



EMPLOYEE BENEFITS

NEW EMPLOYEE GUIDE

MAKE THE MOST OF BENEFITS

**2025-2026
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.

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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
Educational Assistance
Continuing Education (CE)

Employee Assistance Program (EAP)

Magellan Healthcare

Retirement Plan Options

Voya Financial

Voluntary Pet Insurance

Multiple plans and carriers available

Please keep in mind that our health plan is a self-funded plan. This means that CPH assumes the financial risk for providing health care benefits, rather than paying an insurance company to assume this risk. Your health care claims are “processed” by Moda, however the money they use to make those payments comes directly from CPH, which is funded by the premiums paid by both the company and you.

For more information, including plan documents, summaries, forms, and flyers, please visit:

https://psfinc.egnyte.com/fl/IGKoUreMgq/2025_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 elections in your Workday inbox. If you do not enroll within 30 days, you will need to wait until the next open enrollment period to enroll.

If you don't enroll or 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

Therefore, even if you decide to waive coverage, you should visit Workday to add your beneficiaries for employer-sponsored benefits.

How to Enroll

Benefits enrollment is completed online through Workday at <https://www.myworkday.com/cpgh/login.html>. 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.

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)

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.

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.





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 is best for you and your family.

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

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

Network Information

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

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

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

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

	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 (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.)		

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

Pharmacy Coverage

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

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


To encourage the use of low-cost, high-value medications to treat some chronic conditions, we offer a Value-Based prescription tier with a \$2 copay per prescription (after deductible for those on the Iliamna Plan). You can view the current formulary (as of 4/1/2025) here: <https://www.modahealth.com/-/media/modahealth/shared/formulary/largegroup/Prescription-drug-list-large-group.pdf>. Value-based prescriptions are labeled as "Value" in the Tier column.

If you are using a medication in the Non-Formulary tier, or if you are taking a High-Cost Generic medication, we encourage you to talk to your Physician about alternatives to treat your condition. This will save money for you and for the health plan.

Specialty medications are expensive, complex formulations used to treat specific (usually rare) conditions. The increased pricing tier reflects the cost of these drugs.

Your copays are limited by the Annual Out-of-Pocket Maximum each year. Your prescription drug copays and out-of-pocket limits have not changed this year. If you are on the Iliamna Plan, you must meet your medical deductible first before the plan pays for non-preventive prescriptions.

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

	Denali & Redoubt Plans	Iliamna Plan
	30-day supply	30-day supply
Copayment Applies	Deductible is waived	After deductible is met
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

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.

Central Peninsula Hospital offers a dental insurance plan through Moda using the Delta Dental PPO & Premier Networks. You are enrolled in this coverage when you enroll in any of the three medical plan options (Denali, Redoubt, or Iliamna).

Search for PPO Providers at Moda Find Care (www.modahealth.com) and Search for Premier Providers at Moda Find Care (www.modahealth.com). The PPO Network offers members the most savings for the lowest cost. Contracted providers agree to bill Moda directly and to accept a negotiated fee as payment in full. Allowable charges for out-of-network providers are paid based on allowed amounts, as determined by Moda. You may be responsible for any additional amounts (also called balance billing). The deductible and annual maximum are on a calendar-year basis and reset every January 1st.



	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

- Oral examinations, limited to two examinations each year
- Diagnostic services, including examinations and diagnostic x-rays
- Topical fluoride application for covered person under the age of 20, limited to two treatments each year
- Sealants for covered person under age 14, limited to use on permanent teeth
- Space maintainers for covered persons under age 14

Basic services

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

Orthodontia services

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

Major services

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

Vision Insurance

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

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

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.



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



Examinations

Covered routine examination services are:

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

Lenses

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

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

Frames

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

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, 2025, and include the health, vision, dental and prescription coverages.

Full-time employees pay Level 1 and part-time employees pay Level 2:

Monthly Premiums Level 1	Denali Plan		Redoubt Plan		Iliamna Plan	
	CPH Pays	You Pay	CPH Pays	You Pay	CPH Pays	You Pay
Employee Only	\$3,009.60	\$454.22	\$1,377.59	\$207.91	\$1,377.59	\$207.91
Employee + Spouse	\$6,207.15	\$936.80	\$2,841.56	\$428.85	\$2,841.56	\$428.85
Employee + Child(ren)	\$5,823.59	\$878.91	\$2,665.83	\$402.33	\$2,665.83	\$402.33
Employee + Family	\$9,171.78	\$1,384.23	\$4,198.73	\$633.69	\$4,198.73	\$633.69

Monthly Premiums Level 2	Denali Plan		Redoubt Plan		Iliamna Plan	
	CPH Pays	You Pay	CPH Pays	You Pay	CPH Pays	You Pay
Employee Only	\$2,555.39	\$908.43	\$1,169.68	\$415.82	\$1,169.68	\$415.82
Employee + Spouse	\$5,270.34	\$1,873.61	\$2,412.70	\$857.70	\$2,412.70	\$857.70
Employee + Child(ren)	\$4,944.68	\$1,757.82	\$2,263.49	\$804.66	\$2,263.49	\$804.66
Employee + Family	\$7,787.54	\$2,768.47	\$3,565.05	\$1,267.37	\$3,565.05	\$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.

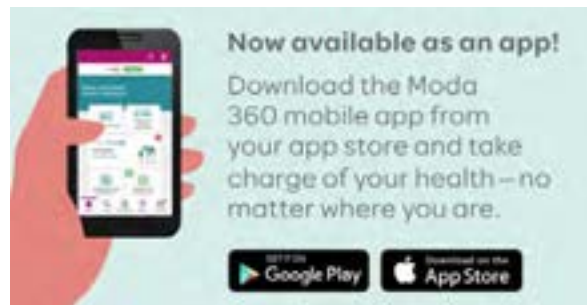
Additional Programs for Health Plan Participants

Moda 360

Healthcare can be complicated. Moda 360 Health Navigators help make it easier for you. As a Moda Health member, you have exclusive access to Moda 360 Health Navigators. You can contact a Health Navigator 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

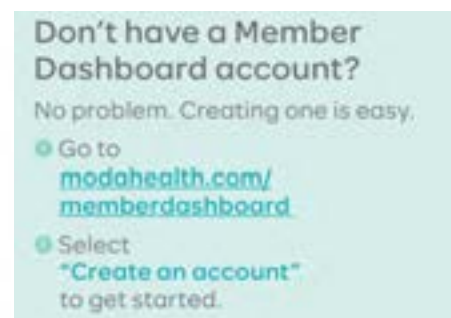
Call 855-232-6886 to connect with a Moda 360 Health Navigator or visit modahealth.com.



As part of your Moda 360 benefits, your Member Dashboard is your personal website where you can view all of 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



Additional Programs for Health Plan Participants

CirrusMD

Virtual doctor's appointments enable convenient access to medical professionals through online and mobile platforms, providing support at your fingertips for you and your family members 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: <ul style="list-style-type: none">• 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 so you can live 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 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!

Here's how it works



Pick Your PT

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



Get Your SWORD Kit

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



Stay Connected

Chat 1:1 with your PT anytime. They'll check in, monitor your progress, and adjust your program as needed.



Feel the Relief

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



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 and who may be able to 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.



Get the
support you
need and
deserve

Health Reimbursement Arrangement



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

What is an HRA?

A Health Reimbursement Arrangement (HRA) allows CPH to set aside funds on a pre-tax basis for you to spend on any qualified expense that is covered under Section 213(d) of the IRS Code. Money not used in one calendar year can be rolled over from year-to-year with the idea being that you, the participant, can save money to be used in years when you have higher health care expenses. CPH's HRA is administered by BenefitHelp Solutions.

Central Peninsula Hospital will contribute \$500 into each employee's arrangement account when they are determined eligible for benefits.

HRA Eligibility

You must be enrolled in the Redoubt Plan to be eligible to participate in the HRA. The HRA is not available to the Denali and Iliamna Plan participants.

Please note that when you terminate coverage or change plans, you will no longer have access to these funds for future claims, unless you choose to purchase COBRA coverage. (You may continue to use the HRA for claims incurred prior to coverage termination, subject to timely filing limits.)



Health Savings Account

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



What is an HSA?

A health savings account (HSA) is a bank account that helps you pay for most medical, dental, vision, and prescription expenses now and into your retirement years. All contributions into this account are pre-tax and yours to keep; and your balance rolls over from year to year. CPH's HSA is administered by BenefitHelp Solutions.

HSA Eligibility

You must be enrolled in the Iliamna Plan to be eligible to participate in the HSA. The HSA is not available to the Denali and Redoubt Plan participants.

You are eligible to contribute and receive contributions to an HSA if you are enrolled in the HDHP plan.

You may not fund an HSA or receive contributions if:

- You are enrolled in a non-HSA-eligible medical plan (e.g., your spouse's PPO plan) 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 Native/Tribal Health Services
- For IHS beneficiaries or Veterans beneficiaries, you cannot contribute to your HSA for 3 months following the month you receive benefits from the Veterans or Native Tribal facilities.
- You have received Veterans Administration benefits in the previous three months, unless you received treatment for a condition that was/is related to your service

Additional rules apply. Please see IRS Publication 969 for more information.

You are responsible for confirming your eligibility to receive contributions from CPH to your HSA.

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

Save, spend, or grow your money.

SAVE You own your HSA and the money in your HSA is always yours (until you spend it, of course). Even if you change medical plans or jobs in the future, any money in your HSA is yours to keep.

SPEND You can use your HSA dollars to pay for most medical, dental, and vision expenses. HSA dollars can be used to pay for eligible expenses for your spouse and dependent children, even if they are not covered by the Moda medical plan. You won't pay taxes when you spend your HSA dollars unless you use them for non-health-related, ineligible expenses. A list of eligible expenses is available at benefithelp.com. Reminder: You can only access funds that are deposited into the account.

GROW Once you have saved the minimum balance in your HSA, you can choose to invest that money in mutual funds. The best part is that the money you invest grows tax free! When you turn age 65, your HSA dollars can be spent, without penalty, on any expense (taxes apply).

Central Peninsula Hospital will help you start saving!

If you enroll in the Iliamna Plan, Central Peninsula Hospital will help you start saving for your health care by contributing \$500 to your HSA.

You can also elect to put additional money from your paycheck on a pre-tax basis. Contributions to an HSA (including the CPH's contribution) cannot exceed the annual IRS contribution limits. The 2026 IRS maximum contributions are:

- Employee-only coverage: \$4,400
- All other coverage tiers: \$8,750
- Employees age 55+ by December 31st may contribute an additional \$1,000 catch-up contribution to their HSA.

The amount you contribute can be changed in Workday at any time throughout the year.

Note: If you and your spouse each contribute to separate HSAs, be sure the total amount does not exceed the IRS family limit. This will result in tax penalties on the excess contributions.

Flexible Spending Accounts



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

• IMPORTANT INFORMATION REGARDING YOUR FSA ACCOUNTS

- **The plan year runs from July 1, 2025 through June 30, 2026.**
- **Enrollment does not continue automatically, you must re-enroll and elect contributions each year.**
- **IRS rules state that once you make your enrollment election for the year, you will not be allowed to change that election until the next Open Enrollment period, unless you have a change in family status, such as marriage, divorce, birth of a child, or change in employment status.**
- **You are responsible for keeping your receipts from eligible purchases made with your FSA funds. In the event you are asked to substantiate a charge, you must provide this information (usually within 30 days).**
- **A full list of eligible expenses is available at benefithelp.com.**
- **If you have funds left in your Healthcare FSA or Health Reimbursement Arrangement (HRA) and wish to enroll in the Iliamna Plan with an HSA on July 1, 2026, your Healthcare FSA and HRA funds will be rolled into limited purpose accounts so that you can maintain the ability to contribute to a Health Savings Account.**

Health Care FSA

(not allowed if you fund an HSA; compatible with an HRA)

- Health Care FSA dollars can be used to pay for eligible out-of-pocket expenses such as deductibles, copays, and other health-related expenses that are not reimbursed by the medical, dental, or vision plans.
- Use dollars to pay for over-the-counter (OTC) medications.
- You may contribute up to \$3,300 to your Health Care FSA for the 2025 plan year. The entire amount you elect is available to you on July 1st or your benefits effective date.
- At the end of the plan year, you can roll over \$660 from your Health Care FSA to use in future years.

Limited Purpose Health Care FSA and HRA

If you have funds left in your Healthcare FSA account or Health Reimbursement Arrangement (HRA) and wish to enroll in the Iliamna Plan with an HSA during Open Enrollment, your Health Care FSA and HRA funds will be rolled into a Limited Purpose Flexible Spending Account or Limited Purpose HRA so you can maintain the ability to contribute to a Health Savings Account.

The Limited Purpose FSA or HRA can be used to pay for dental and vision expenses only.

Dependent Care FSA

- Dependent Care FSA dollars can be used to pay for eligible dependent care expenses that allow you and your spouse to work or attend school full time.
- Eligible expenses include day care, preschool, summer camp, before- and after-school care, and elder care.
- Funds can be used to care for your:
 - Children under 13 years of age;
 - Children 13 and over, spouse, and/or elderly parent who lives with you and is unable to care for themselves.
- You may contribute up to \$5,000 to the Dependent Care FSA for the 2025 plan year if you are married and file a joint return or if you file a single or head of household return. If you are married and file separate returns, you can each elect \$2,500.
- Dependent Care contributions are deposited each pay period. You can only be reimbursed for amounts up to what is currently in your account.
- Dependent Care dollars do not carry over to the next year. Any dollars remaining in your account on June 30th will be lost.

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 the 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 for claims to be submitted.
 - **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. 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: 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: 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

*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 not able 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 these plans 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.

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.

- Employee life insurance benefit: 1x annual earnings up to a maximum of \$500,000*
- Employee AD&D insurance benefit: 1x annual earnings up to a maximum of \$500,000*
- Spouse life coverage: \$1,000 (terminates at age 70)
- Child(ren) life coverage:
 - Day 1 – 14 days: \$1,000
 - >14 days but <6 months: \$500
 - > 6 months but <26 (or 26 year and unmarried & a full-time student): \$1,000

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.

*The benefit is subject to an age reduction schedule. At age 65 the benefit is reduced by 35% and at age 70 it is reduced an additional 15% of the original amount.

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

Electing Coverage During this New Hire Enrollment Period

New Hires will have the opportunity to elect Voluntary Life Insurance for themselves, their spouse, and their child(ren) up to the guaranteed issue amount during their New Hire Enrollment period without completing a health questionnaire, also known as Evidence of Insurability or EOI. In the future, if you decline coverage during this New Hire Enrollment period, you may have to complete an EOI questionnaire to get coverage.

Electing Coverage in the Future

In the future, you can elect Voluntary Life Insurance coverage with some restrictions:

- If you and your spouse sign up during this New Hire 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 this New Hire Enrollment, 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.

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.

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

Income Assurance Program (IAP)

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

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

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.

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)

Consolidated Leave Program (continued)

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

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

- The birth of a child and to care for the newborn child within one year of birth
- The placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement
- To care for the employee's spouse, child, or parent who has a serious health condition
- A serious health condition that makes the employee unable to perform the essential functions of their job
- Any qualifying exigency arising out of the fact the employee's spouse, child, or parent is a covered military member on "covered active duty,"

Or, twenty-six work weeks of leave in a single 12-month period to:

- Care for a covered service member with a serious injury or illness if the eligible employee is the service member's spouse, child, parent, or next-of-kin (military caregiver leave).

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



Educational Assistance

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

Eligibility

All full and part-time employees who have completed one year of service are eligible for this benefit. Per Diem and Temporary employees are not eligible for Educational Assistance. 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	
2 nd Year of Service	\$1,500	\$1,500
3+ Years of Service	\$2,000	\$2,500
	Part Time Employee	
2 nd Year of Service	\$750	\$750
3+ Years of Service	\$1,000	\$1,250

How to Apply

- Submit your application online, at <https://app.smartsheet.com/b/form/135b4b6b441c4979bcc55503bbf44057>
- Applications will be reviewed and are subject to available funds. If approved, you will receive a check and be requested to sign a promissory agreement.
- At the completion of your course, record of passing grades received ("C" or better, or "Pass" if Pass/Fail grading) and all receipts for educational expenses incurred must be turned into Human Resources no later than 30 days after the end date of the course/semester.
- 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 you and your household family 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: <ul style="list-style-type: none">• Improving relationships• Managing life changes• Improving esteem and confidence• Achieving work-life harmony	Connect to local resources for: <ul style="list-style-type: none">• Childcare needs• Caring for an elder• School success• Legal resources	Get tips for staying healthy: <ul style="list-style-type: none">• Sleep practices• Eating well• Finding a gym
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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: www.magellanascend.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 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 one week 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 occur in December and June of each year and are effective January and July of each year. Eligible employees receive an automatic 2% Employer Discretionary contribution based on the employee’s annual salary. CPH will match employee contributions up to a maximum of 3% of the employee’s salary. Employee contributions cannot exceed the IRS limits of \$24,500 for 2026. The annual combined maximum the hospital will contribute is \$7,320.

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/>.



Voluntary Pet Insurance

Voluntary Pet Insurance adds an additional layer of protection against unexpected veterinary expenses. In some cases, you may end up with more money back in your pocket, helping you care for your furry friends without the financial worry!

With Voluntary Pet Insurance coverage, you can focus on giving your pet the best care possible instead of focusing on the cost of treatment. You are able to customize your plan options to fit your personal coverage needs. **Purchasing Voluntary Pet Insurance through the link or QR code below gives you access to exclusive discounts, making it more affordable than buying it independently!**

You will have the choice of multiple provider options, including:

- ASPCA Pet Health Insurance
- Spot Pet Insurance
- Pin Paws Pet Care

ASPCA PET HEALTH
INSURANCE



All employees are eligible for this benefit and can enroll at any time, not just during new hire or open enrollment, by scanning the QR code or using this link: <https://cutt.ly/OEL-Pet>



Note: This benefit is not processed through payroll deductions and will not appear in Workday.



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	www.magellanascend.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	907-714-4773	CPHBenefits@cpgh.org Submit a ticket: HR HelpDesk

Benefits Advocacy – Here To Help

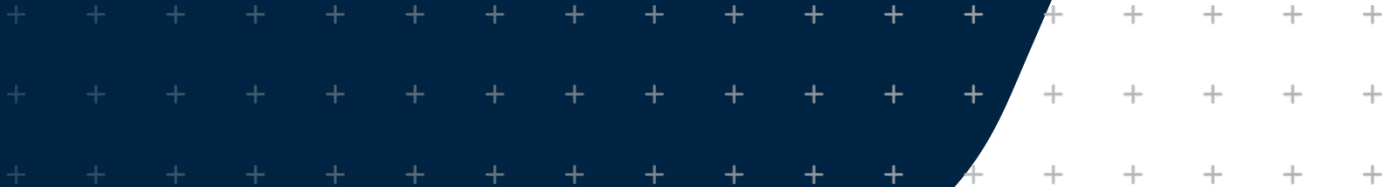
Central Peninsula Hospital has also partnered with IMA, formerly Parker, Smith & Feek to provide you and your family with individualized assistance with insurance problems you are unable to resolve directly with the carriers. This includes claims issues, eligibility questions, network problems and general 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 3 for more details.

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CMS Part D Notice of Creditable or Non-Creditable Prescription Drug Coverage 35

Informs the individual as to whether their current prescription drug coverage is creditable, which means that the coverage is expected to pay on average as much as standard Medicare prescription drug coverage. Accordingly, this information is essential to an individual's decision whether to enroll in a Medicare Part D prescription drug plan.

Special Enrollment Rights 36

Describes how an employee eligible for the group health plan may be entitled to special enrollment rights outside of the Company's open enrollment period, such as for certain losses of prior coverage or the addition of a new dependent.

HIPAA Notice of Privacy Practices 36

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.

General Information about How to Continue Health Coverage 39

Informs the individual of the right to purchase temporary extension of group health coverage when coverage is lost due to a qualifying event, and other available coverage options such as through the Marketplace.

Women's Health and Cancer Rights Act 42

Informs participants about benefits covering mastectomies and related services and how to get detailed information on available benefits.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP) 43

Informs employees about possible State financial assistance for health insurance coverage.

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 *****.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: 7/1/2025

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	<p style="text-align: center;">You have the right to:</p> <ul style="list-style-type: none">❖ 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	<p style="text-align: center;">You have some choices in the way that we use and share information as we:</p> <ul style="list-style-type: none">❖ Answer coverage questions from your family and friends❖ Provide disaster relief❖ Market our services and sell your information
Our Uses and Disclosures	<p style="text-align: center;">We may use and share your information as we:</p> <ul style="list-style-type: none">❖ 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	<p>When it comes to your health information, you have certain rights.</p> <p>This section explains your rights and some of our responsibilities to help you.</p>
<p>Get a copy of health and claims records</p>	<ul style="list-style-type: none"> ❖ 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.
<p>Ask us to correct health and claims records</p>	<ul style="list-style-type: none"> ❖ 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.
<p>Request confidential communications</p>	<ul style="list-style-type: none"> ❖ 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.
	<ul style="list-style-type: none"> ❖ We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.
<p>Ask us to limit what we use or share</p>	<ul style="list-style-type: none"> ❖ 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.
<p>Get a list of those with whom we’ve shared information</p>	<ul style="list-style-type: none"> ❖ 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.
<p>Get a copy of this privacy notice</p>	<ul style="list-style-type: none"> ❖ 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.
<p>Choose someone to act for you</p>	<ul style="list-style-type: none"> ❖ 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.
<p>File a complaint if you feel your rights are violated</p>	<ul style="list-style-type: none"> ❖ 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	<p>For certain health information, you can tell us your choices about what to share.</p> <p>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.</p>
<p>In these cases, you have both the right and choice to tell us to:</p>	<ul style="list-style-type: none"> ❖ Share information with your family, close friends, or others involved in payment for your care ❖ Share information in a disaster relief situation <p><i>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.</i></p>
<p>In these cases, we never share your information unless you give us written permission:</p>	<ul style="list-style-type: none"> ❖ 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](https://www.hhs.gov/hipaa/for-individuals/in-depth/your-rights-under-hipaa/).

Help with public health and safety issues	<p>We can share health information about you for certain situations such as:</p> <ul style="list-style-type: none"> ❖ 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	<ul style="list-style-type: none"> ❖ 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	<ul style="list-style-type: none"> ❖ 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	<p>We can use or share health information about you:</p> <ul style="list-style-type: none"> ❖ 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	<ul style="list-style-type: none"> ❖ 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](https://www.hhs.gov/hipaa/for-individuals/_hipaa-individuals-how-to-protect-your-privacy).

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 beginning 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 beginning 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.

NOTICE: PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, 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 March 17, 2025. 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: *****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: *****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: *****flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268

<p style="text-align: center;">GEORGIA – Medicaid</p>	<p style="text-align: center;">INDIANA – Medicaid</p>
<p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: *****medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p>	<p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ *****.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>
<p style="text-align: center;">IOWA – Medicaid and CHIP (Hawki)</p>	<p style="text-align: center;">KANSAS – Medicaid</p>
<p>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</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
<p style="text-align: center;">KENTUCKY – Medicaid</p>	<p style="text-align: center;">LOUISIANA – Medicaid</p>
<p>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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: *****chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
<p style="text-align: center;">MAINE – Medicaid</p>	<p style="text-align: center;">MASSACHUSETTS – Medicaid and CHIP</p>
<p>Enrollment Website: *****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</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
<p style="text-align: center;">MINNESOTA – Medicaid</p>	<p style="text-align: center;">MISSOURI – Medicaid</p>
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: *****dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@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: *****.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 Rlte 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: *****covera.dmas.virginia.gov/learn/premium-assistance/famis-select *****covera.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: *****dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: *****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 March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

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