Employee Benefits Guide

2023

Rady Children's Hospital San Diego

Employee Benefits Guide 2023

General Information

Core Benefits

Other Benefits

Miscellaneous

NEW! Click this icon ▶ in your benefits guide to watch a video explaining the associated topic.

NEW! See page 39 for a glossary of terms.

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 the Important Notices section of this guide for additional details.

The information in this brochure is a general outline of the benefits offered under Rady Children's Hospital-San Diego 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.

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Contact Information

Plan	Carrier	Phone Number	Website or Email
Human Resources/ Benefits Team	• General Benefits Questions	858.966.5801	benefits@rchsd.org
	• Retirement	858.966.4037	
	• Leave of Absence	858.966.5903	leaveofabsence@rchsd.org
Medical/Pharmacy	• Anthem Blue Cross HMO *(Priority Select & Select)* Group Number - L03624	833.913.2237	anthem.com/ca
Medical/ Pharmacy/HSA	• Anthem Blue Cross HDHP w/HSA Group Number - L03624	800.227.3771	anthem.com/ca
Dental	• Cigna Dental PPO and DHMO Plans Group Number - 3342128	800.244.6224	myCigna.com
Vision	• EyeMed Group Number - 1041027	866.800.5457	eyemed.com
Employee Assistance Program (EAP)	• Magellan	800.327.9298	member.magellanhealthcare.com
Life & Long-Term Disability Insurance	• Unum Life & AD&D Group Number - 953035-002 Disability Group Number - 953035-001	**Member Services:** 800.421.0344 **Disability Claims:** 800.858.6843 **Port/Convert Info:** 866.220.8460	unum.com
Travel Assistance	• Assist America	**US:** 800.872.1414 **Outside the US:** (US Access Code) +609.986.1234	medservices@assistamerica.com REF# 01-AA-UN-762490
Flexible Spending Accounts (FSA)	• TRI-AD Participant Services Employer ID - TIDCHSD	888.844.1372	tri-ad.com
403(b) Retirement	• Fidelity Investments	800.343.0860	netbenefits.com/rchsd
Pension Plan	• Transamerica	888.976.8196	Transamerica.com/ portal/mypension
Voluntary Benefit Plans	• Colonial Account Number - E4245494	800.325.4368	coloniallife.com
Voluntary Life with Long-Term Care	• Chubb	855.241.9891	csmail@gotoservice.chubb.com
Pet Insurance	• Nationwide Pet Insurance	877.738.7874	petinsurance.com/RCHSD

General

Our Commitment

At Rady Children's Hospital-San Diego, we believe that our employees are our most important asset. Rady Children's offers you a comprehensive benefits program to help you and your family achieve and maintain good physical, emotional, and financial well-being. We are providing this guide to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask any questions you may have. For your reference, a list of plan contacts is provided at the beginning of this guide.

While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to the benefit-specific materials that govern the benefit terms (e.g., policies, certificates of coverage, contracts, benefit plan descriptions), as well as the Plan's Summary Plan Description (SPD).

Eligibility

Benefits eligibility is determined by employee classification, number of hours scheduled to work and completion of any applicable waiting period. Generally benefits are effective on the first day of the month after your date of hire or the date you transfer to an eligible classification or position, except for EAP benefits, which are effective on your hire date.

	Eligibility for Benefits		
Employee Classification	Full-Time	Part-Time	Casual
Hours Requirement	Minimum 70 hours per pay period	Minimum 36 hours per pay period	Employees with a minimum 3-month assignment scheduled to work for at least 36 hours per pay period
Benefits Effective Date	1st day of the month after date of hire or date of transfer to an eligible classification or position		
Benefits Offered	• Medical • Dental • Vision • Flexible Spending Accounts (FSA) • Basic Life/AD&D • Employee Assistance Program (EAP) • Voluntary Life • Voluntary AD&D • Spouse Life • Dependent Life • Disability		

Notes:

1. Employees classified as "per diem" and part-time employees who do not meet the minimum hour requirement of 36 hours per pay period are eligible for Medical, Dental, and Vision insurance, at full cost.
2. Per diem employees and part-time employees who do not meet the minimum hour requirement but who work at least 30 hours per month will receive a monthly credit of up to $50 from Rady Children's to help offset the cost of premiums if purchasing medical coverage under one of our plans.
3. All employees are eligible for the Employee Assistance Program through Magellan, and Pet Insurance.

Eligible employees may enroll dependents as follows:

- Legally married spouse
- Registered Domestic Partner
- Children**:**
  - An employee's or spouse/domestic partner's natural child, stepchild, legally adopted child or a child for whom the employee, spouse or domestic partner has legal custody or has been appointed legal guardian by a court of law.
  - A child for whom the employee or employee's spouse/domestic partner is legally required to provide group health coverage pursuant to an administrative court order.
  - A child who is incapable of self-sustaining employment due to a physical or mental condition. If such dependent is age 26 or older, you must provide proof of continuous health coverage for this dependent since the age of 26. Disability must have occurred prior to age 26. A Disabled Dependent Certification form will need to be completed and approved by the insurance carrier.
  - Adult Children up to the age of 26.

* You will need to provide proof of dependent status; see page 5 of this guide for more details.

Child does not include: (i) any person who is covered as an employee, or (ii) any person who is in active service in the armed forces.

Eligibility (continued)

When You Can Enroll or Make Changes

Newly hired employees and employees who transferred from per-diem to a full-time or part-time classification which meets the minimum hours requirement have the opportunity to enroll within the first 31 days of employment or transfer. Employees may also enroll or make changes to their benefits during the annual Open Enrollment period. Once elections are completed, no changes can be made until the next annual Open Enrollment period unless you experience a qualifying status change or life event, including but not limited to:

- Change in employee's marital status
- Birth, adoption or change in custody of eligible dependent
- Death
- Change in your employment status (e.g. a change in standard hours which significantly impacts your premiums)
- Change in your spouse's employment status
- Gain or loss of other employer or government sponsored health plan coverage

Benefit changes will be effective the first of the month following the qualifying event date or the date you notify us, whichever is later. If you're adding a child after birth or adoption, the effective date will be on the date of the event. Please provide proof of the qualifying event, including the date of gain/loss of coverage or dependent eligibility.

To request a mid-year change due to a qualifying status change or life event, select "Life Event" in Employee Self Service in PeopleSoft within 31 days of the status change. Documentation supporting your life event is required.

Failure to do so will result in a delay of the change until next annual Open Enrollment period.

CHIP and Medicaid eligible employees have 60 days to enroll.

Click here to watch a video on Qualifying Life Events.

Eligibility (continued)

Dependent Verification

We have listed the most common types of supporting documentation to verify dependent eligibility for coverage. This list may not be all inclusive. The proof must substantiate the relationship. Documentation must be provided within 31 days of the effective date of coverage. If adding a dependent, the Social Security Number or Tax Identification Number (TIN) should be provided. **A Social Security Number is not required for a child under the age of six (6) months**.

Tip: To easily verify dependent(s) download your IRS transcript at https://www.irs.gov/individuals/get-transcript. Email verification documents to benefits@rchsd.org or fax to 858.966.7834

Dependent Type	Eligibility	Supporting Documents
Spouse	**Married Spouse** **NOTE**: A Federal Tax Return filed as "**Head of Household**" does **NOT** meet the eligibility guidelines. If presented to HR your Spouse will be considered ineligible to enroll as your dependent.	**One of the following will be accepted:** • Federal Tax Return *(1040)*[1] *current filing period (preferred)*, or prior filing period • IRS Transcript current filing period *(preferred)*, or prior filing period • If **Married and filing separately**; • Employee is required to present **both** Federal Tax Returns. Each return **must** indicate "Married Filing Separately" status and include the name and SSN of the Spouse. • If newly Married, within the **last 12 months** you may present a Government Issued Marriage Certificate.
Domestic Partner	**Registered Domestic Partner (RDP)**	Notarized State Declaration of Domestic Partnership *(original)* that has been filed with the State
Natural Birth Child • Birth to age 26[2]	**Biological Child**	**One of the following will be accepted:** • Federal Tax Return *(1040) current filing period (preferred)*, or prior filing period • IRS Transcript current filing period *(preferred)*, or prior filing period • Original Birth Certificate naming employee as child's biological parent • Qualified Medical Child Support Order *(QMCSO)*
Step Child • Birth to age 26[2]	**Child of current Spouse or Domestic Partner** Domestic Partner must be enrolled	**One of the following will be accepted PLUS the Original Birth Certificate[3]:** • Federal Tax Return *(1040) current filing period (preferred)*, or prior filing period • IRS Transcript current filing period *(preferred)*, or prior filing period **NOTE**: Original birth certificate alone will not validate the stepchild's eligibility. Employee/Spouse-RDP relationship must also be substantiated.
Adopted Child • Birth to age 26[2]	**Adopted Child** Eligible at the time of placement	**One of the following documents will be accepted:** • Federal Tax Return *(1040) current filing period (preferred)*, or prior filing period • IRS Transcript current filing period *(preferred)*, or prior filing period • Court Documents naming Employee/Spouse as Guardian • Adoption Record • Qualified Medical Child Support Order *(QMCSO)*
Legal Guardianship/ Legal Custody • Birth to Age 26[2]	**Child is under the protection or in the custody of the Employee/Spouse/RDP**	**One of the following documents will be accepted PLUS Court Documents naming Employee/Spouse-RDP as Legal Guardian/Custodian:** • Federal Tax Return *(1040) current filing period (preferred)*, or prior filing period • IRS Transcript current filing period *(preferred), or prior filing period (not required if named as guardian in the last 12 months)*
Permanently Disabled Adult Child[4]	**Adult Dependent Child over age 26**	**One of the following documents will be accepted AND Original Birth Certificate[3] AND Physician documented incapacity of self-support letter** • Federal Tax Return *(1040) current filing period (preferred)*, or prior filing period • IRS Transcript current filing period *(preferred)*, or prior filing period

1. In accordance with IRS rules, filing Head of Household is considered a single status.
2. Age 26 limit applies to Medical, Dental, Vision and Dependent Child Life Coverage.
3. The birth certificate must include the employee's spouse or RDP's name as parent.
4. Onset of disability must be prior to attaining age 26.

IMPORTANT!

For all newly added dependents, verification documents are required within 31 days of the effective date of coverage.

For your information, official documents of birth, marriage and/or death certificates, from anywhere in the United States may be obtained through www.vitalchek.com. State document fees and courier fees will apply.

It is important to request required documents early to allow for processing time.

Benefits Enrollment

How to Enroll Through PeopleSoft HCM when you are first eligible or during Open Enrollment.

- **STEP 1:** Click on the PeopleSoft HCM icon from your work computer. If you have been approved for Remote Access, you can access PeopleSoft from outside the Hospital by logging into mycitrix.rchsd.org.
- **STEP 2:** Log in using the same **User ID** and **Password** that you use to log into the hospital network.
- **STEP 3:** From **"Employee Self Service"** click on the tile for **"Benefit Details"**. **"Select Enroll in Benefits."**
- **STEP 4:** Click on **"Select"** next to the available event (New Hire or Open Enrollment).
- **STEP 5:** Click on **"Edit"** to enroll or change your election for each benefit (medical, dental, vision, etc.).
- **STEP 6:** Scroll down to review the benefit plan options and the costs for each coverage level and make your selection. Select **"Add/Review Dependents"** to add a dependent and enroll them in benefits. You may also make changes to your **Primary Care Provider** by entering a new **Provider ID**. Once you have made your selections for this plan, select **"Update and Continue."** Repeat Steps 5 and 6 as necessary.
- **STEP 7:** Select **"Edit"** for Life and AD&D to enter your beneficiaries for life insurance. Follow the on-screen instructions regarding primary and secondary beneficiary allocations. Select **"Update and Continue."**
- **STEP 8:** Once you have finished your enrollment selections, select **"Save and Continue"** at the bottom of the screen. At the next screen you will authorize your elections by selecting **"Submit."** ***Remember***, your enrollment is not complete until you have selected **"Submit"** on this screen. This will bring you to a Benefits Enrollment Statement with the details of your benefit elections.
- **STEP 9: Print your final benefit confirmation statement for your records**.
- **STEP 10:** Click on the **"Voluntary Benefits"** link if you wish to enroll in voluntary benefits with Colonial (i.e. Short-Term Disability, Medical Bridge, Accident and Critical Illness) or Chubb (LifeTime Benefit Term).
- **STEP 11:** To log out of PeopleSoft, click on **"Sign out"** in the upper right hand corner.

Note: As long as you save your entries, all changes will be saved in the Enrollment Summary. If you need to step away from your computer and log back in later, you can continue where you left off. Please just be sure to finalize elections on the **"Submit Benefit Choices"** page if you make any additional changes. You must make your enrollment selections within 31 days of your hire date or the date you transfer to a part-time or full-time position which meets the minimum hours requirement. If you have not completed your enrollment and hit **"Submit"** by the deadline, you will not be able to enroll until the next Open Enrollment.

Elections made after the coverage effective date, can result in missed payroll deductions for your benefit premiums. Missed deductions will result in a temporary increase in deductions until the balance is paid off.

If you are having trouble logging on to the system, contact the HR Benefits Team for assistance at benefits@rchsd.org.

Alex® Benefits Guidance

ALEX® provides personalized, confidential benefits guidance on any computer, tablet, or smartphone. Before you make your enrollment decisions, let ALEX help you find the plans that make the most sense for you and your family.

Get personalized, confidential benefits guidance on any device at https://www.myalex.com/rchsd/2023

Medical – Anthem Blue Cross

Medical coverage provides you with benefits that help keep you healthy, such as preventive-care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition. Rady Children's provides you with comprehensive coverage and the choice between three medical plans:

- Anthem Blue Cross Select HMO (CA only)
- Anthem Blue Cross Priority Select HMO (CA only)
- Anthem Blue Cross HDHP w/HSA

How to select a provider for the Anthem Select HMO and Anthem Priority Select HMO

When electing coverage through the Anthem HMO plans, you will be required to select a network primary care physician (PCP)/medical group. The network of PCPs will vary depending on the HMO plan you have selected and where you live. Refer to the page titled, "Find an Anthem Blue Cross Provider" for instructions on how to locate a participating provider in each plan's network. You may also call Anthem at 833.913.2237 for assistance finding a provider.

Your PCP will coordinate your overall care, prior authorizations and any specialist referrals. Each family member may elect a different PCP. If you receive medical care outside of the plan's network without prior authorization, the out-of-network services will only be covered if the treatment is a medical emergency, such as emergency room and urgent care. HMO plans have a limited service area therefore if you have a dependent that lives out-of-state, be sure to check the Away From Home Guest Membership Program availability in that state.

If you do not select a PCP or if you provide an invalid PCP ID number during enrollment, Anthem will auto assign a PCP. To change your assigned PCP, please call Anthem Blue Cross at 833.913.2237. You may change your PCP monthly provided you are not in the middle of treatment. PCP changes will be effective the first of the following month if Anthem is notified before the 15th of the month.

Anthem Select HMO Network

When you enroll in the Anthem Blue Cross Select HMO plan, you will choose your PCP from the Select HMO Network which includes, but is not limited to, the following medical groups in San Diego County:

- Sharp
- UCSD
- Rady Children's

Anthem Priority Select HMO Network

When you enroll in the Anthem Blue Cross Priority Select HMO plan you will choose your PCP from the Priority Select HMO Network which provides a choice of the following provider groups in San Diego, Orange, Los Angeles, San Bernardino and Riverside Counties:

- Rady Children's
- Scripps Health in San Diego County
- Lakeside Medical in Los Angeles County
- Affiliated Doctors of Orange County Medical
- PrimeCare (San Bernardino and Riverside Counties)
- UCSD Physician Network – Palomar Health **New 2023**

SIMNSA HMO Medical Group in Mexico

Anthem is working with Sistemas Medicos Nacionales, S.A. de C.V. (SIMNSA), a HMO provider in Northern Mexico. With SIMNSA, you can choose a primary medical group, receive all care and fill prescriptions in Northern Mexico. This is available to Mexican nationals legally employed in San Diego and Imperial counties, and their dependents of any nationality. Upon receiving your Anthem ID card, please reach out to SIMNSA at: 1.800.424.4652 or 619.407.4082 to select your provider in Mexico. For more information call Anthem member services at 833.913.2237.

HMO – Away From Home Guest Membership Program (Out of State)

In order to enroll in an Anthem Blue Cross HMO plan, you must reside in California. However, your eligible dependents living outside California may be able to enroll in the Away From Home Guest Membership Program in the Anthem Blue Cross HMO Network. This program is designed for members who will be residing outside their home state for a minimum

Medical – Anthem Blue Cross (continued)

of 90 days. To determine if the Away From Home Guest Membership Program will work for your dependents and if there are providers available in your dependent's area, please contact the Anthem Blue Cross customer service number on your ID card.

The following states participate in the Anthem Away From Home Guest Membership Program: **Arizona, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Pennsylvania, Texas, Virginia, Washington D.C., and Wisconsin.** Please note that this list may change, and some states may have regions that are not covered. Before making any benefit choices that involve an out-of-state dependent, call Anthem Blue Cross to determine if the Away From Home Guest Membership Program will be available in their specific Zip Code.

Click here to watch video on Health Maintenance Organizations (HMO).

Preventive Care Benefits

Having regular preventive care can help you stay healthy and catch potential problems early. Your Anthem health plans offer certain in-network preventive care services, pharmacy items, and immunizations at no cost to you. If you go to doctors or facilities that are not in your plan's network, you may have to pay out of pocket.

Preventive care includes the following:

- General preventive physical exams, screenings, and tests (Children and Adults)
- Women's preventive care (e.g. mammogram, well-woman visit)
- Immunizations (e.g. influenza, shingles, pneumonia)

The preventive care that you're eligible for can depend on factors such as age, gender, and family health history. Please talk to your physician about which exams, tests, and immunizations make sense for you.

Preventive care vs. Diagnostic care: What's the difference?

Preventive care helps protect you from getting sick. If your doctor recommends you receive services even though you have no symptoms, that may be considered preventive care. Diagnostic care is when you have symptoms, and your doctor recommends services to determine what's causing those symptoms. While in-network preventive care often has no charge, you typically have to pay your plan's cost-share for diagnostic care.

Anthem Blue Cross High Deductible Health Plan and Health Savings Account

The Anthem Blue Cross High Deductible Health Plan (HDHP) and Health Savings Account (HSA) utilizes the Prudent Buyer network for in-network providers and allows employees the freedom to self-refer and obtain services from multiple medical groups and physicians both within and outside of the network.

Click here to watch a video on High Deductible Health Plans (HDHP).

Health Savings Account Information

If you enroll in the HDHP you have the opportunity to participate in a Health Savings Account (HSA). You may make pre-tax contributions from your paycheck to your HSA each year you're enrolled in the HDHP, up to the annual contribution limit set by the Internal Revenue Service (IRS). These pre-tax contributions lower your taxable income and can help save you money on your taxes each year. You may use funds in your HSA to pay for eligible medical expenses – such as deductibles, coinsurance and prescription drugs – during the year, or you may roll over your HSA balance from year to year to build tax-advantaged savings for future health care expenses.

You are eligible to open or contribute to an HSA if you are:

- Covered by a high deductible health plan (If you are enrolled in an HSA, you are eligible to enroll in a limited purpose FSA for dental and vision expenses.)

You are not eligible to open or contribute to an HSA if you are:

- Covered by a non-high deductible health plan, such as an HMO plan
- Enrolled in a regular healthcare flexible spending account (you or your spouse)
- Covered under Medicare or Medicaid
- Claimed as a dependent on someone else's tax return

Medical – Anthem Blue Cross (continued)

Annual HSA Contributions

	Max Allowed by IRS Per Year	Hospital Contributes (Prorated and Funded Per Pay Period)	You May Contribute (Remaining Amount)	Over Age 55 Catch Up Contribution Amount Per Year
Employee	Up to $3,850	Up to $630	Up to $3,220	$1,000
Employee + Family	Up to $7,750	Up to $1,260	Up to $6,490	$1,000

The IRS has set limits on the total amount that can be contributed to a Health Savings Account each calendar year. This amount includes both employee and employer contributions. The amount Rady Children's contributes is prorated based on date of hire. For 2023, the limit is $3,850 for an individual and $7,750 for a family. If you are over 55 by the end of 2023, the IRS allows you to contribute an additional $1,000 - this is called a Catch Up Contribution.

Customer Identification Program (CIP): Anthem is required by the FDIC to perform customer identification before funds are deposited into your HSA. Should there be any issues with passing the CIP process, Anthem will notify you of the next steps which may include providing additional information or clarification of the information on file. Failure to complete the CIP process will prevent funds from being deposited into your HSA, and may result in the delay or forfeiture of Employer HSA contributions.

Benefits of Health Savings Accounts

The most popular features of HSAs are:

- Account is owned by you and it is portable (meaning you keep the money if you change jobs or retire)
- No "use it or lose it" rule
- Unspent monies roll over each year
- Employer can contribute
- Helps cover deductible
- Provides pre-tax savings
- You can change your contribution anytime

Using Your Money

You can use the money in your HSA to pay for qualified medical expenses that are not paid for by your HDHP. For a full list of eligible expenses, go to irs.gov.

Please keep receipts for items purchased using your HSA. In the event you are audited by the IRS, you will need to present receipts for any eligible items purchased.

Note: Contact the Benefits Department at benefits@rchsd.org to change your HSA contribution amount.

Click here to watch a video on Health Savings Accounts (HSA).

Manage your health plan and HSA funds online at anthem.com/ca.

Once you're an Anthem member go to the Sydney mobile app or anthem.com/ca to register. You can track your health plan deductible and HSA balance. You can also find a doctor, estimate your costs for care, and discover other helpful resources under the Find Care tab.

Non-Qualified Expenses

If you use HSA funds for non-qualified expenses before you turn 65, you will owe a 20% penalty PLUS income tax on the withdrawal. After age 65, if you use HSA funds for non-qualified expenses you will owe income tax only. For a full list of eligible expenses, go to irs.gov.

Find an Anthem Blue Cross Provider

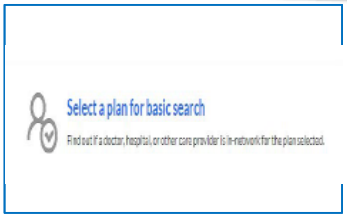
Provider Finder Guide

How to Find a Medical Provider Online

STEP 1

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

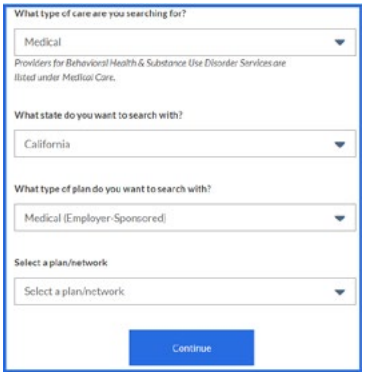
- Click **"Select a plan for basic search"**
- Scroll down to answer questions that will help you narrow your search



STEP 2

Scroll down the screen to complete the following fields:

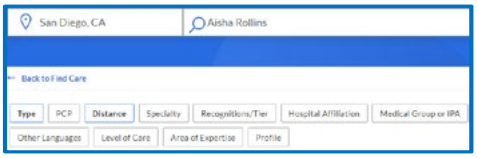
- What type of care are you searching for? Use drop down to select: **Medical**
- What State do you want to search in? Use drop down to select: **California**
- What type of plan do you want to search with? **Medical (Employer-Sponsored)**
- Select a plan/network: Use drop down to select
  - **Select HMO**
  - **Priority Select HMO**
  - **Blue Cross PPO (Prudent Buyer) - Large Group**
- Click **Continue** button

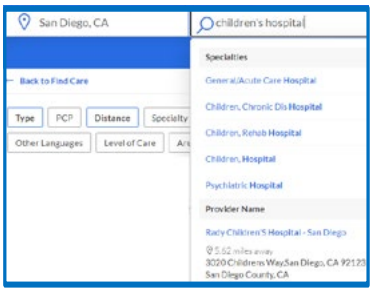


STEP 3

Enter the Zip, City or County in the far left box. You now have 2 ways to search:

- Option 1: Enter in the **Physician's Name, Specialty, NPI or license number** in the Search Box. The results will appear below the Search Box and you can either click on the name provided or you may click on the **See All** text.
- Option 2: Scroll down and click one of the Types of Providers listed. The results will appear on a new screen and you can click on the physicians name to obtain additional details.





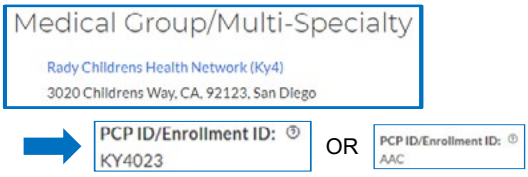
STEP 4

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

STEP 5

HMO Plan Participants

- HMO plan providers in CA only
- Confirm you have selected your Medical Group Affiliation or Location
- Record the 3 or 6-digit PCP/ID to enter into your enrollment form.



Anthem Blue Cross Resources

When you enroll in one of the Anthem Medical plans you also have access to a wide array of services and tools to help support your health and well-being.

Anthem Sydney Mobile

The Sydney mobile app contains everything you need to know about your health plan in one place, making your health care journey easier.

Register on anthem.com/ca or the Sydney mobile app. Have your member ID card handy to register.

From your computer:

1. Go to anthem.com/ca/register
2. Provide the information requested
3. Create a username and password
4. Set your email preferences
5. Follow the prompts to complete your registration

From your mobile device:

1. Download the free Sydney mobile app and select Register
2. Confirm your identity
3. Create a username and password
4. Confirm your email preferences
5. Follow the prompts to complete your registration.

If you need help signing up, please call Anthem at 866.755.2680

LiveHealth Online Telehealth Visits

24/7 Access to Board-Certified Doctors: They can assess your condition, provide treatment options and even send a prescription to the pharmacy of your choice.

Medical Care When You Need It: For conditions like the flu, a cold, sinus infection, pink eye, rashes, fever and more.

Convenience: Since there are no appointments or long waits, most people are connected to a doctor in 10 minutes or less.

Online visits using LiveHealth Online are covered by your Anthem plan. Refer to the benefit summary on pages 14-15 for the copays for each plan. It is recommended that you preregister and download the mobile app before you need care. Please visit livehealthonline.com to sign up or download the app.

Anthem 24/7 NurseLine

24/7 NurseLine serves as your first line of defense for unexpected health issues. You can call a trained, registered nurse to decide what to do about a fever, give you allergy relief tips, or advise you where to go for care. A nurse is always available to help answer your questions, day or night.

A registered nurse can also:

- Help you find doctors, hospitals, and specialists in your area.
- Give you referrals to LiveHealth Online.
- Enroll you in health management programs for certain conditions.
- Remind you about scheduling important screenings and exams, including dental and vision checkups.
- Provide guidance during natural catastrophes and health outbreaks.
- Offer links to health-related educational videos or audio topics.

You can reach the 24/7 NurseLine by calling the customer service number on your ID card.

Changing Your Primary Care Provider

To change your Primary Care Provider (PCP) after you enroll, call 833.913.2237.

If you call:

- Before the 15th of the month, the new PCP will be effective the first of the next month
- After the 15th of the month, the new PCP will be effective the first of the second month

Questions?

Call Anthem Blue Cross Customer Service at 833.913.2237.

Anthem Blue Cross Resources (continued)

Wellness Incentive 200

We understand that you have your own approach to achieving your wellness goals. This program rewards you and your covered spouse, or registered domestic partner, up to $200 for taking part in a wide variety of condition management, preventive care, and wellness activities. You can follow your progress and rewards earned through anthem.com/ca or the Sydney Health mobile app (see page 12 on how to register). Sydney Health serves as your fully integrated digital platform. You do not have to file any claims through Anthem to receive the reward(s). Preventive Care activities are tracked via claims and the rest of the activities as they are completed.

All earned rewards may be redeemed through digital gift cards from the retailers such as MasterCard, Amazon, Bed Bath & Beyond, Gap (all brands), Staples, Target, The Home Depot, and TJ Maxx. The minimum redemption amount is set by the individual retailer.

Well-being Coach provides you with access to certified health coaches by phone or through one-on-one text coaching accessible through the Sydney Health app. It can help you make positive changes and reach health goals that have been difficult to achieve on your own. Health goals can include managing stress, sleeping better, quitting tobacco, and maintaining a healthy weight.

	Activites	Reward Type	Reward
Preventive Care 	**Annual Eye Exam**	Claim	$25
	Annual Adult Wellness Exam or Well Woman Exam	Claim	$25
	Cholesterol Test	Claim	$20
	Colorectal Cancer Screening	Claim	$25
	Flu Shot	Claim	$20
	Mammogram	Claim	$25
Condition Management 	**ConditionCare**	Completion	$50
	Future Moms	Completion	$40
	Well-being Coach Telephonic - Tobacco	Completion	$25
	Well-being Coach Telephonic - Weight	Completion	$25
Wellness 	**Action Plans**	Tracked	$25
	Connect a Device	Tracked	$5
	Health Assessment	Tracked	$20
	Log into Website or App	Tracked	$5
	Track Steps	Tracked	$60
	Update Contact Information	Tracked	$10
	Well-being Coach Digital	Tracked	$20

Note: *Through Anthem's medical plans you can have an annual eye exam that is eligible for a reward. Please note this benefit is for an exam only and any materials (contacts, glasses) are NOT covered.* ***Reward*** *can only be received if you have your annual vision exam through the Anthem medical plan. If you receive your annual eye exam through the EyeMed vision benefit, it* ***may*** *not be eligible for* ***a reward*** *through Wellness 200.*

Wellness Discounts and Savings

As an Anthem health plan member, you qualify for discounts on products and services that help support your health and well-being. These discounts are only available through the Anthem.com/ca website. To find the discounts available to you go to anthem.com/ca, click on **Member Benefits** (In middle of home page), sign-in to your **Anthem health plan account**, and click on **Discounts**. (Right side of screen)

Special offers include:

- More than 11,000 participating fitness centers nationwide for just $25 per month (plus a $25 enrollment fee and applicable taxes) through **Active&Fit Direct**.
- Discounts on **Fitbit** and **Garmin** wellness devices.
- Join the **Jenny Craig** weight loss program for free, and take advantage of discounted food and free coaching (with minimum purchase)
- Savings on acupuncture, chiropractic, massage, fitness equipment, health products, and more through **ChooseHealthy**.
- 15% off coaching through **SelfHelpWorks** to help you lose weight, stop smoking, manage stress or diabetes.
- Discounts on vitamins, minerals, and supplements through **Puritan's Pride**
- And many more!

Medical Plan Benefit Summary

Plan Benefits	Anthem Blue Cross	
	Select HMO	Priority Select HMO
	Member Pays	Member Pays
Routine Preventive Services		
• Preventive Office Visits	No charge	No charge
• Physician Services	No charge	No charge
Office/Virtual Visit		
• Primary Provider	$30/visit	$20/visit
• Specialist	$60/visit	$40/visit
• Mental/Behavioral Health	$30/visit	$20/visit
Telehealth - LiveHealth Online Providers (*www.livehealthonline.com*) Primary/Specialist/Mental/Behavioral Health	$10/visit	$10/visit
Chiropractic Care *(PCP referral and prior authorization required)*	$15 copay (limited to 20 days/calendar year)	$15 copay (limited to 20 days/calendar year)
Urgent Care	$30/visit (waived if admitted)	$30/visit (waived if admitted)
Emergency Room	$150/visit (waived if admitted)	$150/visit (waived if admitted)
Outpatient Lab and X-rays *(except Complex Imaging)*	No charge	No charge
Complex Imaging *(Outpatient)* **MRI, CT, PET scans** *(pre-certification may be required)*	$100/per type of scan per day	$100/per type of scan per day
Outpatient Surgery	$500/visit	$500/visit
Calendar Year Deductible	$1,500 per Member/$3,000 Family (applies to in-patient and skilled nursing facility only)	No charge
Inpatient Hospitalization *(pre-service notification may be required)*	Deductible, then no copay	$250/per admission copay
Calendar Year Out-of-Pocket Maximum	$3,500 Individual/$7,000 Family	$3,500 Individual/$7,000 Family
Retail Pharmacy	**30 day / 90 day supply**	**30 day / 90 day supply**
• Tier 1	$20 copay / $40 copay	$15 copay / $30 copay
• Tier 2	$40 copay / $80 copay	$30 copay / $60 copay
• Tier 3	$70 copay / $140 copay	$50 copay / $100 copay
• Specialty Pharmacy *(Tier 4)*	30% up to $250 copay (30 day supply)	30% up to $250 copay (30 day supply)
Mail Order	**90 days**	**90 days**
• Tier 1	$20 copay	$15 copay
• Tier 2	$80 copay	$60 copay
• Tier 3	$140 copay	$100 copay
• Specialty Pharmacy *(Tier 4)*	30% up to $250 copay (30 day supply)	30% up to $250 copay (30 day supply)

Selecting your benefits can be tricky. Get personalized, confidential benefits guidance from ALEX at https://www.myalex.com/rchsd/2023 to help you choose the benefits that best fit the needs of you and your family.

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Medical Plan Benefit Summary (continued)

Plan Benefits	Anthem Blue Cross HDHP w/HSA Member Pays	
	In-Network Blue Cross PPO (Prudent Buyer Network)	**Out of Network**
Routine Preventive Services		
• Preventive Office Visits	No charge (deductible waived)	30% after deductible
• Physician Services	No charge (deductible waived)	30% after deductible
Office Visit		
• Primary Provider	10% after deductible	30% after deductible
• Specialist	10% after deductible	30% after deductible
Telehealth - LiveHealth Online Providers (*www.livehealthonline.com*)	$10 copay after deductible (Primary/Mental Health) 10% after deductible (Specialist)	
Chiropractic Care *(limits apply)* *(May use any ASH provider and may need authorization for additional visits if appropriate and medically necessary)*	10% after deductible (limited to 30 days/calendar year combined)	30% after deductible (limited to 30 days/calendar year combined)
Urgent Care	10% after deductible	30% after deductible
Emergency Room	20% after deductible	20% after deductible
Outpatient Lab and X-rays *(except Complex Imaging)* *(performed in a stand alone facility e.g., LabCorp or Quest Diagnostics)*	10% after deductible	30% after deductible
Outpatient Lab and X-rays *(except Complex Imaging)* *(performed in a hospital)*	20% after deductible	40% after deductible
Complex Imaging **MRI, MRA, CAT, PET scans** *(pre-certification may be required)* *(performed in a freestanding imaging facility)*	10% after deductible	30% after deductible
Complex Imaging **MRI, MRA, CAT, PET scans** *(pre-certification may be required)* *(performed in a hospital))*	20% after deductible	40% after deductible
Outpatient Surgery Facility *(performed in a clinic or ambulatory surgical center)*	10% after deductible	30% after deductible
Outpatient Surgery Facility *(performed in hospital setting)*	20% after deductible	40% after deductible
Outpatient Professional Services *(Surgeons, Radiologists, Pathologist and Anesthesiologists)*	10% after deductible	30% after deductible
Calendar Year Deductible	**Individual**: $1,500 **Individual in a Family**: $3,000 **Family**: $3,000	**Individual**: $3,000 **Individual in a Family**: $3,000 **Family**: $6,000
Inpatient Hospitalization *(pre-service notification may be required)*	20% after deductible	40% after deductible
Calendar Year Out-of-Pocket Maximum	**Individual**: $3,000 **Individual in a Family**: $3,000 **Family**: $6,000	**Individual:** $9,000 **Individual in a Family:** $9,000 **Family:** $18,000
Retail Pharmacy	**30 day / 90 day supply**	
• Designated Preventive Care Drugs *(Tiers 1a, 1b, 2)*	No charge (deductible waived)	Not Available
• Tier 1	$15 copay after deductible / $30 copay after deductible	Not Available
• Tier 2	$40 copay after deductible / $80 copay after deductible	Not Available
• Tier 3	$60 copay after deductible / $120 copay after deductible	Not Available
• Specialty Pharmacy *(Tier 4)*	30% up to maximum $250 after deductible (30 day supply)	Not Available
Mail Order *(up to 90 days supply)*		
• Tier 1	$15 copay after deductible	Not Available
• Tier 2	$80 copay after deductible	Not Available
• Tier 3	$120 copay after deductible	Not Available
• Specialty Pharmacy *(Tier 4)*	30% up to maximum $250 after deductible (30 day supply)	Not Available

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Dental – Cigna

Cigna's Basic and Maximum PPO plans offer the freedom to choose any dentist; however, you may pay less with in-network dentists because of their negotiated fees for plan members. If you enroll dependents, they must be covered under the same plan you choose for yourself. If you enroll in the Cigna DHMO, you must use a participating in-network dentist for all services in order to receive benefits. There is no out-of-network coverage for the DHMO plan.

Plan Benefits	DHMO	PPO (Basic)		PPO (Max)	
	Cigna Network Only	In-Network	Non-Network*	In-Network	Non-Network*
	Member Pays				
Calendar Year Deductible	None	$50/$150		$25/$75	
Calendar Year Maximum Calendar year maximum only applies to basic and major services.	Unlimited	$1,000		$2,000	
Diagnostic & Preventive Does not count toward the calendar year maximum.					
• Periodic Oral Evaluation	$0 copay	10% No Deductible	20% No Deductible	Covered in full	
• Routine Cleaning *(2 per 12 months)*	$0 copay	10% No Deductible	20% No Deductible	Covered in full	
• Routine X-rays	$0 copay	10% No Deductible	20% No Deductible	Covered in full	
Basic Services					
• Restorations	$0 - $70 copay	20%**		15%**	20%**
• Endodontics	$0 - $220 copay	20%**		15%**	20%**
• Periodontics	$0 - $295 copay	20%**		15%**	20%**
Major Services					
• Inlays/Onlays *(limits apply)*	$0 to $250 copay	40%**	50%**	35%**	40%**
• Complete Denture I	$135 - $190 copay	40%**	50%**	35%**	40%**
• Implants	Not covered	40%**	50%**	35%**	40%**
Orthodontics					
• Child *(to age 19)*	$1,494	35%		35%	
• Adult *(age 19 and older)*	$1,998	35%		35%	
Orthodontia Lifetime Maximum					
• Per Person		$1,000	$1,000	$2,000	$2,000

* Services obtained through a non-PPO provider are subject to Reasonable and Customary Charges and balance billing may occur at a non-contracted provider.

** Percent of covered charges you pay after the deductible

Find a Participating Dentist by Calling 800.244.6224 or Search Online by Visiting www.cigna.com and enter your zip code or city.

DHMO: Cigna Dental Care Access

DPPO: Total Cigna DPPO (Cigna DPPO Advantage and Cigna DPPO)

Digital ID cards are available by registering at www.mycigna.com.

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Vision – EyeMed

Routine vision exams are important, not only for correcting vision, but for detecting serious health conditions. Rady Children's offers you vision coverage through EyeMed.

Benefits include:

- Receive a $0 eye exam and an additional $50 added to your frame allowance when you visit an EyeMed PLUS provider.
- Use both your frame and contact lens allowance in the same year.
- Members-only savings on eyewear, LASIK, hearing aids, and more.

To find a provider in the EyeMed network (including EyeMed PLUS providers for extra savings), visit: https://eyedoclocator.eyemedvisioncare.com

Summary of Benefits

Vision Care Services	In-Network Member Cost	Out-of-Network Member Reimbursement
Exam Services		
• Exam at PLUS Provider	$0 copay	Up to $40
• Exam	$10 copay	Up to $40
• Retinal Imaging	Up to $39	Not covered
Contact Lens Fit and Follow-up		
• Fit & Follow-up - Standard	Up to $40; contact lens fit and two follow-up visits	Not covered
• Fit & Follow-up - Premium	10% off retail price	Not covered
Frame		
• Frame at PLUS Provider	$0 copay; 20% off balance over $170 allowance	Up to $84
• Frame - Retail	$0 copay; 20% off balance over $120 allowance	Up to $84
• Frame - Wholesale*	$0 copay; balance over $84 allowance	Up to $84
Standard Plastic Lenses		
• Single Vision	$25 copay	Up to $30
• Bifocal	$25 copay	Up to $50
• Trifocal	$25 copay	Up to $70
• Lenticular	$25 copay	Up to $70
• Progressive - Standard	$25 copay	Up to $50
• Progressive - Premium Tier 1 - 4	$35 - $135 copay	Up to $50

* Available at wholesale providers, such as Costco Optical; discounts do not apply. View the provider locator to find wholesale providers.

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Vision – EyeMed (continued)

Vision Care Services	In-Network Member Cost	Out-of-Network Member Reimbursement
Lens Option		
• Anti Reflective Coating - Standard	$0 copay	Up to $23
• Anti Reflective Coating - Premium Tier 1 - 3	$15 - $40 copay	Up to $23
• Photochromic - Non-Glass	$75	Not covered
• Polycarbonate - Standard	$40	Not covered
• Polycarbonate - Standard < 19 years of age	$0 copay	Up to $20
• Scratch Coating - Standard Plastic	$15	Not covered
• Tint - Solid and Gradient	$15	Not covered
• UV Treatment	$15	Not covered
• All Other Lens Options	20% off retail price	Not covered
Contact Lenses		
• Contacts - Conventional	$0 copay; 15% off balance over $105 allowance	Up to $74
• Contacts - Disposable	$0 copay; 100% of balance over $105 allowance	Up to $74
• Contacts - Medically Necessary	$0 copay; paid-in-full	Up to $300
Other		
• Hearing Care from Amplifon Network	Discounts on hearing aids; call 1.877.203.0675	Not covered
• Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
Frequency	**ALLOWED FREQUENCY – ADULTS**	**ALLOWED FREQUENCY – KIDS**
• Exam	Once every 12 months	Once every 12 months
• Frame	Once every 24 months	Once every 24 months
• Lenses	Once every 12 months	Once every 12 months
• Contacts Lenses	Once every 12 months	Once every 12 months
• *(Plan allows member to receive either contacts and frame, or frame and lens services)*		

Search and Find Participating Eye Doctors (including EyeMed PLUS providers for extra savings) at eyemed.com or on the EyeMed Members App. Digital ID cards are available by registering at eyemed.com.

Flexible Benefits – TRI-AD

Rady Children's Hospital-San Diego offers Flexible Spending Accounts (FSAs), allowing you to use pre-tax dollars to pay for eligible out-of-pocket health and/or dependent care expenses. If you elect benefits under the plan, you are required to maintain your benefit election(s) until the next annual Open Enrollment period, unless you have a qualifying event or status change during the year as defined by the IRS. The FSA plans are administered by TRI-AD.

Flexible Spending Accounts and Pre-tax Premiums

Qualified insurance premiums are deducted from your salary before taxes (pre-tax). As a result, you lower your gross taxable income, pay fewer taxes and keep more of what you earn.

Flexible Spending Accounts (FSA)

2023 Contribution Maximum Amounts	
General Purpose Account	$2,850
Limited Purpose Account	$2,850
Dependent Care FSA	$5,000, or $2,500 if married and filing separately

You will automatically receive an FSA debit card upon enrollment. You may use this card at the point of service to pay for eligible expenses. If a provider does not accept your FSA debit card, you will need to pay for your expense(s) out-of-pocket and submit a claim for reimbursement, along with the necessary documentation. Claim forms are available on TRI-AD's website: tri-ad.com. TRI-AD can be reached at 888.844.1372.

Health Care FSA

- **General Purpose Account:** You can set aside up to $2,850 this plan year. This money can be used to pay for qualified expenses not covered by medical, vision and dental insurance. A full list of eligible and non-eligible expenses can be found when you establish/login to your FSA account at tri-ad.com. The General Purpose FSA cannot be used in conjunction with the HDHP plan with an HSA.

Click here to watch a video on Flexible Spending Accounts (FSA).

- **Limited Purpose Account:** The limited purpose FSA is only for those employees who are enrolled in the HDHP/HSA plan. It is the same as the general FSA account in that you can set aside up to $2,850 this plan year, except it is limited to dental and vision expenses only. You cannot use the limited purpose FSA for medical expenses as medical expenses would be covered under your Health Savings Account. The limited purpose FSA is designed for those HSA participants that have large dental or vision expenses (e.g. braces, laser eye surgery, etc.) for which they do not want to use their HSA funds.

Dependent Care FSA

Allows you to use pre-tax expenses for dependent care that enables you (and your spouse, if married) to work. Eligible expenses include day care or after school care expenses for a child under age 13 or care for a spouse or adult dependent incapable of self care. The maximum contribution per year is $5,000 or $2,500 if married and filing separately.

Please note, Flexible Spending Accounts are "Use it or Lose it". Leftover funds cannot be carried over to the next plan year or refunded.

TRI-AD Benefits on the Go

Access your accounts from your mobile device.

- Download the app in the iTunes Store™ or on Google Play™
- Select "Register Now" to complete the registration process
- Please enter the Rady employer ID of TIDCHSD and your employee ID (SSN) when prompted

For returning users, please continue to use your previous Username and Password.

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Life and Disability Insurance – Unum

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

Basic Life insurance pays your beneficiary a lump sum if you should pass away. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight or hearing, or if you die in an accident. Coverage is provided through Unum. The cost of coverage is paid in full by Rady Children's.

Employees covered by Unum's Basic Life Insurance, have access to Travel Assistance Services through Assist America. Contact information is located at the front of this guide.

	Unum
Life/AD&D Amount	1x covered annual earnings up to a maximum of $2,000,000
Guaranteed Issue	$200,000
Age Reduction	Reduced by 35% of original amount at age 70; Reduced by 50% of original amount at age 75

* The cost of your Employer Paid coverage is included in your taxable income.

Supplemental Life Insurance and AD&D

Eligible employees can purchase additional supplemental life and AD&D insurance to protect your family's financial security. Coverage is provided through Unum. Employees pay 100% of the after-tax premiums for this coverage.

	Unum
Employee Supplemental Life and AD&D Insurance	**1, 2, 3 or 4x annual earnings:** up to $2,000,000 (basic and supplemental combined) **Guarantee Issue:** up to $200,000
Spouse Supplemental Life Insurance*	$10,000, $25,000, $50,000 or $100,000 not to exceed 50% of EE's voluntary life coverage amount. **Guarantee Issue:** up to $25,000
Chlld(ren) Supplemental Life Insurance	Flat $15,000 (**Live birth to 14 days:** $1,000)
Age Reduction	**Employee/Spouse:** Reduced by 35% of original amount at age 70; Reduced by 50% of original amount at age 75
Cost	The premium is paid in full by employee

* If your spouse is currently disabled, the policy effective date will be delayed until he/she is no longer disabled. Please notify the Benefits Department if you are covering a disabled spouse for life insurance.

Guaranteed Issue amounts apply to initial offering only (e.g. at time of hire). Evidence of Insurability (Health Statement) will be required for all elected amounts above Guarantee Issue, for increases in coverage during Open Enrollment and late entrants for you and your spouse. Late entrants are enrollments after the initial eligibility period. Coverage amount and effective date of Supplemental Life coverage will need to be approved by the carrier.

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Life and Disability Insurance – Unum (continued)

Long-Term Disability Insurance

Long-Term Disability (LTD) coverage pays you a percentage of your income if you are unable to work due to an injury or illness. Benefits are reduced by income from other benefits you might receive while unable to work, such as workers' compensation and social security. If you qualify, LTD benefits begin after a 180-day waiting period. Coverage is provided through Unum. Employees covered under Unum's LTD insurance also receive access to Unum's Employee Assistance Program.

	Unum
Elimination Period	180 days
LTD Benefit *(Day 181 & Beyond)*	Plan provides for 40% of pre-disability monthly earnings to a max of $15,000
Cost	The premium is paid in full by Rady Children's.* Eligible employees have the option to purchase additional coverage up to 60% of base salary, subject to Evidence of Insurabillty and approval.

* The cost of your Employer Paid coverage is included in your taxable income.

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Retirement Benefits

Rady Children's retirement program has two components and varies depending on when you were hired (or rehired).

Rady Children's Pension Plan

Available to employees hired or rehired before July 1, 2014

The Pension plan provides you with retirement income based on your age, earnings and years of service. Rady Children's pays the entire cost of this plan. Benefits generally begin after you have reached age 65, but may begin earlier if you meet the plan's early retirement requirements (although your benefit amount will be adjusted for early retirement). An in-service phased retirement option may also be available. For specific information, please refer to the pension plan's Summary Plan Description (SPD).

Rady Children's 403(b) Retirement Plan

Available to all employees

The 403(b) plan is a tax-deferred retirement plan that allows you to save pre-tax dollars and receive matching contributions from Rady Children's. *You are eligible to begin contributing to the 403(b) plan immediately. Employees who work 1,000 hours within a calendar year are eligible to receive an employer matching contribution.*

Your rate of match, vesting schedule, and whether you are eligible for an employer non-elective contribution will depend on your date of hire. For detailed information, please refer to the 403(b) plan's summary plan description.

Match and vesting for employees hired or rehired on or before 6/30/2014

The hospital will contribute a percentage of your first 8% of salary deferral based on your years of service (see the table below). For example, during your first five years of service, the hospital will contribute 25% of the amount you contribute, up to a maximum employer contribution of 2% of your salary (25% x 8% = 2%). In order to maximize the amount of match you receive, you need to contribute at least 8% of your salary. You are immediately vested in any contributions the hospital makes toward your 403(b) account. Vesting means you own the amount of money the hospital has contributed toward your 403(b) and may take this money with you when your employment with the hospital ends.

Years of Service (hired or rehired on or before 6/30/14)	Percentage of your contribution the hospital will contribute	Maximum percentage of your salary the hospital will contribute
0 - 5	25%	2%
6 - 10	30%	2.4%
11 - 15	35%	2.8%
16 - 20	45%	3.6%
21 - 25	55%	4.4%
26+	65%	5.2%

Match and vesting for employees hired or rehired on or after 7/1/2014

The hospital will match 100% of your deferral up to 3% of your salary. Once you have been employed by the hospital for a year, and worked a 1,000 hours within that year, you will also be eligible to receive an annual discretionary, non-elective, hospital contribution of 1-2% toward your 403(b) regardless of how much you contributed that year.

You are vested in hospital contributions to your 403(b) account after 3 years of service. Vesting means you own the money the hospital has contributed to your account after 3 years of service and you may take this money with you when your employment with the hospital ends. In order to receive a year of service toward vesting, you must be paid for at least 1,000 hours in a calendar year.

Log on to Fidelity NetBenefits® at www.netbenefits.com/rchsd or call the Fidelity Retirement Services Center at 1-800-343-0860 to enroll or make changes to your contributions in the Plan.

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Employee Assistance Program – Magellan

When it comes to balancing family, work and personal needs, your **Employee Assistance Program (EAP),** administered by Magellan Healthcare, can support you with everything from checking off daily tasks to working on more complex issues.

The EAP is provided to all employees, their families, and household members, from the date of hire, at no additional charge. You can access the EAP by calling 800.327.9298, toll free, 24 hours a day or visit member.magellanhealthcare.com.

No situation is too big or too small. When you and your family or household members need assistance, reach out anytime and the EAP will help get you on the right path to meet your needs.

Key Features

- No cost to you and your household members
- Completely confidential service provided by a third party
- Available 24/7/365

Services to help you on your life's journey:

- **Counseling:** Counselors provide support on issues such as anxiety, stress, depression, relationships, substance misuse and more. Counseling is available in-person or by text message, live chat, phone or video conference.
- **Digital emotional wellness tools:** Self-guided programs for mental well-being, grief and loss, resilience, conflict management, chronic pain and more.
- **Lifestyle coaching:** Define and achieve your goals with the support of a coach including help with personal improvement, healthy eating, weight loss and more.

Financial Wellness, Legal services and Identity Theft Resolution

Get expert help to take control of your finances, resolve legal issues, restore credit, research specific topics and/or print your own state-specific legal forms.

Magellan HEALTHCARE®

Work-Life Services

Receive online support in the form of webinars, live talks and articles about important life events and everyday challenges for parents and seniors such as child and elder care, education, parenting and more.

Discount Center

Access hundreds of deals on nationally recognized brand-name products and services, all in one convenient place. Find discounts on consumer goods, travel, child and elder care, fitness centers, movie tickets and more.

How to Get Connected

When you or a family member call 800.327.9298, the Magellan representative will gather information to understand where support is needed.

Magellan will work to find the first available appointment with an appropriate provider, then share the contact information with you so you can call and make an appointment.

You will receive a call back within 5-7 days, or within 24 hours for an urgent situation.

Call the EAP at 800.327.9298 to speak with someone today.

Visit member.magellanhealthcare.com for online tools, articles, resources and more!

Additional Benefits

Infertility Expense Reimbursement

Rady Children's offers a reimbursement program for expenses incurred for infertility treatments. The plan is self-funded by Rady Children's and offers dollar-for-dollar reimbursement up to $5,000 per plan year with a $10,000 lifetime maximum benefit. All benefit eligible employees and their spouses or registered domestic partners are eligible regardless of their medical plan enrollment status. **Please note: For all infertility expense reimbursement claims, the measuring year is July 1 - June 30.** All claims for infertility reimbursement should be sent to TRI-AD.

Voluntary Benefits with Colonial Life

You have the option to purchase Voluntary Benefits in a variety of coverage areas. You pay the full, after-tax cost of any Voluntary Benefits you elect through convenient payroll deductions. Please see plan policies for more information.

Supplemental Short-Term Disability Insurance (STD)

Additional short-term disability coverage is available through Colonial Life. Plan pays on your eighth day of disability for up to six months. You can purchase coverage up to 25% of your monthly income. Pre-existing conditions apply for the first 12 months (nine months for pregnancies) after the coverage effective date.

Group Hospital Confinement Indemnity Insurance (Group Medical Bridge)

This plan is designed to bridge the gap for medical plan deductibles for inpatient hospitalizations. In order to qualify for this benefit, you must be hospitalized for at least 20 consecutive hours. Two benefit levels are available ($500 and $1,500) and pay as a lump sum limited to one payment per calendar year. Pre-existing conditions apply.

Accident Insurance

This plan is designed to help offset costs associated with unexpected injuries as a result of an accident. The payment schedule varies based on the type of injury and treatment.

Group Specified Disease Insurance (Critical Illness)

This plan is designed to help pay for non-medical and out-of-pocket expenses upon diagnosis of a specified critical illness, such as cancer, stroke, heart attack, or coma. Colonial Life's policy also includes a benefit for the extended treatment of cancer. Pre-existing conditions apply.

Leaves of Absence

A Leave of Absence (LOA) is time off from work for an extended period (more than 7 days) for something other than a scheduled vacation. Visit the HR Benefits section of the Rady Children's intranet for more information about the type(s) of leave you may be eligible for, including Pregnancy, Family and Medical, Personal, Military, and Educational Leave. You may also contact a member of our HR Leaves Team at 858.966.5903 (x225903) or by email at leaveofabsence@rchsd.org.

How to log into Colonial Life to enroll, make changes or verify your enrollment:
https://harmonyenroll.coloniallife.com/SelfEnrollLogin.Web/Login.aspx

Login ID: RCHSD + Employee SSN (no spaces)

Password: First 4 letters of last name + Last 4 digits of SSN (no spaces)

Additional Benefits (continued)

Individual Voluntary Life Insurance with Long Term Care from Chubb

For additional financial protection, eligible employees can enroll in Voluntary Life Insurance with a Long Term Care (LTC) rider through Chubb's LifeTime Benefit Term. The benefit offers protection in two ways:

- **As Life Insurance:** The LifeTime Benefit Term policy offers up to $225,000 in life insurance benefits (up to $112,500 for spouses/domestic partners) to offer financial protection for you and your family.
- **For Long Term Care (LTC):** The LifeTime Benefit Term policy can be used to pay for Long Term Care, such as home health care, assisted living, adult day care, and nursing home benefits. LTC monthly benefits equal 4% of your approved life insurance policy amount, and you can receive these benefits for up to 50 months. Please note that any LTC benefits you receive will be deducted from the life insurance policy amount.
- **To enroll:** You will need to enroll in Chubb LifeTime Benefit Term through a licensed benefit counselor (AP Elan Group). To schedule an appointment, visit https://calendly.com/d/d7b-6np-gf7/rady-children-s-hospital-2023-open-enrollment

Important note: You will pay Chubb directly for this policy (not via payroll deductions).

- **Customer Service Center (for current Chubb policyholders):**
  LifeTime Benefit Term Plans
  855.241.9891 -
  8:30 am - 7 pm EST, Monday-Friday
  Email: csmail@gotoservice.chubb.com
- **Claims Department (for current Chubb policyholders):**
  LifeTime Benefit Term Claims
  Employees can call 855.241.9891 to file a claim.
  Claims can be faxed to 603.352.1179
  Claims can be sent by email to CLAIMS@gotoservice.chubb.com

Voluntary Pet Insurance/Nationwide

Nationwide Insurance offers pet insurance policies that can provide you with the coverage you need should your pet become injured or ill. Contact Nationwide Pet Insurance at 877.738.7874 or visit petinsurance.com/rchsd for more details.

When Benefits End

Below is a description of how your benefits end when your employment ends. Refer to the Important Notices at the end of this guide for detailed information about COBRA continuation coverage.

Health Benefits (medical, dental, vision)

Your current medical, dental and vision insurance will end on the last day of the month in which your employment ends. You may elect to continue your medical, dental and vision coverage by paying the full cost of the premium under COBRA (Consolidated Omnibus Budget Reconciliation Act). Information will be mailed to your home from our COBRA administrator, TRI-AD, including instructions on how to enroll and the amount of the premiums. For additional information, you may contact TRI-AD, the COBRA administrator, directly at 888.844.1372.

Health Care Flexible Spending Account (FSA)

When your employment ends, you are no longer eligible to make pre-tax contributions to your health care or limited purpose FSAs. Your eligibility to incur claims for reimbursement ends on the last day of your employment. You have 90 days after the plan year ends (3/31) to submit any claims for reimbursement incurred prior to your last day of eligibility or employment. If you have a remaining balance in your account, you may be able to continue your FSA through COBRA. For additional information, you may contact TRI-AD, the FSA administrator, directly at 888.844.1372.

Dependent Care Flexible Spending Account (FSA)

When your employment ends, you are no longer eligible to make pre-tax contributions to your dependent care FSA. If you have a remaining account balance, you have until the last day of the plan year (12/31) to incur employment related Dependent Care expenses and may submit claims for reimbursement up to 90 days (March 31) after the plan year ends. For additional information, you may contact TRI-AD, the FSA administrator, directly at 888.844.1372. The Dependent Care FSA is not eligible for continuation through COBRA.

Life and Disability Benefits

Your life and disability insurance will end on your last day of employment. You will receive information with your final paycheck on how you can continue your coverage directly with Unum. You may contact UNUM directly at 866.220.8460 for additional information.

Voluntary Benefits

Voluntary benefits (Colonial Life, Trustmark, Allstate, and Assurity) will end on your last day of employment; however, you may be able to convert certain policies to individual policies by contacting the carrier directly.

403(b) Retirement Plan

When your employment ends the options for your account may include leaving your funds in the plan, rolling them over to another qualified plan or IRA, or taking a taxable distribution. For additional information, contact Fidelity Investments at 800.343.0860. If you have an outstanding loan from your 403(b) Plan at Fidelity, loan payments can continue to be paid as scheduled.

Contributions

Semi-Monthly Contributions (Twice Per Month)				
Medical	**Full-Time: 1.0 - .875 FTE (80 - 70 hours/PP)**	**Part-Time 1: .873 - .7 FTE (69.9 - 56.0 hours/PP)**	**Part-Time 2: .69 - .45 FTE (55.9 - 36.0 hours/PP)**	**Per Diem (billed monthly)**
Anthem Priority Select HMO				
• Employee Only	$47.97	$106.00	$183.40	$595.28
• Employee + Spouse/DP	$173.88	$238.57	$369.50	$1,323.08
• Employee + Child(ren)	$129.02	$210.16	$318.41	$1,111.39
• Employee + Family	$268.11	$381.59	$532.18	$1,817.03
Anthem Select HMO				
• Employee Only	$54.54	$122.56	$213.27	$684.33
• Employee + Spouse/DP	$200.02	$275.85	$429.29	$1,539.73
• Employee + Child(ren)	$148.03	$243.13	$369.99	$1,300.21
• Employee + Family	$309.04	$442.05	$618.55	$2,114.56
Anthem HDHP w/HSA				
• Employee Only	$87.07	$167.90	$275.60	$989.15
• Employee + Spouse/DP	$267.60	$392.65	$559.18	$2,225.53
• Employee + Child(ren)	$221.49	$330.91	$475.00	$1,879.35
• Employee + Family	$455.27	$624.03	$858.55	$3,056.39

Credit for Medical Premiums

Rady Children's has a credit program for benefit-eligible employees with an hourly rate up to $23.99/hour. This credit, as shown below, is applied to your medical premium deduction each paycheck.

Hourly Rate	Credit
$20.00 to $23.99	$11

Waiver for Medical Coverage

If you choose not to participate in a Rady Children's medical plan and you waive your coverage in PeopleSoft HCM, you are eligible for a credit on your first two paychecks each month, when medical premiums would otherwise be withheld, based on your full-time or part-time FTE status. You must actively "waive" coverage in PeopleSoft in order to receive the waiver credit.

Classification	Allocated Hours (FTE)	Waiver Credit
Full-Time	80 hours - 70 hours	$19.42
Part-Time 1	69.9 hours - 56 hours	$16.17
Part-Time 2	55.9 hours - 36 hours	$11.84

Note: Deductions and credits occur on the first two paychecks of each month. If there are three paychecks in a month, no deductions will be taken from the third check.

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.

Contributions (continued)

Semi-Monthly Contributions (Twice Per Month)				
Dental	**Full-Time: 1.0 - .875 FTE (80 - 70 hours/PP)**	**Part-Time 1: .873 - .7 FTE (69.9 - 56.0 hours/PP)**	**Part-Time 2: .69 - .45 FTE (55.9 - 36.0 hours/PP)**	**Per Diem (billed monthly)**
Cigna PPO Basic				
• Employee Only	$1.49	$3.46	$6.09	$28.16
• Employee + Spouse/DP	$13.99	$16.89	$19.99	$57.13
• Employee + Child(ren)	$16.46	$19.53	$23.62	$66.03
• Employee + Family	$27.94	$32.43	$38.43	$105.33
Cigna PPO Max				
• Employee Only	$5.57	$7.50	$10.11	$48.16
• Employee + Spouse/DP	$20.78	$23.61	$27.38	$97.97
• Employee + Child(ren)	$23.99	$27.01	$31.06	$113.29
• Employee + Family	$39.16	$43.62	$49.56	$180.83
Cigna DHMO				
• Employee Only	$1.32	$2.27	$3.53	$12.32
• Employee + Spouse/DP	$5.45	$6.80	$8.62	$25.64
• Employee + Child(ren)	$6.44	$7.77	$9.84	$22.64
• Employee + Family	$8.73	$10.87	$13.72	$36.67

Semi-Monthly Contributions (Twice Per Month)				
Vision	**Full-Time: 1.0 - .875 FTE (80 - 70 hours/PP)**	**Part-Time 1: .873 - .7 FTE (69.9 - 56.0 hours/PP)**	**Part-Time 2: .69 - .45 FTE (55.9 - 36.0 hours/PP)**	**Per Diem (billed monthly)**
EyeMed				
• Employee Only	$0.88	$1.15	$1.52	$5.93
• Employee + Spouse/DP	$1.28	$1.82	$2.54	$11.86
• Employee + Child(ren)	$1.21	$1.71	$2.39	$11.44
• Employee + Family	$1.93	$2.88	$4.16	$17.74

Note: Deductions and credits occur on the first two paychecks of each month. If there are three paychecks in a month, no deductions will be taken from the third check.

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.

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 certain 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.

Discrimination Is Against the Law

Rady Children's Hospital-San Diego 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). Rady Children's Hospital-San Diego 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 generally 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 858-966-5801.

Patient Protections

The HMO medical plans require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the HMO's network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Anthem Blue Cross at 833-913-2237or anthem.com/ca/find-care.

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

You do not need prior authorization from the plan or any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional who participates in the HMO's network and who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Anthem Blue Cross at 833-913-2237 or anthem.com/ca/find-care.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Anthem Blue Cross Select HMO, Priority Select HMO, and Prudent Buyer. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately at anthem.com/ca/find-care or calling 833-913-2237. 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 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.

Important Notices (continued)

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.

Important Notices (continued)

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 considered to be 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 get 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 get 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.

Important Notices (continued)

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 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 considered 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/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

Important Notices (continued)

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.

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

Note: When your employment ends, you are no longer eligible to make pre-tax contributions to your health care flexible spending account. Your eligibility to incur claims for reimbursement ends on the last day of your employment. You have 90 days to submit for reimbursement any claims incurred prior to your last day of eligibility. If you have a remaining balance of your year-to-date contributions to the account, you may be able to continue your FSA participation through COBRA. For additional information, you may contact TRI-AD, the FSA administrator, directly at 888.844.1372.

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 for eligibility 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:

Human Resources – Benefits Dept. benefits@rchsd.org

Medicare Part D – Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Rady Children's Hospital-San Diego 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.**
- **Rady Children's Hospital-San Diego/Anthem Blue Cross of California has determined that the prescription drug coverage offered by Rady Children's Hospital-San Diego Medical Plans are, 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.**

Important Notices (continued)

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 Rady Children's Hospital-San Diego coverage will not be affected. If you keep this coverage and elect Medicare, the Rady Children's Hospital-San Diego coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Rady Children's Hospital-San Diego 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 Rady Children's Hospital-San Diego 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 (i.e., 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 will 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 Rady Children's Hospital-San Diego changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will 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 your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800.MEDICARE (800-633-4227). TTY users should call 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 800-772-1213 (TTY 800-325-0778).

REMEMBER

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

Date:	October 2022
Name of Entity / Sender:	Rady Children's Hospital-San Diego
Contact:	Human Resources – Benefits Dept.
Address:	3020 Children's Way – MC: 5040 San Diego, CA 92123
Phone:	858-966-5801

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

Rady Children's Hospital-San Diego 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 – Benefits Department at 858-966-5801.

Important Notices (continued)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Rady Children's Hospital-San Diego 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 November 1, 2022, and is anticipated to end on January 31, 2023. Open Enrollment for most other states will begin on November 1 and close on January 15 of each year. Some states have expanded the open enrollment period beyond January 15, 2023 for coverage to begin in 2023. Notably, Covered California continues its special enrollment periods for coverage beginning in 2023.

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 9.12% (for 2023) of your household income for the year, then that coverage is not Affordable. 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 a 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.

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 Rady Children's Hospital-San Diego	**4. Employer Identification Number (EIN)** 95-1691313	
5. Employer address 3020 Children's Way – MC: 5040	**6. Employer phone number** 858-576-1700	
7. City San Diego	**8. State** CA	**9. ZIP code** 92123
10. Who can we contact about employee health coverage at this job? Human Resources – Benefits Department		
11. Phone number (if different from above) 858-966-5801	**12. Email address** Benefits@rchsd.org	

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.

Important Notices (continued)

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, 2022. 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://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service:
800-359-1991 | TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
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
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 800-457-4584

Important Notices (continued)

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888-346-9562

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

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

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.maine.gov/dhhs/ofi/applications-forms
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: 617-886-8102

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

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
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/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800-701-0710

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: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 844-854-4825

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

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

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 800-692-7462

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

Important Notices (continued)

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

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877-543-7669

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp/
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, 2022, 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

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, reduced FSA contributions, 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).

Glossary (continued)

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. 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.

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 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.

Click here to watch a video on Benefits Key Terms Explained.