonable for a service. If a out-of-network provider charges more, you may be responsible for the difference, this is called Balance Billing.
Covered Services	Care that the plan helps pay for.
FSA, HRA, or HSA Eligible	The plan can be paired with one or more tax-advantaged account to help pay for eligible health care expenses.
PPO Hospital	An in-network hospital that generally costs less than a non-PPO hospital. Example: Any hospital in Alaska, except Providence Hospital.
Non-PPO Hospital	A hospital outside the plan's network that typically results in higher out-of-pocket costs, even after insurance pays. Example: Providence Hospital in Anchorage.

Medical Insurance

A complete understanding of your medical insurance plans is key to supporting your mental and physical well-being while also safeguarding you against unforeseen medical expenses.

Central Peninsula Hospital offers three medical insurance plan options through **Moda**. Please take the time to understand the features and differences of each plan to choose the coverage that best suits you and your family's needs.

Moda Network Information

In-Network Providers	Lower copays and coinsurance. Providers bill Moda directly and accept negotiated rates as payment in full.
Out-of-Network Providers	No discounted rates. You may pay charges above Moda's allowable amount (balance billing - When a provider bills you for the amount insurance doesn't cover). There is also no out-of-pocket maximum if you see an out-of-network provider.
Primary Network (Alaska)	**Connexus Network** is the primary network for Alaska, Idaho, and SW Washington.
Alaska Non-Hospital Providers	All licensed professional (non-facility) providers in Alaska are in-network.
Alaska Hospitals	All major Alaska hospitals are in-network **except Providence Hospital in Anchorage**.
Outside Alaska	**Aetna Signature PPO** is the wrap network for the lower 48 states.
Finding Providers (Alaska, Idaho & SW WA)	Search the Connexus Network at: https://www.modahealth.com/ProviderSearch/faces/webpages/providerSearch.xhtml.
Finding Providers (Outside of the Connexus Network)	Search Aetna Signature PPO providers at: https://www.aetna.com/asa.
Deductible & Out-of-Pocket Max	Reset every **January 1** (calendar-year basis). Covered charges incurred in and applied toward the deductible in October, November, and December will be applied toward the deductible in the following year.

Value-Based Care = Lower Costs

Value-Based Care focuses on keeping you healthier by encouraging providers to work together, coordinate your care, prioritize preventive care and chronic conditions management and avoid unnecessary services. Providers in Moda's **Value-Based Provider (VBP) Network** agree to follow specific care standards and coordinate treatment across doctors, clinics, and hospitals. In return, the plan offers lower out-of-pocket costs when you use these providers.

When you use a Value-Based Provider you pay less!

	Value Based	Other	Value Based	Other
	Denali & Redoubt Plans	Denali & Redoubt Plans	Iliamna Plan (HDHP)	Iliamna Plan (HDHP)
Primary Care Visits	**Deductible is waived, you pay a $10 copay**	You pay 20% after the deductible is met	**$10 copay after deductible is met**	You pay 20% after the deductible is met

Pro Tip to Save Money: If you pay your CPH bill within 60 days you get **25% off.**

Contact Patient Financial Services for details.

Prior Authorization

Prior authorization (also called preauthorization) for all hospital admissions should be obtained by you or your attending physician. **Providers typically handle authorization, but members should always confirm who will be responsible.** Failure to obtain prior authorization for an admission may result in a reduction of benefits or possible non-payment of the claim. Contact Moda Health to obtain a prior authorization for hospital admissions, case management services, or medical necessity reviews. They may be reached at 855-232-6886.

Preventive Care

Preventive care is 100% covered – Don't forget your annual exam.

Preventive care is 100% covered with your Moda medical plan and includes various services, such as:

- Check-ups
- Wellness exams
- Immunizations
- Screening
- Annual physical
- Routine blood work
- And more

The Financial Value of Preventive Care

- A 45-year-old woman could receive approximately $2,000 - $4,000 in services per year by receiving commonly used preventive services, including an annual physical exam, well-woman exam, Pap smear, routine lab work, recommended vaccines, mammogram, colon cancer screening, and birth control—all covered at no cost when using in-network providers.
- A 45-year-old man could receive approximately $1,200 - $2,500 in services per year by receiving commonly used preventive services, including an annual physical exam, routine lab work, recommended vaccines, colon cancer screening, prostate (PSA) screening, and skin cancer screening—all covered at no cost when using in-network providers.
- Early detection reduces treatment costs **2–4x vs. late-stage disease.**
- So, the **real value isn't just $1–4K per year… it's avoiding $50K–$500K events and protecting your health!**

Estimates are based on typical Alaska provider costs and may vary based on provider, facility, and services received. Preventive services must be billed as preventive and received in-network to be covered at no cost.

Which Medical Plan is Right For Me?

Choosing a medical plan is a personal decision—and the right choice looks different for everyone. The goal is to find a plan that fits your health needs, comfort level, and financial situation. As you review your options, think about how you typically use health care and what would help you feel most confident and supported throughout the year.

	PPO Plans- Denali/Redoubt	HSA-Eligible HDHP- Iliamna
When You Pay for Care	You pay less when you receive care.	You may pay more upfront until you meet your deductible.
Doctor Visits	Set copays—predictable and easy to plan cost of medical services.	You pay the full cost first, then share costs after your deductible.
Savings & Accounts	• Eligible for a Flexible Spending Account (FSA) to help pay for qualified health expenses. • The Redoubt Plan includes an employer-funded HRA to help cover eligible costs.	• Eligible for a Health Savings Account (HSA) to help pay for qualified health expenses, with contributions from both you and CPH.
Good Fit If You…	• Prefer predictable costs. • Visit the doctor regularly. • Take ongoing prescriptions.	• Don't expect to need much care. • Want the option to save for future health expenses. • Are comfortable covering higher upfront costs if needed.
May Be Challenging If You…	Want to be able to save money, pre-tax in an HSA for eligible medical expenses.	Would feel financial strain paying for care before meeting the deductible.

A Thoughtful Way to Choose

Both plans offer valuable coverage but work in different ways.

The HDHP can save you money each paycheck, while the PPO may provide more predictability when you need care. Neither is "better"—it's about what works best for you and your situation.

Before deciding, consider:

- Would I feel comfortable paying more upfront if something unexpected happens?
- Do I prefer steady, predictable costs throughout the year?
- Would I take advantage of an HSA to save for future health care expenses?

If having to pay more upfront for care would create financial stress or uncertainty, a PPO plan may offer you more peace of mind.

Additional Resources

Check out some of these videos to learn more about insurance, such as:

- PPO: https://flimp.live/education-ppooverview
- HDHP with an HSA: https://flimp.live/education-hdhphsa
- Benefit Terms: https://flimp.live/education-benefitsexplained
- Balance Billing: https://flimp.live/education-balancebilling
- How to read an Explanation of Benefits: https://flimp.live/education-readinganeob
- Primary Care vs. Urgent Care vs. ER: https://flimp.live/education-primarycare
- Managing Prescription Drug Costs: https://flimp.live/education-prescriptiondrugcosts

Access these links on your phone by scanning the QR code!

Please see page 7 for definitions and to **understand how annual deductibles differ** between the Denali/Redoubt Plans and the Iliamna Plan.

	Denali Plan	Redoubt Plan	Iliamna Plan
FSA, HRA, or HSA Eligible Note: You can have a Dependent Care FSA with all medical plans	FSA Eligible	HRA Eligible FSA Eligible	HSA Eligible Limited Purpose FSA Eligible
Employer Contribution	N/A	CPH Contributes $500 to your HRA	CPH Contributes $500 to your HSA
Annual Deductible (individual / family) Value based providers All other providers	$1,000 / $2,000 $1,250 / $2,500	$2,000 / $4,000 $2,500 / $5,000	$2,000‡ / $4,000‡ $2,500‡ / $5,000‡
Out-of-pocket Maximum – Applied to in-network only (individual / family)	$3,000 / $6,000	$4,000 / $8,000	$4,000 / $8,000
Preventive Care	Covered in full **(deductible waived)**		
Virtual Care Visits Through CirrusMD	Covered in full **(ded. waived)**		Covered in full (after ded.)
Primary Care Physician Services Value Based Providers PPO Network Hospital Non-PPO Hospital	$10 copay **(ded. waived)** Covered at 80% (after ded.) Covered at 60% (after ded.)		$10 copay (after ded.) Covered at 80% (after ded.) Covered at 60% (after ded.)
Other Office, Urgent Care, & Home Visits Central Peninsula Hospital PPO Network Hospital Non-PPO Hospital	Covered at 80% (after ded.) Covered at 80% (after ded.) Covered at 60% (after ded.)		
Emergency Room Services	Covered 90% (after ded.) then a $250 copayment		
Inpatient Hospital Services Central Peninsula Hospital PPO Network Hospital Non-PPO Hospital	Covered at 90% (after ded.) Covered at 80% (after ded.) and a $250 copayment Covered at 60% of allowable charges (after ded.) and a $250 copayment		
Outpatient Hospital Services Central Peninsula Hospital PPO Network Hospital Non-PPO Hospital	Covered at 90% (after ded.) Covered at 80% (after ded.) Covered at 60% of allowable charges (after ded.)		
Value Based Diagnostic Testing Central Peninsula Hospital PPO Network Hospital Non-PPO Hospital	Covered at 90% (after ded.) Covered at 90% (after ded.) N/A		
Outpatient Rehabilitation Therapy Central Peninsula Hospital (No limit) PPO Network Hospital (20 per year limit) Non-PPO Hospital (20 per year limit)	Covered at 90% (after ded.) Covered at 80% (after ded.) Covered at 60% of allowable charges (after ded.)		
Chiropractic Care (12 per year)	Covered at 80% (after ded.)		

‡IRS rules require that you meet the deductible before most medical care and prescriptions are covered, this excludes preventive care. This means you pay full price for most care and prescriptions until you meet the deductible.

Pharmacy Coverage

Enrollment	You are enrolled in this dental coverage when you enroll in any of the three medical plan options (Denali, Redoubt, or Iliamna).
Network	Moda is the Pharmacy Benefits Manager with a large selection of in-network pharmacies using the **Navitus Network.**
Local In-Network Pharmacies	Safeway, Three Bears, Fred Meyer, Walgreens, Walmart, and Soldotna Professional.
Mail Order	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.
Formulary	You can view the current formulary (as of 3/1/2026) here: https://www.modahealth.com/-/media/modahealth/shared/formulary/largegroup/Prescription-drug-list-large-group.pdf. In this document you'll be able to identify your prescriptions tier—such as Generic/Select or Generic/Specialty—which tells you how the drug is covered and what it may cost.
Value Based Prescriptions = Save Money	Value-Based prescription tier with a $2 copay per prescription (after deductible for those on the Iliamna Plan). Value-based prescriptions are labeled as "Value" in the Tier column of the formulary linked above.
More Ways to Save	If you're taking a medication that isn't on the plan's drug list or is a high-cost generic, talk with your doctor about lower-cost alternatives that may work just as well.
Generic Requirement	When a generic drug is available, choosing the brand-name version means you'll pay the brand-name copay plus any extra cost—exemptions based on medical necessity are subject to plan approval.

moda HEALTH	Denali & Redoubt Plans	Iliamna Plan
	30-day supply	30-day supply
Value Based	$2 copay*	$2 copay
Generic/Select	$10 copay*	$10 copay
Generic Specialty	$10 copay*	$10 copay
Formulary Brand/High-Cost Generic	$35 copay*	$35 copay
Non-Formulary Brand	$70 copay*	$70 copay
Specialty Preferred	$150 copay*	$150 copay
Specialty Non-Preferred	$300 copay*	$300 copayment
Out-of-Pocket Maximum (individual/family)	$3,100 / $5,700	Combined with medical out-of-pocket maximum

*Indicates deductible waived.
You can get a 90-day supply at a Participating Retail Pharmacy or via Mail Order for 2x the 30-day supply copayment amount.

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. If you have questions about your options, please contact Human Resources.

Dental Insurance

A complete understanding of your dental insurance plan is key to protecting your smile and your wallet.

Enrollment	You are enrolled in this dental coverage when you enroll in any of the three medical plan options (Denali, Redoubt, or Iliamna).
In-Network Providers	Moda uses the **Dental PPO & Premier Networks.** 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.
Out-of-Network Providers	No discounted rates: You may be responsible for any additional amounts (also called balance billing).
Finding Providers	Search for PPO & Premier Providers at Moda Find Care (www.modahealth.com).
Save The Most Money	**Dental PPO** Network providers agree to lower rates. Choosing one of these providers will provide you with the lowest cost.
Save Money with More Flexibility	The **Dental Premier** Network is the largest network in Alaska and the nation with 90% of dentists in-network. These providers have slightly higher rates than Dental PPO providers.
Deductible & Out-of-Pocket Max	Reset every January 1 (calendar-year basis).

	Denali, Redoubt, and Iliamna Plans
Deductible (individual / family) Waived for in-network dentists	$50 / $150
Annual Benefit Maximum Per Member	$2,000
Diagnostic/Preventive Services Exams, x-rays, etc.	Covered in full
Basic Services Fillings, extractions, etc.	Covered at 80%
Major Services Crowns, bridges, dentures, etc.	Covered at 50%
Orthodontia	50% with a $50 lifetime deductible $2,000 per person per lifetime

Preventive care does not accumulate toward the annual maximum benefit.

Preventive

- Two dental checkups per year.
- X-rays and exams when needed.
- Fluoride treatments (up to 2 per year) for children under 20.
- Sealants for children under 14 (permanent teeth only).
- Space maintainers for children under 14.

Teledentistry

Teledentistry lets you connect with a dentist by phone, text, or video for a virtual visit to evaluate dental concerns and decide if an in-person appointment is needed.

It works well for non-emergency issues like tooth pain, chipped teeth, small cavities, bumps, or jaw pain; urgent or hands-on care will still be scheduled in the dental office.

During your virtual visit, a licensed dentist can send a prescription to your pharmacy or connect you with an in-network dentist for follow-up care. You can access Teledentistry through your Member Dashboard.

Vision Insurance

A complete understanding of your vision insurance plan is key to investing in your health and managing potential costs down the road.

Enrollment	You are enrolled in this vision coverage when you enroll in any of the three medical plan options (Denali, Redoubt, or Iliamna).
In-Network Providers	**Connexus Network** is the vision network. Members will maximize their benefits by using in-network providers for vision services.
Out-of-Network Providers	No discounted rates: You may be responsible for any additional amounts (also called balance billing).
Finding Providers	Search the Connexus Network at: https://www.modahealth.com/ProviderSearch/faces/webpages/providerSearch.xhtml.
Deductible	There is no deductible for covered vision services or supplies.

moda HEALTH

	In-Network
Vision Exam *Every year*	$25 copay
Eyeglass Lenses *Every year*	Covered at 100%
Frames *Every year*	$120 allowance for frames
Contacts *Every year* *In lieu of glasses*	$105 allowance

Vision Exams
- Eye health exam (inside and out).
- Vision testing.
- Eye coordination testing.
- Color vision, side vision, and eye pressure tests.
- Prescriptions and recommendations.

Lenses
- Eyeglasses lenses.
- Lens coatings or tinting.
- Fittings lenses into frame.
- Contact lens (instead of glasses).
- Contact lens fitting.

Frames
- Frames.
- Frame parts.
- Fitting frames to your face.

What is not covered:
- Non-prescription glasses or sunglasses.
- Vision therapy.
- Special eye training.
- Medical or surgical treatment.

Medical, Dental, Vision, and Prescription Premium Rates

Benefits are a big part of your total pay, and they can be expensive. CPH pays most of the cost to provide coverage for employees and their families.

You will have the option to choose between the three medical 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 a higher deductible. Employees who want a lower deductible have the option to purchase the Denali Plan at a higher employee contribution rate.

The following contributions are effective July 1, 2026, and include the health, vision, dental and prescription coverages. Your premium level depends on hours worked and ACA eligibility (see page 4).

Full-time employees pay Level 1:

Monthly Premiums Level 1	Denali Plan		Redoubt Plan		Iliamna Plan	
	CPH Pays	You Pay	CPH Pays	You Pay	CPH Pays	You Pay
Employee Only	$3,181.28	$454.22	$1,456.17	$207.91	$1,456.17	$207.91
Employee + Spouse	$6,561.23	$936.80	$3,003.65	$428.85	$3,003.65	$428.85
Employee + Child(ren)	$6,155.90	$878.91	$2,817.90	$402.33	$2,817.90	$402.33
Employee + Family	$9,694.98	$1,384.23	$4,438.24	$633.69	$4,438.24	$633.69

Part-time employees pay Level 2:

Monthly Premiums Level 2	Denali Plan		Redoubt Plan		Iliamna Plan	
	CPH Pays	You Pay	CPH Pays	You Pay	CPH Pays	You Pay
Employee Only	$2,727.07	$908.43	$1,248.26	$415.82	$1,248.26	$415.82
Employee + Spouse	$5,624.42	$1,873.61	$2,574.80	$857.70	$2,574.80	$857.70
Employee + Child(ren)	$5,276.99	$1,757.82	$2,415.57	$804.66	$2,415.57	$804.66
Employee + Family	$8,310.74	$2,768.47	$3,804.56	$1,267.37	$3,804.56	$1,267.37

Please note that when your contributions 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 have a change in family status, 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. Bi-weekly premiums are taken out of the first two paychecks each month.

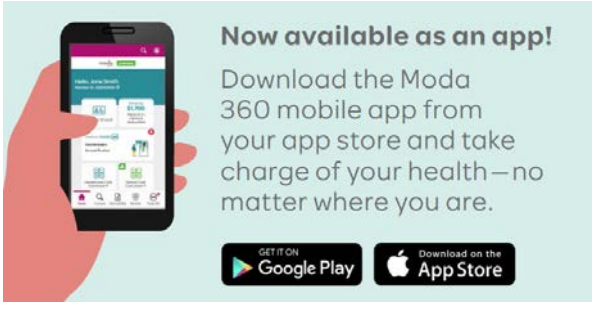
Additional Programs for Health Plan Participants

Moda 360

Healthcare can be complicated, but Moda 360 Health Navigators help make it easier. As a Moda Health member, you have exclusive access to Moda 360 Health Navigators. Health Navigators are available if you need help with:

- Accessing specialized programs and support for many chronic conditions.
- Finding in-network providers and specialists that are right for you.
- Understanding your claims and provider billing information.
- Setting up your appointments.
- Getting answers about prior authorization requirements.

Call 855-232-6886 to connect with a Moda 360 Health Navigator or visit modahealth.com.



As part of your Moda 360 benefits, your Member Dashboard is your personal website where you can view all your medical and dental plan details and resources from one easy-to-use online location. Access programs that are right for you today, and when your needs change, get recommendations for new ones to ensure you are always getting the most out of your plans.

Use your Member Dashboard to:

- Get Care Reminders to help you stay up to date with preventive screenings, vaccines and doctor visits.
- Check the status of your claims/EOBs and your medical deductible.
- Search for in-network doctor's, optometrists, dentists and pharmacies (if applicable) near you.
- Get estimate costs for medical and dental services.
- Download your member ID card when you need it .

Don't have a Member Dashboard account?

No problem. Creating one is easy.

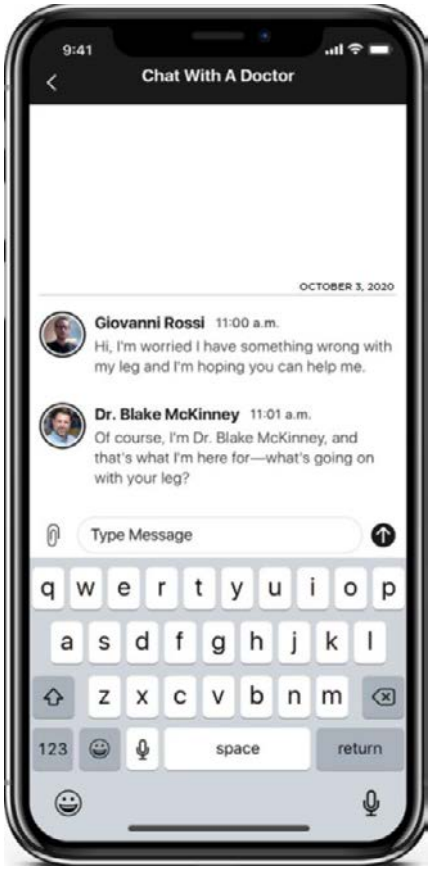
1. Go to modahealth.com/memberdashboard
2. Select "Create an account" to get started.

Additional Programs for Health Plan Participants

CirrusMD

Virtual doctor's appointments enable convenient access to medical professionals through online and mobile platforms, providing you and your family members support at the tips of your fingers, whenever you need it.

When Virtual Healthcare is Appropriate	When Virtual Healthcare is Not Appropriate
Virtual healthcare is a great option for routine issues such as: • Cold and flu symptoms • Allergies • Pink eye • Urinary tract infections • Rash • Sinus problems • Quick assessment for severity • Stomach aches	Virtual healthcare is not a good option for diagnoses that require a hands-on exam and/or lab test, emergencies or for injuries such as sprains and broken bones.



EXAMPLE

Over the weekend, Linda's daughter begins itching her eye excessively. Knowing her primary care physician is not in the office, Linda utilizes virtual healthcare. She simply speaks with a doctor virtually, sends in photos of her child's eye, and the doctor is able to prescribe an antibiotic for pink eye.

Rather than waiting in an urgent care, Linda is able to stay home and care for her daughter!

CirrusMD is easy to use!

- Book an appointment from anywhere, anytime at **cirrusmd.com/modahealth** or download the app for Apple or Android.
- Text message or Video chat with a board-certified doctor from your phone, tablet, or computer.
- Prescriptions can be sent to the nearest pharmacy.

All three of the **Moda** medical plans include telemedicine benefits.

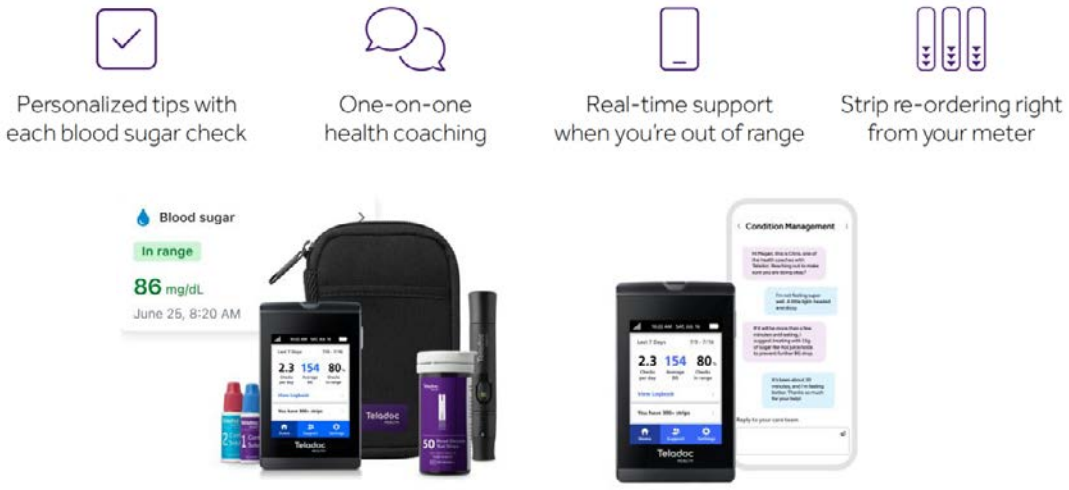
- On the Denali and Redoubt Plans it is covered in full, even if you haven't met your deductible.
- On the Iliamna Plan it is covered in full after you have met your deductible.

Register today at cirrusmd.com/modahealth so that you are ready to use this benefit when you need it.

Additional Programs for Health Plan Participants

Teladoc Health Diabetes Management Program

When you register for the Teladoc 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:

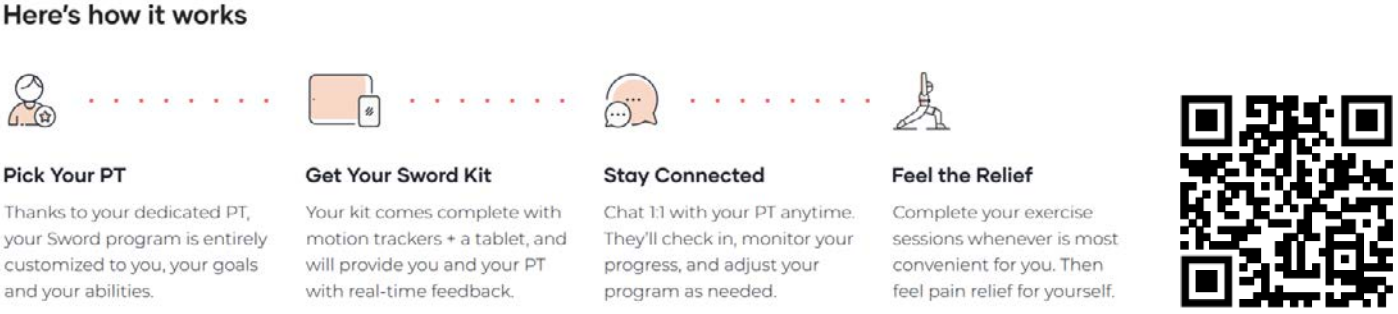


Call 800-835-2362 or visit TeladocHealth.com/Register. The Diabetes Management program supports people diagnosed with Type 1 or Type 2 diabetes and helps make living with diabetes easier. The program team works with you to provide personalized plans to get you towards your healthiest life possible. The program provides a connected meter and unlimited strips and lancets. If members of the program team see that your glucose levels are 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. Spanish support options are also available. Getting registered for the Teladoc Health Diabetes Management program is easy and only takes a few minutes.

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.

Visit join.swordhealth.com/moda/register to get started!



Additional Programs for Health Plan Participants

Behavioral Health 360 Champions

Our Behavioral Health 360 Champions bring all the support and tools you need for mental wellness right to you. Our world is moving fast. 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.

Your Behavioral Health 360 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.

The Behavioral Health 360 program also provides you with specialized behavioral health expertise and support to ensure you get care for your specific needs.

- **Spring Health**: Personalized mental health care, anytime.
- **Meru Health**: Mobile therapy with continuous therapist support.
- **Gemini**: On-demand support for children with developmental disabilities.
- **Cyti Psychological**: Barrier-free therapy, your way.
- **Hazelden Betty Ford Foundation**: Compassionate care for substance use disorders.

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

Passport to Health

Central Peninsula Hospital offers the Passport to Health program to employees and their dependents who have been identified with health conditions in which they may benefit from in-person health coaching. The program is free and voluntary.

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.

Health Reimbursement Arrangement (HRA)

Eligibility & Automatic Enrollment	**Available only to employees enrolled in the Redoubt Plan**. Not available with the Denali or Iliamna Plans. You are **automatically enrolled** in an HRA if you elect the Redoubt Plan.
What is an HRA?	An HRA lets CPH set aside **pre-tax** dollars to help pay for qualified health care expenses.
Who Administers the HRA?	BenefitHelp Solutions.
Employer Contribution	**CPH contributes $500** to your HRA when you are determined eligible for benefits.
HRA Eligible Expenses	The HRA can be used for covered medical, dental, vision, and prescription expenses for you and your covered family members that you pay out of pocket. Only expenses that happen after your coverage begins can be reimbursed. An expense counts when you receive the care, not when you get the bill or pay it.
No Double Payment	The HRA can only pay for costs not already paid by insurance.
Partial Reimbursement	If insurance pays part of a bill, the HRA can cover the remaining eligible amount.
Unused Funds	Unused HRA funds **roll over year-to-year** while you remain eligible.
If Coverage Ends or You Change Plans	You lose access to HRA funds for future claims unless you elect COBRA. Claims incurred before coverage ends may still be reimbursed (subject to filing deadlines). Note: incurred means the date you received care—not when you get the bill.
How to Receive Reimbursement	See page 23.
Questions?	Contact BenefitHelp Solutions customer service at 855-378-0197.

Health Savings Account (HSA)

Eligibility	**You must be enrolled in the Iliamna Plan to participate in the HSA.** The HSA is not available with the Denali or Redoubt Plans.
What is an HSA?	A Health Savings Account (HSA) is a personal bank account that helps you pay for eligible **medical, dental, vision, and prescription** expenses now and in the future.
Triple Tax Advantage	Deposits are made pre-tax. HSA spending is tax-free when used for eligible expenses. Your money grows, tax-free, and can be invested once you reach the minimum balance.
Who Administers the HSA?	BenefitHelp Solutions.
HSA Eligibility – You Are NOT Eligible If…	• You are enrolled in a non-HSA-eligible plan (such as a spouse's PPO or a health care FSA). • You are claimed as a dependent on someone else's tax return. • You are enrolled in Medicare, TRICARE, or TRICARE for Life. • You receive Native/Tribal Health Services or Veterans benefits (restrictions apply).
Veterans & IHS Rules	If you receive Veterans or Native/Tribal Health benefits, you cannot contribute to an HSA for 3 months following the month you receive those benefits (unless care was for a service-related condition).
Important Responsibility	**You are responsible for confirming your eligibility** to receive CPH contributions to your HSA. Additional rules apply — see IRS Publication 969. **If you are not HSA-eligible and receive contributions, you may owe taxes and penalties.**
Account Setup Requirement	BenefitHelp Solutions will send identity verification information. You must complete verification within **60 days,** or the account will be closed.
CPH Contribution	If you enroll in the Iliamna Plan, **Central Peninsula Hospital contributes $500** to your HSA to help you get started.
Employee Contributions	You may contribute additional money through payroll on a **pre-tax basis**. Contribution amounts can be changed in Workday at any time.
2026 IRS Contribution Limits	• Employee-only coverage: $4,400. • All other coverage tiers: $8,750. • Age 55+ catch-up: Additional $1,000.
Spousal HSA Note	If both you and your spouse have HSAs, your **combined contributions cannot exceed the IRS family limit.** Excess contributions may result in tax penalties.
Account Ownership	Your HSA is yours to keep—even if you change jobs or health plans. Any unused money stays with you.
Investment	Once you reach the minimum balance, you can invest your HSA funds.
After Age 65	After age 65, you can use it for any expense (taxes may apply).
How to Receive Reimbursement	See page 23.
Questions?	Contact BenefitHelp Solutions customer service at 855-378-0197.

Flexible Spending Accounts (FSA)

Eligibility	**Healthcare FSA:** Denali, Redoubt, or waived coverage. **Dependent Care FSA:** Any plan or waived coverage.
Who Administers the FSAs?	BenefitHelp Solutions.
How FSAs Work	You choose an annual contribution. Funds are deducted **pre-tax** from each paycheck and can be used for eligible expenses.
Benefits Card & Reimbursements	Use your Benefits Card at eligible locations wherever Visa is accepted. See page 24 for additional reimbursement instructions.
Re-Enrollment	**Required** every year during Open Enrollment.
Plan Year	July 1, 2026 – June 30, 2027.
Changing During The Year	**Not allowed** unless you have a qualifying life event (marriage, divorce, birth, employment change).
Receipts	You must **keep receipts** and provide documentation if requested (usually within 30 days).
Eligible Expenses List	Available at benefithelpsolutions.com.

	Health Care FSA	Dependent Care FSA
What's it For?	Medical, dental, and vision out-of-pocket costs.	Child or dependent care so you (and spouse) can work or attend school.
HSA Compatibility	❌ Not allowed if you fund an HSA.	✅ Compatible with all medical plans.
Eligible Expenses	Medical, dental, and vision costs, such as deductibles, copays, and coinsurance. Funds can also be used for prescription meds, eligible OTC meds, medical supplies, and other IRS-approved health care expenses.	Day care, preschool, summer camp, before/after-school care, elder care. **Note:** Dependent Care FSA reimbursements are limited to the current balance in your account at the time of the claim.
Who Can Be Covered	Employee and eligible dependents.	Children under 13; dependents 13+ or adults unable to care for themselves.
Annual Contribution Limit	Up to $3,400.	Up to $7,500 (joint/single/HOH) or $3,750 each if married filing separately.
When Funds Are Available	Full amount available July 1st (or benefits effective date).	Available as contributed each pay period.
Rollover Rules	Up to $680 can roll over.	❌ No rollover.
Unused Funds	Funds over the allowed rollover amount are forfeited.	Funds are forfeited.

Requesting Reimbursement from Your HRA, HSA, or FSA through BenefitHelp Solutions

There are two main ways to request reimbursement:

1. Pay at the Time of Service with Your Visa Benefits Card

- Your card will automatically deduct the expense from your account.
- You may need to submit supporting documentation after the transaction.

Note: With an HSA and Dependent Care FSA, you can only reimburse yourself for an amount currently available in your account. Using your card for more than your balance may result in overdraft fees.

2. Pay Out of Pocket and Request Reimbursement Later

You can request reimbursement in one of the following ways:

- Online: Submit a Reimbursement Request Form with supporting documents through your member portal: https://bhsconsumer.lh1ondemand.com/Login.aspx
- Mobile App: Complete the form and upload documents using the BenefitHelp Solutions app.
- Mail or Fax: Download the form from the member portal and send it, along with documentation, to:

BenefitHelp Solutions
P.O. Box 2823
Fargo, ND 58108
Fax: 855-778-9837

Required Supporting Documentation (All Submission Methods)

When submitting a reimbursement request (online, app, mail, or fax), include:

1. Date of Service
2. Type of Service Performed
3. Provider's Name
4. Amount Charged
5. For Prescriptions: Include Rx number or prescription name
6. For Dependent Care: Include the provider's Tax ID SSN

Acceptable Documentation Includes:

- Itemized billing statement from provider (must include dates and service types).
- Explanation of Benefits (EOB) from your insurance company.
- Receipt from provider with all required information.

Important Notes:

- Services must occur during the Plan Year.
- Expenses before your effective date or after termination of the account are not eligible.
- Some accounts have a runout period, which is the extra time after the plan year ends to submit claims. **These timelines vary by account.**
  - **HRA:** You have 90 days after termination from the plan, whether due to loss of eligibility or termination of employment, to submit claims.
  - **Health Care FSA:** If you lose eligibility for the FSA due to retirement, termination of employment, layoff, reduction in hours, or any other reason, you have until the first day of the month following your end date to submit claims. Refer to your plan document for details regarding COBRA and continued coverage.
  - **Dependent Care FSA:** You may incur eligible dependent care expenses until the end of the plan year following your termination date. After that, you have 90 days to submit claims for those expenses.
- Claims not submitted by the runout deadline will be denied. Appeals cannot be used for late claims.
- Claims are typically processed within 3-5 business days. Reimbursements are mailed or direct deposited to you (the member).

Note: Checks cannot be sent directly to providers.

Disability Insurance

Understanding your disability benefit options is crucial, as they safeguard your income and ensure your financial stability in the long run.

Central Peninsula Hospital offers all full-time and part-time employees Basic Short-Term Disability coverage through **Lincoln Financial**. You are automatically enrolled in the benefit at no cost to you. Short-term disability (STD) insurance allows you to continue earning a portion of your salary if you are unable to work due to an illness or injury.

If you want additional coverage, you may purchase additional Voluntary Short-Term Disability Coverage. Deductions occur on the first paycheck each month. For additional information on Short-Term Disability Insurance please refer to the QR code on page 3. The amount you pay for these plans is deducted from your paycheck on a post-tax basis. This ensures that any benefit payments you receive are not taxed.

Basic Short-Term Disability Insurance

- Elimination period (the time you have to wait before benefits begin): 14 days (benefits begin on day 15), contingent upon satisfying the definition of disability as stated in the policy.
- Benefit continues for up to 24 weeks*.
- Benefit amount: 70% of your basic annual earnings (excluding overtime, bonuses and commission) up to a maximum of $200 per week.

Voluntary Short-Term Disability Insurance

- Elimination period (the time you have to wait before benefits begin): 14 days (benefits begin on day 15) contingent upon satisfying the definition of disability as stated in the policy.
- Benefit continues for up to 24 weeks*.
- Benefit amount: 70% of your basic annual earnings (excluding overtime, bonuses and commission) up to a maximum of $1,000 per week.

Note on Voluntary STD: if you do not enroll during this enrollment period you will be considered a late entrant. Late entrants will have to provide evidence of insurability if they choose to enroll in voluntary STD coverage during a future enrollment period.

*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

- Vaginal births: benefits start on the 15th day and run through six (6) weeks, less the 14-day elimination period.
- Cesarean section births: benefits start on the 15th day and run through eight (8) weeks, less the 14-day elimination period.

Disability Insurance (continued)

If you are unable to return to work after the Short-Term Disability benefit period ends, you may be eligible for Long-Term Disability (LTD), which provides additional salary continuation. Central Peninsula Hospital offers you the opportunity to purchase long-term disability insurance through **Lincoln Financial**.

If you elect Long-Term Disability, CPH shares the cost. For additional information on Long-Term Disability Insurance, please refer to the QR code on page 3. The amount you pay for is deducted from your paycheck on a post-tax basis.

If you receive Long-Term Disability benefits, Lincoln Financial Group will provide you with a W-2 at the end of the year that reflects your LTD benefits that were paid.

Long-Term Disability Insurance

- Elimination period: 180 days (benefits begin on day 181) contingent upon satisfying the definition of disability as stated in the policy.
- Benefit continues up to Social Security normal retirement age.
- Benefit amount: 60% of your basic annual earnings (excluding overtime, bonuses, and commission) up to a maximum of $10,000* per month.

*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.

Note on LTD: if you do not enroll during this enrollment period you will be considered a late entrant. Late entrants will have to provide evidence of insurability if they choose to enroll in voluntary LTD coverage during a future enrollment period.

Pre-existing Conditions

Disability due to pre-existing condition must meet certain criteria to be payable. Please see the policy documents for more information.

Substance Abuse and Mental Illness Limitation

Benefits for disability due to substance abuse and mental illness will be payable for up to 24 months. Please see the policy documents for more information.

Progressive Partial Disability Benefit with Return-to-Work Incentive

The plan includes a partial disability benefit. The Progressive Partial calculation encourages employees to try to return to work by allowing them to receive an overall higher level of income than they would receive from their total disability benefit. Please see the policy documents for more information.

Family Income Benefit

If an employee dies after having been disabled for a minimum of 180 consecutive days and the employee was receiving a monthly benefit under the policy an eligible survivor will receive a lump sum benefit equal to three times the employee's last gross monthly LTD Benefit.

Basic Life and AD&D Insurance

Consider your life and accidental death and dismemberment coverage options carefully, as these benefits greatly enhance your financial well-being by providing financial support to those who depend on you.

Life and accidental death and dismemberment (AD&D) insurance through **Lincoln Financial** provides financial protection for those who depend on you for financial support. Upon your death, your designated beneficiary will receive the life benefit. If you die as the result of an accident, your beneficiary will receive both the life and AD&D benefits.

Basic Life and AD&D Insurance

Central Peninsula Hospital provides you with basic life and AD&D insurance at no cost to you.

Coverage Options	Benefit Amount
Employee Life and AD&D:	1x annual earnings rounded up to the next higher $1,000, up to a maximum of $500,000*. AD&D benefit is equal to the life benefit amount.
Spouse Life:	$1,000, terminates at age 70. There is no spouse AD&D benefit.
Dependent Child(ren) Life:	Live birth to 14 days: $1,000. 14 days to 6 months: $500. 6 months to 19 (or 26 if a full-time student): $1,000. There is no dependent AD&D benefit.
Age reduction schedule: at age 65, benefit is reduced by 35% of the original amount, at age 70 benefit is reduced another 15% of the original amount. Benefits end when you retire.	

If you are eligible for $50,000 or more in basic Central Peninsula Hospital-paid life insurance, you are required to pay income tax on the value of the coverage, in excess of $50,000.

Designate a Beneficiary

In the event of your death, Lincoln Financial would pay your Life and/or AD&D policy to your beneficiaries. Designate your beneficiaries for your Basic Life and AD&D insurance as well as any Voluntary Life insurance in Workday.

You may change this designation at any time. You are automatically the beneficiary on your Spouse and/or Child Life policy.

Voluntary Life and AD&D Insurance

Consider enrolling in Voluntary Life Insurance to enhance your financial protection beyond employer-paid coverage, offering added peace of mind and greater support for your loved ones in the event of the unexpected.

Voluntary Life and AD&D Insurance

Depending on your personal situation, basic life and AD&D insurance might not be enough coverage for your needs. Central Peninsula Hospital provides you the option to purchase voluntary life and AD&D insurance at group rates through **Lincoln Financial**. You may also purchase voluntary coverage for your spouse and eligible children. For additional information on Life and AD&D Insurance, please refer to the QR code on page 3.

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.

You may elect additional life insurance, AD&D coverage, or both—the amounts don't have to match, and you're not required to choose both.

Coverage options:

- **Employee Life:** $10,000 increments up to $750,000 or 7x annual salary, whichever is less; guarantee issue: $300,000 (not to exceed 7x annual salary).
- **Employee AD&D:** $10,000 increments up to $500,000 or 5x annual salary, whichever is less.

- **Spouse Life:** $5,000 increments up to 100% of the employee coverage amount or $500,000; guarantee issue: $30,000. Coverage cannot exceed the employee election.
- **Spouse AD&D:** $5,000 increments up to 100% of the employee coverage amount or $500,000. Coverage cannot exceed the employee election.

- **Dependent Child(ren) Life:** Birth to 6 months: $500; 6 months to age 19 (or 26 if a full-time student): $1,000, $5,000, or $10,000. Guarantee issue: Full Amount.
- **Dependent Child(ren) AD&D:** Birth to age 26: $1,000, $5,000, or $10,000

When to Elect Coverage

You have the opportunity to elect Voluntary Life Insurance for you, your spouse, and child(ren) up to the guaranteed issue amount during the initial enrollment period without completing a health questionnaire, also known as Evidence of Insurability or EOI. If you decline coverage during your initial enrollment period and choose to elect coverage during a future enrollment, you may have to complete an EOI questionnaire to get coverage.

During this or future open enrollment periods, you can elect Voluntary Life Insurance coverage with some restrictions:

- If you and your spouse sign up during your initial enrollment period, at future open enrollments you can increase your coverage by two increments ($20,000 for Employees and $10,000 for a spouse), up to the maximum, without needing to provide EOI. You can even go above the usual guaranteed limit, as long as the increase is within two increments of your current coverage.
- If you or your spouse waive coverage during the initial enrollment period, you can still sign up during future open enrollments and get up to two increments ($20,000 for Employees and $10,000 for a spouse) of coverage without needing to provide EOI. Any elections above two increments will require EOI.
- Children can be covered without EOI at any open enrollment period.
- If you elect beyond the guarantee issue amount, EOI will need to be submitted and is subject to approval pending Lincoln's underwriting.
- Employees and spouses who previously withdrew from the plan or were denied coverage due to an EOI will need to submit a new EOI for any amount of coverage.

Consolidated Leave Program

The Consolidated Leave Program is a two-part program that 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 Per 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)	444 Hours (55.5 Hours)	524 Hours (65.5 Days)
10th Anniversary	0.13846	11.08 Hours	288 Hours (36 Days)	468 Hours (58.5 Days)	548 Hours (68.5 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 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.

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.

Consolidated Leave Program (continued)

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.

CPH Observed Holidays

- **New Year's Day**
- **Memorial Day**
- **Independence Day**
- **Labor Day**
- **Thanksgiving Day**
- **Christmas Eve Day**
- **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.

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.

Consolidated Leave Program (continued)

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 in the following circumstances:

1.) The first two (2) shifts each calendar year due to an employee's, an employee's child's or spouse/domestic partner's personal illness or injury.

- Immediately due to: an employee's, an employee's child's or spouse/domestic partner's admission to the hospital. b. An employee's, an employee's child's, or spouse/domestic partner's non-elective outpatient surgery or non-elective procedure requiring anesthesia.
- Leave due to the birth or adoption of the employee's child.
- Hours lost due to being placed on mandatory leave relating to exposure to a communicable disease without symptoms.

2.) Following thirty-two (32) consecutive hours of absence due to an employee's, an employee's child's, spouse or domestic partner's personal illness or injury.

If an employee returns to work after using IAP but is unable to complete their scheduled shift due to the same illness or injury, they will resume IAP usage. The employee must provide a physician's release to Human Resources confirming that the absence is due to the continuation of the same illness or injury. This does not apply to the first two (2) shifts of IAP within a calendar year.

If the employee returns to work and completes their shift, any further absences will be treated as a new absence, unless they are on approved intermittent leave for the same condition.

The supervisor will document the use of IAP in the employee's time record. Human Resources may request that a physician's release be obtained before the employee can return to work.

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 and Sick Leave

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).

Sick Leave: Paid Sick Leave is a benefit accrued each pay period based on hours worked, up to a maximum of fifty-six (56) paid hours per year. The paid sick leave program is a benefit for all employees not eligible to accrue PTO/IAP. Full and part time employees are eligible for paid sick leave by utilizing accrued PTO and/or IAP in accordance with the Consolidated Leave Policy.

Paid sick leave may be used for the following purposes:

a. The employee's own health needs, including: I. Illness or injury II. Preventive care (medical, dental, or mental health appointments)
b. To care for a covered family member (including a child, spouse, parent, domestic partner, or other qualifying relation) who: I. Is ill or injured II. Has a medical, dental, or mental health appointment
c. For reasons related to domestic violence, sexual assault, or stalking, affecting either the employee or a covered family member, including: I. Seeking medical treatment or counseling II. Obtaining legal assistance or participating in related proceedings III. Relocating or taking other protective actions.

Paid Sick Leave Accrual Schedule
(For Per Diem Employees and Employees Not Eligible to Accrue PTO/IAP)

Plan in Effect	IAP Accrual Per Hour	Accrual Per 30 Hours Worked	Maximum
Date of Hire (or July 1st, 2025 for those employed prior to policy effective date)	0.033334	1 Hour	56 hours (7 days)

For further questions regarding PTO, IAP, Sick Leave, 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. Maximum funds can be used once a year from January through December. Funds are reset on January 1st of each year.

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, including laptops, which employees may keep after the course is completed, education involving sports, games, hobbies (unless job-related), meals, lodging or transportation.

	Maximum Reimbursement	
	Undergraduate Course	Graduate Courses
	Full Time Employee	
2nd Year of Service	$1,500	$1,500
3rd + Year of Service	$2,000	$2,500
	Part Time Employee	
2nd Year of Service	$750	$750
3rd + Year 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.
- If grades and receipts are insufficient, employees will repay Central Peninsula Hospital back in four installments through payroll.

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

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.

Continuing Education hours do not roll over from year to year, employee CE hours will be replenished each year on January 1st.

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 it 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.

Employee Assistance Program

Employee Assistance Programs extend beyond confidential counseling, offering a wide array of services. Recognizing the full scope of your EAP is essential for enhancing your mental well-being, as it provides valuable support for various day-to-day challenges.

Central Peninsula Hospital provides all employees and household members with an Employee Assistance Program (EAP) through **Magellan Healthcare**. The EAP is a valuable resource that can help you identify and resolve many workplace, family, social, economic, and mental health issues.

Talk to a counselor about:	Connect to local resources for:	Get tips for staying healthy:
• Improving relationships • Managing life changes • Improving esteem and confidence • Achieving work-life harmony	• Childcare needs • Caring for an elder • School success • Legal resources	• Sleep practices • Eating well • Finding a gym

EAP Benefits with Magellan Healthcare

- Completely confidential. Central Peninsula Hospital does not receive any information about who contacts the EAP.
- Available 24/7/365.
- Includes three **FREE** in-person, phone, or online counseling sessions per issue.
- LifeMart Discount Program.
    - Discounts on things like hotels, flights, rental cars, event tickets, subscriptions and much more!

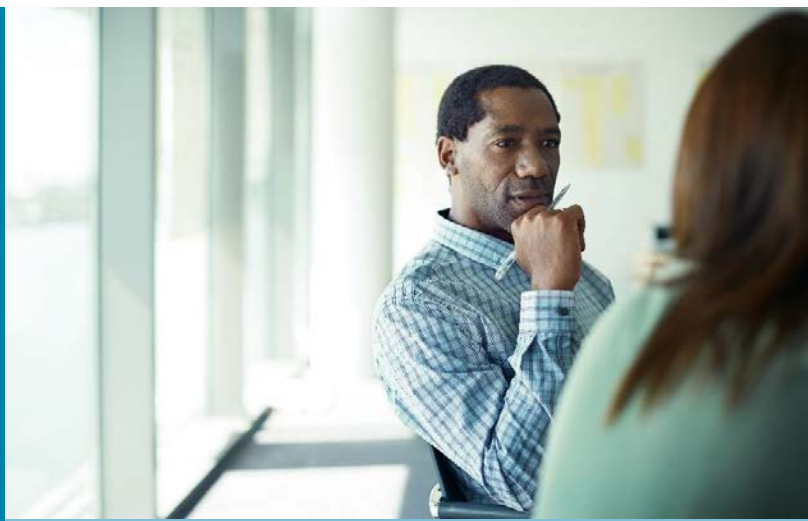
Call or go online for help with:

- Depression
- Conflict resolution
- Drug or alcohol abuse
- Marital or family difficulties
- Additional online resources
- Legal concerns
- Help finding child and elder care
- Wills and estate planning
- Financial counseling

EXAMPLE:

Jim has recently been struggling to balance his responsibilities at work with his responsibilities at home. At times, he struggles to find childcare and finds that this impacts his performance on the job.

Jim contacted the EAP to talk through these struggles, and they were also able to provide trusted childcare resources that he now uses regularly!



Call: 800-478-2812 (TTY 711)
Website: https://member.magellanhealthcare.com

EAP resources are available for free to you and your household members.

Magellan HEALTH

403(b) Retirement

Whether you are nearing retirement or in the early planning stages, a retirement savings account is crucial for securing financial stability in retirement. It helps ensure a steady income stream later in life when work is no longer a primary source of income.

Central Peninsula Hospital's employees have the option to participate in a 403(b) Employer Contributory Plan through Voya Financial. 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 and type (pre-tax or Roth) or opt out at any time throughout the year in the Voya app or website. 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 7-10 business days from date of hire to bypass auto-enrollment).

Employer Match and Discretionary: To receive Employer Discretionary and Matching contributions, you must be full or part-time, and complete one year of service. Once eligibility requirements have been met, employees will be enrolled in the next enrollment period which occurs 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 $24,500 for 2026. The annual combined maximum the hospital will contribute is $7,474.

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/.

VOYA® FINANCIAL

Pet Insurance

Central Peninsula Hospital has partnered with IMA to bring three different options for insuring your precious pets. Each benefit plan varies; coverage and prices differ. Employees will pay for the coverage they elect directly through the website. Be sure to check out each plan to decide which one is right for you and your furry friend(s).

Note: this benefit is not processed through payroll deductions and you can use the discount at any time. Follow the link or QR code at the bottom of the page for access to exclusive discounts and more information.

ASPCA Pet Health Insurance

There are many reasons why more pet parents today are covering their pets with ASPCA Pet Health insurance. Most of all, they want to make sure they'll have financial support if their pet is hurt or sick.

With ASPCA Pet Health insurance, you can take comfort in knowing your pets have coverage, and that you have help giving your pets the best care possible without worrying about the cost.

Spot Pet Insurance

Spot coverage helps you protect your pet in case of accidents, illnesses, and emergencies. With pet insurance from Spot, you can get coverage for surgery, cancer treatment, prescription medicine, microchip implantation, X-rays, behavioral issues, dental disease, and more, for covered conditions.

Pin Paws Pet Care

Pin Paws Pet Care includes pet insurance with no age or breed restrictions, and a whole lot more. Along with pet insurance, this plan provides the same benefits as Pin Paws Plus such as dynamic lost-pet notification to help quickly reunite you with your lost pet, and provides access to 24/7 Pet Telehealth, savings on pet medications, and discounts on pet-centric products and services.

For more information and to compare plans, scan the QR code or visit: **https://ima.nbm.store/petinsurance**

Contact Information

Refer to this list when you need to contact a benefits vendor. Many questions can be answered directly by these partner entities. For general information, contact Human Resources.

Medical, Vision, Eligibility, Claims, Moda 360 Health Navigator, and Provider Questions	Moda Health	855-232-6886	www.modahealth.com
Dental	Moda Health	855-232-6863	www.modahealth.com
Prescription Drugs	Moda Health	855-232-6696	M-F 7:30 a.m. - 5:30 p.m. PST
Virtual Care	CirrusMD		cirrusmd.com/modahealth
Behavioral Health	Behavioral Health 360 Champions	833-212-5027	bhchampions@modahealth.com
Virtual Physical Therapy	SWORD Virtual Therapy		join.swordhealth.com/moda/register
Diabetes Management Program	Teladoc Health Diabetes Management Program	800-835-2362	TeladocHealth.com/Register
Flexible Spending Accounts (FSA), Health Reimbursement Arrangement (HRA) and Health Savings Account (HSA)	BenefitHelp Solutions	855-378-0197	benefithelpsolutions.com
Employee Assistance Program	Magellan Behavioral Health	800-478-2812	https://member.magellanhealthcare.com
Life and Disability Insurance	Lincoln Financial	800-423-2765	www.lfg.com
403(b) Retirement Plan	Voya Financial	800-584-6001	voyaretirementplans.com
Benefit Eligibility, Enrollment., Qualified Family Status Change, Family Medical Leave	Human Resources	907-714-5305 or 907-714-4773	CPHBenefits@cpgh.org Submit a ticket: HR HelpDesk

Benefits Advocacy – Here To Help

Central Peninsula Hospital has also partnered with IMA, formerly 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.

Your Account Manager	Email	Phone
Amanda Hesser	**amanda.hesser@imacorp.com**	907-865-6837

ANNUAL HEALTH PLAN
IMPORTANT NOTICES

If you (and/or your dependents) have Medicare or will be eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 40 for more details.

TABLE OF CONTENTS

NOTICE: CMS PART D NOTICE OF CREDITABLE COVERAGE

When you or a family member becomes eligible for Part D (Medicare's prescription drug benefit), it is important to understand when to enroll in Part D. You can wait as long as you maintain "creditable" coverage (i.e., coverage which on average expects to pay at least as well as Part D expects to pay on average). But if you do not have creditable coverage, you need to enroll in Part D at the earliest opportunity to avoid future penalties.

Below are highlights to note:

- A continuous break in creditable coverage of 63 or more days will trigger a late enrollment penalty payable for life.
- The longer you go without creditable coverage, the higher the penalty. For the rest of your life, you would be charged an additional 1% of Part D base premium for each month you are late.
- When creditable coverage ends, a special enrollment period of two (2) months may be provided to enroll in Part D (but note that this is only available when normal coverage ends, not when retiree or COBRA coverage ends).
- The Part D annual open enrollment occurs each year from October 15th through December 7th for coverage to begin January 1st.

The information below indicates whether prescription drug coverage under our plan is creditable.

Creditable Coverage
Denali Plan
Redoubt Plan
Iliamna Plan

Anyone needing to learn more about Medicare should contact a Medicare-approved counselor in their state at https://www.shiphelp.org.

REMEMBER: If you have creditable coverage through our plan, keep this Notice as proof. 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 you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

DATE:	7/1/2026
NAME OF ENTITY/SENDER:	Central Peninsula Hospital
CONTACT--POSITION/OFFICE:	Human Resources
ADDRESS:	250 Hospital Place
	Soldotna, AK 99669
PHONE NUMBER:	907-714-4773

NOTICE: SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards the other coverage). However, you must request enrollment within 31 days after you 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 31 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, see the contact information at the beginning of these notices.

A special enrollment right also arises for employees and their dependents who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

Notice: HIPAA Notice of Privacy Practice

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. It also describes how your protected health information may be used or disclosed to carry out treatment, payment or healthcare operation or for any purposes that are permitted or required by law.

Your Rights	**You have the right to:** ❖ Get a copy of your health and claims records ❖ Correct your health and claims records ❖ Request confidential communication ❖ Ask us to limit the information we share ❖ Get a list of those with whom we've shared your information ❖ Choose someone to act for you ❖ File a complaint if you believe your privacy rights have been violated
Your Choices	**You have some choices in the way that we use and share information as we:** ❖ Answer coverage questions from your family and friends ❖ Provide disaster relief ❖ Market our services and sell your information
Our Uses and Disclosures	**We may use and share your information as we:** ❖ Help manage the health care treatment you receive ❖ Run our organization ❖ Pay for your health services ❖ Help with public health and safety issues ❖ Do research ❖ Comply with the law ❖ Respond to organ and tissue donation requests and work with a medical examiner or funeral director ❖ Address workers' compensation, law enforcement and other government requests ❖ Respond to lawsuits and legal action

Your Rights	**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.
Get a copy of health and claims records	❖ You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. ❖ We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	❖ You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. ❖ We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	❖ You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
	❖ We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	❖ You can ask us not to use or share certain health information for treatment, payment or our operations. ❖ We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	❖ You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. ❖ We will include all the disclosures except for those about treatment, payment and health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost- based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	❖ You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	❖ If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. ❖ We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	❖ You can complain if you feel we have violated your rights by contacting us using the information on page 9. ❖ You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. ❖ We will not retaliate against you for filing a complaint.
Your Choices	**For certain health information, you can tell us your choices about what to share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:	❖ Share information with your family, close friends, or others involved in payment for your care ❖ Share information in a disaster relief situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we never **share your information unless you give us written permission:**	❖ Marketing purposes ❖ Sale of your information

Our Uses and Disclosures	How do we typically use or share your health information.	
	We typically use or share your health information in the following ways.	
Help manage the health care treatment you receive	❖ We can use your health information and share it with professionals who are treating you.	Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
Run our organization	❖ We can use and disclose your information to run our organization and contact you when necessary. ❖ **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	Example: We use health information about you to develop better services for you.
Pay for your health services	❖ We can use and disclose your health information as we pay for your health services.	Example: We share information about you with your dental plan to coordinate payment for your dental work.
Administer your Plan	❖ We may disclose your health information to your health plan sponsor for plan administration.	Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Uses and disclosures of certain substance use disorder treatment records

If we receive or maintain any information about you from a substance use disorder treatment program that is covered by Section 543 of the PHSA (42 USC 290dd-2) and 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose those records for purposes of treatment, payment, or health care operations, we may use and disclose those records for treatment, payment, and health care operations purposes as described in this notice. However, we will not use or disclose a Part 2 Program record about you, or testimony that describes the information contained in a Part 2 Program record about you, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority against you, unless authorized by your consent or the order of a court after it provides you notice of the court order. Although we do not anticipate using any Part 2 Program records for fundraising purposes, you will be provided with a clear and conspicuous opportunity to elect not to receive any fundraising communications from us before we will use any Part 2 Program records for fundraising purposes.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: Your Rights Under HIPAA | HHS.gov.

Help with public health and safety issues	We can share health information about you for certain situations such as: ❖ Preventing disease ❖ Helping with product recalls ❖ Reporting adverse reactions to medications ❖ Reporting suspected abuse, neglect or domestic partner violence ❖ Preventing or reducing a serious threat to anyone's health or safety
Do research	❖ We can use or share your information for health research

Comply with the law	❖ We will share information about you if State or Federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with Federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	❖ We can share health information about you with organ procurement organizations. ❖ We can share health information with a coroner, medical examiner or funeral director when an individual dies.
Address workers' compensation, law enforcement and other government requests	We can use or share health information about you: ❖ For workers' compensation claims ❖ For law enforcement purposes or with a law enforcement official ❖ With health oversight agencies for activities authorized by law ❖ For special government functions such as military, national security and presidential protective services
Respond to lawsuits and legal actions	❖ We can share health information about you in response to a court or administrative order or in response to a subpoena.

Our Responsibilities

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

For more information see: Your Rights Under HIPAA | HHS.gov.

NOTICE: CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

Introduction

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

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

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

What is COBRA Continuation Coverage?

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

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 (for fully insured plans issued in California, coverage generally last for 36 months). 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, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

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

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

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

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

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact information at the begining of these notices. 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.

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

Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? For more information, see the contact information at the beginning of these notices.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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+)	**FLORIDA – Medicaid**
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – 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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2026, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 3/31/2026)