EMPLOYEE BENEFITS GUIDE 2025

Rady Children's®

Employee Benefits Guide 2025

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Click on the icons or scan the QR codes throughout this guide to watch videos explaining a variety of benefits topics.

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

Please see page 40 for more details.

The information in this brochure is a general outline of the benefits offered under the Rady Children's Hospital-San Diego benefits program. Certain plan limitations are provided in this Wrap Summary Plan Description (SPD), which is based on the official Plan Documents that may include policies, contracts, plan procedures, and SPDs for individual plans. This Wrap SPD and the 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.

Contact Information

Plan	Carrier	Phone Number	Website or Email
Human Resources/ Benefits Team	• General Benefits Questions	858.966.1700 ext. 245801	benefits@rchsd.org
	• Retirement	858.966.4037	
Medical/Pharmacy (HMO)	• Anthem Blue Cross HMO *(Priority Select & Select)* Group Number - L03624	833.913.2237	anthem.com/ca
Medical/Pharmacy (HDHP w/HSA)	• Anthem Blue Cross HDHP w/HSA Group Number - L03624	800.227.3771	anthem.com/ca
Medical/Behavioral Health	• Rula	323.205.7088	rula.com/radychildrens
Telehealth	• LiveHealthOnline	888.548.3432	livehealthonline.com
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:** 800.445.0402 **LTD 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 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	• Unum 944936-STD *(CA employees)* 946404-STD *(Non CA employees)* 944937-Accident 944938-Critical Illness 944939-Hospital	800.985.2429	www.unum.com/access
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

Eligibility

Benefits eligibility is determined by employee classification, number of hours regularly scheduled to work, and completion of any applicable waiting period. Benefits are generally effective on the first day of the month coinciding with or following 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	Tier 1	Tier 2	Casual
Hours Requirement	Minimum 56 hours per pay period	Minimum 36 hours per pay period	Employees with a minimum 3-month assignment scheduled to work at least 36 hours per pay period
Benefits Effective Date	1st day of the month coinciding with or following 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/AD&D • Spouse/Child Life • Disability		

Notes:

1. Employees classified as Per Diem and part-time employees who do not meet the minimum requirement of 36 hours per pay period are eligible for Medical, Dental, and Vision insurance, at full cost. Premiums will not be deducted through payroll; TRI-AD will direct bill on a monthly basis.
2. Per Diem employees and part-time employees who do not meet the minimum hours 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 and Pet Insurance.

Eligible employees may enroll the following dependents:

- 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 the 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 age 26.

* You will need to provide proof of dependent status; see page 4 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 transfer 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 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 on the first of the month following the qualifying life 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 life event, including the date of gain/loss of coverage or dependent eligibility.

To update your benefits due to a qualifying status change or life event, select "Life Events" in PeopleSoft Employee Self-Service within 31 days of the change. Supporting documentation is required.

If you do not complete this process within 31 days, you will not be able to make changes to your benefits until the next Open Enrollment period.

CHIP and Medicaid eligible employees have 60 days to enroll.

How to Enroll or Update your Benefits

Log into PeopleSoft using the same **User ID** and **password** that you use to log into the hospital network. Once logged in, click on the Benefit Details tile in Employee Self-Service and click "Select" next to the applicable event (Open Enrollment or New Hire) to get started. For step-by-step enrollment instructions, please visit the Benefits page on the intranet. **Please note:** Your elections will not be considered complete until you hit **Submit** on the final screen in PeopleSoft. If you do not hit **Submit**, your changes/elections will not be processed.

Eligibility (continued)

Dependent Type	Eligibility	Supporting Documents
Spouse	**Married Spouse** **NOTE**: A Federal Tax Return filed as "**Head of Household**" does **NOT** meet the eligibility guidelines to enroll your spouse.[1]	**One of the following will be accepted:** • Federal Tax Return (1040) for current filing period *(preferred)*, or prior filing period • IRS Transcript for 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	**Biological Child**	**One of the following will be accepted:** • Federal Tax Return (1040) for current filing period *(preferred)*, or prior filing period • IRS Transcript of 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	**Child of current Spouse or Domestic Partner** Domestic Partner must be enrolled	**One of the following will be accepted PLUS the Original Birth Certificate**[2]: • Federal Tax Return (1040) for current filing period (preferred), or prior filing period • IRS Transcript for 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	**Adopted Child** Eligible at the time of placement	**One of the following documents will be accepted:** • Federal Tax Return (1040) for current filing period *(preferred)*, or prior filing period • IRS Transcript for 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[3]**/ Legal Custody** • Birth to Age 18	**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) for current filing period *(preferred)*, or prior filing period • IRS Transcript for 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 AND Physician documented incapacity of self-support letter** • Federal Tax Return (1040) for current filing period *(preferred)*, or prior filing period • IRS Transcript for current filing period *(preferred)*, or prior filing period

1. In accordance with IRS rules, filing Head of Household is considered a single status.
2. The birth certificate must include the employee's spouse or RDP's name as parent.
3. If the adoption or legal guardianship occurs under the employee's spouse/RDP, the employee/spouse/RDP relationship must be substantiated.
4. Onset of disability must be prior to attaining age 26.

Dependent Verification

We have listed the most commonly required supporting documentation for different types of dependent coverage. This list may not be all-inclusive. The proof must substantiate the relationship. Documentation must be provided within 31 days of effective date of coverage. If adding a dependent (over the age of six (6) months), 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

IMPORTANT!

For all newly added dependents, verification documents are required within 31 days of the effective date of coverage. Please email to benefits@rchsd.org or fax to 858-966-7834.

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.

ALEX® Benefits Guidance

Before you make your enrollment decisions, let ALEX help you find the plans that best fit your needs.

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

You don't have time to spend hours meticulously lining up benefits PDFs side-by-side to try and spot the difference between plans. Instead, get support with a recommendation from ALEX Go.

With ALEX Go, You Can:

- Get personalized benefits advice at your own pace with a text-based experience in English or Spanish
- Compare your plans with a family member's plans to figure out which option gives you the best coverage for the lowest cost
- Save money by choosing the right medical plan for you, forecasting HSA savings, and more
- Review voluntary benefits like hospital indemnity, critical illness, and accident coverage
- Access support on the go with an experience that works just as well on your computer or your phone

Medical – Anthem Blue Cross

Rady Children's provides you with comprehensive medical coverage and the choice between three plans:

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

To learn more about what services are covered under preventive care click on this link: Preventive Care Plans & Guidelines | Anthem.

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. Refer to the handout titled, "Find an Anthem Blue Cross Provider" on the Benefits intranet page 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.

Your PCP will coordinate your overall care, prior authorizations and any specialist referrals. Each family member may select 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.

To change your assigned PCP, please call Anthem Blue Cross at 833.913.2237. You may change your PCP on a monthly basis 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, 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, 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:

- Scripps Physicians Medical Group
- Rady Children's
- Lakeside Medical * in Los Angeles County
- Hoag Medical Group
- PrimeCare (San Bernardino and Riverside Counties)
- UCSD Physician Network – Primary Care

* For other Lakeside Medical Group Locations visit www.anthem.com/ca/find-care

Please note Scripps Health is not in the Priority Select Network

SIMNSA HMO Medical Group in Mexico

Anthem works with Sistemas Medicos Nacionales, S.A. de C.V. (SIMNSA), an HMO provider that allows you to choose a primary medical group, receive care and fill prescriptions in Northern Mexico. This is available to Mexican nationals legally employed and living in San Diego and Imperial counties, and their dependents of any nationality. Upon receiving your Anthem ID card, please reach out to SIMNSA at: 800.424.4652 or 619.407.4082 to select your provider in Mexico. For more information call Anthem member services at 833.913.2237.

Medical – Anthem Blue Cross (continued)

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

You must reside in California to enroll in one of the HMO plans. However, your eligible dependents living outside California may be able to enroll in the Away From Home Guest Membership Program. This program is designed for members who will be residing outside their home state for a minimum of 90 days. To determine if there are providers available in your dependent's area, please contact the Anthem Blue Cross customer service number on your ID card.

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 PPO 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.

Health Savings Account

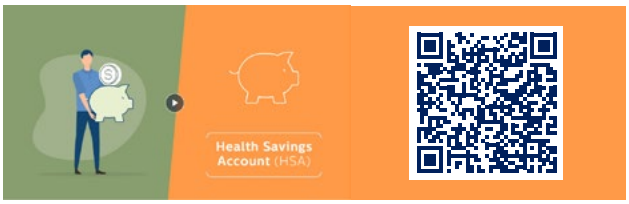
If you enroll in the HDHP you have the opportunity to participate in a Health Savings Account (HSA). You may make pre-tax contributions from your paycheck to your HSA each year you're enrolled in the HDHP, up to the annual contribution limit set by the Internal Revenue Service (IRS). These pre-tax contributions 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 the 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 General Purpose healthcare Flexible Spending Account (you or your spouse)
- Covered under Medicare (including Part A), TRICARE or Medicaid
- Claimed as a dependent on someone else's tax return



Medical – Anthem Blue Cross (continued)

Annual HSA Contributions

	Max Allowed by IRS in 2025	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 $4,300	Up to $630	Up to $3,670	$1,000
Employee + Family	Up to $8,550	Up to $1,260	Up to $7,290	$1,000

The IRS sets 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 enrollment. If you are over age 55 by the end of 2025, the IRS allows you to contribute an additional $1,000 as a Catch Up Contribution.

Customer Identification Program (CIP): Anthem is required to perform customer identification before funds are deposited into your HSA. If there are 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 (you keep the money if you change jobs or retire)
- In addition to eligible medical expenses, you can use your HSA to pay for eligible dental and vision expenses, too
- Unspent monies roll over each year
- Employer can contribute
- Can use funds to help cover HDHP deductible
- Provides pre-tax savings
- You can change your contribution anytime

Using Investments to Grow Your HSA Dollars

One of the key benefits of an HSA is the ability for you, as the account holder, to invest the dollars you contribute, growing the value of your account over time. In addition to the benefit of having more dollars to pay for healthcare costs in the future, it is also a great option for retirement savings.

After your HSA balance reaches $1,000, anything over that amount can be invested.

Your contributions will grow tax-free and can help pay for future medical expenses.

For additional information regarding investing your HSA dollars, log into your account at anthem.com/ca.

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.

Medical – Anthem Blue Cross (continued)

Using Your HSA Funds

You can use the money in your HSA to pay for qualified expenses that are not covered by your HDHP, dental, and/or vision insurance. For a full list of eligible expenses, go to irs.gov and search for Publication 502.

Please keep receipts for items purchased using your HSA as backup in the event you are audited by the IRS.

HSA Example:

The Wilson family's HSA plan:

- $3,660 annual contribution
- $1,260 employer contribution + $100 per pay period employee contribution

Expenses		HSA balance
Preventive visits and lab tests	Covered at 100%	$3,660
Physical therapy	$800	$2,860
Prescription drugs	$200	$2,660
HSA rollover to next year		$2,660
HSA funds eligible to be invested		$1,660

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

Manage your health plan and HSA funds online at anthem.com/ca or through the Sydney mobile app.

Anthem Blue Cross Resources

Anthem Sydney Mobile App

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

Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you such as language(s) spoken or location.

My Health Dashboard

Use My Health Dashboard to find news on topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals.

Live Chat

Use the interactive chat feature or talk to an Anthem representative when you have questions about your benefits or need information.

Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker, then consult with a doctor through a video visit or text session.

Community Resources

Search for free or reduced cost services offering support in areas such as housing, transportation, and child care.

My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

Get Started with Sydney

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

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 non-emergent conditions like the flu, a cold, sinus infection, pink eye, rashes, fever and more.

Connect with mental health support from home: If you're feeling anxious, depressed, or need support with situations at home or at work, you can talk with a therapist online. In most cases, you can set up a secure visit seven days a week. You can also schedule a visit with a psychiatrist for support on managing your medication.

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 "Medical Plan Benefit Summary" on page 13-14 for the copays for each plan. Visit livehealthonline.com to get started.

Building Healthy Families

Building Healthy Families offers support for all phases of family planning (e.g. pre-conception, pregnancy, and post-partum).

- Access to 24/7 live support for pregnancy questions; provides resources and trackers for your health and baby's milestones
- Up to $40 incentive for completing various phases of program
- 12 months of free lactation support through LiveHealth Online starting from your child's date of birth

Visit anthem.com/ca or search "Building Healthy Families" in the Sydney app to learn more.

Questions?

Call Anthem Blue Cross Customer Service at 833.913.2237.

Anthem Blue Cross Resources (continued)

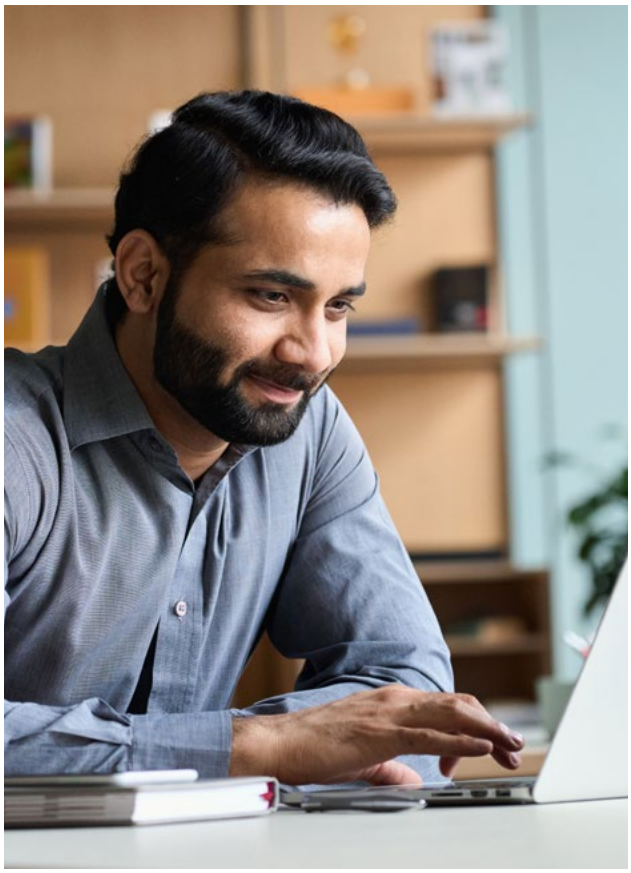
Anthem 24/7 NurseLine

NurseLine serves as your first line of defense for unexpected health issues. You can call a registered nurse to discuss what to do about a fever, to ask for allergy relief tips, or to get advice on 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.
- 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.

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



Rula

Finding a therapist just got easier.

Rula is an additional behavioral health provider group covered by your Anthem insurance with over 10,000 therapists, psychologists, and psychiatrists in all 50 states. Rula provides in-network, concierge-level behavioral health services. Rula offers individual (for ages 5+), couples, and family therapy, as well as psychiatric services (for ages 13+).

To utilize these benefits, follow the steps below.

1. **Visit rula.com/radychildrens or scan the QR code to register today:**
2. **Select your therapist:** Share your therapist preferences so Rula can match you with the right provider.
3. **Complete registration:** Register within 12 hours of selecting your therapist. No charges will be made until after your first appointment (cancel anytime).
4. **Verify your benefits:** Rula will check with your insurance and let you know your payment estimate before your appointment.
5. **Confirm your appointment:** You will receive a confirmation notice 1-2 days before your appointment along with a video call link.

If you have any questions, please call 323.205.7088.

Anthem Blue Cross Resources (continued)

Wellness Incentive 200

This program rewards you and your covered spouse, or registered domestic partner, up to $200 for participating 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 mobile app (see page 10 on how to register). 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 are tracked as they are completed.

All earned rewards may be redeemed through digital gift cards from retailers such as MasterCard, Amazon, Gap (all brands), Staples, Target, The Home Depot, and TJ Maxx.

Well-being Coach provides you with access to certified health coaches by phone or through one-on-one text coaching accessible through the Sydney mobile 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.

	Activities	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	up to $50
	Building Healthy Families	Completion	up to $40
	Well-being Coach Telephonic - Tobacco	Completion	$25
	Well-being Coach Telephonic - Weight	Completion	$25
Wellness	**Action Plans**	Tracked	up to $25
	Connect a Device	Tracked	$5
	Health Assessment	Tracked	$20
	Log into Website or App	Tracked	$5
	Track Steps	Tracked	up to $60
	Update Contact Information	Tracked	$10
	Well-being Coach Digital	Tracked	up to $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. Reimbursement 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 will not be eligible for reimbursement through Wellness 200.*

Wellness Discounts and Savings

Anthem medical plan members qualify for discounts on products and services that help support your health and well-being. To find the discounts available to you go to anthem.com/ca, sign-in to your **Anthem health plan account**, and click on **Discounts** under the "Care" section at the top of the home page.

Special offers include:

- More than 11,000 participating fitness centers nationwide for just $28 per month (plus a $28 enrollment fee and applicable taxes) through **Active&Fit Direct**
- Discounts on **Fitbit** and **Garmin** wellness devices
- Savings on acupuncture, chiropractic, massage, fitness equipment, health products, and more through **ChooseHealthy**
- **The Living Well Courses:** Offers online wellness programs and savings on coaching to help you lose weight, stop smoking, manage stress or diabetes, restore sound sleep, or address alcohol or substance dependence.
- 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 Care/Mental/Behavioral Health** * Will be charged the plan's Specialist copay for Specialist care	$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[1]	$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)

1. Deductible may also apply for physician/service fees if having outpatient surgery in a hospital.

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

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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 a 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**: $1,650 **Individual in a Family**: $3,300 **Family**: $3,500	**Individual**: $3,300 **Individual in a Family**: $3,300 **Family**: $6,600
Inpatient Hospitalization *(pre-service notification may be required)*	20% after deductible	40% after deductible
Inpatient Hospital *(Physician and other services)*	10% after deductible	30% after deductible
Calendar Year Out-of-Pocket Maximum	**Individual**: $3,400 **Individual in a Family**: $3,400 **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	Unlimited	$1,000		$2,000	
Diagnostic & Preventive					
• Periodic Oral Evaluation	$0 copay	10% No Deductible	20% No Deductible	Covered in full	
• Routine Cleaning	$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% No Deductible		35% No Deductible	
• Adult *(age 19 and older)*	$1,998	35% No Deductible		35% No Deductible	
Orthodontia Lifetime Maximum					
• Per Person	N/A	$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 by Visiting www.cigna.com and entering 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.

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
• Anti Reflective Coating - Standard	$0 copay	Up to $23
• Anti Reflective Coating - Premium Tier 1 - 3	$15 - $40 copay	Up to $23
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
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)*		

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

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.

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Flexible Spending Accounts – TRI-AD

Flexible Spending Accounts (FSAs), allow you to use pre-tax dollars to pay for eligible out-of-pocket health and/or dependent care expenses, which helps lower your taxable income so you can keep more of what you earn each year. 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 an IRS-qualifying life event or status change during the year. The FSA plans are administered by TRI-AD.

TRI-AD merged with Navia Benefit Solutions and you will start to see their name and logo in communications via mail, email, and websites. However, you can continue to use your current TRI-AD benefits card, and the name change will not impact your TRI-AD online account or any other aspect of your FSA benefits.

Flexible Spending Accounts (FSA)

2025 Contribution Maximum Amounts	
General Purpose Account	$3,200
Limited Purpose Account	$3,200
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:** 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 account at tri-ad.com. The General Purpose FSA cannot be used in conjunction with the HDHP plan with an HSA.
- **Limited Purpose Account:** The Limited Purpose FSA is for employees who are enrolled in the HDHP/HSA plan and can be used for eligible dental and vision expenses only. The Limited Purpose FSA is designed for HSA participants who 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 funds for dependent care expenses that enable 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.

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 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.

It is recommended that you add your personal email address when registering for the multi-factor authentication security feature. This way, any verifications will go to your personal email address in the event you're unable to access your work email (e.g. you're on LOA).

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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 a covered loss or if you pass away 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 over $50,000 is included in your taxable income.

Supplemental Life and AD&D Insurance

Eligible employees can purchase additional supplemental life and AD&D insurance through Unum to protect your family's financial security. 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) **Guaranteed Issue:** up to $200,000
Spouse or Registered Domestic Partner Supplemental Life Insurance*	$10,000, $25,000, $50,000 or $100,000 not to exceed 50% of EE's voluntary life coverage amount. **Guaranteed Issue:** up to $25,000
Child(ren) Supplemental Life Insurance	Flat $15,000 (**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

* If you apply and are approved for coverage while on a Leave of Absence, your coverage will not be effective until you return to active employment.

Guaranteed Issue amounts apply to initial offering only (e.g. at time of hire). Evidence of Insurability (Health Statement) will be required for you and/or your spouse for all elected amounts above the Guaranteed Issue, for increases in coverage during Open Enrollment and late entrants (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) through Unum 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 sources 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. Evidence of Insurability (Health Statement) will be required for late entrants (enrollment after the initial eligibility period).

	Unum
Elimination Period	180 days
LTD Benefit *(Day 181 & Beyond)*	Plan provides 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.

If you enroll and are approved for LTD buy-up coverage while on a leave of absence, the buy-up will not be effective until the date you return to active employment. Please reach out to the Benefits Department if you have any questions.

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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) retirement plan allows you to make pre-tax and/or Roth (after-tax) deferrals 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 (SPD).

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

The hospital will match a percentage of your deferrals up to 8% of your salary. The matching percentage will be based on your years of service (see the table below). For example, during your 6th year of service, the hospital will contribute 30% of the amount you contribute, up to a maximum employer contribution of 2.4% of your salary (30% x 8% = 2.4%). 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 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 deferrals up to 3% of your salary. Once you have been employed by the hospital for a year, and worked 1,000 hours within that year, you may also be eligible to receive an annual discretionary, non-elective, hospital contribution of at least 1% of your salary, 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 and you may take this money with you when your employment 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.

If you have questions or would like additional information, please contract HR at 858.966.4037 or x244037.

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 HEALTHCARE®

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, at no cost. The EAP is available 24/7 and is a completely confidential service provided by a third party. You can access the EAP by calling 800.327.9298, toll free, 24 hours a day or visit member.magellanhealthcare.com.

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. Includes up to 8 sessions with an EAP counselor per issue, per year, as clinically appropriate.
- **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 and Legal Resources

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.

Meet with a Money Coach

- Three 30-minute telephone consultations per topic, per year at no cost
- Money Coaches have an average of 22 years of relevant professional experience and several certifications. They provide confidential, unbiased guidance to help support your financial wellness goals; they don't sell products
- Get support for concerns such as debt and credit, spending and saving, maternity leave, large purchases, caring for parents and more

Legal services

Receive one free 60-minute consultation per issue, per year by phone or in-person with an attorney* or mediation expert who will listen and help you determine whether mediation is a suitable method to resolve the legal issue. Members receive a preferential discount for services beyond 60 minutes.

* Legal advice on employment matters is excluded.

Estate planning: 25% discount on the hourly fee

- Wills
- Trusts
- Power of attorney

Family law: 35% discount on the hourly fee

- Divorce
- Juvenile court proceedings
- Elder care

Standard legal services: 25% discount on the hourly fee

- Civil and consumer rights
- Personal property
- Taxes and audits

Document preparation discounts:

- **Single Will Package:** $99.00
- **Couples Will Package:** $179.00
- **Minor's or Special Needs Trust:** $249.00
- **Individual Estate Protection:** $649.00
- **Protection of Couples' Estate:** $999.00

Identity Theft Resolution

The Identity Theft Resolution service provides education on how to prevent identity theft and guidance to help restore your credit if you have an issue.

You and your household members receive one free 60-minute telephone consultation with a Fraud Resolution Specialist™ (FRS) per issue, per year. The FRS will answer your questions and give you the direction and

Employee Assistance Program (continued)

tools you need to start resolving the fraud issues. You also have the option to purchase resolution services on a self-pay basis and have the company work under power of attorney until all issues are resolved.

Your program is here to help

The FRS will provide you with an ID Theft Emergency Response Kit and assist with:

- Completing and submitting a Uniform ID Theft Affidavit to the proper authorities, Credit Reporting Agencies and creditors
- Providing fraudulent account forms or letters to itemize each fraudulent occurrence
- Obtaining a free copy of your credit report
- Reporting fraudulent activity and notifying local and Federal authorities and creditor fraud departments
- Placing a fraud alert and/or credit freeze (if allowed by State law) on your credit file

Work-Life Services

Specialists provide expert guidance and personalized referrals to service providers including childcare, adult care, education, home improvement, consumer information, emergency preparedness and more.

Discount Center

Access discounts on will and estate planning, 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

Fertility Expense Reimbursement

Rady Children's offers a reimbursement program for expenses incurred for fertility treatments. The plan is self-funded by Rady Children's and offers dollar-for-dollar reimbursement up to 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 fertility expense reimbursement claims, the measuring year is January 1 - December 31.** All claims for fertility reimbursement must be faxed or mailed to the third-party administrator, TRI-AD.

Education

Tuition Assistance

- Up to $2,000 per fiscal year for tuition expenses from an accredited institution
- Available to Part-Time and Full-Time employees after 12 months of continuous employment

Education Hours

- Paid Time Off for Job-Related Educational Events (seminars, conferences)
- Up to 16 hours per fiscal year; approval subject to fund availability
- Available to Part-Time and Full-Time employees

Nelson Funds for Education

- $300 available in rolling 2-year period for educational events, offerings, textbooks, conferences, seminars, etc. (excludes professional license renewal, subscriptions, and/or membership fees)
- Available to Part-Time, Full-Time, and Per Diem employees after 12 months of continuous employment

Tuition Reduction Scholarship provided by National University System

- 25% reduction in tuition for employees
- 15% reduction in tuition for spouses, dependents, and domestic partners
- **National University System Affiliates:** National University, City University of Seattle, and North Central University

Visit the Rady Children's Intranet for additional information on these programs.

Voluntary Benefits with Unum

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)

Short Term Disability Insurance replaces part of your income while you recover from a covered illness or injury for up to 25 weeks, after satisfying a 7-day elimination period. California employees can purchase coverage up to 25% of weekly earnings to a maximum of $2,500 per week (your benefit will not be reduced or offset by other sources of income, including CA SDI). Non-California employees can purchase up to 60% of weekly earnings to a maximum of $2,500 per week (your benefit may be reduced or offset by other sources of income). Pre-existing conditions apply 3 months prior and within the first 12 months of effective date of coverage.

Group Accident

Accident Insurance pays a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur off the job and includes a range of incidents, from common injuries to more serious events. It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles. You'll have base coverage without medical underwriting. The plan includes a $50 wellness benefit (per insured, per calendar year) for receiving covered health screenings including annual exams, sports physicals, immunizations and more.

Additional Benefits (continued)

Group Hospital

IMPORTANT: This is a fixed indemnity policy, NOT health insurance.

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Group Hospital Insurance allows you to receive benefits when you're admitted to the hospital for a covered accident, illness, or childbirth. You must be hospitalized for at least 20 hours to be eligible for benefits. Two benefit choices are available ($500 or $1,500) for hospital admission. Receive an additional benefit of $100 per day (up to 30 days per covered stay) if you are confined to a hospital after initial admission. The plan includes a $75 wellness benefit (per insured, per calendar year) for receiving covered health screenings including annual exams, sports physicals, immunizations and more. No medical underwriting is required.

Additional Benefits (continued)

Log into Selerix to enroll, make changes, or verify your Unum enrollment:

https://boonchapman.benselect.com/radychildrenshospital

First Time User: Your login is your social security number with no dashes. Your initial password (PIN) is the last 4 digits of your SSN + the last 2 digits of your birth year. You can change your password (PIN) after logging in for the first time.

Group Critical Illness

Critical Illness insurance pays a lump sum benefit at the first diagnosis (after the coverage effective date) of a covered condition such as heart attack, stroke, cancer, progressive diseases, and more. The money can help you pay out-of-pocket medical expenses, like co-pays and deductibles. Choose $10,000, $20,000 or $30,000 of coverage. Children (up to age 26) are automatically included with Employee coverage at no additional cost. If you receive a payout for one illness, you may still be covered for any remaining eligible conditions and for the reoccurrence of any covered critical illness with the exception of skin cancer. See the plan document for full details and eligibility criteria. The plan includes a $50 wellness benefit (per insured, per calendar year) for receiving covered health screenings including annual exams, sports physicals, immunizations and more.

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 RCHSD Life with LTC Virtual Enrollment Scheduling Link

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 if your pet becomes injured or ill. Contact Nationwide Pet Insurance at 877.738.7874 or visit petinsurance.com/rchsd for more details.

Additional Benefits (continued)

Alexa's PLAYC Discount

Alexa's PLAYC, offered in San Diego and Murrieta, provides a nurturing, inclusive, play-based preschool program for children ages 18 months to 5 years, welcoming both those with autism spectrum disorder and typically developing peers. Rady Children's prides itself on keeping tuition costs low and offering employees an additional 10% discount, making the Alexa's PLAYC program even more accessible to our dedicated staff. To learn more and submit an Interest List Application, visit https://www.rchsd.org/programs-services/alexas-playc/.

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 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 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 General 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 (3/31) 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. Only the Life/AD&D benefit(s) can be continued; LTD is not eligible for continuation. Contact Unum at 866.220.8460 for additional information.

Voluntary Benefits

Voluntary benefits will end on your last day of employment; however, you may be eligible to continue your policies by contacting Unum at 866.220.8460.

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	**Tier 1: 1.0 - 0.7 FTE (56 - 80 hours/PP)**	**Tier 2: .450 - .698 FTE (36 - 55.9 hours/PP)**	**Per Diem (billed monthly)**
Anthem Priority Select HMO			
• Employee Only	$57.94	$221.51	$718.99
• Employee + Spouse/DP	$210.02	$446.28	$1,598.01
• Employee + Child(ren)	$155.84	$384.57	$1,342.34
• Employee + Family	$323.82	$642.76	$2,194.61
Anthem Select HMO			
• Employee Only	$65.88	$257.59	$826.54
• Employee + Spouse/DP	$241.58	$518.49	$1,859.69
• Employee + Child(ren)	$178.79	$446.88	$1,570.40
• Employee + Family	$373.26	$747.08	$2,553.97
Anthem HDHP w/HSA			
• Employee Only	$105.16	$332.87	$1,194.70
• Employee + Spouse/DP	$323.20	$675.38	$2,688.00
• Employee + Child(ren)	$267.52	$573.70	$2,269.89
• Employee + Family	$549.88	$1,036.96	$3,691.51

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
$21.00 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, you are eligible for a credit on your first two paychecks each month, based on your FTE. You must actively "waive" coverage in PeopleSoft in order to receive the credit.

Classification	Allocated Hours (FTE)	Waiver Credit
Tier 1	56 hours - 80 hours	$19.42
Tier 2	36 hours - 55.9 hours	$11.84

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	**Tier 1: 1.0 - 0.7 FTE (56 - 80 hours/PP)**	**Tier 2: .450 - .698 FTE (36 - 55.9 hours/PP)**	**Per Diem (billed monthly)**
Cigna PPO Basic			
• Employee Only	$1.58	$6.47	$29.69
• Employee + Spouse/DP	$14.87	$21.25	$60.24
• Employee + Child(ren)	$17.50	$25.11	$69.63
• Employee + Family	$29.70	$40.85	$111.07
Cigna PPO Max			
• Employee Only	$5.92	$10.75	$50.78
• Employee + Spouse/DP	$22.09	$29.10	$103.31
• Employee + Child(ren)	$25.50	$33.01	$119.47
• Employee + Family	$41.63	$52.68	$190.68
Cigna DHMO			
• Employee Only	$1.43	$3.80	$13.58
• Employee + Spouse/DP	$5.86	$9.27	$27.59
• Employee + Child(ren)	$6.93	$10.59	$24.37
• Employee + Family	$9.40	$14.77	$39.46

Semi-Monthly Contributions (Twice Per Month)			
Vision	**Tier 1: 1.0 - 0.7 FTE (56 - 80 hours/PP)**	**Tier 2: .450 - .698 FTE (36 - 55.9 hours/PP)**	**Per Diem (billed monthly)**
EyeMed			
• Employee Only	$0.88	$1.52	$5.93
• Employee + Spouse/DP	$1.28	$2.54	$11.86
• Employee + Child(ren)	$1.21	$2.39	$11.44
• Employee + Family	$1.93	$4.16	$17.74

Note: Deductions 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 some out-of-network surprise medical bills. More information about surprise billing requirements included under the No Surprises Act and similar state laws can be found on the medical insurance company's website or the Plan Sponsor's website. Additional information may be found in your Explanation of Benefits for any affected claims.

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 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 858.576.1700.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our 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, please contact 858.576.1700.

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 in our network 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, please 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 by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under covered medical, dental, and vision plans (the "Plan"). **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than their gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or,
- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

- The parent-employee dies;
- The parent-employee's employment ends for any reason other than their gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or,
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified of a Qualifying Event:

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

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

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

NOTICE AND ELECTION PROCEDURES

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

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

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their dependent children.

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

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. (See Notice and Election Procedures.)

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

If your family experiences another Qualifying Event during the 18 months of COBRA continuation of coverage, the spouse and dependent children in your family can receive up to 18 additional months of COBRA continuation of coverage, for a maximum of 36 months, if the Plan is properly notified about the second Qualifying Event. This extension may be available to the spouse and any dependent children receiving COBRA continuation of coverage if the employee or former employee dies; becomes entitled to Medicare (Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second Qualifying Event would have caused the spouse or the dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. (See Notice and Election Procedures.)

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

IF YOU HAVE QUESTIONS

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans subject to ERISA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

For more information about the Marketplace, visit www.healthcare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

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

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

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

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

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

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

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

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

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

For information about Special Enrollment Rights, please contact:

Human Resources – Benefits Department at benefits@rchsd.org

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 858.576.1700.

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 on November 1, 2024, and end on January 31, 2025. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com or KeenanDirect at 855-653-3626 or www.KeenanDirect.com.

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

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

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

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

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

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

STATES WITH INDIVIDUAL MANDATE

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

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

3. Employer name 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)	**12. Email address** benefits@rchsd.org	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Important Notices (continued)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 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
Phone: 800-699-9075

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

Important Notices (continued)

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

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

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

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

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone 888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/

Utah Medicaid Buyout Program
Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT – Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 800-250-8427

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

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

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

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

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

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

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

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

Important Notice from Rady Children's Hospital-San Diego About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can easily find it. This notice has information about your current prescription drug coverage with 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 **has determined that the prescription drug coverage offered by Anthem Blue Cross of California is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

If you decide to join a Medicare drug plan, your current 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 (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information.

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

Date:	October 2024
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:	858.576.1700

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

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

For more information about Medicare prescription drug coverage:

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

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

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

SUMMARY ANNUAL REPORT FOR
THE RADY CHILDREN'S HOSPITAL-SAN DIEGO COMPREHENSIVE HEALTH AND WELFARE BENEFIT PLAN

This is a summary of the annual report of the The Rady Children's Hospital-San Diego Comprehensive Health and Welfare Benefit Plan (Employer Identification Number 95-1691313, Plan Number 509) for the plan year 01/01/2023 through 12/31/2023. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Rady Children's Hospital-San Diego has committed itself to pay certain medical, dental, vision, healthcare FSA (medical, dental, vision) and severance claims incurred under the terms of the plan.

Insurance Information

The plan has insurance contracts with EyeMed Vision Care on behalf of the Fidelity Security Life Ins Company, Colonial Life & Accident Insurance Company, Cigna Health and Life Insurance Company and affiliates, Magellan Healthcare, Unum Life Insurance Company of America, Blue Cross of California and Combined Insurance to pay certain life, accidental death & dismemberment, medical, dental, vision, temporary disability, long-term disability, employee assistance program, accident and hospital indemnity claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2023 were $53,330,579.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- Insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the plan administrator, at 3020 Childrens Way, San Diego, CA 92123-4223 and phone number, 858-966-8194.

You also have the legally protected right to examine the annual report at the main office of the plan: 3020 Childrens Way, San Diego, CA 92123-4223, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office

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

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 03/31/2026)

Glossary

Affordable Care Act and Patient Protection (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, covering preventive care without cost-sharing, 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 end employment 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. State taxes may apply. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

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 most covered expenses.

Out-Of-Network

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

Out-Of-Pocket Limit

The most an employee could pay during a coverage period (usually one year) for their 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 your 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.