EMPLOYEE BENEFITS *Guide*

2026

EISENHOWER HEALTH

Employee Benefits Guide 2025-2026

General Information

Core Benefits

Other Benefits

Miscellaneous

If you (and/or your dependents) have Medicare or you will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 49 for more details.

The information in this brochure is a general outline of the benefits offered under Eisenhower Health's benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

This brochure is considered a Summary of Material Modification.

Our Commitment

Our greatest asset, and the key to our success, is our employees. You make the difference for the people we care for and the community we serve. That's why we've designed a benefits program to make a difference for you and your family.

Introduction

Eisenhower understands the importance of offering a comprehensive benefit program that meets the needs of our diverse workforce. We are pleased to continue to provide a suite of quality benefit plans to all benefit eligible employees for the 2025-2026 plan year.

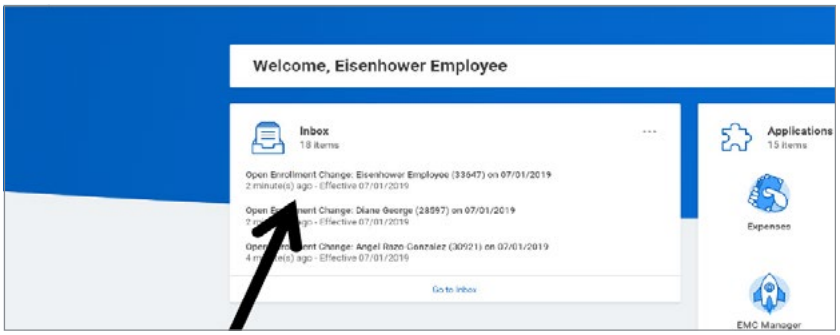
How To Enroll In Benefits

Enrollment: Online Benefit Election Process

The online enrollment process for benefits is through Ikenet or from home. In order to enroll online, you will need to have access to Workday.

From Home

Follow the "from home" set up to access Workday while you are signed onto an on campus work station. IkeNet page https://ikenet/human-resources/workday/ or IkeNet→Web Services→Workday. Once signed on from home the instructions are the same.

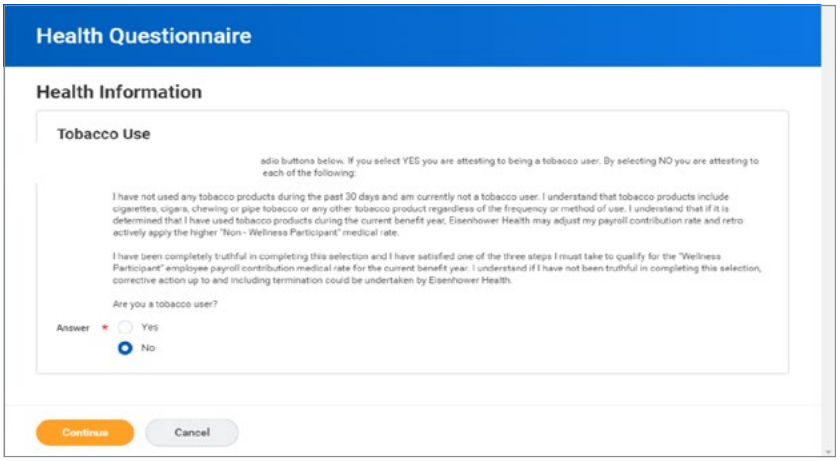


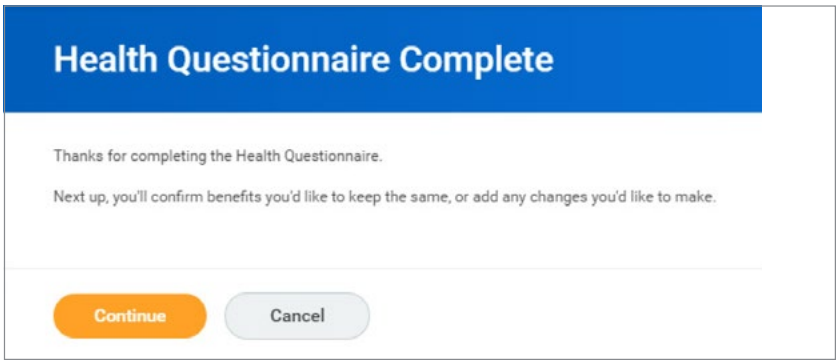
From Ikenet

From the Web Services drop down menu, select Workday.

Log in to Workday using your **User ID** (your employee #) and your **Password** (your network password).

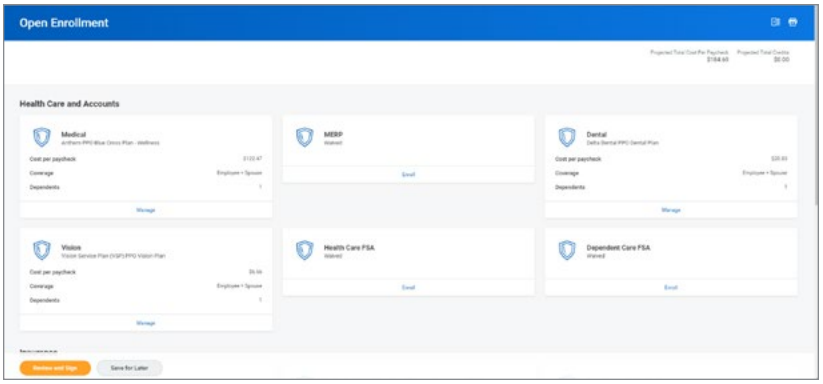
- In the "**Inbox**" window on the left of your screen choose "**Benefit Change**" followed by your name and employee number.
- Click on this item in your Inbox in Workday, another window will open.
- Select the "Let's Get Started" button. You will be presented with the Health Information screen where you can validate your Tobacco status and click "Continue".
- A confirmation of completion screen will appear, click "Continue".

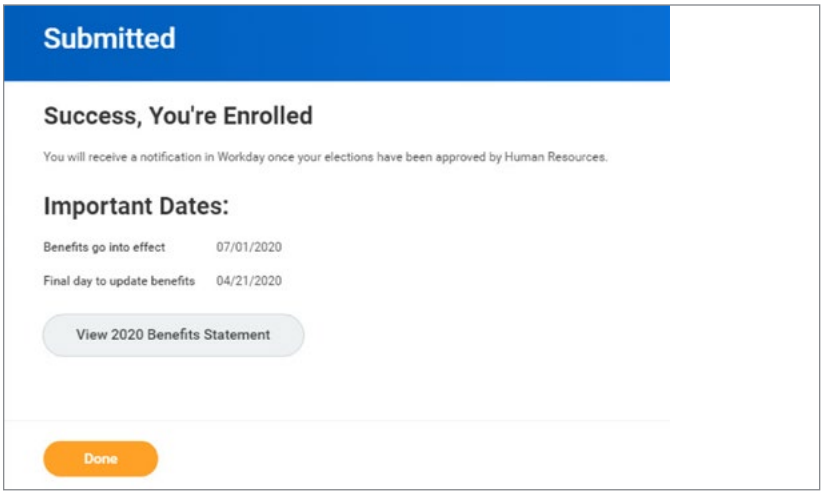




How To Enroll In Benefits (continued)

- The next screen will show a "Card" for each benefit that is available to you, allowing you to "Manage" existing coverage or "Enroll" in the plan during this session. You can click on "Manage" or "Enroll" on any of the cards in any order to review details of your current elections or enroll.
- Once you have reviewed your elections, be sure to scroll to the bottom of all cards that are displayed. Click the "Review and sign" button.
- A view summary page will appear showing all of your elections made during the enrollment process.
- Again scroll to the bottom of the page, read the electronic signature information, check the "I Accept" and click "Submit".
- The confirmation screen that your elections have been submitted will appear. You can view your elections using the "View 2025-2026 Benefits Statement" button.





Please Note: If you're adding dependents, you must upload appropriate documentation in order to complete the enrollment; see page 5 for details. If you are waiving benefits, you must upload proof of other coverage.

A Healthy Approach To Benefits

Eisenhower has always been on the forefront in pioneering innovative ways of delivering exceptional health care to members of our community. As such, the benefit package offered to benefit eligible employees is one of the most advanced programs in the health care industry today.

This guide gives you the information you need to make your decisions. It includes highlights about the plans and what you pay for most benefits. Our program provides you with the opportunity to choose the combination of benefits that best meet your personal and family needs. Please read it carefully along with any supplemental materials you receive.

Benefit Costs

Regardless of which plans you select, Eisenhower pays a large portion of your benefit program costs. Please refer to the Benefit Costs on pages 34-36 for the payroll contributions required for enrollment in the various Eisenhower benefit plans. If you have questions, please contact the Human Resources Department at 760.837.8500.

The Tax Advantage

As you know, every dollar you earn is subject to a variety of taxes: income tax, Social Security tax, state and local taxes, etc. Using pre-tax earnings means using tax-free dollars. Basically, the IRS allows you to spend a portion of your gross pay to purchase certain employee benefits before taxes are deducted (except Social Security tax). When contributions are deducted on a pre-tax basis, you are subject to IRS restrictions on when you may start, stop or change to your benefit selections (see Qualifying Event Status Change on page 6).

How the Program Works

With the Eisenhower benefits program, you have the opportunity to make new benefit choices each year. The choices you make should reflect your needs for financial protection and security.

Benefit	Coverage
Medical	Eisenhower Anthem Blue Cross Prudent Buyer PPO Plan
Dental	Delta Dental Preferred Option (PPO) Plan
Vision	Vision Service Plan (VSP) Vision Care
Flexible Spending Accounts	
• Health Care Spending Account (HSA)	Up to $3,300/year
• Dependent Care Spending Account	Up to $5,000/year
Basic Employee Life and Accidental Death and Dismemberment (AD&D) Insurance	**All eligible employees:** 1 times annual salary up to $50,000
Basic Dependent Life Insurance *(when enrolled in the Eisenhower PPO Plan)*	
• Spouse/Registered Domestic Partner	$1,000 (paid by Eisenhower)
• Child(ren)	$1,000 (paid by Eisenhower)
Supplemental Employee Life Insurance	1, 2, 3, 4, 5 or 6 times your basic annual salary up to a maximum of $1,200,000 (Statement of Health required in some circumstances)
Supplemental Dependent Life Insurance	
• Spouse/Registered Domestic Partner	Increments of $5,000 up to the lesser of 50% of the combined employee Basic Life and Supplemental Life or $150,000 (Statement of Health required in some circumstances)
• Child(ren)	$5,000 (Employee Supplemental Life must be elected to enroll in child(ren) Supplemental Life.)
Supplemental Accidental Death and Dismemberment (AD&D) Insurance	
• Employee	$25,000 to $500,000 (in $25,000 increments)
• Employee & Child(ren)	Children receive 25% of employee coverage
• Employee & Family	Spouse/Registered Domestic Partner receives 60% of employee coverage; **or** Spouse/Registered Domestic Partner receives 50% and Children receive 15% of employee coverage **Amounts over $300,000 cannot exceed 10 times annual salary**
Voluntary Long Term Disability (LTD) Insurance	50% income replacement up to a maximum of $6,000 monthly benefit (Statement of Health required in some circumstances)
Voluntary Plans	• Universal Life with Long Term Care • Life Insurance - Universal LifeEvents • Critical Illness Insurance • Accident Insurance • Hospital StayPay Insurance • Allstate Identity Protection • Wishbone Pet Insurance • LegalShield

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Eligibility

Eligibility for benefits is determined by employee classification, number of hours scheduled to work and a waiting period before benefits are effective.

	Eligibility for Benefits	
	Full-Time	**Part-Time**
Hours Requirement	Minimum of 72 hours or more per pay period	48 hours, but less than 72 hours per pay period
Benefits Effective Date	31st day of employment*	
Benefits Offered	• Medical • Dental • Vision • Basic Life and Accidental Death & Dismemberment (AD&D) • Basic Dependent Life • Supplemental Life • Supplemental Dependent Life • Supplemental AD&D • Voluntary Long Term Disability (LTD) • Flexible Spending Accounts (FSA)	
When Benefits Terminate	Date of Termination	

* Benefits begin on the first day of employment for Residents and Fellows.

Covering Your Dependents

Eligible dependents include:

- Your legal married partner.
- Registered domestic partners include an individual who has filed, along with the Employee, a Declaration of Domestic Partnership with the State of California (or from another state), and at the time of enrollment in the plans meets all of the following requirements:
  - Both persons have a common residence;
  - Neither person is married to someone else or is a member of another Domestic Partnership with someone else that has not been terminated, dissolved or adjudged a nullity;
  - The two persons are not related by blood in a way that would prevent them from being married to each other in this state;
  - Both persons are at least 18 years of age.
- Children up to age 26.
  - **Children include:** natural born, adopted, step children, foster children with court order, and children of registered domestic partners.
  - Children may only be covered as dependents of one of the parents, if both you and your spouse/registered domestic partner are employed at Eisenhower.

PLEASE NOTE

You cannot cover your spouse/registered domestic partner or child(ren) as a dependent if he/she is a full-time or part-time employee of Eisenhower.

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Dependent Verification Matrix

Dependent Verification Information

Below is a list of required supporting documentation for enrolling your eligible dependents to the benefit plans.

Covered Dependent	Verification Documents
Spouse	**County Issued Marriage License and one** of the following: Copy **of most recent IRS 1040 Tax Form** with Employee & Spouse listed or a Copy of **household bill/statement of account** with Employee & Spouse at the same address and dated within the last 60 days.
Registered Domestic Partner	**Certificate of Registered Domestic Partnership (State issued) and one** of the following: Copy of **most recent IRS 1040 Tax Form** with Employee & RDP listed or a Copy of **household bill/statement of account** with Employee & RDP at the same address and dated within the last 60 days.
Birth Child *(birth to age 26)*	**Birth Certificate** naming Employee as parent.
Step Child *(birth to age 26)*	**Birth Certificate** naming Spouse as parent and **County Issued Marriage License** listing spouse.
Child of RDP *(birth to age 26)*	**Birth Certificate** naming RDP as parent and **Certificate of Registered Domestic Partnership** listing RDP as parent.
Adopted Child *(birth to age 26)*	**Adoption Record** naming Employee or Spouse as parent/guardian.
Legal Custody *(birth to age 18)*	**Court Document** appointing employee or Spouse/RDP as legal guardian/custodian.
Disabled Adult Child *(over age 26)*	**Social Security Disability Certificate** naming Employee or Spouse as guardian/parent.

Important: Social Security numbers **must** be listed for you and each of your covered dependents. Dependents will not be enrolled in benefits until all of the required verification documents are provided. Attach copies of your documents to your enrollment elections in Workday.

Where can I get copies of my documents if I don't have them?

The County Registrar of the county of issue regarding marriage and birth certificates. Most counties have on-line ordering or toll free numbers.

www.IRS.gov, or your tax preparer if you used one.

Official documents of birth, marriage and death from anywhere in the United States can be obtained through www.vitalchek.com.

Copies of court orders can be obtained from the specific court, or from the attorney who handled the case.

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Enrollment Timeframes

Benefit Eligible New Hires

Complete your enrollment in Workday within 14 days of your hire date. Benefits orientation is held during your general new hire orientation.

Remember, the choices you make as a new hire will be fixed for the remainder of the plan year and cannot be changed until the next open enrollment period unless you experience a qualified change in status.

As a new hire you are also eligible to select the "Wellness" rate as long as you attest to not using tobacco products. To retain the wellness rate in future years you will be required to participate in wellness activities as communicated throughout the year.

Open Enrollment

Each year there is an open enrollment period during which you will choose the benefits you want for the upcoming plan year (July 1 - June 30). It is important to choose your benefit options carefully because the choices you make will be fixed for the entire plan year and cannot be changed unless you experience a qualifying event status change.

In addition, you will need to re-enroll in the Flexible Spending Accounts each year in order to participate. Your current FSA elections will not roll over to the following plan year.

Qualifying Events Status Change

Other than Open Enrollment, you may change or drop your coverage, or add or remove dependents ONLY in the event you have a qualifying event change in status. Under the current IRS code that governs our benefits program, you can change your pretax benefit choices within 30 days under the following circumstances:

- You get married or registered by the state of California (or another state) as a domestic partner, legally separated, divorced or your marriage is annulled.
- You add a dependent child through birth, marriage, adoption, placement for adoption, foster child placement court order.
- Your spouse/registered domestic partner or dependent child dies.
- Your spouse/registered domestic partner has a change in employment or status that affects benefits coverage.
- You change from an eligible benefits status to ineligible status or vice versa.
- You experience an involuntary loss of other group benefit coverage.
- Your eligible dependent child reaches age 26.

You must report qualified status changes (including newborns) that affect your benefit elections to the Human Resources Department within 30 days of the occurrence.

No change will be made to coverage outside the 30 day time frame.

Spousal Surcharge

If your spouse or Registered Domestic Partner is eligible for coverage through their employer but you want to add them to the Eisenhower medical plan, you must select the appropriate "with surcharge" coverage option when making your elections.

If You Don't Enroll as a New Hire

If you are eligible to participate in the Eisenhower benefits program, but fail to enroll by the specified deadline, you will not be eligible to enroll until the next Open Enrollment period, and you will receive the following default benefits:

- Employee Only Medical Coverage with corresponding Non-Wellness Deductions
- Basic Employee Life Insurance
- Basic Employee Accidental Death and Dismemberment (AD&D) Insurance
- Employee Assistance Program (EAP)

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Taking Care of Your Health

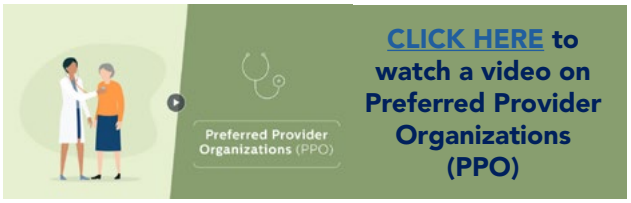
To keep you and your family living a healthy, happy life, Eisenhower is pleased to offer quality medical coverage that provides choice, flexibility and affordability. The Eisenhower Benefits Program allows eligible employees to enroll in medical coverage under the Eisenhower Anthem Blue Cross Prudent Buyer Preferred Provider Organization (PPO) Plan.

Eisenhower Anthem Blue Cross PPO Plan

The Eisenhower Anthem Blue Cross Prudent Buyer PPO Plan is like three plans in one. Each time you need medical treatment, you have the freedom to decide where you receive your treatment. This plan gives you three choices. You can use:

- **Tier 1:** Eisenhower and ancillary services, and Eisenhower physicians who are also Anthem Blue Cross Prudent Buyer PPO network providers.
  - To locate a Tier 1 physician, select an Eisenhower physician from the Medical Staff Roster (Ikenet or eisenhowerhealth.org) and verify with the physician's office that they accept Anthem Blue Cross.
  - **Please note:** Benefits will only be paid at Tier 1 level at Eisenhower facilities regardless of where you reside.
- **Tier 2:** Other Anthem Blue Cross Prudent Buyer PPO network providers (non-Eisenhower).
- **Tier 3:** Providers who do not participate in the Anthem Blue Cross Prudent Buyer PPO network (some Eisenhower physicians may fall in the Tier 3 category).The choice is always yours. Highlights of the Eisenhower Anthem Blue Cross Prudent Buyer PPO Plan are shown in the chart on pages 9-10. See plan materials for complete details.

IMPORTANT! Many of our Eisenhower physicians are in the Anthem Blue Cross Prudent Buyer PPO network. However, due to frequent changes, you should ALWAYS verify that your Eisenhower provider is also contracted with Anthem Blue Cross before obtaining services/treatment. If your Eisenhower physician is not also an Anthem Blue Cross Prudent Buyer PPO provider, the plan may pay benefits at the Tier 3 level. You may access Anthem Blue Cross of California Provider Finder at www.anthem.com/ca.



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Taking Care of Your Health (continued)

Maternity Services - Eisenhower Family Birth Center

On May 27, 2021, Eisenhower Health opened the new Eisenhower Family Birth Center. Benefited employees and their covered family members will have access to this state-of-the-art, 50,000 square-foot facility that delivers everything needed for a safe and comfortable birthing experience. The Eisenhower Family Birth Center includes:

- 14 private labor, delivery, recovery, postpartum (LDRP) rooms
- 8 private-rooms in our Level II newborn intensive care unit (NICU)
- 2 dedicated operating rooms
- 7 postpartum rooms and 4 antepartum rooms

If you or your covered spouse/RDP receive services at Eisenhower Family Birth Center, the hospital (facility only) charges will be covered at 100% after $230 copay.

Covered Dependent Children are not eligible for coverage for any expenses in connection with pregnancy and delivery except for prenatal care.

Any other copays, **limitations and exclusions** will still apply for Eisenhower's ancillary services according to our benefit plan.

Transgender Services

Services and supplies received in connection with gender transition may be covered after prior diagnosis of gender identity disorder or gender dysphoria has been received from a doctor. Coverage is provided in accordance with the terms and conditions of this plan and apply to all other covered medical conditions, including: medical necessity requirements, medical management and exclusions for cosmetic services, except as specifically stated in your Employee Benefits Plan Document/Summary Plan Description. You may access the Plan Document/Summary Plan Description on the Personal Choices website at https://app.strivebenefits.com/EisenhowerHealth **Username:** EisenhowerEE; **Password:** benefits (see page 37).

You must obtain approval in advance for all transgender services in order for these services to be covered by the plan. Benefits are not payable for these services if prior approval has not been obtained. For more information, please contact Keenan at 888.773.7215.

PLEASE NOTE

The following exclusion defines benefits that are NOT PAYABLE under the medical plan:

Charges for injuries received while the Covered Person is operating a motor vehicle if, at the time of the accident, their blood contained in excess of 80 milligrams (or, if different, the legal limit of the state in which the accident occurred) of alcohol per 100 milliliters of blood.

For a complete list of exclusions, please refer to the Employee Benefits Plan Document/Summary Plan Description located on the Personal Choices website at https://app.strivebenefits.com/EisenhowerHealth (see page 37).

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Medical

Plan Benefits	Eisenhower Anthem Blue Cross PPO Plan		
	Tier I Eisenhower Health & EH Designated Providers	Tier 2 Other Anthem PPO Providers	Tier 3 Non-PPO Providers
	Member Responsibility		
Annual Deductible *(Individual/Family) (Calendar Year)*	None	$575/$1,750	$1,150/$3,450
Out-of-Pocket Maximum *(Calendar Year)*	$1,150 individual	$3,450 individual $10,350 family	$11,500 individual
Inpatient Services			
• Hospitalization Services	$230 copay	25% coinsurance	50% coinsurance
• Physician Visits	$5 copay	25% coinsurance	50% coinsurance
• Surgery – Physician	$5 copay	25% coinsurance	50% coinsurance
• Anesthesia	$5 copay	25% coinsurance	50% coinsurance
• Maternity	$230 copay	10% coinsurance (deductible waived)	50% coinsurance
• Bariatric Surgery	10% coinsurance	35% coinsurance (Anthem Blue Cross COE only)	Not covered
• Life Threatening Condition	$5 copay	25% coinsurance	50% coinsurance
Outpatient Services			
• Lab/X-Ray			
– Office	$5 copay	25% coinsurance	50% coinsurance
– Hospital	$5 copay	25% coinsurance	50% coinsurance
• PET Scan/MRI	$115 copay/visit	25% coinsurance	50% coinsurance
• CT Scan	$115 copay/visit	25% coinsurance	50% coinsurance
• Surgery			
– Office	$5 copay	25% coinsurance	50% coinsurance
– Same-Day	$85 copay	25% coinsurance	50% coinsurance
– Special Procedures	$85 copay	25% coinsurance	50% coinsurance
– Ambulatory Surgical Facility *(Anthem Blue Cross Utilization Review required. Additional $300 Deductible and Coinsurance increased by 15 percentage points penalty per occurrence if not pre-authorized.)*	Services not provided at Eisenhower (See Tier 2 or Tier 3)	25% coinsurance	50% coinsurance ($300 limit)
– Physician	$5 copay	25% coinsurance	50% coinsurance
• Anesthesia	$5 copay	25% coinsurance	50% coinsurance
• Cardiac Rehabilitation	$5 copay	25% coinsurance	50% coinsurance
• Physical and Occupational Therapy	$5 copay	25% coinsurance	50% coinsurance
• Speech Therapy	10% coinsurance + $115 copay (Copay applies one time per year)	25% coinsurance	50% coinsurance
• Manipulative Therapy/Chiropractic Care *(24 visits per calendar year)*	$30 copay	$30 copay	50% coinsurance
• Acupuncture *(24 visits per calendar year)*	$30 copay	25% coinsurance	50% coinsurance
• Podiatry	$5 copay	$5 copay	50% coinsurance
Physician Services			
• Office Visits			
– Physician	$25 copay	25% coinsurance	50% coinsurance
– Physician – Eisenhower Teaching Clinic	$0 copay	Not covered	Not covered
– Specialist	$30 copay	25% coinsurance	50% coinsurance

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Medical (continued)

Plan Benefits	Eisenhower Anthem Blue Cross PPO Plan		
	Tier I Eisenhower Health & EH Designated Providers	Tier 2 Other Anthem PPO Providers	Tier 3 Non-PPO Providers
	Member Responsibility		
Emergency Care			
• Urgent Care	$30 copay	25% coinsurance	50% coinsurance
• Emergency Room Services	$115 copay	$170 copay	$230 copay
• Ambulance	10% coinsurance	10% coinsurance (deductible Waived)	10% coinsurance (deductible Waived)
Preventive Care/Wellness Services			
• Well Baby/Child Care	$25 copay	25% coinsurance	50% coinsurance
• Routine Physical Exam *(Adults only over age 18; One Routine Physical Exam every 12 months)*	$25 copay	25% coinsurance	50% coinsurance
• Routine Lab Work	$5 copay	25% coinsurance	50% coinsurance
• Elective Mammogram	$5 copay	25% coinsurance	50% coinsurance
• Routine Pap Smear *(and related services)*	$5 copay	$5 copay	50% coinsurance
• Prostate Cancer Testing (PSA)	$5 copay	$5 copay	50% coinsurance
• Nutritional Counseling Program *(Combined 8 sessions (30 minutes each) per calendar year)*	$0 copay	25% coinsurance	Not covered
• Diabetes Healthcare Instruction	$5 copay	Not covered	Not covered
• Adult Vaccines	Certain vaccines are covered - See page 11	Certain vaccines are covered - See page 11	Certain vaccines are covered - See page 11
Other Services			
• Allergy Testing	$30 copay	25% coinsurance	50% coinsurance
• Allergy Injection/Treatment	$5 copay	25% coinsurance	50% coinsurance
• Blood and Blood Product	$5 copay	25% coinsurance	50% coinsurance
• Durable Medical Equipment	Services not provided at Eisenhower (See Tier 2 or Tier 3)	25% coinsurance (deductible waived)	50% coinsurance (deductible waived)
• Extended Care Facility/Skilled Nursing Facility *(100 days/calendar year maximum; 365 days lifetime)*	Services not provided at Eisenhower (See Tier 2 or Tier 3)	10% coinsurance	50% coinsurance
• Hearing Aid Device	50% coinsurance	50% coinsurance	50% coinsurance
• Home Health Care *(90 visits/calendar year maximum)*	Services not provided at Eisenhower (See Tier 2 or Tier 3)	10% coinsurance	50% coinsurance
• TeleHealth Visit - LiveHealth Online	Not covered	$10 copay	Not covered
• Hormone Replacement Therapy Implant	$30 copay	25% coinsurance	50% coinsurance
• Sleep Center	$5 copay	Not covered	Not covered
Hospice Center			
• Inpatient	Services not provided at Eisenhower (See Tier 2 or Tier 3)	10% coinsurance	50% coinsurance
• Outpatient *(180 days lifetime maximum)*	Services not provided at Eisenhower (See Tier 2 or Tier 3)	10% coinsurance	50% coinsurance
Behavioral Health and Substance Abuse			
• Office Visit	$5 copay	$5 copay	50% coinsurance
• Inpatient Hospitalization	$230 copay	$230 copay	50% coinsurance

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Medical (continued)

Adult Vaccines	Physician's Office	Pharmacy
COVID-19	✔	✔
Flu*	✔	✔
HPV**	✔	✔
Hepatitis A	✔	✔
Meningitis	✔	✔
Pneumonia	✔	✔
Shingles	✔	✔
Tdap* ^	✔	✔

* Covered through Employee Health for employees only

** Up to age 46

^ Tdap vaccine is only covered for dependent children in doctor's office and pharmacy.

All **child Immunizations birth to 18 years old** (including flu shots) in accordance with the recommendations of the American Academy of Pediatricians, are covered under the medical plan in a physician's office.

Eisenhower Teaching Clinics

In order to provide the patient population necessary for the Residency Programs, benefited employees and their covered family members will have access to primary care services at both Teaching Clinics. Adults and/or children can receive services. Since it is extremely important to provide our residents with a diverse patient population, **Eisenhower is waiving the physician office copay at both Teaching Clinics when seen by a resident.** Any other copays will still apply for Eisenhower's ancillary services according to our benefit plan.

For more information or to schedule an appointment, please see page 54 for contact information.

TeleHealth - LiveHealth Online

LiveHealth Online lets you talk face-to-face with a doctor through your mobile device or a computer with a webcam. This service helps you to connect with a board-certified doctor when your primary care doctor cannot be reached for consultation. Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections, allergies and more! With LiveHealth Online, you have a doctor by your side 24/7. It's faster, easier and more convenient than a visit to an urgent care center. A typical LiveHealth Online session lasts about 10 minutes. The cost for an online doctor visit is just $10. Please note that LiveHealth Online should not be used for emergency care. If you experience a medical emergency, call 911 immediately.

Log on to livehealthonline.com or download the mobile app to get started today!

TeleHealth - LiveHealth Online Psychology

If you're feeling stressed, worried, or having a tough time, you can talk to a licensed psychologist or therapist through video using LiveHealth Online Psychology. It's easy to use, private and, in most cases, you can see a therapist within four days or less. All you have to do is sign up at livehealthonline.com or download the app to get started. The cost for an online therapy visit is just $5.

Make your first appointment — when it's easy for you

- Use the app or go to livehealthonline.com and log in. Select LiveHealth Online Psychology and choose the therapist you'd like to see.
- Or, call LiveHealth Online at 844.784.8409 from 7 a.m. to 11 p.m.
- You'll get an email confirming your appointment

Anthem Blue Cross Utilization Review

When you are enrolled in the Eisenhower Anthem Blue Cross PPO Plan, you must receive approval before any hospitalization or outpatient surgery at an ambulatory surgical center. The Anthem Blue Cross Utilization Review program helps ensure that your medical treatment, including the length of your hospital stay, is appropriate given the nature of your illness or injury. If you do not follow the Anthem Blue Cross Utilization Review procedures, plan benefits may be significantly reduced and an additional penalty deductible may apply. See the Quick Reference Guide on page 54 of this booklet for Anthem Blue Cross

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Medical (continued)

Utilization Review contact information.

Anthem Blue Cross Imaging Management Program

This program provides real-time clinical review of advanced diagnostic imaging (CT, MRI, Nuclear Cardiology and PET) performed in an outpatient setting.

It is your responsibility to see that your physician starts the pre-authorization process before scheduling you for any service subject to the utilization review process. If you receive any such service without going through the utilization review process, you will be subject to a $300 non-compliance penalty. The pre-authorization is performed by Carelon Medical Benefits Management through Anthem Blue Cross. Providers can call the Anthem UM number at 800.274.7767 or AIM directly at 877.291.0360.

A Provider Web portal (www.americanimaging.net) is also available for the ordering physician to submit pre-authorization requests and receive approvals on a real time basis.

Bariatric Surgery Criteria

- **Pre-Surgery Counseling:** Candidates for bariatric surgery are required to undergo an orientation program. In addition, successful completion of such sessions in advance of approving coverage for bariatric surgery is required.
- **Physician's Statement:** The patient's physician should present written documentation of at least a 12 month good faith effort to lose weight, prior to the surgery.
- Lowest copay if the Bariatric Surgery is performed at Eisenhower.

Spousal/RDP Surcharge

A surcharge will be added to your employee contribution if your spouse/registered domestic partner is eligible for and has the opportunity to be enrolled in group insurance from another company. If you elect to have them participate in the Eisenhower Anthem Blue Cross PPO Plan instead of the plan offered to them through their employer, there will be a $50 per pay period surcharge.

Declining Medical Coverage

You may decline coverage under the Eisenhower Anthem Blue Cross PPO Plan by selecting the Waive benefit choice online during enrollment. You must have other medical coverage to be able to decline coverage in the Eisenhower Anthem Blue Cross PPO Plan. You must submit proof of other coverage (ID Card) to waive. See page 17 for possible CompleteCare eligibility.

A full-time employee who declines coverage will receive a $35 credit in each paycheck where normal benefit deductions are taken in lieu of benefits.

A part-time employee may also decline coverage and must have other medical coverage. You must submit proof of other coverage (ID Card) to waive. However, you are not eligible to receive a credit in your paycheck for declining coverage.

Deductible Carry-Over

Covered medical expenses incurred in the last three months of a Calendar Year and applied toward that year's Deductible, can be carried forward and applied toward the Covered Person's Deductible for the next Calendar Year.

Keenan TPA Benefits Portal

Member Portal, TPABenefits.Keenan.com is Live!

Keenan TPA https://tpabenefits.keenan.com is excited to announce the launch of our new Member Portal for Eisenhower Medical Center. This portal replaces MESA. Access to MESA is no longer available.

Features Include:

- Review Eligibility, Benefits & Claims
- View and print Explanation of Benefits (EOBs) & ID Cards
- Access Provider Search Sites

Registration is quick and easy. Login to https://tpabenefits.keenan.com and click **"Register for a new account"**. For registration or login questions, call Keenan Customer Service at 888.773.7215.

We've Gone Paperless!

We are no longer mailing EOBs. Log into the portal to view and print your EOBs today.

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Prescription Drugs

Express Scripts – Eisenhower's Prescription Benefit Manager

Prescription Drug costs continue to rise, and as a result Eisenhower has a Two-Tier Prescription Drug Plan (Generic and Brand Formulary) through Express Scripts, our prescription benefit manager. Brand Name Drugs will need to be on the Preferred Brand Formulary in order to be eligible. If you wish to see the National Preferred Brand Formulary listing, please access the "Personal Choices" Website or www.express-scripts.com.

To find a participating pharmacy please log on to www.express-scripts.com or call the number on the back of your ID card.

	Express Scripts Network Retail Pharmacies		
	Supply Limit: 1-31 Days	**Supply Limit: 32-62 Days***	**Supply Limit: 63-100 Days***
Retail**			
• Generic	$20 copay	$40 copay	$60 copay
• Brand Formulary	$40 copay	$80 copay	$120 copay
• Brand Member Requested *(when Generic Available)*	Brand copay plus cost difference between Brand Name and Generic Name Drug		
• Brand Substitution not Allowed by Prescriber	Brand copay plus cost difference between Brand Name and Generic Name Drug. **Note:** If member tried/failed the Generic Drug and Prior Authorization is obtained, the Brand copay will apply.		

* **Note:** Only maintenance medications are allowed for 32 and above day supply at retail.

** With a prescription from your doctor, the following adult vaccines will be covered at a retail pharmacy: Pneumonia (Pneumococcal) , Whooping Cough (Tdap), and Shingles (Shingrix and Zoster), COVID, Flu for dependents, meningitis, HPV to age 46.

	Express Scripts Mail Order Service	
	Supply Limit: Up to 31 Days	**Supply Limit: Up to 100 Days**
Mail Order		
• Generic	$15 copay	$30 copay
• Brand Formulary	$35 copay	$70 copay
• Brand Member Requested *(when Generic Available)*	Brand copay plus cost difference between Brand Name and Generic Name Drug.	
• Brand Substitution not Allowed by Prescriber	Brand copay plus cost difference between Brand Name and Generic Name Drug. **Note:** If member tried/failed the Generic Drug and Prior Authorization is obtained, the Brand copay will apply without penalty.	

Accredo for Specialty Injectable Medication

Express Scripts offers prescription services for specialty injectable and oral medications through the Accredo Specialty Pharmacy. Specialty injectable medications are typically high cost and used for more severe conditions such as Cancer, Aids, Hepatitis C, Multiple Sclerosis, Rheumatoid Arthritis and Hemophilia. Accredo offers a concierge service for Express Scripts patients including direct outreach to your doctor to collect your prescription, and phone access to nurses and pharmacists. Accredo can process your order as quickly as 48 hours and will make arrangements with you for delivery, and shipping is free of charge. Call Customer Service at 800.803.2523 for information about the Accredo pharmacy and how to get started.

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Prescription Drugs (continued)

Step Therapy

For some of the more common conditions there are many drug choices available. The Express Scripts Step Therapy Program encourages cost-effective choices through a letter-based Prior Authorization process. First-line drugs are automatically allowed and include generic or preferred brand name. Second-line products would include higher cost products, or non-preferred brand name medicine. If you attempt to purchase a second-line drug first, the purchase will be denied with a message to try a first-line alternative. Express Scripts will immediately send you a letter that outlines choices you can discuss with your doctor. (In order to start a second line drug first, your physician would need to establish a medical necessity for that product and secure Prior Authorization through Express Scripts.) If non-formulary brands are approved with a Prior Authorization, it is 100% copay to member.

Drug Quantity Limits

The Drug Quantity Management program manages prescription costs by ensuring that the quantity of units supplied for each copay are consistent with clinical dosing guidelines as recommended by the Food & Drug Administration (FDA). The program is designed to support safe, effective, and economic use of drugs while giving patients access to quality care. Express Scripts clinicians maintain a list of quantity limit drugs, which is based upon manufacturer-recommended guidelines and medical literature. Online edits help make sure optimal quantities of medication are dispensed per copay and per days' supply.

Prior Authorization

Prior Authorization is a program that helps you get the prescription drugs you need with safety, savings and — most importantly — your good health in mind. It helps you get the most from your healthcare dollars with prescription drugs that work well for you and that are covered by your pharmacy benefit. It also helps control the rising cost of prescription drugs for everyone in your plan. The program monitors certain prescription drugs to ensure that you are getting the appropriate drugs for your disease state. It works much like healthcare plans that approve certain medical procedures before they're done, to make sure you're getting tests you need: If you're prescribed a certain medication, that drug may need a "prior authorization." It makes sure you're getting a cost-effective drug that works for you. For instance, prior authorization ensures that covered drugs are used for treating medical problems rather than for other purposes.

Prior authorization will be required for certain medications. If you have questions on a particular drug, please contact Customer Service or visit www.express-scripts.com to perform a coverage check. Please have your doctor call Express Scripts at 800.753.2851 to go through clinical review of your medication, if it is subject to prior authorization. This review will take approximately nine (9) minutes via phone. Your doctor may also log on to Esrx.com/PA to complete this review online. The online review takes about three (3) minutes.

Advanced Utilization Management

Advanced Utilization Management (UM) programs use a stepwise approach to manage patient drug utilization and your drug spend. They guide patients to safer, more cost-effective drug choices using clinically based criteria, designed to ensure that each choice reflects the right patient, right drug and right amount. Together, the Advanced Utilization Management programs, Prior Authorization, Step Therapy and Drug Quantity Management, constitute the primary means for curtailing drug spend.

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Prescription Drugs (continued)

Keenan Pharmacy Care Management (KPCM) Program

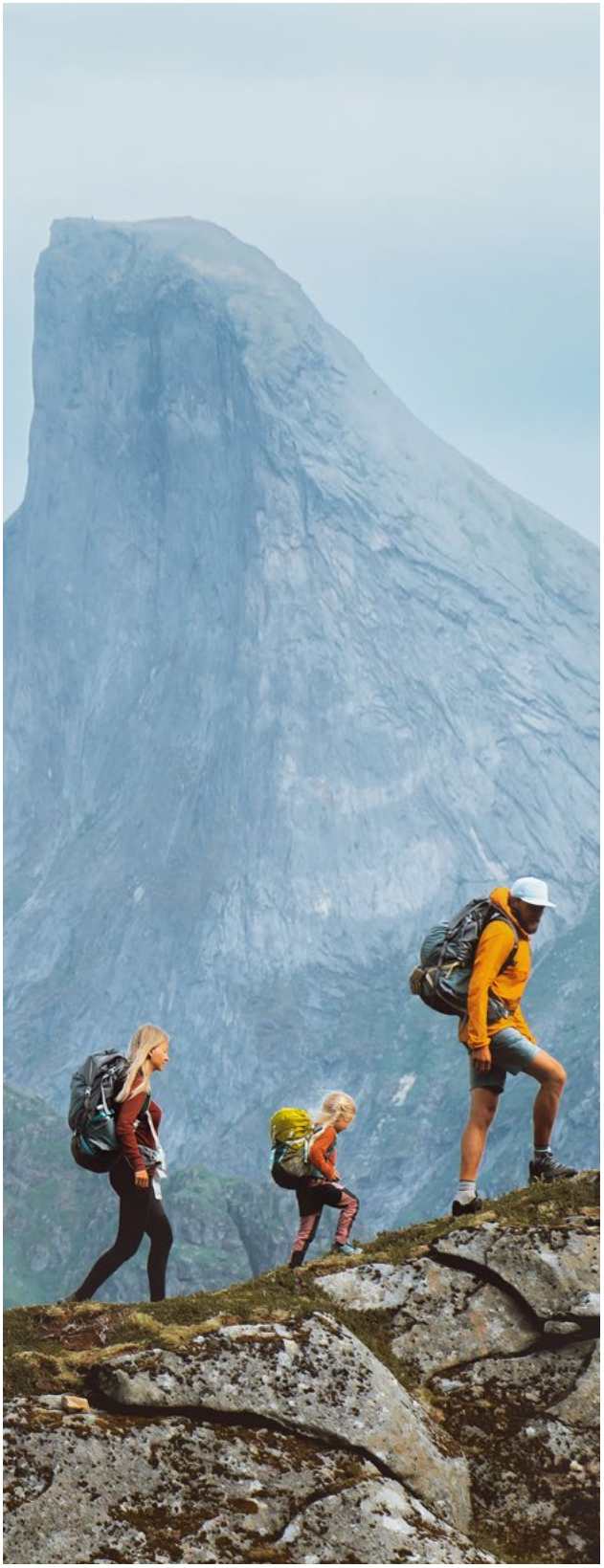
This program will help reduce your out of pocket prescription spend. KPCM is an innovative program which analyzes all of your prescription drugs and communicates with your doctor on quality of care and cost-saving opportunities. This program is an enhancement to your existing pharmacy benefit plan. There are no copayment or formulary changes. At times, KPCM may call you to discuss pharmacy care options. These calls and your prompt reply will provide opportunities for you to save money. You may also choose to proactively call KPCM and complete a medication review which will begin the process of contacting your doctor to identify potential cost-savings. For questions regarding this program or to complete a proactive medication review, you may contact KPCM at 800.241.8440.

KPCM Specialty

The focus of this program is to present you with the right drug for the right price while keeping drug interactions and safety top priority. The prior authorization process for specialty drugs involves periodic communications with your doctor to ensure the correct drug at the right dose is provided to you. You may at times receive phone calls from KPCM to share when safety improvements and/or cost saving opportunities have been identified and selected by your doctor.

Select Home Delivery – Active Choice

Allows members two 30-day courtesy fills at retail before a member must make an active choice to fill maintenance medications at retail or home delivery. After the second fill at retail, if the member does not inform Express Scripts of their choice, the member will start paying 100% of the cost of the drug at retail until they do. If the decision is to stay at retail, there is no penalty. Active Choice empowers members so they feel in control of how they receive their prescription benefit.



Employee Assistance Program

Employee Assistance Program

CLICK HERE to watch a video on Employee Assistance Programs

The Employee Assistance Program (EAP) is a service designed to help you manage life's challenges. The services, paid by your employer, are available to eligible members and their dependents. You have access to confidential clinical counseling (in-person, telephonic or web-based available) to deal with a wide range of emotional health, family and work issues. Your EAP also features services to help you balance work and life and take care of all kinds of chores and challenges.

Easy Access to Support

Hartford Ability Assist Counseling Services through ComPsych can be accessed through a dedicated toll-free number 24 hours a day, seven days a week. ComPsych staff provides immediate crisis resolution, information, and referrals to appropriate counseling and support services. Master's-level staff clinicians with crisis intervention experience, including multilingual resources, are available to handle emergency or urgent care cases.

Benefits of an EAP

- Unlimited 24/7 telephonic access to master's-level clinicians for intake, assessment and referral.
- Referrals to local resources and services such as community and governmental agencies.
- Confidential face-to-face sessions.
- Financial and legal support by phone with experienced financial professionals and lawyers during regular business hours or by appointment.
- Access to self-assessment tools and other resources through GuidanceResources Online.

Call your ComPsych representative at 800.964.3577 or visit guidanceresources.com to access hundreds of personal health topics and resources for child care, elder care, attorneys or financial planners.

If you're a first-time user, click on the **Register** tab.

1. In the Organization Web ID field, enter: **HLF902**
2. In the Company Name field at the bottom of personalization page enter: **ABILI**
3. After selecting **"Ability Assist program"**, create your own confidential user name and password.

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CompleteCare

What is a CompleteCare?

The Medical Expense Reimbursement Plan, CompleteCare, reimburses you (the employee), your spouse/registered domestic partner and your dependents for eligible health care expenses and premium expenses incurred under alternate group health coverage.

Who is Eligible?

This plan is voluntary and available to all benefit eligible employees and their eligible dependent spouse/registered domestic partner or child(ren) who are currently enrolled in the Eisenhower Health medical plan for 2024-2025, as well as new hires.

CompleteCare Benefits

- Co-pays, deductibles and co-insurance reimbursed by CompleteCare up to $9,200/single and $18,400/family per year.
- No premium contribution deducted from your paycheck.

How Does the CompleteCare work?

- Waive coverage for yourself and eligible dependent spouse/registered domestic partner or child(ren) under the Eisenhower Health medical plan.
- Enroll yourself and/or dependent spouse/registered domestic partner or child(ren) into a qualified alternate plan, typically your spouse's plan.
- Enroll in the CompleteCare plan by contacting Catilize Health. You will need to complete an enrollment form as well as an attestation form.
- You will receive a CompleteCare ID card. The CompleteCare ID card should be presented at the time of service after the ID card for your alternate plan. The CompleteCare ID card will give the provider information for filing claims for co-pays, co-insurance and deductibles.

IRS Rules

- You may be enrolled in an HRA or FSA. You CANNOT be reimbursed from both the CompleteCare and your HRA or FSA plans.
- **You are NOT eligible for the CompleteCare if your alternate coverage is:**
  - A high deductible health plan (HDHP) with active contributions to a Health Savings Account (HSA);
  - Medicare, Medicaid, Tricare (Retiree only) or an Individual Policy.

The Completecare Plan is administered by Catilize Health, who has a dedicated staff to personally handle your claims. Any paper claims can be submitted by FAX, Email or by U.S. Mail. Claim forms are available from Catilize Health. if you have questions regarding Claims or Benefits, please call Catilize Health at 877.872.4232, FAX 877.599.3724 or Email: MERP@catilizehealth.com.

If You Have Any Questions, please Call Catilize Health at 877.872.4232, or Email: MERP@catilizehealth.com.

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Dental

The Delta Dental Preferred Option (PPO) is designed to allow you the choice of receiving your dental care from any licensed dentist you wish. However, you receive the maximum benefits available under the plan when you choose a Delta Dental PPO dentist. In addition, when you see any Delta Dental dentist, no claim forms are required. When you go out-of-network, you pay higher coinsurance.

Plan Benefits	Delta Dental Preferred Option	
	PPO Dentist*	Non-PPO Dentist**
	Member Responsibility	
Annual Deductible/Person *(calendar year)*	$50; (waived for diagnostic, preventive services and accidents)	$50; (waived for diagnostic, preventive services and accidents)
Annual Maximum Benefit *(excluding orthodontia)*	$1,500/person/cal year	$1,500/person/cal year
Diagnostic and Preventive Services		
• Oral Exams, Cleanings, X-Rays, Biopsy/Tissue Exams, Fluoride Treatment, Space Maintainers, Specialist Consultation	No charge	20%
Basic Services		
• Oral Surgery *(extractions), Fillings, Root Canals, Periodontic (gum)* Treatment, Sealants	20%	20%
Major and Prosthodontic Services		
• Implants, Crowns, Jackets, Cast Restorations, Bridges, Full and Partial Dentures	50%	50%
Orthodontia Services		
• Adults and Eligible Dependent Children	50%	50%
• Maximum Lifetime Orthodontic Benefits	$1,500	
TMJ or MPD	50%; up to $500 lifetime maximum	
Dental Accident	100%; up to $1,000 annual maximum	

* Based on PPO-negotiated fees. Your obligation for covered charges is limited to the deductible and coinsurance percentage amount.

** Based on Delta-approved fees. Your obligation for covered charges includes the deductible and coinsurance percentage up to the Delta-approved fee. In addition, all charges in excess of the Delta-approved fee are your responsibility.

To locate a dentist, log on to Delta Dental's website at www.deltadentalins.com.

Declining Dental Coverage

Dental coverage is optional. A full-time employee who declines coverage will receive a $5 credit for 24 pay periods. A part-time employee may also decline coverage; however, is not eligible to receive any credit for declining coverage.

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Vision

Vision Service Plan (VSP) is one of America's oldest and largest eye care organizations and offers a large national network of eye care professionals. With VSP, you have the choice to see network providers and take advantage of higher benefit coverage or see the provider of your choice and still receive plan benefits.

Plan Benefits	Vision Service Plan (Choice Plan)	
	In-Network	Out-of-Network
Frequency		
• Eye Exam	Once every 12 months	
• Lenses/Contacts	Once every 12 months	
• Frames	Once every 24 months	
• Contact Lenses	Once every 12 months instead of eyeglasses	
	MEMBER RESPONSIBILITY	**PLAN PAYS**
Exam and Eyeglasses	$20 copay	
Comprehensive Exam	Covered in full after copay	Up to $50
Essential Medical Eye Care *(Additional exams and services beyond routine care to treat $20 per exam immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. Coordination with your medical coverage may apply. Ask your VSP doctor for details.)*	$20 copay per exam Available as needed	
Lenses *(additional charges may apply for selected lens options)*		
• Single	Covered in full after copay	Up to $50
• Bifocal	Covered in full after copay	Up to $75
• Trifocal	Covered in full after copay	Up to $100
• Lenticular	Covered in full after copay	Up to $125
• Impact Resistant	Covered in full (for dependent children only)	
• Standard Progressive	Covered in full	Up to $75
LightCare *($170 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts)*	Combined with exam Every 24 months	
Frames	Covered in full after copay, up to $170	Up to $70
Contact Lenses		
• Medically Necessary *(copay is combined with exam)*	$20 copay in lieu of lens/frames	Up to $210
• Elective	Plan pays up to $170	Up to $105
Contact Lens Exam *(fitting & evaluation)*	Up to $60 Copay	Up to $105

Please note: Claims for eye surgery and any pre- or post-operative services should be directed through the medical plan.

When you use a VSP provider, you are eligible for these added benefits:

- 20% discount on extra pairs of prescription eyeglass lenses and frames from any VSP provider within 12 months of your last WellVision Exam.
- 20% discount on optional items such as oversized lenses, coated lenses, etc.
- 15% discount on contact lens exam.
- Discount on laser vision correction surgery (LASIK and PRK).

For a list of VSP eye care professionals near you, call VSP at 800.877.7195 or visit their Website at www.vsp.com.

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Life and AD&D

Basic Life Insurance

As a benefit eligible Eisenhower employee, you automatically receive Basic Life Insurance paid for by Eisenhower. In addition, Eisenhower also pays for life insurance for your spouse/registered domestic partner and dependents if they are covered by the Eisenhower medical plan.

Plan Benefits	Hartford*
Eligible Class	Full-Time Employees/Part-Time Employees
Coverage Amount	
• Employee	1x base annual earnings to a maximum of $50,000
• Spouse/Registered Domestic Partner / Each Eligible Dependent Child	$1,000
Age Reduction	
• At age 70	Reduction to 65%
• At age 75	Reduction to 45%
• At age 80	Reduction to 30%

* Benefit coverage amount will reduce after age 70.

Supplemental Life Insurance

To supplement your Basic Life coverage, you may elect to purchase additional term life insurance coverage for you and your dependents. Your supplemental coverage choices are shown in the Life Insurance chart below. See the bottom of the chart for the Evidence of Insurability (EOI) statement of health requirements.

Plan Benefits	Hartford*
Eligible Class	Full-Time Employees/Part-Time Employees
Coverage Amount	
• Employee	1, 2, 3, 4, 5 or 6 times annual salary, up to $1,200,000
• Spouse/Registered Domestic Partner **	Increments of $5,000 up to the lesser of 50% of the combined basic life and supplemental employee life (Statement of Health may be required) or $150,000.
• Eligible Dependent Child**	$5,000/child
Age Reduction	Not subject to reduction

* EOI Statement of Health is required if you are a new hire requesting more than 3x or $700,000 of coverage, if your spouse/registered domestic partner is requesting more than $20,000 of coverage, or if you or your dependents apply for coverage within 90 days of being hospitalized. A Statement of Health is required in all cases if enrollment or increases in this plan are requested after the initial newly benefit eligible employee enrollment period ends.

** Employee Supplemental Life must be elected to elect Spouse/RDP and/or Child(ren) Supplemental Life.

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Life and AD&D (continued)

Basic Accidental Death & Dismemberment (AD&D) Insurance

As a benefit eligible Eisenhower employee, you automatically receive Basic AD&D Insurance paid for by Eisenhower. If you die as the result of an accident, your beneficiaries receive AD&D benefits in addition to your life insurance benefits. If you are seriously injured as a result of an accident, you will receive all or a part of the death benefit, depending on the nature of your injury.

Plan Benefits	Hartford*
Eligible Class	Full-Time Employees/Part-Time Employees
Coverage Amount	
• Employee	1x base annual earnings to a maximum of $50,000 plus $3,000**
Age Reduction	
• At age 70	Reduction to 65%
• At age 75	Reduction to 45%
• At age 80	Reduction to 30%

* Benefit coverage amount will reduce after age 70.

** Eligible employees who complete the online enrollment will automatically be covered for $3,000 of Employee Only Basic AD&D coverage.

Supplemental Accidental Death and Dismemberment (AD&D) Insurance

You may purchase additional Supplemental AD&D Insurance on yourself in whole dollar amounts from $25,000 to $500,000 in $25,000 increments. To supplement your Basic AD&D insurance, you may also cover your dependents. Their insurance is a percentage of your AD&D Insurance amount. The Supplemental AD&D Insurance Highlights chart shows your coverage options. The amount of the AD&D benefit paid is based on the loss as shown in the following chart. The full benefit represents the amount of coverage you have purchased.

Plan Benefits	Hartford
Eligible Class	Full-Time Employees / Part-Time Employees
Coverage Amount	
• Employee	From $25,000 to $500,000 (Amounts over $300,000 cannot exceed 10x your base annual earnings)
• Spouse/Registered Domestic Partner Only	60% of employee's AD&D amount
• Spouse/Registered Domestic Partner and Children	50% of employee's AD&D amount for Spouse/Registered Domestic Partner; 15% of employee's AD&D amount for each child
• Children Only	25% of employee's AD&D amount

Loss Description	AD&D Schedule of Benefits Employee Benefit Amount
Life	Full benefit
Both hands; or Both feet; or Sight in both eyes; or Speech and hearing in both ears; or Either hand or foot and sight in one eye	Full benefit
Quadriplegia	Full benefit
Paraplegia	3/4 of full benefit
Hemiplegia; or Speech; or Either hand or foot; or Sight in one eye; or Hearing in both ears	1/2 of full benefit
Hearing in one ear; or Loss of thumb and index finger of same hand	1/4 of full benefit

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Voluntary Long Term Disability

Long Term Disability (LTD) Insurance is designed to provide you with a monthly income in the event you suffer a long term disability and are unable to continue working.

If you apply for coverage more than 31 days after your initial eligibility date, you must provide evidence of insurability by answering medical questions on the application. The insurance company must approve your coverage before it will be in effect.

Plan Benefits	Hartford	
Eligible Class	Full-Time Employees/Part-Time Employees	
Monthly Benefit	50% of monthly earnings to a maximum benefit of $6,000 per month (if working an alternative schedule, basic monthly earnings will include overtime up to a maximum of 12 hours per day)	
Elimination Period	180 days	
Benefit Duration	**AGE AT DISABILITY**	**MAXIMUM PERIOD OF PAYMENT**
	Prior to Age 63 to Normal Retirement Age	42 Months
	Age 63	36 months
	Age 64	30 months
	Age 65	24 months
	Age 66	21 months
	Age 67	18 months
	Age 68	15 months
	Age 69 and over	12 months

LTD coverage is integrated with other disability benefits such as Workers' Comp, Social Security, etc. If your disability makes you eligible to receive income from any of these programs, then the LTD plan will pay the difference between the amount you receive from other programs and the benefit level under which you are covered. Your monthly LTD benefit payments continue for as long as you are no longer disabled or reach the maximum period of payment (whichever occurs first). Please refer to the chart above for your maximum period of payment.

Because you pay for Voluntary LTD on an after-tax basis, any Voluntary LTD payments you receive are not taxable as income.

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Flexible Spending Accounts

CLICK HERE to watch a video on Flexible Spending Accounts (FSA)

Flexible Spending Accounts

A Flexible Spending Account allows you to save your money for certain health care and dependent care expenses by letting you pay with pre-tax dollars. You don't pay taxes on this money. This means you'll save an amount equal to the taxes you would have paid on the money you set aside. There are two separate accounts, one for health care expenses, and one for dependent (child) care expenses.

You may enroll in the Health Care Reimbursement Account, the Dependent Care Reimbursement Account, or both. When you enroll, you decide how much money to contribute to your accounts for the coming plan year, July 1 to June 30. These contributions are deducted from each of your 26 paychecks a year and deposited to your accounts. You may contribute up to:

- **The Health Care Reimbursement Account:** $3,300 per year (or $126.92 per paycheck)
- **The Dependent Care Reimbursement Account:** $5,000 per year (or $192.31 per paycheck);
- **Minimum election amounts for each FSA:** $250 per year (or $9.62 per paycheck).

Important IRS Rules

It is important to carefully choose how much money to place in your accounts due to the tax advantages both reimbursement accounts provide. The IRS has established the following strict guidelines for how they may be used.

- If you contribute pre-tax dollars to a reimbursement account and then do not use all of the dollars you deposit, you will lose any remaining balance in the account at the end of the plan year. This is called "use it or lose it"
- After you enroll, you cannot change the amount in your accounts unless you have a qualified change in status (see page 6).
- You cannot transfer funds from one reimbursement account to the other.

Please note: For FSA tracking and claims submissions, visit https://keenan.wealthcareportal.com/Page/Home

- If you use a Dependent Care Reimbursement Account, the IRS will not allow you to take a dependent care credit on your tax return for reimbursed expenses. For some people, the tax credit may be greater than the savings from a Dependent Care Reimbursement Account. If you are in doubt about which is best for you, consult a professional tax advisor.

Use it or Lose it

If you contribute pre-tax dollars to a reimbursement account and then do not use all of the dollars you deposit, you will lose any remaining balance in the account at the end of the plan year. This is called "use it or lose it"

However, In May 2005, the IRS has modified the "use it or lose it" to allow employers to design cafeteria plans that enable participants to be reimbursed for claims incurred up to 2½ months after the close of the plan year. Eisenhower has adopted this extended grace period for the Health Care Flexible Spending Account. This extended grace period will not apply to the Dependent Care Flexible Spending Account.

So if you have money left over in your Health Care Reimbursement account at the end of the Plan Year, you will have an extra 2½ months to spend that money on eligible health care expenses. The grace period will run from July 1 to September 15 for incurred expenses. The deadline for filing claims is 9/15/25. If you have any questions regarding the extended grace period, please contact your FSA Administrator, Keenan TPA, at 888.773.7215

Health Care Reimbursement Account

The Health Care Reimbursement Account is designed specifically for medical, dental and vision care expenses you expect to incur during the plan year that are not covered or reimbursed by any health care plan. Health Care Reimbursement accounts are based on the Plan Year: July 1 through June 30.

Keep in mind that the Patient Protection and Affordable Care Act of 2010 changed the rules pertaining to the purchase of over-the-counter (OTC) products using Flexible Spending Account (FSA) pre-tax funds. OTC drugs and medicines will no longer be reimbursable unless you have a Note of Medical Necessity (NMN) from your doctor. Items

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Flexible Spending Accounts (continued)

that are included in OTC are Advil, ibuprofen, cough syrup, cold medications, etc. Participants can still use their FSA funds to purchase OTC items that are NOT considered a drug or a medicine, such as bandages, contact lens solution, etc.

Receiving Your Reimbursement

You may receive reimbursement from your Health Care Flexible Spending Accounts by:

- Obtaining a Healthcare Reimbursement form from Ikenet/Human Resources/Benefit Information.
- Completing the form and attaching copies of all receipts.
- Mailing/faxing to Keenan HealthCare at the address/fax number on the form.

To obtain reimbursement from your FSA, a claim form must be submitted to Keenan. Claims can be mailed, sent via e-mail or faxed along with itemized receipts from the service provider or an Explanation of Benefits (EOB) from your insurance company.

- Name of employee or dependent receiving care
- Dates of service (must be within the plan year)
- Name of service provider
- Services provided
- Charges incurred
- Amount paid by insurance company

FSA Benefit Cards

If have elected Health Care FSA coverage, Keenan will automatically issue you a FSA benefit card. Your entire Health Care FSA election amount will be available to you on the day that your coverage is effective. You can use it to pay for your eligible FSA healthcare expenses. You must retain your receipts/itemized statements when using your card. In most cases you may be required to send documentation to support the expense so that the FSA Benefit card transaction can be approved. Additional cards can be requested for your spouse or dependent children over the age of 18. There is no cost for these cards.

Dependent Care Reimbursement Account

The Dependent Care Reimbursement Account allows you to pay for eligible dependent child care expenses on a tax-free basis. To be eligible, expenses must be:

- For the care of a child under age 13, or for the care of a disabled dependent of any age (an invalid parent, for example), ***and***
- Necessary to enable you and your spouse/registered domestic partner to work or attend school on a full-time basis.

The care may be provided either in your home or at a licensed center outside of your home. If the care is provided in your home, then the service cannot be provided by a child of yours under age 19, by your spouse or by your dependents. If the care is provided outside of your home, the facility must be in compliance with all applicable state and local regulations. If dependent care is provided outside your home, your dependent must return to your home for at least eight hours each day.

Receiving Your Reimbursement

To obtain reimbursement from your Dependent Care Account (DCA), a claim form must be submitted to Keenan. Claims can be mailed, e-mailed or faxed along with itemized receipts.

- Name of dependent receiving care
- Dates of service
- Name of service provider
- Social Security or tax id number

Canceled checks, bankcard receipts, credit card receipts and credit card statements are NOT acceptable forms of documentation. You are responsible for paying your health care provider directly.

You will only be reimbursed for up to your account balance at the time you submit your claim. If your claim is for more than your account balance, the unreimbursed portion of your claim will be tracked by Keenan. You will be automatically reimbursed as additional deductions are taken and deposited into your account until your entire claim is paid out.

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Voluntary Benefits

Trustmark Universal Life Insurance with Long Term Care

Trustmark's Universal Life insurance can supplement existing life insurance coverage you may already have. Universal Life is permanent insurance with premiums that do not increase as you get older. Universal Life insurance not only offers benefits if you die, it also builds cash value you can use while you are alive. Another important feature is that you can continue the policy if you change jobs or retire.

Your Universal Life insurance policy is flexible:

- You can apply for coverage for yourself, your spouse, registered domestic partner, children and dependent grandchildren. You can cover your dependents only if you elect coverage for yourself. Dependent coverage amounts cannot exceed your amount of coverage.
- You can select the coverage amount that makes sense for you and you can adjust your coverage as your needs change. The coverage provides many other advantages such as:
  - Pays a living benefit of up to 75% upon diagnosis of a terminal illness.
  - A Long Term Care rider can as much as double the value of your life insurance by paying a monthly benefit equal to 4% of your death benefit for up to 25 months for home healthcare, assisted living, adult day care, hospice or nursing services.
  - Restoration of death benefit when LTC benefits are accessed.
  - To protect against inflation, this policy also gives you the option to purchase automatic increases in coverage amounts at certain policy anniversaries

Trustmark Universal LifeEvents® Insurance with Long Term Care

This is permanent life insurance designed to take care of needs throughout your lifetime, paying a higher death benefit during working years. Universal LifeEvents death benefit reduces to one-third at age 70 or the beginning of the 15th policy year, whichever occurs last; however the higher benefit amount can be utilized to help with the cost of long-term care services.

Benefits include coverage for:

- Benefits up to $300,000
- Long Term Care rider can as much as double the value of your life insurance by paying a monthly benefit equal to 4% of your death benefit for up to 25 months for home healthcare, assisted living, adult day care, hospice or nursing services.
- Restoration of death benefit when LTC benefits are accessed
- Waiver of Premium

Key Components:

- Guaranteed Benefit Increases with $1 increases in weekly premium
- Family coverage including grandchildren
- Guaranteed Renewable to age 100

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Voluntary Benefits (continued)

Trustmark Critical Illness Insurance

This coverage provides a substantial cash benefit upon the diagnosis of a covered condition. It helps pay for your expenses not covered by medical insurance. Benefits can be used however you choose, and can help you focus more on your recovery and less on your wallet.

Covered Conditions include:

- Invasive Cancer
- Stroke
- Major Organ Transplant
- Occupational HIV Infection
- Coronary Artery By-Pass Surgery (25% benefit)
- Heart Attack
- Renal failure - kidney
- Paralysis of at least two limbs
- Blindness
- ALS (Lou Gehrigs Disease)
- Carcinoma in situ (25% benefit)

Key Components:

- Benefits up to $100,000
- Subsequent Benefit provides one payout for each and every covered condition. Benefits for conditions with a partial payout are paid once for each condition.
- Health Screening Benefit - $100
- Family coverage
- No coordination with other insurance
- Benefit is paid to the employee

Trustmark Accident Insurance

This benefit helps pay for the unexpected expenses that result from accidents, above and beyond what health insurance pays. Benefits can be used how the employee chooses, from medical insurance deductibles to the cost of driving to a doctor appointment or child care expenses.

Benefits include coverage for:

- **Initial care benefits:** physician visit, ambulance, emergency room treatment, hospital benefits, lodging, surgery, emergency dental
- **Injury benefits:** burn, concussion, dislocation, eye injury, fracture, herniated disc, laceration, loss of finger, toe, hand, foot, or sight; tendon ligament, rotator cuff injury, torn knee cartilage

Please refer to schedule of benefits for benefit amounts.

Key Components:

- Accidental Death Benefit up to $50,000 for employee
- Benefits up to $100,000 for Catastrophic Accident for employee
- 24-hour coverage
- Amateur organized sports are covered (except if being paid)
- Family coverage
- No coordination with other insurance
- Benefit is paid to the employee
- Health Screening Benefit - $50

Each of these plans is being offered through after-tax payroll deductions. To learn more or enroll in any or all of these new benefits, you must meet with an on-site Trustmark enrollment counselor during open enrollment from April 15- April 28, 2025. To register for an appointment please visit: www.myenrollmentschedule.com/eisenhower.

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Voluntary Benefits (continued)

Trustmark Hospital StayPay® Insurance

Hospital stays can be **really expensive**, and health insurance might not cover everything. You may have copays, deductibles and other surprise expenses. Trustmark Hospital StayPay **helps you keep a hospital trip affordable**. It's designed to **pair with your medical plan** so you can be more confident in your protection. You can get **cash benefits** for hospital stays due to a covered sickness or accident, normal childbirth or mental wellness/addiction recovery. You also have flexibility to **adjust your benefit** amount as your needs change.

Schedule of Benefits	
First Day Stay Benefit	$1,000
Daily Hospital Stay Benefit	$100
Daily Hospital ICU Benefit	$200
Additional features	
• Childbirth Hospital Stay	Included
Wellness Checks	
• Routine Screening Test	$50
• Follow-up Test	$50
Claim Free Return	Included
Immediate Care	
• Emergency Room	$100
Rehabilitation Services	
• Inpatient Mental Wellness or Addiction Recovery	$100

More Flexible Hospital StayPay Features

- Benefits paid in cash with **no restrictions** on how you use them.
- **Apply for family members** as well as for yourself.
- **Guaranteed issue** with **no medical questions**, as long as you are actively at work.
- Once you have a policy, your rate is locked in and **will not increase due to age**.
- Fully **portable** - keep your coverage, at the same rate and benefits, if you change jobs or retire.
- Pay for coverage via **convenient payroll deduction**, as long as you stay with your employer.

Plan forms GUL.205/IUL.205, CACI-82001, A-607 and HII 119 and applicable riders are underwritten by Trustmark Insurance Company, Lake Forest, Illinois. Underwriting conditions may vary, and determine eligibility for the offer of insurance. Benefits may not be available in all states and may be named differently. Your policy will contain complete information. Trustmark®, LifeEvents® and Trustmark Hospital StayPay® are registered trademarks of Trustmark Insurance Company.

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Voluntary Benefits (continued)

Allstate Identity Protection

Allstate Identity Protection Pro + Cyber

Allstate Identity Protection delivers comprehensive financial and identity monitoring, plus powerful mobile cybersecurity to help you protect yourself. See and manage your personal data, safeguard your personal mobile devices, and help protect your identity. Plus, should the worst occur, rely on up to $1 million fraud expense reimbursement and up to $1 million cyber and ransomware expense reimbursement. Should you opt for a family plan, we'll extend our fraud expense reimbursement to up to $2 million.

Allstate Identity Protection includes these features, plus much more:

- Data breach notifications
- Comprehensive identity and credit monitoring
- Social media monitoring
- Coverage available for family, including parents, in-laws, and grandparents age 65+
- Full service, 24/7 remediation support
- 401(k) and HSA fraud reimbursement

For more information, contact Allstate ID Protection at www.myaip.com/eisenhowerhealth.

Wishbone Pet Insurance

Give your best friend their best life with Wishbone Pet Health Insurance! Wishbone offers high-value, easy-to-use pet health insurance at exclusive employee benefit rates. With Wishbone, you get:

- 90% reimbursement on accidents and illnesses
- A low $250 annual deductible
- Fast claims processing
- Visit any licensed veterinarian
- Easy-to-use member account
- And so much more!

Plus, choose one of two optional routine care add-ons to maximize your savings on pet care. All Wishbone policies include 24/7 pet telehealth and a durable pet ID tag with a lost pet recovery service.

Fetch a quote today!

For more information, contact Wishbone Pet Insurance at www.wishboneinsurance.com/eisenhowerhealth

LegalShield

Affordable Legal Coverage

Legal Plan Benefits:*

- Legal consultation and advice
- Dedicated law firm
- Legal document review (up to 15 pages each)
- Access to legal forms/contracts
- Letters and phone calls made on your behalf
- Traffic ticket assistance
- Will preparation
- 24/7 emergency legal access
- Mobile app
- And more!

Affordable legal protection – Only $18.95 monthly. For more information, contact your Independent Associate www.legalshield.com/info/EisenhowerHealth.

* This is a general overview of the legal plan coverage available from PPLSI for illustration purposes only. See a plan contract for specific state of residence for complete terms, coverage, amounts, conditions and limitations.

Wellness

Eisenhower cares about the health and well-being of its employees. Eating right, exercising, meditating and practicing other positive lifestyle behaviors that promote good physical, mental and emotional health are all positive steps you can take to create a more balanced, healthy way of life. Eisenhower is committed to maintaining a supportive environment and promoting a healthy culture where you and your co-workers can pursue these actions to optimize your personal health.

With this in mind, the Eisenhower Five Star Wellness Program offers its employees numerous components based on the five pillars for optimizing health: Exercise, Nutrition, Pulmonary Health, Stress Reduction, and Weight Management. The components include biometric screening, wellness and condition management coaching, nutrition and weight management, a Five Star Employee Wellness website, and other wellness resources.

Wellness Participation Incentives

Qualifying for the Wellness Participant Incentive for the 2025-26 Benefit Plan Year, and avoiding the $27.50 per Pay Period Non-Wellness Participant Surcharge

Benefit eligible employees who complete the following three steps will qualify for the "Wellness Participant" payroll contribution rate for the 2025-26 benefit plan year:

1. Have completed a prescribed personal wellness course of action (if required) during the 2024-25 benefits year by March 31, 2025, as indicated in the letter from Keenan HealthCare mailed to your home address in October 2024.
2. Complete a biometric screening during April - May 2025.
3. Acknowledge that you are "tobacco-free" by indicating your tobacco use status through the 2025-26 Online Open Enrollment, or complete a tobacco cessation program during the 2025-26 benefits year.

New Hires: *New employees will have 31 days after the date of hire to indicate they are tobacco-free via online enrollment, or they will be assessed the "Non-Wellness Participant" payroll contribution rate for the 2025-26 benefits year. New employees hired April 2025 and after, are not required to complete a biometric screening for the 2025-26 benefits year but will be required in 2026-27 to receive the "Wellness Participant" rate.*

Qualifying for the Wellness Participant Incentive for the (Next) 2026-27 Benefit Plan Year

If you want to qualify for the "Wellness Participant" employee contribution rate for the (next) 2026-27 benefit plan year, in addition to completing a biometric screening during April - May 2025, you must also complete a prescribed personal wellness course of action during the 2025-26 benefits year, based on an analysis of your 2025 biometric screening results and medical/pharmacy claims history. Each wellness participant will receive a "Personalized Wellness Plan" letter from Keenan, mailed to their home address during Fall 2025. The deadline for completing the prescribed course of action will be March 31, 2026.

Biometric Screening

Offered by eHealthScreenings, a HIPAA-compliant external vendor, the biometric screening will provide information about your health status and risk for chronic conditions. You will need to complete a Biometric Screening by May 31, 2025, as one of the 3 required steps to earn the 2025-26 Wellness Participant employee contribution rate, and avoid the $27.50 per pay period Non-Wellness Participant surcharge.

The screening will assess your body mass index (BMI), percent body fat, blood pressure, cholesterol, triglycerides, and blood glucose. For 2025, there will be three options for completing your biometric screening: 1) on site at an Eisenhower facility, 2) a lab visit at a LabCorp facility, scheduled through eHealthScreenings, or 3) by completing a physician form with results from your personal physician. You can access the biometric screening options by calling 888.708.8807, extension 1, or by logging into https://www.ehealthscreenings.com/signup, **and entering the screening key KEE13**.

Upon completion of the screening, eHealthScreenings will send an e-mail notification to you when your results are available to view online.

Your screening results will also be sent securely by eHealthScreenings to Eisenhower's health management program provider, TrestleTree, to help determine what action steps, if any, will be required for you to take during

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Wellness (continued)

the 2025-26 benefit plan year to qualify as a "Wellness Participant" in the 2026-27 benefit plan year (see additional information in the Wellness Participation Incentives section on "Qualifying for the Wellness Participant Incentive for the (Next) 2026-27 Benefit Plan Year").

Confidentiality of your personal screening data will be maintained in compliance with HIPAA and other applicable laws and regulations.

Living Tobacco-Free

To qualify for the "Wellness Participant" medical premium rate, all employees enrolled in Eisenhower's medical plan who are not tobacco users (including cigarettes, electronic smoking devices, cigars, pipes, or smokeless tobacco) must electronically acknowledge during Benefit Enrollment that they are not using those products.

Employees who are not tobacco-free have the alternative of qualifying as a "Wellness Participant" by completing a Tobacco Cessation Program or other alternative during the 2025-26 benefit plan year. TrestleTree, the Eisenhower health coaching vendor, offers tobacco cessation coaching at no cost to you. You can enroll by calling 855.246.4830 or by emailing allengagement@trestletree.com. Eisenhower also offers ongoing tobacco cessation classes to our employees, and the cost for the classes, if any, is reimbursed to employees if they successfully complete the program. (Please access the Five Star Wellness website on Ikenet for further information.)

Five Star Wellness Program Resources

Eisenhower offers its employees a variety of resources to help them reduce their health risks, maintain good health, and manage chronic conditions through its Five Star Wellness Program.

Wellness and Condition Management Coaching and Education

To support Eisenhower's Five Star Wellness Program, Eisenhower has contracted with an external provider, TrestleTree, to offer a wide array of wellness and condition management services that are available to Eisenhower employees, including personal wellness and condition management coaching, nutrition counseling, weight management, stress reduction, tobacco cessation, health education classes, wellness challenges, and other health services. Wellness coaching participants can get assistance with nutrition, exercise, stress, obesity and weight management, tobacco cessation, and sleep.

Condition management coaching participants can get assistance in managing various chronic conditions, such as diabetes, hypertension, dyslipidemia, asthma, COPD, CAD and CHF.

For more information about the wellness and condition management services through TrestleTree, contact TrestleTree at 855.246.4830 or allengagement@trestletree.com.

For Spouses and Domestic Partners: The condition management coaching program has been extended to employees' spouses and domestic partners enrolled in Eisenhower's medical plan. Those individuals who are at high risk for chronic conditions, based on medical/pharmacy claims analysis, will receive a letter to their home address to encourage them to contact the condition management coach offered through TrestleTree, to see if they qualify for the program. Benefited spouses/domestic partners who qualify for the program will receive a one-time $50 reward card for initial enrollment in the condition management coaching, and a $250 reward card for completing their personalized plan during the 2025-26 benefits year. Those experiencing chronic conditions who do not receive a notification letter may also potentially qualify for participation in the program through self-enrollment. For more information about the condition management coaching program for spouses and domestic partners, contact TrestleTree at 855.246.4830 or allengagement@trestletree.com.

Confidentiality of the Wellness and Condition Management Coaching participants' personal health information and their participation in the program will be maintained in compliance with HIPAA and other applicable laws and regulations.

Diabetes Prevention Coaching

Diabetes prevention coaching is available through TrestleTree, Eisenhower's health coaching provider, to support you if you are at risk for prediabetes, and take steps to address it. The CDC-recognized program focuses on nutrition, exercise, and weight management. There will be two group sessions available during 2025-26, and individuals participating in the program will also work individually with a TrestleTree health coach. You

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Wellness (continued)

can participate in this program at no extra cost. Upon enrollment, you will be sent an iHealth scale for you and your coach to track your progress. The program is flexible, convenient, and follows guidelines from the Centers for Disease Control and Prevention (CDC) to help you make small changes that can improve your health and decrease your risk over time. For more information, and to see if you qualify, contact TrestleTree at 855.246.4830 or allengagement@trestletree.com.

Wellness Challenges

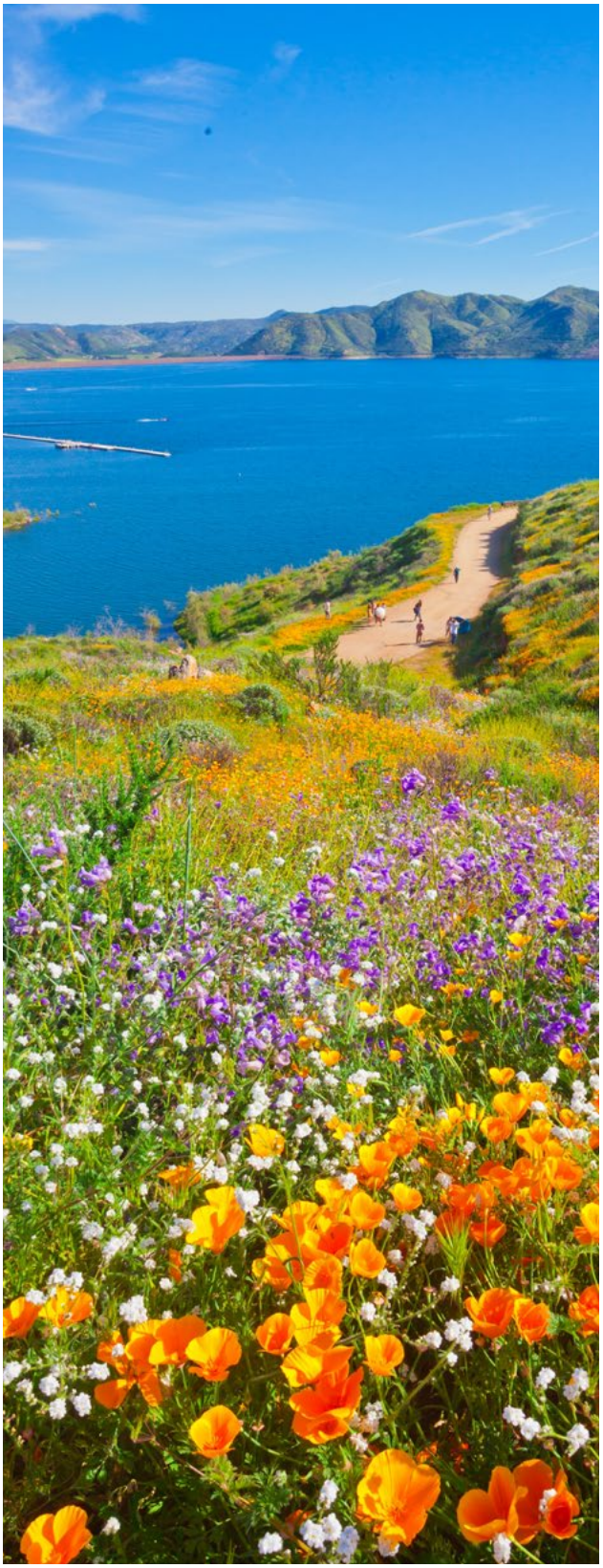
Online wellness challenges are offered quarterly to all Eisenhower employees and their spouses, domestic partner, and families. Wellness challenges focus on various wellness topics, such as nutrition, physical activity, stress management, and other health-improvement activities. Device integration is available through Fitbit, Apple Health, and many other devices, and teams are encouraged to assist as you move through the challenge. More information on online challenges will be available throughout the year.

Calm Meditation Mobile App

Calm is a mindfulness and meditation mobile app with 24/7 access to tools and resources to become a mentally stronger you. It can help you improve your well-being by promoting better sleep, reducing stress and anxiety, and developing more mindfulness. Eisenhower employees can get access to the premium version of the mobile app. To access the subscription, go to IkeNet > Human Resources > Calm. It will support you in living a more mindful, happy, fulfilled life.

Five Star Wellness Website

Eisenhower has created a Five Star Wellness website that provides an array of online health and wellness resources, including information on health-related topics focusing on the wellness program's five pillars of Exercise, Nutrition, Pulmonary Health, Stress Reduction, and Weight Management. The website, which can be accessed through the Eisenhower intranet, also includes the Five Star Employee Wellness Resource Guide for on-site wellness services at various Eisenhower locations, and links to other wellness resources such as Hartford Ability Assist, Eisenhower's employee assistance program.



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Other Valuable Benefits

Eisenhower Primary Care 365

Eisenhower is offering employees and their family members the opportunity to join the Eisenhower Primary Care 365 Program at a discounted rate.

What is Eisenhower Primary Care 365?

Eisenhower Primary Care 365 is a medical practice dedicated to your personalized care with a focus on preventive care. Eisenhower 365 physicians see fewer patients than traditional primary care physicians in order to increase time spent with you in face-to-face appointments, coordinate your care with other physicians and focus on developing a personal relationship with you.

With online communication direct to your physician, longer office visits and your choice of available physicians, Eisenhower Primary Care 365 is relationship-based health care. You can focus year-round on prevention and wellness, which is truly health care as it should be.

Eisenhower employees and their family members are being offered a discounted rate for participation in this program. If you are looking for a primary care physician for you and your family, this may be the right option for you. Detailed information about Eisenhower Primary Care 365, including answers to frequently asked questions, is available at www.eisenhowerhealth.org/365.

Eisenhower employees receive 50 percent off the member rate, making Eisenhower Primary Care 365 a tremendous benefit for you and your family.

Joining the Program

If you choose to join the Eisenhower Primary Care 365 program, to get the Eisenhower employee discount, you may sign online through Ikenet. If you prefer to ask more questions first or join by phone, please call 760.360.3365.

Member Age	Rate* for Individual Members	Rate*/Member if More than One Paying Member in Immediate Family**	Children Ages 0 to 18 with One or More Parents as Members
Under 55 Years	$250/year	$230/year	$50
56 Years and Better	$350/year	$330/year	$50

* An administrative fee applies to quarterly or monthly payment plans.

** Immediate family is defined as a single parent and dependent children through age 25 or spouses/registered domestic partners including dependent children through age 25.

Dependent children ages 19-25 are eligible at a discounted rate when one or more parents are members.

Eisenhower 403(b) Retirement Plan

After you have received your first paycheck from Eisenhower Health, all employees are eligible to participate in the 403(b) plan for voluntary payroll deductions. Limits for Employer Contributions for 2025 are $23,500 for employees under age 50, and $31,000 for employees who will be age 50 or above in 2025.

Employees who elect to participate will be eligible to have Employer Matching contributions up to 5% of your annual eligible compensation. Employer contributions will have a vesting schedule of 20% per year for five years, for 100% vesting.

Your 403(b) plan is open year round for enrollment and changes. For participants ages 60 to 63, this amount will increase to $34,750. **Note:** Once participants turns 64, they revert to the standard age 50 and above catch up contribution limit. Starting in 2026, all catch-up contribution for participants earning over $145,00 in the prior calendar year must be made on a Roth (after-tax)basis. The plan offers both traditional pre-tax employee contributions; or the employee may elect to make post-tax Roth contributions. The Employer Match will always be pre-tax. Loans are available on the employee's pre-tax and Roth contributions.

Your 403(b) Retirement Plan accepts rollovers from your prior employer retirement plans (i.e., 403[b], 401[k] and 457, as well as individual IRA accounts).

The Eisenhower 403(b) Retirement Plan is administered by Lincoln Financial Advisors and your Plan Representatives are available on site Mondays, 11:00 AM – 1:30 PM, in Café 34, or by calling San Diego Office 619.543.9995. Enrollment can also be completed online at www.lincolnfinancial.com; follow the online registration instructions. Prospectus and fund choices are also available online.

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PTO Cash Out Option

On an annual basis during Open Enrollment, employees may cash out a portion of their accrued Paid Time Off (PTO), which is paid on the paycheck of May 30th, 2025. A maximum of 80 hours may be cashed out, and a minimum of 80 hours must remain in the employees' PTO bank. If employees elect to cash out PTO hours, PTO accruals will be suspended for one pay period following the cash out due to IRS regulations.

Additional Benefits

- Leave of Absence, Bereavement Leave and Jury Duty
- Time Off Benefits - Paid Time Off (PTO) and Extended Leave Bank (ELB)
- Educational Assistance Programs (Full-Time and Part-Time Employees)
- Direct deposit of payroll checks
- Credit Union Membership offering payroll deductions for savings and loan payments
- Renker Wellness Center
- Discounts at local restaurants, hotels, car rentals, health clubs and entertainment and recreational facilities
- Discounts in Café 34 and Café Eisenhower
- 10% discount at Eisenhower Gift Shop (excludes candy and food items)
- 10% discount at Collector's Corner
- Skechers/Safety Shoes - 30% discount on most Skechers shoes for you and family
- See "Employee Deals + Discounts" under the "Featured" tab on Ikenet

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Rates

Employee Contributions per Pay Period - Effective July 1, 2025

Eisenhower pays for the majority of your benefits. However, contributions are required from you for the options you choose. The following tables show what you pay for benefits each pay period. Deductions are taken in 24 pay periods per year.

The following tables show what you pay for benefits in 2025-2026.

	Full-Time Employees	Part-Time Employees
Medical: Eisenhower Anthem Blue Cross PPO Plan *(Wellness Participant)*		
• Employee Only	$29.59	$49.87
• Employee + Child(ren)	$98.51	$156.85
• Employee + Spouse/Registered Domestic Partner (RDP)	$137.58	$218.98
• Employee + Spouse/RDP *(with Surcharge*)*	$187.58	$268.98
• Employee + Family: Spouse/RDP and Dependents	$187.06	$248.33
• Employee + Family: Spouse/RDP and Dependents *(with Surcharge*)*	$237.06	$298.33
Medical: Eisenhower Anthem Blue Cross PPO Plan *(Non-Wellness Participant)*		
• Employee Only	$57.09	$77.37
• Employee + Child(ren)	$126.01	$184.35
• Employee + Spouse/Registered Domestic Partner (RDP)	$165.08	$246.48
• Employee + Spouse/RDP *(with Surcharge*)*	$215.08	$296.48
• Employee + Family: Spouse/RDP and Dependents	$214.56	$275.83
• Employee + Family: Spouse/RDP and Dependents *(with Surcharge*)*	$264.56	$325.83
Dental: Delta Dental Preferred Option (DPO)		
• Employee Only	$10.53	$16.57
• Employee + Child(ren)	$17.93	$24.12
• Employee + Spouse/RDP	$21.64	$29.06
• Employee + Family: Spouse/RDP and Dependents	$30.92	$37.08
Vision		
• Employee Only	$4.21	$4.34
• Employee + Child(ren)	$6.61	$7.08
• Employee + Spouse/RDP	$6.61	$6.93
• Employee + Family: Spouse/RDP and Dependents	$10.82	$11.43

* If you elect to have your spouse/registered domestic partner participate in the Eisenhower Anthem Blue Cross PPO Plan instead of the plan offered to them through their employer, there will be a $50 per pay period Surcharge cost. Employees with domestic partner coverage will also be subject to the imputed income tax for their coverage.

Domestic Partners and Imputed Income: Due to current federal tax law, Eisenhower Health will need to report the fair market value of the benefit offered to your registered domestic partner and your registered domestic partner's child as income on your W-2 form and you may have to report that value as income on your tax returns if your registered domestic partner does not meet the definition of dependent cited in the Internal Revenue Code. Please consult a tax professional if you have a question regarding the tax status of your registered domestic partner or your registered domestic partner's child.

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Rates (continued)

Supplemental AD&D Insurance

Coverage Amount*	Employee Only	Employee and Child(ren)	Employee and Spouse/Registered Domestic Partner or Family
$25,000	$0.18	$0.30	$0.30
$50,000	$0.35	$0.60	$0.60
$100,000	$0.70	$1.20	$1.20
$150,000	$1.05	$1.80	$1.80
$200,000	$1.40	$2.40	$2.40
$250,000	$1.75	$3.00	$3.00
$300,000	$2.10	$3.60	$3.60
$350,000	$2.45	$4.20	$4.20
$400,000	$2.80	$4.80	$4.80
$450,000	$3.15	$5.40	$5.40
$500,000	$3.50	$6.00	$6.00

* Maximum coverage available is $500,000 (amounts over $300,000 cannot exceed 10x your annual base earnings)

Supplemental Life Insurance

Age of Employee/ Spouse/Registered Domestic Partner*	Per Pay Period Cost Per $1,000 Coverage
Less than 30	$0.0165
30 - 34	$0.0235
35 - 39	$0.0265
40 - 44	$0.0395
45 - 49	$0.0630
50 - 54	$0.0990
55 - 59	$0.1815
60 - 64	$0.2475
65 - 69	$0.4090
70+	$0.8485
All Children	Per Pay Period Cost for $5,000 Coverage $0.165

* You must purchase Supplemental Employee Life Insurance for yourself in order to elect coverage for your dependents.

Example

To calculate your cost, assume you are 35 years old, earn $32,600 a year and choose Supplemental Life Insurance equal to two (2) times your base annual salary:

Calculate Coverage Amount

$32,600 x 2 = $65,200 (rounded to $66,000)

Calculate Your Cost Per Pay Period

Divide this result by $1,000 = $66,000/$1,000 = 66

You're 35 years old, your rate is = $0.0265

Multiply 66 x $0.0265 = $1.75 per pay period (24 pay periods per year)

Note: The above calculation can be used for employee or spouse.

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Rates (continued)

Voluntary Long Term (LTD) Disability Insurance

Age of Employee	Per Pay Period Cost Per $100 of Basic Monthly Earnings
Less than 25	$0.0870
25 - 29	$0.0940
30 - 34	$0.1050
35 - 39	$0.1230
40 - 44	$0.1520
45 - 49	$0.1995
50 - 54	$0.2570
55 - 59	$0.3080
60 - 64	$0.3005
65+	$0.3040

How you can calculate your monthly Long Term Disability benefit amount and the cost per pay period for LTD coverage:

Example

Assume you are 35 years old, earn $4,000 a month and choose Voluntary Long Term Disability Insurance Coverage

Calculate Coverage Amount(Your monthly benefit will be 50% of your base monthly salary)

Monthly salary of $4,000 x 0.50 = $2,000 per month benefit

Calculate Your Cost Per Pay Period

Your monthly salary of $4,000 divided by $100 = 40

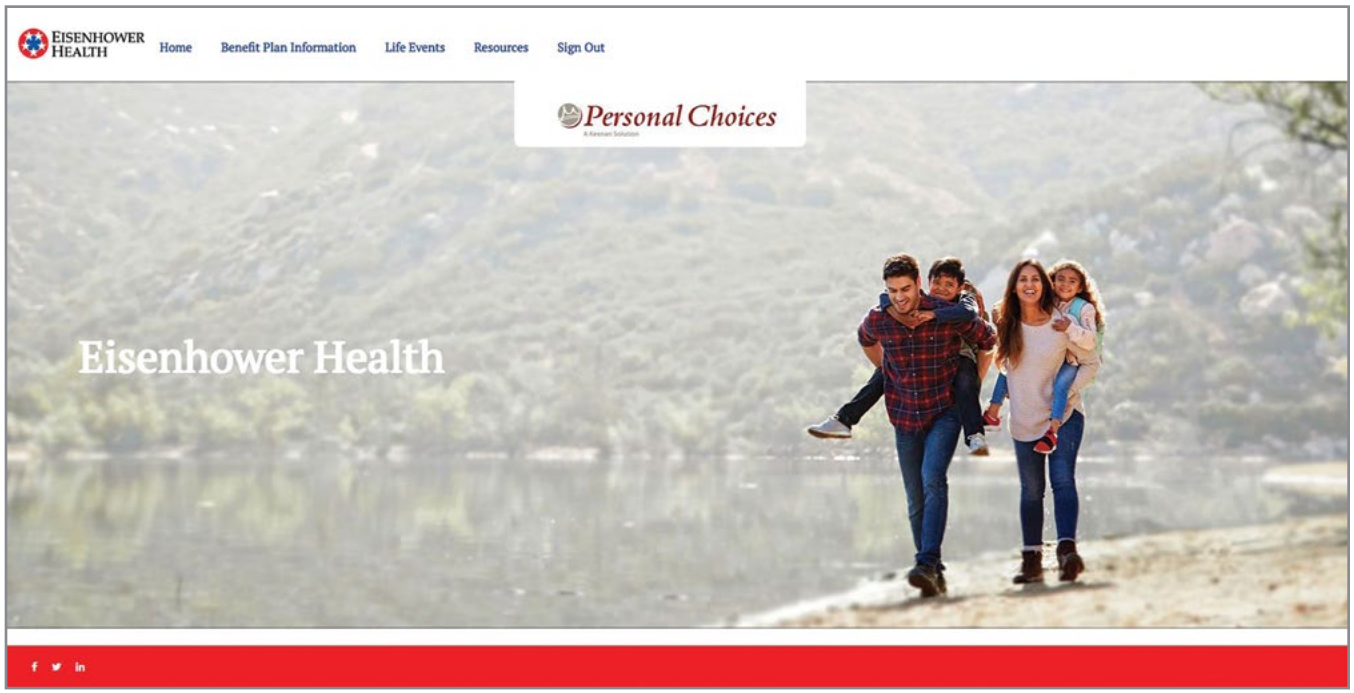
You're 35 years old and your rate is = $0.1230

Multiply 40 x $0.1230 = $4.92 per pay period (24 pay periods per year)

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Personal Choices Website

Check your Personal Choices website. Personal Choices can be accessed 24/7 from work or home PCs or smartphone and offers immediate answers to benefit questions. You can view and compare your benefit choices, link to carrier websites, download forms and analyze your benefit needs.



The following is a summary of some of the benefit information on Personal Choices:

- **Benefits:** This section lists benefit plans offered to Eisenhower Hospital employees, as well as a detailed description of each plan. This section can be used to compare and contrast different plans. It also contains your Summary of Benefits and Coverage (SBC), Plan Document/Summary Plan Descriptions, Evidence of Coverage (EOC) booklets and insurance forms.
- **2025 Open Enrollment:** Provides detailed plan information on new plan options.
- **Life Events:** Provides employees with information for specific life events that impact plan enrollment.
- **Resources:** Contains company forms, carrier links and information on Federal Programs including COBRA, FMLA, and HIPAA. Contact Human Resources for more specific information.

To Access Personal Choices

From Home or Work

In your internet browser on your computer or mobile smart phone, enter
https://app.strivebenefits.com/EisenhowerHealth

Username: EisenhowerEE

Password: benefits

Important Notices

No Surprises Act Notice

Our medical plans are subject to the No Surprises Act, which limits the amount covered persons may have to pay for some out-of-network surprise medical bills. More information about surprise billing requirements included under the No Surprises Act and similar state laws can be found on the medical insurance company's website or the Plan Sponsor's website. Additional information may be found in your Explanation of Benefits for any affected claims.

Statement of Belief – Grandfathered Status

The Eisenhower Health Medical Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, such as the requirement for the provision of preventive health services without any cost-sharing. However, grandfathered health plans must comply with specific consumer protections in the Affordable Care Act, such as the elimination of lifetime limits on benefits.

Questions regarding which protections apply and do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator:

Eisenhower Health
39000 Bob Hope Drive
Rancho Mirage, CA 92270
760.837.8500

You may also contact theEmployee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.askebsa.dol.gov. This website includes a table summarizing which protections do and do not apply to grandfathered health plans.

Discrimination is Against the Law

Eisenhower Health complies with the applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics). Eisenhower Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for pregnancy hospital stay (for delivery) for a mother and her newborn may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply to this minimum length of stay. Early discharge is permitted only if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA) Annual Notice

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 760.837.8500.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Anthem Blue Cross. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under covered medical, dental, and vision plans (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 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 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 does not 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 are an employee, you will become a Qualified Beneficiary if you lose 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 are the spouse of an employee, you will 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 their 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 employment ends for any reason other than their 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 of a Qualifying Event:

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

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if part of the employer's plan), are not eligible for continuation under COBRA.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, or as otherwise permitted by the COBRA administrator, no later than the date specified in the election form, and properly submitted to the Plan Administrator.

Each notice must include all of the following items: the covered employee's full name, address, phone number, and Social Security Number; the full name, address, phone number, and Social Security Number of each affected dependent, as well as each dependent's relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred; a copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are made on the date they are sent to the employer or Plan Administrator.

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 on behalf of their dependent children.

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

DISABILITY EXTENSION OF THE 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 receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This 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. (See Notice and Election Procedures.)

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If your family experiences another Qualifying Event during the 18 months of COBRA continuation of coverage, the spouse and dependent children in your family can receive up to 18 additional months of COBRA continuation of 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 receiving COBRA continuation of coverage if the employee or former employee dies; becomes entitled to Medicare (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 the dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. (See Notice and Election Procedures.)

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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.

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

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 an 8-month special enrollment period[1] 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

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 subject to ERISA, 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. (Address 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.

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the employer for non-COBRA beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period greater than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description or contact the Plan Administrator for more information.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including your spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Flexible Spending Accounts (FSAs) – Termination and Claims Submission Deadlines

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 90 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or the Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and/or your dependents into this plan. However, you must request enrollment no later than 60 days after the determination to remain eligible for such assistance.

If you have a change in family status such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death, or Qualified Medical Child Support Order, you may be able to enroll yourself and/or your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption, or placement for adoption or divorce (including legal separation and annulment).

For information about Special Enrollment Rights, please contact:

Eisenhower Medical Center
Human Resources
760.837.8500

Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

Eisenhower Health Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources

Wellness – Alternative Standards

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all participating employees. If you think you might be unable to meet a standard for a reward under the wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 760.837.8500 and we will work with you (and, if requested, with your doctor) to find a wellness program with the same reward that is right for you with regard to your health status.

Important Notice Regarding Wellness Information

Five Star Wellness] is a voluntary program available to all employees who participate in Eisenhower Health medical plan] and is subject to federal law including the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act.

If you choose to participate, you may be asked to complete a voluntary health risk assessment that asks questions about your health-related activities and behaviors and whether you have or had certain medical conditions. You may also be asked to complete a voluntary biometric screening which includes your body mass (BMI), percent of body fat, blood pressure, cholesterol, triglycerides, and blood glucose and the sleep survey will assess your quality of sleep.

The information gathered from your health risk assessment and/or biometric screening will be used to provide you with information to help you understand your current health, potential risks, and may also be used to offer you services through the wellness program. You are also encouraged to share your results or concerns with your own doctor.

The law requires us to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Eisenhower Health may use aggregate, non-employee-specific information to design a program to address health risks in the workplace, your personally identifiable information will never be disclosed publicly or to your employer. Medical information that personally identifies you in connection with the wellness program will not be disclosed to your supervisors or managers and will never be used to make decisions regarding your employment. Anyone (e.g., a registered nurse, a doctor, a health coach, etc.) who receives information about you for the purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

All medical information obtained through the wellness program will be maintained in compliance with HIPAA and other applicable laws and regulations.

If you have any questions or concerns, please contact [760.837.8500.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Eisenhower Health in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away.

Open Enrollment for health insurance coverage through Covered California will begin on November 1, 2024, and end on January 31, 2025. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com or KeenanDirect at 855-653-3626 or www.KeenanDirect.com.

Open Enrollment for most other states begins on November 1 and closes on January 15 of each year. For more information on Open Enrollment and other opportunities to enroll, visit www.healthcare.gov.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value. If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.02% (for 2025) of your household income for the year, then that coverage for you is not Affordable. Affordability for dependent family members is determined separately and is based on the total cost of family coverage. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's medical plan. If you receive premium savings for Marketplace coverage, the IRS may seek reimbursement of those funds.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered medical coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

STATES WITH INDIVIDUAL MANDATE

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/Rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com. The information is numbered to correspond to the Marketplace application.

3. Employer name Eisenhower Health	**4. Employer Identification Number (EIN)** 95-6130458	
5. Employer address 39000 Bob Hope Drive	**6. Employer phone number** 760.837.8500	
7. City Rancho Mirage	**8. State** CA	**9. ZIP code** 92270
10. Who can we contact about employee health coverage at this job? Rafael Rubalcava, Jr., Human Resources		
11. Phone number (if different from above) 760.837.8504	**12. Email address** RRubalcavaJr@eisenhowerhealth.org	

As your employer, we offer coverage that meets the minimum value standard to the employees as described in this Guide. The coverage offered to you meets the minimum value standard and the cost of this coverage to you is intended to be affordable based on employee wages.

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 877-KIDS-NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHIP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
800-221-3943 | TTY: Colorado relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
800-359-1991 | TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 855-692-6442

FLORIDA – Medicaid
Website:
http://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 877-357-3268

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

INDIANA – Medicaid
Website: https://www.in.gov/medicaid/
Or http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 800-403-0864
Member Services Phone: 800-457-4584

Important Notices (continued)

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 800-338-8366
Hawki Website: http://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid/free-service/hipp
HIPP Phone: 888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 800-792-4884
HIPPA Phone: 800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 877-524-4718
Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 888-342-6207 (Medicaid hotline) or
855-618-5488 (LaHIPP)

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

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 800-862-4840 | TTY: Massachusetts relay 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 800-657-3672

MISSOURI – Medicaid
Website:
https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

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

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov/
Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
HIPP Program Toll-Free Phone: 800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800-701-0710 (TTY: 711)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 866-614-6005

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888-365-3742

OREGON – Medicaid
Websites: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/en/services/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 800-986-KIDS (5437)

Important Notices (continued)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 888-828-0059

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone 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
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid Phone: 800-432-5924
CHIP Phone: 800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-Free Phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

Important Notice from Eisenhower Health About Your Prescription Drug Coverage and Medicare

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

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

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Eisenhower Health coverage will not be affected. If you keep this coverage and elect Medicare, the Eisenhower Health coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Eisenhower Health coverage, be aware that you and your dependents will be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

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

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Eisenhower Health changes. You also may request a copy of this notice at any time.

Date:	April 2025
Name of Entity / Sender:	Eisenhower Health
Contact:	Human Resources
Address:	39000 Bob Hope Dr. Rancho Mirage, CA 92270
Phone:	760.837.8500

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…

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

For more information about Medicare prescription drug coverage:

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

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

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

Glossary

Affordable Care Act and Patient Protection (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, covering preventive care without cost-sharing, etc, among other requirements.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Brand Name Drug

The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

The Consolidated Omnibus Budget Reconciliation Act allows people who lose their jobs to continue their employer-sponsored insurance coverage for up to 18 months.

Children's Health Insurance Program (CHIP)

The government program that provides free or low-cost health coverage for children up to age 19 in families whose income is too high to qualify for Medicaid but too low to afford private insurance. CHIP covers U.S. citizens and eligible immigrants. In some states, CHIP covers pregnant people. CHIP goes by different names in some states.

Claim

A request for payment that you or your health care provider submits to your health insurer to be paid or reimbursed for items or services you have received. Most often, you will not be responsible for making claim requests. Usually, billing and claims specialists employed by the health care provider (e.g. primary care office, hospital) will make the claim on your behalf.

Coinsurance

A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

Copayment (Copay)

A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Comprehensive Coverage

A health insurance plan that covers the full range of care that you may need. This may include preventive services (like flu shots), physical exams, prescription drugs, and doctor or hospital care.

Deductible

The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Formulary

A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Generic Drug

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)

High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

Health Savings Account (HSA)

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. State taxes may apply. You

must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

Health Reimbursement Arrangements (HRAs)

Unlike HSAs, only an employer may fund an HRA and the funds revert back to the employer when the employee leaves the organization. HRAs are not subject to the same contribution limits as HSAs, and they may be paired with either high-deductible plans or traditional health plans.

In-Network

Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Out-of-Pocket Maximum

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Out-Of-Network

A health plan may not cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-Of-Pocket Limit

The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including co-payments and co-insurance.

Plan Year

The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount.

Premium

The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

Preventive Care

Health care services you receive when you are not sick or injured— so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

Qualifying Life Event

A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include moving to a new state, certain changes in your income, and changes in your family size.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Notes

Quick Reference Guide

	Telephone	Website/Email
Health Care		
• Keenan TPA (PPO)	888.773.7215	https://tpabenefits.keenan.com
• Anthem Blue Cross Utilization Review (PPO)	800.274.7767	www.anthem.com/ca
• Hartford Ability Assist Counseling Services through ComPsych (EAP)	800.964.3577	http://guidanceresources.com/
• Delta Dental Preferred Option (PPO) Plan	888.335.8227	www.deltadentalins.com
• Vision Service Plan (VSP)	800.877.7195	www.vsp.com
• Express Scripts Prescription Drugs	855.891.8864	www.express-scripts.com
• Keenan Pharmacy Care Management (KPCM) Program	800.241.8440	
• CompleteCare	877.872.4232	https://catilize.com/
Wellness/Condition Management		
• TrestleTree	855.246.4830	allengagement@trestletree.com
Life, AD&D and Disability		
• Hartford	800.523.2233	www.thehartford.com
Other Voluntary Plans		
• Trustmark	800.918.8877	www.trustmarkbenefits.com
• Allstate Identity Protection	800.789.2720	www.myaip.com/eisenhowerhealth
• Wishbone Pet Insurance	800.887.5708	www.wishboneinsurance.com/eisenhowerhealth
• LegalShield	714.904.6501	www.legalshield.com/info/EisenhowerHealth
Flexible Spending Accounts		
• Keenan TPA (FSA)	888.773.7215	https://keenan.wealthcareportal.com/Page/Home
Retirement/Savings		
• 403(b) Retirement Plan		
– Lincoln Financial Advisors	800.585.5347	www.lincolnfinancial.com
– Lincoln Financial General Customer Service	800.234.3500	www.lincolnfinancial.com
– VALIC	800.448.2542	www.valic.com
All Other Inquiries		
• Eisenhower Human Resources Department	760.837.8500	
• Eisenhower Teaching Clinics	760.773.1460	
• Eisenhower Primary Care 365 Program	760.360.3365	