Employee Benefits

2019 Guide

CROZER-KEYSTONE
HEALTH SYSTEM

Employee Benefits Guide 2019

1. General Information

7. Core Benefits

28. Other Benefits

35. Miscellaneous

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

This brochure presents an overview of the benefit programs sponsored by Crozer-Keystone and is not intended to be all-inclusive, nor is it to be used as a summary plan description. In the event of a conflict between this guide and the plan documents, the plan documents will govern. Crozer-Keystone reserves the right to change or modify its benefit programs as appropriate without advance notification.

This brochure is considered a Summary of Material Modification.

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Introduction

Our Commitment

Crozer-Keystone Health System (CKHS) has a vision – to be recognized for the quality of service we provide and lead our industry in customer satisfaction. To succeed, we remain committed to hiring and retaining the best, most talented employees for our business.

CKHS fosters an environment where your contributions can be appreciated and recognized. We want to make a difference and ultimately build a fulfilling and rewarding career for you.

Choose the Coverage that's Right for You!

This Employee Benefits Guide provides essential information about the benefit plans available to eligible employees and their families. These plans encourage development and well-being.

The goal is to make a difference in your life and career so you can make a difference in the lives of others. No matter where you are, the plans sponsored by CKHS will be with you every step of the way.

Our employee benefit program is designed to cover many of life's most concerning contingencies – health care, prescription drugs, dental treatment, loss of income through disability insurance and family financial protection. These are issues we all must address to have a sense of personal and family security. Each of the benefit selections is summarized throughout this benefit summary guide. More detailed information on each benefit, important benefits information such as the HIPAA Notice of Privacy Practices, uniform summary of benefits, Summary Plan Descriptions, and related forms are available through Benefitsolver, our internet based Benefits Administration System. See page 4 for more information. To access Benefitsolver login to www.benefitsolver.com.

Eligibility

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

	Eligibility for Benefits*	
Employee Classification	Full-time employees	Part-time employees
Hours Requirement	72 hours per pay period	40-71 hours per pay period
Waiting Period (benefits effective date)	1st of month following 30 days of continuous employment	
Benefits Offered	• Medical / Prescription Drugs • Dental • Vision • Flexible Spending Accounts (FSA) • Basic Life / AD&D • Employee Assistance Program (EAP) • Optional Life • Optional AD&D • Spouse Life • Dependent Life • Disability	• Medical / Prescription Drugs • Dental • Vision • Flexible Spending Accounts (FSA) • Basic Life / AD&D • Employee Assistance Program (EAP) • Optional Life • Optional AD&D • Spouse Life • Dependent Life • Disability
When Benefits Terminate	All benefits end the last day of the month; life and disability end the date of termination	

* Eligibility may vary based on collective bargaining agreements and/or every weekend/every other weekend schedules.

Eligible employees may enroll dependents as follows:

- Legally married partner

  If your legally married partner is enrolled or eligible for medical insurance through another group health plan, they may not be covered on the CKHS medical, dental and vision plans.

- Children
  - An employee's, married partner's natural child, stepchild, legally adopted child, or a child for whom the employee or married partner has legal custody or has been appointed legal guardian by a court of law.
  - The employee, or married partner is legally required to provide group health coverage for the child pursuant to an administrative or court order.
  - A child who is incapable of self-sustaining employment due to a physical or mental condition. If such dependents is age 26 or older, you must provide proof of continuous health coverage for this dependent since the age of 26.
  - Adult Children up to the age of 26 (does not include spouses or children).

    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.

New Hires and Newly Eligible Employees

If you do not indicate your benefits elections online (enroll or waive coverage) by your Enrollment Due Date, you will automatically be enrolled in the EPO Medical plan with the Tobacco Premium for employee coverage only and payroll deductions will be taken to reflect this coverage. You cannot change this election until the next Open Enrollment or you experience a life qualifying event.

Eligibility (continued)

When You Can Enroll or Make Changes

Newly hired employees have the opportunity to enroll during the eligibility waiting period. Eligible 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 event status change or life event, such as:

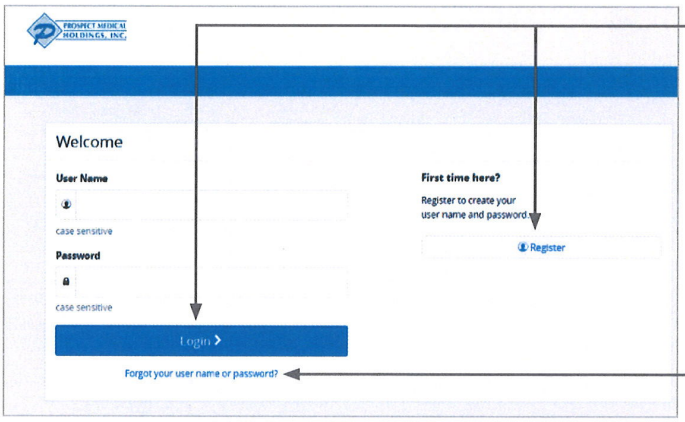
- Change in employee's marital status
- Birth, adoption or change in custody of eligible dependent
- Death
- Change in your employment status (i.e., benefit ineligible to benefit eligible)
- Change in your married partner's employment status
- Gain or Loss of eligibility for a dependent due to age change
- Loss of other coverage (i.e., married partner's health plan coverage ends or Medicare / Medicaid eligibility ends)
- Legal decree, judgment or order (i.e., Qualified Medical Child Support Order – QMCSO)

You must notify the Human Resources Department of any family or employment status changes within 31 days of the status change. Failure to do so will result in delay of change until the next annual Open Enrollment period.

Benefits Enrollment Website

ENROLLING IS EASY

Company Key: prospect

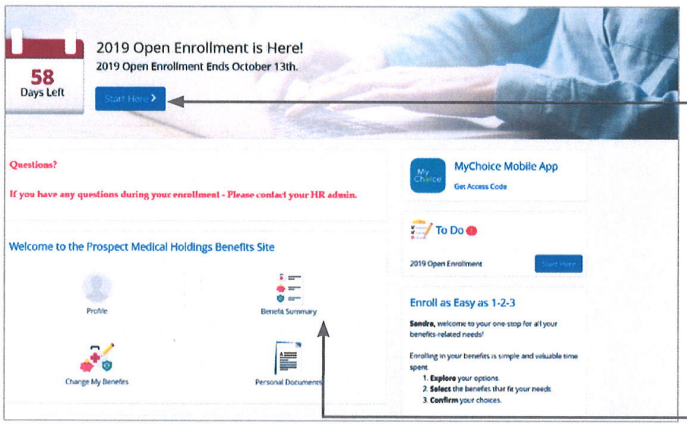


Get started

Visit **www.benefitsolver.com** and login by entering your user name and password. If you are a first-time user, click on 'Register' to set up your user name, password and security questions. Our 'Company Key' is **prospect** (note: it's case sensitive).

Forgot your password?

1. Visit **www.benefitsolver.com** and click on the 'Forgot your password?' link.
2. Enter your social security number, company key and date of birth.
3. Answer your security phrase.
4. Enter and confirm your new password, then click 'Continue' to return to this page and login.



Begin enrollment

Click 'Start Here' and follow the instructions to enroll in your benefits or waive coverage.

You must make your elections by the deadline located to the left of the 'Start Here' button.

Wondering what something means?

View the online glossary in the 'Reference Center.'

Want to review your current plan?

You have year-round access to your benefit summary and specific benefit elections at **www.benefitsolver.com**.

1. Click 'Benefits Summary'.
2. Review your current plan.

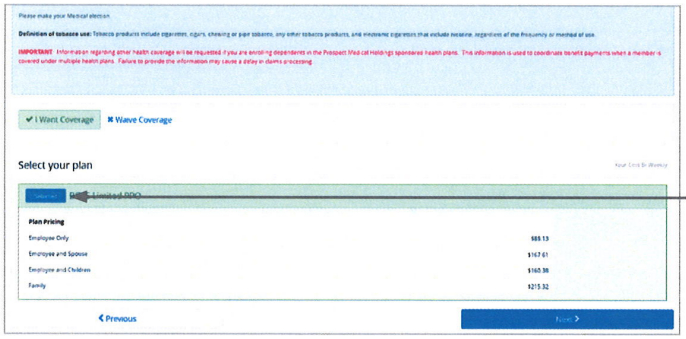
SCAN & ENROLL

Enroll in your benefits from your mobile device. Visit **www.benefitsolver.com** or simply scan this QR code and tap your way through your elections. If you don't already have a QR code reader on your smart phone or tablet, download one from your device's app store.

PROSPECT MEDICAL HOLDINGS, INC.

www.benefitsolver.com
Company Key: **prospect**

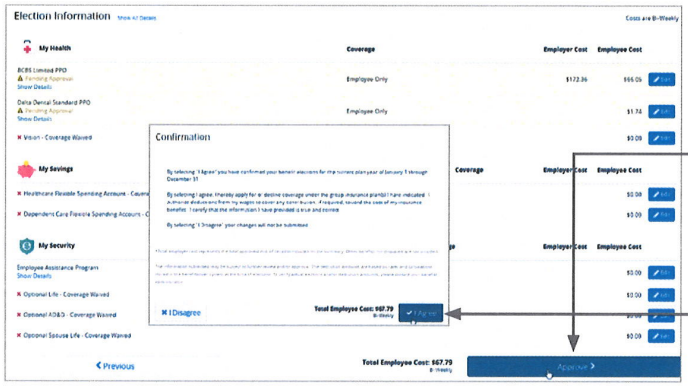
Benefits Enrollment Website (continued)



Make your elections

Review your options as you walk through the enrollment process. Click 'Select' on the plan(s) you choose. Track your choices along the enrollment bar which updates with your total cost.

If you have any questions as you go through enrollment you may refer to the 'Reference Center' tools. They can also help you make the correct elections.



Review your elections

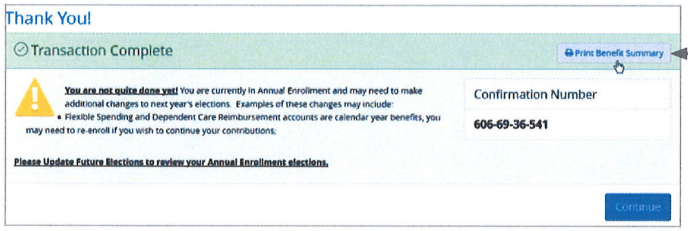
Review, edit and approve your personal information, elections, dependents and total cost.

Approve

Once you have reviewed your elections and they are accurate, click 'Approve'.

Confirm your choices

Your enrollment isn't complete until you confirm your benefit elections.



Print

Print your election information and confirmation number for future reference.

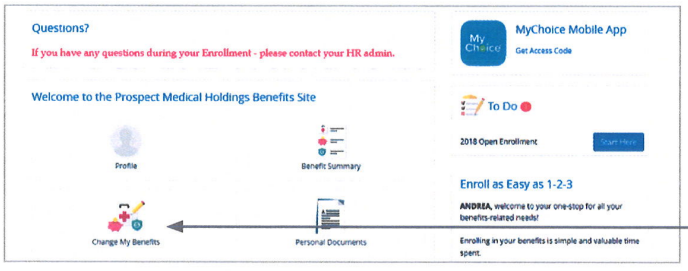
MAKE MID-YEAR CHANGES

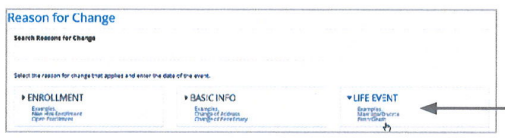
The benefit elections you make will remain in effect until the end of the plan year, unless you are affected by one of these life changing events:

- Getting married or divorced,
- A change in job status (for you or an enrolled dependent), or
- Having a baby or adopting a child.

If you experience any of these qualifying events, you must provide the required supporting documentation and make changes within **31 days** of the event.

1. Login to **www.benefitsolver.com.**
2. Click on the 'Start Here' button to change your benefits or your basic information.
3. Select the life event button and make your changes.





PROSPECT MEDICAL HOLDINGS, INC.

www.benefitsolver.com
Company Key: **prospect**

Benefits Enrollment Website (continued)

Access your benefits where you want

The MyChoice℠ Mobile App

This is one app you will definitely want to download because it will help make your life so much easier. Here are some of the valuable features the MyChoice app offers:

- **Current Benefits** - View your current enrollment in:
  - Medical, dental and vision plans
  - Flexible spending accounts
  - Voluntary and supplemental benefits
- **Family Status Change** - Getting married or having a baby? Report these changes using the app!
- **Beneficiaries** - View your primary and contingent beneficiaries for applicable insurance policies.
- **ID Card** - View your virtual card. Keep all of your Medical ID information at your fingertips!
- **Contact Info** - Easily contact Human Resources/Benefits for general questions about your benefits, benefits enrollment, life events or required documentation.

You can do all this and more with just the tap of a finger!

Medical: EPO

The Medical Exclusive Provider Organization (EPO) requires that you receive your healthcare from providers in the Preferred EPO Network. The EPO is designed to be a cost-effective means of obtaining your healthcare services to protect you and your family in the event of an illness or injury. The EPO plan offers a full range of coverage with low out of pocket costs. All services must be received from providers in the Preferred EPO Network unless it is an emergency, otherwise the service will not be covered. Tier 2 benefits apply when services are rendered by a Tier 2 provider.

Accessing Care In the EPO Plan	Crozer-Keystone Health System (CKHS) Facilities include Crozer-Chester Medical Center, Delaware County Memorial Hospital, Springfield Hospital, Taylor Hospital, Community Hospital and affiliated providers	
	Residing within 25 miles of PMH Facility	Residing outside 25 miles of PMH Facility
Hospital Services	Must use CKHS facilities. If service(s) not available at one of these facilities, you may access any facility in the Blue Cross / Blue Shield PPO Network. The Blue Shield Health Advocate 877.455.6777 may assist and help coordinate your care.	May use any facilities in the Blue Cross / Blue Shield PPO Network. The Blue Shield Health Advocate 877.455.6777 may assist with coordination of your care.
Primary Care Physician (PCP) and Specialist	You do not need to designate a PCP, but you must use providers in the Preferred EPO Network. If required Specialty is not in the Preferred EPO Network, you may access Specialists in the Blue Cross / Blue Shield PPO Network. You may call Keenan TPA for assistance.	You may use providers in the Blue Cross / Blue Shield PPO Network.
Women's Preventive Care		
• Mammograms	May use CKHS facilities or any Blue Cross / Blue Shield PPO Lab facility.	
• Ob / Gyn Services	May use CKHS facilities or any Blue Cross / Blue Shield PPO Lab facility.	
Lab and X-ray (excludes Women's Preventive Services)	Must use CKHS facilities. If services not available at a CKHS facility, you may use any Blue Cross / Blue Shield PPO Lab facility.	May use CKHS facilities or any Blue Cross / Blue Shield PPO Lab facility.
Urgent Care	May use any Blue Cross / Blue Shield PPO Urgent Care Center.	
Accessing Care	The EPO Plan provides comprehensive coverage for individuals who reside within the CKHS Service Area using the Preferred EPO Network.	
CKHS Service Area	25 mile radius from a CKHS facility. Refer to the qualified zip code list in the Benefits Guide	
Dependent Coverage	Dependent coverage is based on your zip code, even if they live elsewhere. If any of your enrolled dependents reside outside the CKHS Service Area and are unable to access a PMH Preferred Network Provider, you are covered for medical emergencies only. If your dependents reside outside the CKHS Service Area, the PPO plans are better choices.	
Preferred EPO Network List	www.benefitsolver.com	
Blue Cross / Blue Shield PPO Network List	www.bcbs.com Click on Find a Doctor, under Network Type, choose BlueCard® PPO Plan, under Location, enter City, County, State or Zip, Click Find	
Questions Regarding the EPO Plan	Call Keenan TPA at 877-853-3626	

Medical: EPO (continued)

PMH Service Area Zip Codes

The following zip codes are within the 25 driving miles from a CKHS facility. If you live in one of these zip codes, you must use the Preferred EPO Network. If you move mid-year, please note your provider selection may change if you are an EPO member.

080:	08001, 08002, 08007, 08012, 08014, 08020, 08021, 08023, 08025, 08026, 08027, 08028, 08029, 08030, 08031, 08032, 08033, 08034, 08035, 08039, 08043, 08045, 08049, 08051, 08056, 08059, 08061, 08062, 08063, 08066, 08067, 08069, 08070, 08071, 08072, 08074, 08078, 08079, 08080, 08083, 08084, 08085, 08086, 08090, 08093, 08096, 08097, 08098, 08099
081:	08100, 08101, 08102, 08103, 08104, 08105, 08106, 08107, 08108, 08109, 08110
083:	08358
190:	19003, 19004, 19008, 19010, 19013, 19014, 19015, 19016, 19017, 19018, 19022, 19023, 19026, 19028, 19029, 19032, 19033, 19035, 19036, 19037, 19039, 19041, 19043, 19050, 19052, 19060, 19061, 19063, 19064, 19065, 19066, 19070, 19072, 19073, 19074, 19076, 19078, 19079, 19080, 19081, 19082, 19083, 19085, 19086, 19087, 19088, 19089, 19091, 19092, 19093, 19094, 19096, 19098, 19099
191:	19100, 19101, 19102, 19103, 19104, 19105, 19106, 19107, 19108, 19109, 19110, 19112, 19113, 19118, 19119, 19121, 19122, 19123, 19125, 19127, 19128, 19129, 19130, 19131, 19132, 19133, 19134, 19139, 19140, 19142, 19143, 19144, 19145, 19146, 19147, 19148, 19151, 19153, 19160, 19161, 19162, 19170, 19171, 19172, 19173, 19175, 19176, 19177, 19178, 19179, 19181, 19182, 19183, 19184, 19185, 19187, 19188, 19190, 19191, 19192, 19193, 19194, 19195, 19196, 19197
193:	19301, 19311, 19312, 19317, 19319, 19331, 19333, 19339, 19340, 19342, 19345, 19348, 19355, 19357, 19366, 19373, 19374, 19375, 19380, 19381, 19382, 19383, 19388, 19395, 19397, 19398, 19399
194:	19401, 19403, 19404, 19405, 19406, 19407, 19408, 19409, 19415, 19428, 19429, 19432, 19444, 19452, 19456, 19462, 19481, 19482, 19483, 19484, 19485, 19487, 19488, 19489, 19493, 19494, 19495, 19496
197:	19703, 19707, 19710, 19720, 19721, 19732, 19735, 19736
198:	19800, 19801, 19802, 19803, 19804, 19805, 19806, 19807, 19808, 19809, 19810, 19850, 19880, 19884, 19885, 19886, 19887, 19888, 19889, 19890, 19892, 19893, 19894, 19895, 19896, 19897, 19898, 19899

Medical: EPO (continued)

Plan Benefits	EPO	
	CKHS Facilities and Affiliates*	Services Not Available in the Preferred EPO Network**
Lifetime Plan Maximum (per Individual)		
• Essential Health Benefits	Unlimited	
Plan Year Deductible (Individual / Family)	$200 / $600	
Annual Out-of-Pocket Maximum (Individual / Family)		
• Medical	$2,500 / $7,500	
• Pharmacy	$2,500 / $5,000	
Inpatient Services - Facility		
• Hospital Room & Board, Semi Private	No charge after deductible	$600/admit, then 10% after deductible
Outpatient Services - Facility		
• Surgery	No charge after deductible	$300/service, then 10% after deductible
• Outpatient Lab, X-Ray, Diagnostic	No charge after deductible	10% after deductible
• Ambulatory Surgical Center	No charge after deductible	$300/admit, then 10% after deductible
• Hospital-Outpatient Treatment (nonsurgical & other expenses)	No charge after deductible	10% after deductible
Physician Services		
• Office Visit (Primary Care)	$30 copay	
• Office Visit (Specialist)	$35 copay	
• Surgeon, Assistant Surgeon, Anesthesia	No charge after deductible	
• Teladoc Consultation	N/A	$10 copay
Emergency Care		
• Urgent Care	$30 copay	
• Emergency Room Services (waived if admitted)	No charge after deductible	$150 copay after deductible
• Emergency Room Physician	No charge after deductible	
• Ambulance	10% after deductible	
Preventive Care / Wellness Services		
• Physical Exams and Periodic Check-Ups	No charge	
• Well Baby and Well Child Care	No charge	
• Well Woman Exams	No charge	
• Immunizations	No charge	

* When service is available

** Members may access BCBS/BlueCard Participating Providers only when services are not available in the Preferred EPO network or Emergency Services

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.

Medical: EPO (continued)

Plan Benefits	EPO	
	CKHS Facilities and Affiliates*	Services Not Available in the Preferred EPO Network**
Other Provider Services		
• Physical, Speech, Occupational & ABA Therapy (60 combined visits/cal yr)	$35 copay	
• Chiropractic Care	Not covered	
• Acupuncture (20 visits/cal yr)	$35 copay	Not covered
• Allergy Services		
– Primary Care Physician	$30 copay	
– Specialist	$35 copay	
– Injections & Serum	No charge	
Pregnancy and Maternity Care		
• Pre-Natal Care	No charge	
• Inpatient Hospital Room and Semi Private	No charge after deductible	$600/admit, then 10% after deductible
General Medical Services		
• Physician's Office, Lab and X-Ray		
– Primary Care Physician	No charge after OV copay	
– Specialist	No charge after OV copay	
• Independent Lab and X-Ray	No charge after deductible	
• Advanced Imaging	No charge after deductible	$100 copay after deductible
• Skilled Nursing or Extended Care Facility (up to 100 visits/cal year)	No charge after deductible	$100 copay after deductible
• Home Health Care (up to 100 visits/cal year)	$30 copay	
• Hospice Care	No charge after deductible	$100 copay after deductible
• Durable Medical Equipment	No charge after deductible	
• Hearing Aid Services & Ancillary Equipment	No charge, deductible waived $2,000 allowance every 24 months (does not count towards OOP Max)	
Mental or Nervous Disorders and Substance Abuse		
• Inpatient Facility	No charge after deductible	$600/admit, then 10% after deductible
• Inpatient Physician	No charge after deductible	
• Outpatient Visits (physician)	$30 copay	

* When service is available

** Members may access BCBS/BlueCard Participating Providers only when services are not available in the Preferred EPO network or Emergency Services

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Medical: Limited PPO

The Limited PPO provides the same provider network and benefits as the EPO plan except you are not limited to the Preferred EPO network. You have flexibility to use the PMH National PPO Network (Tier 1) or the Blue Cross/Blue Shield Network (Tier 2). Your cost sharing will depend on whether you use Tier 1 or Tier 2 networks. There is no out-of-network coverage unless it is an emergency.

Plan Benefits	Limited PPO	
	Tier 1 PMH National PPO Network*	Tier 2 Blue Cross / Blue Shield Preferred Network
Lifetime Plan Maximum (per Individual)		
• Essential Health Benefits	Unlimited	
Plan Year Deductible (Individual / Family)	$200 / $600	$1,550 / $4,650
Annual Out-of-Pocket Maximum (Individual / Family)		
• Medical	$2,500 / $7,500	$4,750 / $9,500
• Pharmacy	$2,500 / $5,000	
Inpatient Services - Facility		
• Hospital Room & Board, Semi Private	No charge after deductible	20% after deductible
Outpatient Services - Facility		
• Surgery	No charge after deductible	20% after deductible
• Outpatient Lab, X-Ray, Diagnostic	No charge after deductible	20% after deductible
• Ambulatory Surgical Center	No charge after deductible	20% after deductible
• Hospital-Outpatient Treatment (nonsurgical & other expenses)	No charge after deductible	20% after deductible
Physician Services		
• Office Visit (Primary Care)	$30 copay	20% after deductible
• Office Visit (Specialist)	$35 copay	20% after deductible
• Surgeon, Assistant Surgeon, Anesthesia	No charge after deductible	20% after deductible
• Teladoc Consultation	N/A	$10 copay
Emergency Care		
• Urgent Care	$30 copay	
• Emergency Room Services (waived if admitted)	No charge after deductible	20% after deductible
• Emergency Room Physician	No charge after deductible	20% after deductible
• Ambulance	10% after deductible	10% after deductible
Preventive Care / Wellness Services		
• Physical Exams and Periodic Check-Ups	No charge	
• Well Baby and Well Child Care	No charge	
• Well Woman Exams	No charge	
• Immunizations	No charge	

* When service is available and based on covered benefits where you are employed.

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Medical: Limited PPO (continued)

Plan Benefits	Limited PPO	
	Tier 1 PMH National PPO Network*	Tier 2 Blue Cross / Blue Shield Preferred Network
Other Provider Services		
• Physical, Speech, Occupational & ABA Therapy (60 combined visits/cal yr)	$35 copay	20% after deductible
• Chiropractic Care	Not covered	
• Acupuncture (20 visits/cal yr)	$35 copay	Not covered
• Allergy Services		
– Primary Care Physician	$30 copay	20% after deductible
– Specialist	$35 copay	20% after deductible
– Injections & Serum	No charge	20% after deductible
Pregnancy and Maternity Care		
• Pre-Natal Care	No charge	
• Inpatient Hospital Room and Semi Private	No charge after deductible	20% after deductible
General Medical Services		
• Physician's Office, Lab and X-Ray		
– Primary Care Physician	No charge after OV copay	20% after deductible
– Specialist	No charge after OV copay	20% after deductible
• Independent Lab and X-Ray	No charge after deductible	20% after deductible
• Advanced Imaging	No charge after deductible	20% after deductible
• Skilled Nursing or Extended Care Facility (up to 100 visits/cal year)	No charge after deductible	20% after deductible
• Home Health Care (up to 100 visits/cal year)	$30 copay	20% after deductible
• Hospice Care	No charge after deductible	20% after deductible
• Durable Medical Equipment	No charge after deductible	20% after deductible
• Hearing Aid Services & Ancillary Equipment	No charge, deductible waived	20%, deductible waived
	$2,000 allowance every 24 months (does not count towards OOP Max)	
Mental or Nervous Disorders and Substance Abuse		
• Inpatient Facility	No charge after deductible	20% after deductible
• Inpatient Physician	No charge after deductible	20% after deductible
• Outpatient Visits (physician)	$30 copay	20% after deductible

* When service is available and based on covered benefits where you are employed.

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Medical: Standard PPO

The Standard PPO plan offers freedom of choice and allows you the ability to go out-of-network. You may obtain services from any provider you choose, but your costs will be lower when utilizing the PMH National PPO Network (Tier 1) or the Blue Cross/ Blue Shield Network (Tier 2) Provider. Your out-of-pocket costs will be lowest when care is received within the PMH National PPO Network. For services received Out-of-Network, you will be responsible for any difference between the covered expense and actual charges.

Plan Benefits	Standard PPO		
	Tier 1 PMH National PPO Network*	Tier 2 Blue Cross / Blue Shield Preferred Network	Tier 3 Out-of-Network**
Lifetime Plan Maximum (per Individual)			
• Essential Health Benefits	Unlimited		
Plan Year Deductible (Individual / Family)	$200 / $600	$1,550 / $4,650	$5,000 / $15,000
Annual Out-of-Pocket Maximum (Individual / Family)			
• Medical	$2,500 / $7,500	$4,750 / $9,500	$8,400 / $25,200
• Pharmacy	$2,500 / $5,000		N/A
Inpatient Services - Facility			
• Hospital Room & Board, Semi Private	No charge after deductible	20% after deductible	40% after deductible
Outpatient Services - Facility			
• Surgery	No charge after deductible	20% after deductible	40% after deductible
• Outpatient Lab, X-Ray, Diagnostic	No charge after deductible	20% after deductible	40% after deductible
• Ambulatory Surgical Center	No charge after deductible	20% after deductible	40% after deductible
• Hospital-Outpatient Treatment (nonsurgical & other expenses)	No charge after deductible	20% after deductible	40% after deductible
Physician Services			
• Office Visit (Primary Care)	$30 copay	20% after deductible	40% after deductible
• Office Visit (Specialist)	$35 copay	20% after deductible	40% after deductible
• Surgeon, Assistant Surgeon, Anesthesia	No charge after deductible	20% after deductible	40% after deductible
• Teladoc Consultation	N/A	$10 copay	Not covered
Emergency Care			
• Urgent Care	$30 copay		40% after deductible
• Emergency Room Services (waived if admitted)	No charge after deductible	20% after deductible	
• Emergency Room Physician	No charge after deductible	20% after deductible	
• Ambulance	10% after deductible	10% after deductible	
Preventive Care / Wellness Services			
• Physical Exams and Periodic Check-Ups	No charge		40% after deductible
• Well Baby and Well Child Care	No charge		40% after deductible
• Well Woman Exams	No charge		40% after deductible
• Immunizations	No charge		40% after deductible

* When service is available and based on covered benefits where you are employed.

** When utilizing Out-of-Network benefits, the Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the provider / facility any difference between the Plan's payment and the provider's / facility's full charge for the services.

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Medical: Standard PPO (continued)

Plan Benefits	Standard PPO		
	Tier 1 PMH National PPO Network*	Tier 2 Blue Cross / Blue Shield Preferred Network	Tier 3 Out-of-Network**
Other Provider Services			
• Physical, Speech, Occupational & ABA Therapy (60 combined visits/cal yr)	$35 copay	20% after deductible	40% after deductible
• Chiropractic Care	Not covered	Not covered	Not covered
• Acupuncture (20 visits/cal yr)	$35 copay	Not covered	Not covered
• Allergy Services			
– Primary Care Physician	$30 copay	20% after deductible	40% after deductible
– Specialist	$35 copay	20% after deductible	40% after deductible
– Injections & Serum	No charge	20% after deductible	40% after deductible
Pregnancy and Maternity Care			
• Pre-Natal Care	No charge		40% after deductible
• Inpatient Hospital Room and Semi Private	No charge after deductible	20% after deductible	40% after deductible
General Medical Services			
• Physician's Office, Lab and X-Ray			
– Primary Care Physician	No charge after OV copay	20% after deductible	40% after deductible
– Specialist	No charge after OV copay	20% after deductible	40% after deductible
• Independent Lab and X-Ray	No charge after deductible	20% after deductible	40% after deductible
• Advanced Imaging	No charge after deductible	20% after deductible	40% after deductible
• Skilled Nursing or Extended Care Facility (up to 100 visits/cal year)	No charge after deductible	20% after deductible	40% after deductible
• Home Health Care (up to 100 visits/cal year)	$30 copay	20% after deductible	40% after deductible
• Hospice Care	No charge after deductible	20% after deductible	40% after deductible
• Durable Medical Equipment	No charge after deductible	20% after deductible	40% after deductible
• Hearing Aid Services & Ancillary Equipment	No charge, deductible waived	20%, deductible waived	40%, deductible waived
	$2,000 allowance every 24 months (does not count towards OOP Max)		
Mental or Nervous Disorders and Substance Abuse			
• Inpatient Facility	No charge after deductible	20% after deductible	40% after deductible
• Inpatient Physician	No charge after deductible	20% after deductible	40% after deductible
• Outpatient Visits (physician)	$30 copay	20% after deductible	40% after deductible

* When service is available and based on covered benefits where you are employed.

** When utilizing Out-of-Network benefits, the Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the provider / facility any difference between the Plan's payment and the provider's / facility's full charge for the services.

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Medical: Premier PPO

This Premier PPO plan offers the ultimate freedom of choice and is the richest plan offered. You may obtain services from any provider you choose, but your costs will be lower when utilizing the PMH National PPO Network (Tier 1) or the Blue Cross/Blue Shield Network (Tier 2) Provider. For services received Out-of-Network, you will be responsible for any difference between the covered expense and actual charges.

Plan Benefits	Premier PPO		
	Tier 1 PMH National PPO Network*	Tier 2 Blue Cross / Blue Shield Preferred Network	Tier 3 Out-of-Network**
Lifetime Plan Maximum (per Individual)			
• Essential Health Benefits	Unlimited		
Plan Year Deductible (Individual / Family)	$500 / $1,000		
Annual Out-of-Pocket Maximum (Individual / Family)			
• Medical	$2,000 / $5,000	$2,400 / $6,000	$4,400 / $13,200
• Pharmacy	$2,500 / $5,000		N/A
Inpatient Services - Facility			
• Hospital Room & Board, Semi Private	No charge after deductible	10% after deductible	30% after deductible
Outpatient Services - Facility			
• Surgery	No charge after deductible	10% after deductible	30% after deductible
• Outpatient Lab, X-Ray, Diagnostic	No charge after deductible	10% after deductible	30% after deductible
• Ambulatory Surgical Center	No charge after deductible	10% after deductible	30% after deductible
• Hospital-Outpatient Treatment (nonsurgical & other expenses)	No charge after deductible	10% after deductible	30% after deductible
Physician Services			
• Office Visit (Primary Care)	$20 copay	$25 copay	30% after deductible
• Office Visit (Specialist)	$20 copay	$25 copay	30% after deductible
• Surgeon, Assistant Surgeon, Anesthesia	10% after deductible		30% after deductible
• Teladoc Consultation	N/A	$10 copay	Not covered
Emergency Care			
• Urgent Care	$20 copay	$25 copay	30% after deductible
• Emergency Room Services (waived if admitted)	No charge after deductible	$100 + 10% after deductible	
• Emergency Room Physician	10% after deductible	10% after deductible	
• Ambulance	10% after deductible	10% after deductible	
Preventive Care / Wellness Services			
• Physical Exams and Periodic Check-Ups	No charge		Not covered
• Well Baby and Well Child Care	No charge		Not covered
• Well Woman Exams	No charge		Not covered
• Immunizations	No charge		Not covered

* When service is available and based on covered benefits where you are employed.

** When utilizing Out-of-Network benefits, the Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the provider / facility any difference between the Plan's payment and the provider's / facility's full charge for the services.

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Medical: Premier PPO (continued)

Plan Benefits	Premier PPO		
	Tier 1 PMH National PPO Network*	Tier 2 Blue Cross / Blue Shield Preferred Network	Tier 3 Out-of-Network**
Other Provider Services			
• Physical, Speech, Occupational & ABA Therapy (60 combined visits/cal yr)	$20 copay	$25 copay	30% after deductible
• Chiropractic Care (limited to 12 visits/cal yr)	$25 copay		Not covered
• Acupuncture (limited to 20 visits/cal yr)	$25 copay		
• Allergy Services			
– Primary Care Physician	$20 copay	$25 copay	30% after deductible
– Specialist	$20 copay	$25 copay	30% after deductible
– Injections & Serum	$20 copay	$25 copay	30% after deductible
Pregnancy and Maternity Care			
• Pre-Natal Care	No charge		30% after deductible
• Inpatient Hospital Room and Semi Private	No charge after deductible	10% after deductible	30% after deductible
General Medical Services			
• Physician's Office, Lab and X-Ray			
– Primary Care Physician	No charge after OV copay		30% after deductible
– Specialist	No charge after OV copay		30% after deductible
• Independent Lab and X-Ray	No charge after deductible	$35 copay after deductible	30% after deductible
• Advanced Imaging	No charge after deductible	$35 copay after deductible	30% after deductible
• Skilled Nursing or Extended Care Facility (up to 100 visits/cal year)	No charge after deductible	10% after deductible	30% after deductible
• Home Health Care (up to 100 visits/cal year)	10% after deductible		Not covered
• Hospice Care	No charge after deductible	10% after deductible	Not covered
• Durable Medical Equipment	10% after deductible		30% deductible waived
• Hearing Aid Services & Ancillary Equipment	10%, deductible waived		30%, deductible waived
	$2,000 allowance every 24 months (does not count towards OOP Max)		
Mental or Nervous Disorders and Substance Abuse			
• Inpatient Facility	No charge after deductible	10% after deductible	30% after deductible
• Inpatient Physician	10% after deductible		30% after deductible
• Outpatient Visits (physician)	$20 copay	$25 copay	30% after deductible

* When service is available and based on covered benefits where you are employed.

** When utilizing Out-of-Network benefits, the Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the provider / facility any difference between the Plan's payment and the provider's / facility's full charge for the services.

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Medical: Value Plan

The Value Plan offers freedom of choice and allows you the ability to go out-of-network. You may obtain services from any provider you choose, but your costs will be lower when utilizing the PMH National PPO Network (Tier 1) or the Blue Cross/Blue Shield Network (Tier 2) Provider. This PPO has high deductibles and cost sharing but your annual preventive exams are always covered at 100% within the Tier 1 or Tier 2 networks. For services received Out-of-Network, you will be responsible for any difference between the covered expense and actual charges.

Plan Benefits	Value PPO		
	Tier 1 PMH National PPO Network*	Tier 2 Blue Cross / Blue Shield Preferred Network	Tier 3 Out-of-Network**
Lifetime Plan Maximum (per Individual)			
• Essential Health Benefits	Unlimited		
Plan Year Deductible (Individual / Family)	$5,900 / $11,800		$10,000 / $20,000
Annual Out-of-Pocket Maximum (Individual / Family)			
• Medical	$5,900 / $11,800		$30,000 / $60,000
• Pharmacy	$2,000 / $4,000		N/A
Inpatient Services - Facility			
• Hospital Room & Board, Semi Private	No charge after deductible		50% after deductible
Outpatient Services - Facility			
• Surgery	No charge after deductible		50% after deductible
• Outpatient Lab, X-Ray, Diagnostic	No charge after deductible		50% after deductible
• Ambulatory Surgical Center	No charge after deductible		50% after deductible
• Hospital-Outpatient Treatment (nonsurgical & other expenses)	No charge after deductible		50% after deductible
Physician Services			
• Office Visit (Primary Care)	No charge after deductible		50% after deductible
• Office Visit (Specialist)	No charge after deductible		50% after deductible
• Surgeon, Assistant Surgeon, Anesthesia	No charge after deductible		50% after deductible
• Teladoc Consultation	N/A	$10 copay	Not covered
Emergency Care			
• Urgent Care	No charge after deductible		10% after deductible
• Emergency Room Services (waived if admitted)	No charge after deductible		10% after deductible
• Emergency Room Physician	No charge after deductible		10% after deductible
• Ambulance	No charge after deductible		10% after deductible
Preventive Care / Wellness Services			
• Physical Exams and Periodic Check-Ups	No charge		50% after deductible
• Well Baby and Well Child Care	No charge		50% after deductible
• Well Woman Exams	No charge		50% after deductible
• Immunizations	No charge		50% after deductible

* When service is available and based on covered benefits where you are employed.

** When utilizing Out-of-Network benefits, the Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the provider / facility any difference between the Plan's payment and the provider's / facility's full charge for the services.

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Medical: Value Plan (continued)

Plan Benefits	Value PPO		
	Tier 1 PMH National PPO Network*	Tier 2 Blue Cross / Blue Shield Preferred Network	Tier 3 Out-of-Network**
Other Provider Services			
• Physical, Speech, Occupational & ABA Therapy (60 combined visits/cal yr)	No charge after deductible		50% after deductible
• Chiropractic Care (limited to 12 visits/cal yr)	Not covered		
• Acupuncture	Not covered		
• Allergy Services			
– Primary Care Physician	No charge after deductible		50% after deductible
– Specialist	No charge after deductible		50% after deductible
– Injections & Serum	No charge after deductible		50% after deductible
Pregnancy and Maternity Care			
• Pre-Natal Care	No charge		50% after deductible
• Inpatient Hospital Room and Semi Private	No charge after deductible		50% after deductible
General Medical Services			
• Physician's Office, Lab and X-Ray			
– Primary Care Physician	No charge after deductible		50% after deductible
– Specialist	No charge after deductible		50% after deductible
• Independent Lab and X-Ray	No charge after deductible		50% after deductible
• Advanced Imaging	No charge after deductible		50% after deductible
• Skilled Nursing or Extended Care Facility (up to 100 visits/cal year)	No charge after deductible		50% after deductible
• Home Health Care (up to 100 visits/cal year)	No charge after deductible		50% after deductible
• Hospice Care	No charge after deductible		50% after deductible
• Durable Medical Equipment	No charge after deductible		50% after deductible
• Hearing Aid Services & Ancillary Equipment	20%, deductible waived		50%, deductible waived
	$2,000 allowance every 24 months (does not count towards OOP Max)		
Mental or Nervous Disorders and Substance Abuse			
• Inpatient Facility	No charge after deductible		50% after deductible
• Inpatient Physician	No charge after deductible		50% after deductible
• Outpatient Visits (physician)	No charge after deductible		50% after deductible

* When service is available and based on covered benefits where you are employed.

** When utilizing Out-of-Network benefits, the Plan payment will be based on the Maximum Allowable Charges for the services. You will be responsible to pay the provider / facility any difference between the Plan's payment and the provider's / facility's full charge for the services.

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Prescription Drugs

When you enroll in the EPO or PPO medical plans, you are automatically enrolled in the prescription drug plan administered by Express Scripts Inc. The prescription drug information is combined with your medical ID card. To access a complete listing of Express Scripts pharmacies near you, log onto www.express-scripts.com.

Your Prescription Drug plan has several coverage tiers, each with different copays. Tiers (and copays) are determined based on:

- Where the prescription is filled - at the Crozer-Keystone Employee Pharmacy, an Express Scripts, Inc. (ESI) pharmacy, or via mail order through ESI.
- The type of drug - generic, Formulary Brand, Non-Formulary Brand, or specialty.
- The quantity purchased - a 30- or 90-day supply.

Benefit Categories	CKHS Pharmacy	Express Scripts Mandatory Generic Retail*
Retail (30-day supply)		
• Generic	$20	$35
• Formulary Brand	$40	$60
• Non-Formulary Brand**	$70	$85
• Specialty Drugs**	Generic: 25% to max $85; Brand: $85	Not covered
Mail Order (90-day supply)		
• Generic	$30	$60
• Formulary Brand	$70	$130
• Non-Formulary Brand**	$130	$190

* If a brand name drug is dispensed and a generic drug is available, member will be responsible for the Brand copay plus the difference in cost between the brand and generic drug.

** Prior authorization is required for non-formulary and specialty prescriptions.

Pay Less for Prescription Drugs in The Crozer-Keystone Employee Pharmacy

You'll pay the least for your prescription drugs if you fill your prescriptions in the Crozer-Keystone Employee Pharmacy, located on the main Crozer campus. The Employee Pharmacy also offers a free System-wide courier service to make it easy for employees who work at a location other than the main Crozer campus to take advantage of the savings. Simply drop off your prescriptions in the inpatient pharmacy at DCMH, Springfield, or Taylor and pick it up at the same place. (Courier service is not available at Community Hospital because there is no inpatient pharmacy at Community.) Same day service is available for most sites. The Employee Pharmacy serves Crozer-Keystone employees and their eligible dependents only.

Crozer-Keystone Employee Pharmacy

Hours: Monday through Friday – 7am to 4pm

24-Hour Access:

Ask your physician's office to call in a new prescription to
610.447.2850 or 15-2850

Refill a prescription using the Refill Telemanager
610.447.2850 or 15-2850

This document is intended to highlight and / or summarize certain aspects of the employer's benefit program. It is not a contract or official plan document. All statements in this summary are subject to the terms and conditions of the official plan document / contract, as interpreted by the appropriate plan fiduciary.

Telemedicine

Whether you're sick or don't have time to wait for a doctor's appointment, you can still access care for non-life-threatening conditions through our Telemedicine program. This program gives you 24/7/365 access to clinical support and expertise through the convenience of phone or video consults. Take control of your health when, where and how it best works for you, and get the care you need at your convenience.

Telemedicine can treat many medical conditions, including:

- Cold and flu symptoms
- Allergies
- Asthma
- Bronchitis
- Fever
- Nausea
- Respiratory infection
- Rashes/Skin infections
- Sore throat
- Sinus problems
- Urinary tract infections
- And more!

Refer to the Medical plans in this Guide for copayment information. To access your Telemedicine services, please use the contact information printed in the back of this Guide.

Wellness

PMH's employees are its greatest assets, and we take their health and well-being very seriously. That's why PMH provides the Healthy Prospects employee wellness program to promote and support wellness among its workforce.

If you are enrolled in the PMH benefits plan, you will have access to a wide array of the wellness program services and tools to help you to improve your health, at no cost to you, including:

- Biometric screening
- Health advising
- Health assessment
- Health coaching
- Chronic condition management
- Wellness challenges
- Discounts on fitness centers
- Tobacco cessation
- Other wellness program activities and resources
- Wellness incentive program

Wellness Incentive

Benefit eligible employees who participate in certain components of the wellness program in 2019 will have the opportunity to earn a $50 per month ($600 per year) lower Wellness Participant medical premium during the 2020 benefits year.

To earn the $50 per month lower Wellness Participant medical premium during 2020, you must meet the following criteria during 2019:

1. Complete a biometric screening (onsite, or with your personal physician).
2. Complete an online health assessment on the Healthy Prospects site.
3. Earn 60 wellness points on the Healthy Prospects site.

New Hire employees that become active on medical benefits on or after June 1, 2019, will not need to complete the wellness activities in 2019 to avoid the 2020 wellness surcharge.

Biometric Screening

Biometric screening involves simple tests that will provide you with information on key indicators for your risk for cardiovascular disease, stroke, diabetes, and other health conditions, including your body fat percentage, body mass index (BMI), blood pressure, cholesterol and triglyceride levels, and blood glucose. The screenings will be conducted during the first half of 2019, by HealthFitness. The screening results will be confidential, and no individual results will be reported to PMH.

Registration is required and space is limited. Be on the lookout for information from Human Resources regarding onsite biometric screenings. Earn a $50 per month ($600 per year) lower Wellness Participant medical premium during the 2020 benefits year through completion of a biometric screening, an online health assessment, and 60 wellness points in 2019.

Health Assessment

An online health assessment evaluates your risks for chronic health conditions. Once you complete your health assessment, you will receive a summary of your results, as well as an action plan customized to your health risks.

Earn a $50 per month ($600 per year) lower Wellness Participant medical premium during the 2020 benefits year through completion of a biometric screening, an online health assessment, and 60 wellness points in 2019. The online health assessment can be accessed by visiting the Healthy Prospects site.

Wellness (continued)

Wellness Points

Wellness points can be obtained and tracked within the Healthy Prospects site, offered by HealthFitness, or through participation in health coaching. There are many options to earn Wellness Points, including health coaching, online challenges, preventive care exams (e.g. medical, dental, vision), and having biometric screening results within optimal ranges. For the full list of Wellness Points options, log onto the Healthy Prospects site.

Health Coaching

Prospect Medical Holdings employees have access to health coaching through HealthFitness. You may self-enroll in health coaching through your Healthy Prospects site, or by calling the toll-free number at 800.337.8508, and select option 2. If you are identified as being at moderate to high risk based on your biometric screening or health assessment results, you may receive an outreach call from a HealthFitness coach to offer you support in developing and pursuing a plan of action to reduce your risk.

Areas of focus for health risk reduction include:

- Physical activity
- Healthy eating
- Sleep
- Tobacco cessation
- Stress management

If you are living with a chronic health condition, and are identified as being eligible for condition management assistance based on HealthFitness' analytics, you may receive an outreach call to offer you the services of a HealthFitness health coach who specializes in managing chronic conditions. You may also contact a health coach by calling the toll-free number at 800.337.8508, and select option 2, to get assistance with managing your chronic condition.

Areas of focus for chronic condition management include:

- Asthma
- Diabetes
- Chronic low back or neck pain
- Coronary artery disease (CAD)
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Depression

Tobacco-Free Incentive

Employees who indicate they are tobacco users during benefits enrollment will be assessed a $50 per month tobacco surcharge for the 2019 benefits year. As an incentive to be tobacco-free, employees who indicate during benefits enrollment that they do not use tobacco products, or who complete a tobacco cessation program (see below), will receive a waiver of the surcharge.

If you indicate during benefits enrollment that you are tobacco-free, you are verifying that you have not used tobacco products during the past 30 days, are currently tobacco-free, and will not use tobacco products during the 2019 benefits year. Tobacco products include cigarettes, cigars, chewing or pipe tobacco, any other tobacco products (including electronic cigarettes or "vapes"), regardless of the frequency or method of use. Misrepresentation of your tobacco status may result in the imposition of the tobacco-use surcharge for the entire year, as well as disciplinary action.

Wellness (continued)

Tobacco Cessation Program – Employees who are current tobacco users can become eligible for waiver of the tobacco surcharge by meeting the following tobacco cessation program requirements:

1. Complete 6 sessions of telephonic tobacco cessation coaching with HealthFitness within 90 days of the effective date of health insurance coverage.

2. Submit written confirmation to your Human Resources representative after completion of the 6 telephonic tobacco cessation coaching sessions. Your completion of the required sessions will be verified by Human Resources through reporting from HealthFitness.

Once the above requirements are met and verified, the $50 per month tobacco surcharge will be removed from the employee cost of health care insurance effective the first pay period following the submission of verification of the completed tobacco cessation program, and the tobacco surcharge collected prior to that pay period will be rebated.

To access the tobacco cessation program, contact HealthFitness at 800.337.8508, and select option 2.

Medical Expense Reimbursement Plan (MERP)

What is MERP?

The Medical Expense Reimbursement Plan reimburses you (the employee) and your dependents for eligible health care expenses incurred under alternate group health coverage.

Who is Eligible?

This plan is voluntary and available to all benefit eligible employees and their eligible dependent child(ren) who are currently enrolled in the Prospect Medical Plan and who enroll in a qualified, alternate group Medical Plan for 2019.

MERP Benefits

- Co-pays, deductibles and co-insurance reimbursed by the MERP up to $7,900/ single and $15,800/ family per year.
- No premium contribution deducted from your paycheck.

How Does the MERP work?

- Waive coverage for yourself and/or eligible dependent child(ren) under the Prospect Medical Plan.
- Enroll yourself and/or dependent child(ren) into a qualified alternate plan, typically your spouse's plan.
- Enroll in the MERP plan by contacting J&K Consultants.
- You will receive a MERP ID card. The MERP ID card should be presented at the time of service after the ID card for your alternate plan. The MERP ID card will give the provider information for filing claims for co-pays, co-insurance and deductibles.

IRS Rules

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

The MERP is administered by J&K Consultants, who has a dedicated staff to personally handle your claims. Any paper claims can be submitted by fax, email or by U.S. mail. Claim forms are available from J&K. If you have questions regarding claims or benefits, please call J&K at 877.872.4232, fax 877.599.3724 or email: Merp@JANDKCONS.COM.

Dental: Delta Dental Basic PPO Plan

The Delta Dental Basic PPO plan provides you great dental benefits at a reasonable cost. With a table of allowance plan, you know in advance exactly how much the plan covers for each dental service. Delta Dental will pay the share specified on your table of allowance; you are responsible for the share of the dentist's fee not covered by the allowance. Be sure to use a participating Delta network dentist to reduce your out-of-pocket cost. You pay the least out-of-pocket if you use a Delta PPO network dentist.

Plan Benefits*	Delta Dental Basic PPO Plan	
	Delta Dental PPO Dentists**	Non-Delta Dental PPO Dentists**
	Plan Pays	
Annual Deductible (waived for Diagnostic and Preventive Services)		
• Individual / Family	$0 / $0	
Annual Maximum Benefit	$1,750	$ 1,500
Diagnostic and Preventive Services		
• Oral Exams, Routine Cleanings, X-Rays, Fluoride Treatment	D0120 Periodic oral exam - established patient: $12 D0272 Bitewings (two films): $12 D1110 Prophylaxis (cleaning): $26	
Basic Services		
• Fillings (Amalgam)	D2150 Amalgam fillings, two surfaces - primary or permanent: $41 D2160 Amalgam fillings, three surfaces - primary or permanent: $54	
• Endodontics (Root Canals)	D3310 Root canal (anterior - excluding final restoration): $227	
• Oral Surgery (Tooth Extraction)	D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal): $30	
• Periodontics (Gingivectomy per Quadrant)	D4341 Periodontal scaling and root planning - four or more teeth per quadrant: $50	
Major Services		
• Crowns, Inlays, Onlays, Cast Restorations, Prosthodontics (Dentures, Bridges, complete or partial)	D2750 Crown; porcelain fused to high noble metal: $338 D5110 Complete denture - maxillary: $392	
Orthodontics		
• Child (to age 23)	50%	
• Adult	50%	
• Lifetime Maximum	Adult - $1,000 Child - $1,500	

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.

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

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Dental: Delta Dental of California PPO Plan

Delta Dental PPO offers a network of dentists who have agreed to reduced contracted rates for their services and they cannot "balance bill" enrollees for additional charges. You are able to visit any licensed dentist of your choice, but you will usually have less out-of-pocket expenses when you visit a Delta Dental PPO network dentist. A Delta Dental Premier® dentist is your next best bet; their contracted rates are slightly higher than those of PPO dentists, but you will still enjoy some cost protections. Enrollees who visit Delta Dental dentists receive the advantages of no billing beyond the charges allowed by the plan and the submission of claims by dentists.

Plan Benefits*	Delta Dental PPO	
	Delta Dental PPO Dentists**	Non-Delta Dental PPO Dentists**
	Member Responsibility	
Annual Deductible (waived for Diagnostic and Preventive Services)		
• Individual / Family	$25 / $75	$50 / $150
Annual Maximum Benefit	Plan Pays up to $1,500	Plan Pays up to $1,000
Diagnostic and Preventive Services		
• Oral Exams, Routine Cleanings, X-Rays, Fluoride Treatment	No charge (deductible waived)	20% (deductible waived)
Basic Services		
• Fillings (Amalgam)	20%	20%
• Fillings (Porcelain / Ceramic)	20%	20%
• Endodontics (Root Canals)	20%	20%
• Oral Surgery (Tooth Extraction)	20%	20%
• Periodontics (Gingivectomy per Quadrant)	20%	20%
Major Services		
• Crowns, Inlays, Onlays, Cast Restorations	50%	50%
• Prosthodontics (Dentures, Bridges, complete or partial)	50%	50%
Orthodontics		
• Child (to age 26)	50%	50%
• Adult	50%	50%
• Lifetime Maximum	$1,500	$1,500

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.

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

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.

Vision

Your vision plan option is administered by Vision Service Plan (VSP), one of America's oldest and largest eye care organizations. VSP offers a network of thousands of eye care professionals located throughout the country. You may use any provider, but you will receive greater benefits when you select a VSP Choice Network Preferred Provider. To use your VSP plan, just call a VSP provider and make an appointment and identify yourself as a VSP member. There are no claim forms to file when you use a VSP provider; you simply pay any amounts not covered by the plan. To use other providers, you will need to pay in full for the services, and then file a claim with VSP.

Plan Benefits	VSP	
	In-Network	Out-of-Network
Frequency		
• Eye Exam	Every calendar year	
• Lenses / Contacts	Every calendar year	
• Frames	Every other calendar year	
Copay	MEMBER RESPONSIBILITY	PLAN PAYS
• Exam	$15 copay	Up to $45 reimbursement after $15 copay
• Materials	$20 copay	Eye wear reimbursement listed below after $20 copay
Prescription Lenses	PLAN PAYS	PLAN PAYS
• Single	100% after copay	Up to $45 reimbursement
• Lined Bifocal	100% after copay	Up to $65 reimbursement
• Lined Trifocal	100% after copay	Up to $85 reimbursement
• Standard Progressive Lenses	100% after copay	Up to $65 reimbursement
• Custom and Premium Progressive Lenses	$95 - $175 after copay	Up to $65 reimbursement
Frames*	$250 allowance after copay	Up to $47 reimbursement
Contacts (in lieu of glasses)**		
• Medically Necessary	100% after copay	Up to $210 reimbursement
• Elective	$200 allowance; copay waived	Up to $150 reimbursement (lenses / exam combined)
• Contact Lens Exam	Up to $60 copay	Up to $150 reimbursement (lenses / exam combined)

* You may use your frame allowance toward ready-to-wear non-prescription sunglasses from a VSP doctor.

** Contacts (every calendar year) in lieu of lenses and frames. Contact lens exam (fitting and evaluation) covered in full, not to exceed $60 copay; members also receive 15% discount on contact lens exam and services.

To locate a VSP provider, log on to www.vsp.com.

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Basic Life and AD&D

Life and AD&D Insurance is an important part of your comprehensive benefits package. These plans provide peace of mind and the financial protection for you and your family in the event of death or a serious accident. Benefit eligible employees are automatically covered for Basic Life and Accidental Death and Dismemberment Insurance through Unum, paid for by CKHS.

Plan Benefits	Unum
Eligible Class	Full-Time Employees / Part-Time Employees
Coverage Amount*	1x base annual pay, up to $50,000, $15,000 minimum
Age Reduction	
• At age 70	Reduction to 65% of the benefit amount
• At age 75	Reduction to 50% of the benefit amount

* If the value of any pre-tax life insurance coverage is greater than $50,000, the amount over $50,000 is added to your taxable compensation as "imputed income."

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Optional Life

Eligible employees may enroll in Optional Life Insurance at affordable group rates through Unum. Premiums are determined by your age and will be withheld from your paycheck. You may elect spouse life coverage even if you don't elect Optional Life for yourself. You also have the option to elect dependent life insurance for your eligible dependent children. You may not be covered as an employee and as a dependent.

For any Optional Life amount elected after your initial eligibility period or above the guarantee issue amount, you must complete a medical questionnaire (Evidence of Insurability) and be approved for the amount elected. Your coverage will be effective the first of the month following approval. You do not have to purchase the same amount for Optional Life and Optional AD&D.

Plan Benefits	Unum Optional Life
Eligible Class	Full-Time Employees / Part-Time Employees
Coverage Amount	
• Employee	1x, 2x, 3x, 4x or 5x annual earnings, rounded to the next higher $10,000
• Spouse	Increments of $10,000 to $50,000
• Child(ren) to age 26	$10,000
Maximum Benefit	
• Employee	$1,300,000
• Spouse	$50,000
• Child(ren)	$10,000
Guaranteed Issue*	
• Employee	Lesser of 2x annual salary or $200,000
• Spouse	$20,000
• Child(ren)	$10,000
Waiver of Premium**	Included
Age Reduction	
• At age 70	Reduction to 65% of the benefit amount
• At age 75	Reduction to 50% of the benefit amount

* Guarantee Issue is the amount of insurance you are guaranteed without having to complete Evidence of Insurability (EOI). Any amounts above the Guaranteed Issue amount is subject to underwriting where you will be required to complete an EOI form.

** If you become Totally Disabled while insured, the Waiver of Premium Provision may continue your Life and/or Disability Insurance without any further payment of premiums by you.

Annually, during the Open Enrollment period you may increase your Optional Life election one level without the Evidence of Insurability requirement up to the Guaranteed Issue amount.

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Optional AD&D

Eligible employees may enroll in Optional AD&D at affordable group rates through Unum. If you elect Optional AD&D for yourself, you may elect Optional AD&D coverage for your family.

Plan Benefits	Unum Optional AD&D
Eligible Class	Full-Time Employees / Part-Time Employees
Coverage Amount	
• Employee (coverage terminates at age 75)	1x to 10x annual earnings, rounded to the next higher $10,000 increment
• Spouse and child(ren)	40% for spouse and 10% for child(ren)
• Spouse, no child(ren)	50%
• Child(ren), no spouse	15%
Maximum Benefit	
• Employee	$500,000
• Spouse	$250,000
• Child(ren)	$75,000
Age Reduction	
• At age 70	Reduction to 65% of the benefit amount
• At age 75	Reduction to 50% of the benefit amount

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.

Disability

Voluntary Short Term Disability

Short Term Disability (STD) is a voluntary program provided by Unum and is offered to full-time and part-time benefit eligible employees. STD is integrated with LTD. Benefits will be coordinated with any income from other sources which may reduce your benefit. If you are interested in enrolling, please refer to the Disability insert for plan details and the contribution rate sheet for cost information.

Long Term Disability

If you are unable to work for an extended period of time, disability benefits can replace a portion of your income while you are disabled to help pay for ongoing living expenses such as rent, mortgage, car payments, utilities or out-of-pocket medical expenses. Long Term Disability (LTD) is provided by CKHS for full-time employees at no cost to you. Part-time employees can pay for coverage at CKHS group rates. LTD is integrated with STD. Benefits will be coordinated with an income from other sources which may reduce your benefit. You have the opportunity to increase your benefit. Please refer to the disability insert for plan details and the contribution rate sheet for cost information.

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.

Flexible Benefits

CKHS has established a Cafeteria Plan under Section 125 of the IRS Code allowing you to use pretax dollars to pay for eligible out-of-pocket expenses. If you elect benefits under the plan, you are required to maintain your benefit election(s) until the next annual open enrollment period, unless you have a qualifying event status change during the year as defined by the IRS.

Premium Conversion – Medical, Dental, Vision, and Flexible Spending Account(s)

Qualified insurance premiums are deducted from your salary before taxes. This process is called pre-taxing. By pre-taxing, you lower your gross taxable income. As a result, you pay fewer taxes and keep more of what you earn.

Flexible Spending Accounts (FSA)

Flexible Spending Accounts are based on the IRS "Use It or Lose It" rule. Leftover funds cannot be carried over to the next plan year or reimbursed.

Medical Care FSA

Allows you to pretax out-of-pocket expenses not covered by insurance plans. Eligible expenses include dental and vision expenses, and health plan deductibles and copays. The maximum contribution per year is $2,650.

For your convenience, you will receive a Debit Card from TRI-AD to access your funds.

Dependent Care FSA

Allows you to pretax expenses for dependent care 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. The maximum contribution per year is $5,000.

Please note, flexible spending accounts are based on the "Use it or Lose it" rule. Leftover funds cannot be carried over to the next plan year or reimbursed. Keep your receipts. The FSA Administrator or IRS may request them at any time.

Benefits by TRI-AD

Mobile App Now Available!

Manage your reimbursement accounts on the go! With the Benefits by TRI-AD mobile app, you can access your accounts from your mobile device. Download your FREE app in the iTunes Store™ or on Google Play™.

Employee Assistance Program

Our Employee Assistance Program is provided by Unum's Work-life Balance and is available 24 hours a day, seven days a week. No matter what's going on in your life — personal problems, planning for life events or simply managing daily life can affect your work, health and family. Our EAP program is a no-cost, company-sponsored benefit that is available to you and your dependents that offers confidential support, resources and information to get through life's challenges.

The program offers three face-to-face visits per incident every six months and unlimited telephonic sessions.

Confidential Counseling on Personal Issues

Our Employee Assistance Program is a confidential counseling service to help address the personal issues you face. Work-life Balance will refer you to a local counselor or to resources in your community. Call any time with personal concerns, including:

- Relationships
- Job pressures
- Problems with your children
- Marital conflicts
- Substance abuse
- Grief and loss
- Stress, anxiety or depression

Information, Referrals and Resources for Work-Life Needs

Whether you are a new parent, a caregiver for an elder, sending a child off to college, buying a car or doing home repairs, you're bound to have questions or need resource referrals. The Work-life Balance specialists will help you sort out the issues and provide you with information based on your specific criteria. You will receive a personalized reference package containing helpful resources and literature, covering areas such as:

- Finding child or elder care
- Planning for college
- Budgeting, money management
- Purchasing a car

Other Services

- **Financial Information, Resources and Tools:** Saving for college, retirement planning, tax questions, credit card or loan problems, estate planning.
- **Free Online Will Preparation:** Prepare your will online and download to your computer.
- **Legal Information, Resources and Consultation:** Divorce and family law, bankruptcy, debt obligations, criminal actions, landlord and tenant issues, civil lawsuits, real estate transactions, contracts.
- **Medical Bill Saver:** Helps you save on medical bills not covered by your insurance.

EAP - Work-life Balance can be a call or click away:

Toll-free 24/7 access: 800.854.1446 (multi-lingual)

www.unum.com/lifebalance

Travel Assistance and Identity Theft Recovery Service

As part of Unum's Work-life Balance, Unum provides two personal services – Emergency Travel Assistance and Identity Theft Recovery Service programs.

Emergency Travel Assistance

If you have a medical emergency while you are more than 100 miles away from home, you don't have to face it alone. With one simple phone call, you can be connected to Assist America's staff of medically trained, multilingual professionals who can advise you in a medical emergency, 24 / 7. You have immediate access to:

- pre-qualified, multilingual doctors, hospitals, pharmacies, and dentists anywhere in the world
- medical consultation, evaluation, and referral
- hospital admission assistance
- emergency medical evacuation
- lost prescription assistance
- legal and interpreter services
- passport replacement assistance

You or your family (whether traveling together or separately) can activate Assist America's emergency services with one call to the number on your Assist America ID card, whether you are on vacation or on a business trip (spouse business travel excluded).

Within the U.S.: 800.872.1414

Outside the U.S.: 609.986.1234

Email: medservices@assistamerica.com

Reference number: 01-AA-UN-762490

Identity Theft Recovery Service

If your identity is stolen, you may not know where to turn and what you should do to best protect yourself. Unum's Identity Theft Recovery Service offers a valuable support network of professionals who will monitor your identity after an incident and provide full restoration and recovery services.

These services include:

- **Full-services fraud resolution:** Let the professionals handle the stressful work for you.
- **Credit monitoring service:** Receive triple-bureau monitoring after an identity theft incident.
- **Credit restoration:** Get help regaining good standing with creditors.
- **Tax fraud support:** Rely on Enrolled Agents to work with the IRS on your behalf.
- **Financial counseling:** Receive guidance to help get back on your feet.
- **Free legal consultations and discounts on legal services:** Get legal advice in serious cases.

If you experience an identity theft incident, call 800.984.6812.

Important Notices

Discrimination Is Against the Law

Prospect Medical Holdings, Inc. complies with the applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Prospect Medical Holdings, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Prospect Medical Holdings, Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with it, such as:
  - Qualified sign language interpreters
  - Written information in other formats (e.g., large print, audio, accessible electronic formats, etc.)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Human Resources.

If you believe that Prospect Medical Holdings, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Human Resources, 866.874.3972, TTY 866.874.3972, Client ID 799447. You can file a grievance in person, or by mail, fax, or email. If you need help filing a grievance, Human Resources is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)
Email: OCRMail@hhs.gov

Complaint forms are available at:

https://www.hhs.gov/sites/default/files/civil-rights-complaint-form-0945-0002-exp-04302019.pdf

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 866.874.3972 (TTY: 866.874.3972) Client ID 799447.

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 866.874.3972 (TTY: 866.874.3972) Client ID 799447.

BHVIMAHVIE

Ecm1 Bbl rosop111Te Ha pyccKoM >13b1Ke, TO saM gocTynHbl 6ecnnaTHb1e ycnyr111 nepesoga. 3soH111Te 866-874-3972 (TTY Code 799447)Client ID 799447.

Filipino

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 866.874.3972 (TTY: 866.874.3972) Client ID 799447.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 866.874.3972 (TTY: 866.874.3972) 번으로 전화해 주십시오.

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 866.874.3972 (TTY (հեռատիպ)՝ 866.874.3972): Client ID 799447

Cambodian

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Important Notices (continued)

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 866-874-3972 (TTY Code 799447).

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。866.874.3972 (TTY: 866.874.3972) Client ID 799447）まで、お電話にてご連絡ください。

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 866.874.3972-1 (رقم هاتف الصم والبكم: 866.874.3972-1) Client ID 799447.

Punjabi

ਧਿਆਨ ਦਿਓ :ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ ,ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।-1 866.874.3972 (TTY:-1 866.874.3972) Client ID 799447' ਤੇ ਕਾਲ ਕਰੋ।

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 866.874.3972 (TTY: 866.874.3972) Client ID 799447.

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 866.874.3972 (TTY: 866.874.3972) Client ID 799447 पर कॉल करें।

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for pregnancy hospital stay (for delivery) for a mother and her newborn generally may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply for this minimum length of stay and early discharge is only permitted 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 714.796.5784 for more information.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Keenan EBTPA/Blue Shield of California. 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 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

Important Notices (continued)

you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally 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 his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or,
- You become divorced or legally separated from your spouse.

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. The employer must notify the Plan Administrator of the following Qualifying Events:

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

For all other Qualifying Events (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, no later than the date specified in the election form, and properly addressed 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 the 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

Important Notices (continued)

copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

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

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

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

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, 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.

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.

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), has jurisdiction with respect to the COBRA continuation coverage requirements of the Public Health Service Act (PHSA) that apply to state and local government employers, including counties,

Important Notices (continued)

municipalities, public school districts, and the group health plans that they sponsor (Public Sector COBRA). COBRA can be a daunting and complex area of federal law. If you have any questions or issues regarding Public Sector COBRA, you may contact the Plan Administrator or email HHS at phig@cms.hhs.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

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

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.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

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

For information about Special Enrollment Rights, please contact: Sandie Sekely, Director of Benefits 714.796.5784.

Important Notices (continued)

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

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

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

If you do decide to join a Medicare drug plan and drop your current Prospect Medical Holdings, Inc. 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 Prospect Medical Holdings, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Prospect Medical Holdings, Inc. Medical Plan changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

Important Notices (continued)

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

REMEMBER

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

Date:	October 2018
Name of Entity / Sender:	Prospect Medical Holdings, Inc.
Contact:	Human Resources
Address:	600 City Parkway W, Suite 800 Orange, CA 92868
Phone:	714.796.5784

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

Prospect Medical Holdings, Inc. 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 at 714.796.5784.

Wellness – Alternative Standards

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

Important Notices (continued)

Important Notice Regarding Wellness Information

Healthy Prospects is a voluntary program available to employees who participate in Prospect Medical Holdings, Inc. and is subject to federal law including the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act.

If you choose to participate, you may be asked to complete a voluntary health risk assessment that asks questions about your health-related activities and behaviors and whether you have or had certain medical conditions. You may also be asked to complete a voluntary biometric screening which includes height, weight, body mass index (BMI), body fat, glucose, blood pressure, HDL/LDL/total cholesterol, and triglycerides.

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

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

All medical information obtained through the wellness program will be maintained by HealthFitness, and the privacy of the personal health information collected through all wellness program activities will be protected as mandated by applicable federal and state privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA). PMH will only receive aggregate reporting which will be used by Prospect Medical Holdings, Inc. to design wellness initiatives that focus on the greatest needs of the employee population. No individual results will be shared with Prospect Medical Holdings, Inc.

If you have any questions or concerns, please contact Sandie Sekely at sandie.sekely@prospectmedical.com.

Important Notices (continued)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Prospect Medical Holdings, Inc. 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 offers "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 begins November 1, 2018 and ends on January 31, 2019. Open Enrollment for most other states will close on December 15, 2018.

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 9.56% (for 2018) and 9.86% (for 2019) of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

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

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

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

Part B: Exchange Application Information

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.

3. Employer name Prospect Medical Holdings, Inc.	**4. Employer Identification Number (EIN)** 33-0564370	
5. Employer address 600 City Parkway West, Suite 800	**6. Employer phone number** 714.796.5784	
7. City Orange	**8. State** CA	**9. ZIP code** 92868
10. Who can we contact about employee health coverage at this job? Sandie Sekely, Director of Benefits, PMH Corporate		
11. Phone number (if different from above)	**12. Email address** sandie.sekely@prospectmedical.com	

Important Notices (continued)

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. 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:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855.MyARHIPP (855.692.7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
800.221.3943/ State Relay 711
CHP+: https://colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 800.359.1991/ State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 877.357.3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 404.656.4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877.438.4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 800.403.0864

IOWA – Medicaid
Website:
http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 888.346.9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 785.296.3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/agencies/dms
Phone: 800.635.2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 888.695.2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 800.442.6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 800.862.4840

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp | Phone: 800.657.3739

MISSOURI – Medicaid
Website:
https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573.751.2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800.694.3084

Important Notices (continued)

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855.632.7633
Lincoln: 402.473.7000
Omaha: 402.595.1178

NEVADA – Medicaid
Medicaid Website: https://dwss.nv.gov/
Medicaid Phone: 800.992.0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603.271.5218
NH Medicaid Service Center Hotline: 888.901.4999

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609.631.2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800.701.0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800.541.2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919.855.4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 844.854.4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888.365.3742

OREGON – Medicaid
Websites: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 800.699.9075

PENNSYLVANIA – Medicaid
Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 800.692.7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855.697.4347

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: http://gethipptexas.com/
Phone: 800.440.0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877.543.7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 800.250.8427

VIRGINIA – Medicaid and CHIP
Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 800.432.5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 855.242.8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 800.562.3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 855.MyWVHIPP (855.699.8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 800.362.3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307.777.7531

To see if any other states have added a premium assistance program since January 31, 2018, 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

Contact Information

Below is a listing of the toll-free numbers you can call with questions about the plans available to you. You can also use the website (if available) to access information from providers for the various plans.

Plan	Phone Number	Website
Medical		
• Prospect Medical Holdings, Inc.		
– Keenan Customer Service	877.853.3626	www.keenan.com/benefits
– Express Scripts Prescription Drugs	877.849.5523	www.express-scripts.com
Dental		
• Delta Dental PPO	800.765.6003	www.deltadentalins.com
Vision		
• Vision Service Plan (VSP)	800.877.7195	www.vsp.com
Medical Expense Reimbursement Plan (MERP)		
• J&K Consultants	Phone: 877.872.4232 Fax: 877.599.3724	Email: Merp@JANDKCONS.COM
Telemedicine		
• Teladoc	800.Teladoc	teladoc.com/bsc
Employee Assistance Program (EAP)		
• Unum Life Balance	800.854.1446	www.unum.com/lifebalance
• Emergency Travel Assistance	U.S.: 800.872.1414 Outside the U.S.: 609.986.1234	Email: medservices@assistamerica.com Reference Number: 01-AA-UN-762490
• Identity Theft Recovery Service	800.984.6812	N/A
Life / AD&D, Optional Life / Optional AD&D, STD and LTD		
• Unum	866.679.3054	www.unum.com
Flexible Spending Accounts (FSA) and COBRA		
• TRI-AD	888.844.1372	www.tri-ad.com/FSA www.tri-ad.com/COBRA
Benefitsolver	N/A	www.benefitsolver.com **Company Key: prospect**

Keenan
HealthCare

Innovative Solutions. Enduring Principles.

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