



## 2022 Employee Benefit Highlights

### Eligibility

- **Benefits start the first of the month following 60 days of employment**
- Part time employees assigned 20 to 29 hours per week
- Full time employees assigned 30 or more hours per week
- Dependent Child(ren), Spouse or Domestic Partner coverage available

### Health and Welfare Benefits

- **Medical/Rx: *UMR and Navitus***
  - Three Plan options: HDHP (High Deductible Health Plan with HSA), Base Plan PPO, and Buy-Up Plan PPO
  - Utilizing the United HealthCare Choice Plus provider network with special discounts for using the El Rio preferred network
  - Not all services available under the El Rio preferred network
  - Includes Prescription Coverage with advantages when utilizing El Rio's convenient Retail Pharmacy
- **El Rio Employee Appointment Scheduling & Telemedicine: 520.309.3117**
  - Expedited service for employees and their families.
  - **Health Savings Account (HSA): *Optum Bank***
    - For employees enrolled in the High Deductible Health Plan (HDHP)
    - El Rio contributes \$50 for employee only coverage and \$100 for family coverage per pay period
- **Employee Assistance Program: *OptumEAP***
- **Dental: Two Plan options – *Delta Dental of AZ*, Base PPO plan and Buy-Up PPO Plan**
- **Vision: Two Plan options - *Avesis Vision* – Base Plan: Eye exam \$0 copay; Lenses & frames \$0 copay; Frame allowance \$150 every 24 months. Buy Up Plan: Eye exam \$10 copay; Lenses & frames \$10 copay; Frame allowance \$175 every 12 months.**
- **Flexible Spending Account (FSA):**
  - Health Care FSA and Dependent Care FSA; Limited Purpose FSA available to those electing the HDHP
- **Life Insurance and Accidental Death & Dismemberment: *Reliance Standard***
  - Basic Life 100% employer paid at 2x annual salary to a maximum of \$500,000
  - Additional Voluntary Employee, Spouse & Child Life, and AD&D Employee or Family
- **Short Term Disability: *Reliance Standard***
  - Base Option 100% employer paid. Benefit is 60% of weekly earnings to a maximum of \$2,500/week. Benefits begin after a 44-day elimination period and are payable for up to 19 weeks. A second plan option is also available to buy-up to a 14-day elimination period.
- **Long Term Disability: *Reliance Standard***
  - 100% employer paid; 60% of earnings; begins after 180 day elimination period.
- **403(b) Retirement Plan – *The Standard***
  - All Full and Part time employees are automatically enrolled in the 403b retirement plan on their first day of employment and will have 6% of their gross pay deducted from their paychecks, unless you designate a change or opt out. Employee deductions are on a pre-tax basis, an after tax Roth option is also available.
  - El Rio Health contributes 1.5% of your gross wages and matched up to 3% for employees who work at least 20hours/week. Contributions begin after six months of employment.
- **Additional Fringe Benefits**
  - Accident, Critical Illness, and Hospital Indemnity – *Reliance Standard*
  - Long Term Care Insurance – *UNUM*

### Paid Time Off (PTO)

- Group I:
  - Up to 2 years seniority: 9.23 hours/pay period / 30 days annually
  - <5 years seniority: 10.46 hours/pay period / 34 days annually
  - <10 year seniority: 11.08 hours/pay period / 36 days annually
  - >11 year seniority: 11.69 hours/pay period / 38 days annually
- Group II:
  - Up to 2 years seniority: 8 hours/pay period / 26 days annually
  - <5 years seniority: 9.23 hours/pay period / 30 days annually
  - <10 years seniority: 10.46 hours/pay period / 34 days annually
  - 10 but <15 years seniority: 11.08 hours/pay period / 36 days annually
  - >15 years seniority: 11.69 hours/pay period / 38 days annually

# BENEFITS

INFORMATION GUIDE UNDERSTANDING YOUR OPTIONS

2022

EL RIO  
Health





# Hello!

Welcome to your 2022 Benefits Plan Year. El Rio Health is proud to offer a range of employee benefit plans to help protect you in the case of illness or injury. This Benefits Information Guide is a comprehensive tool designed to familiarize you with the plans and programs you and your family can enroll in for the plan year. If you have any questions regarding your benefits, please contact Human Resources.

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 2 months, Federal law gives you more choices about your prescription drug coverage. Please see page 25 for more details.



# Eligibility & Enrollment

## Who can Enroll?

If you are an employee scheduled to work a minimum of 20 hours per week, you are eligible to participate in the benefits program. Eligible employees may also choose to enroll family members, including a legal spouse/ domestic partner and/or eligible children.

An employee may be unable to pay for and/or receive employer contributions on a pre-tax basis for the cost of the benefits of an employee’s state registered / unregistered domestic partner that does not meet the definition of the employee’s tax dependent under IRC Section 152.

## When Does Coverage Begin?

**Regular, full-time employees:** You are eligible to enroll on your date of hire, but your coverage begins the first of the month following 60 days of employment.

Your enrollment choices remain in effect through the end of the benefits plan year, January 1, 2022 – December 31, 2022.



**If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status during the plan year. Please review details on IRS qualified change in status events for more information.**

## How do I Enroll?

### DayForce

To enroll, simply follow these steps:

- Log into [Dayforcehcm.com](http://Dayforcehcm.com) or click the Dayforce link in Sharepoint. If using Sharepoint, you will automatically be logged into Dayforce.
- If you are logging in from an outside computer, you will need to have your employee ID and password.
- Once you are in Dayforce, click on benefit, overview tab. Here you can elect benefits or make changes to your retirement contributions.

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## What if My Needs Change During the Year?

You are permitted to make changes to your benefits outside of the open enrollment period if you have a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the qualified event. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse's/ domestic partner's loss or gain of coverage through our organization or another employer.
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace or Federal Exchange and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of qualified status changes, please refer to the "Legal Information Regarding Your Plans" contents.

## Do I Have to Enroll?

Although the federal penalty requiring individuals to maintain health coverage has been reduced to \$0, some states have their own state-specific individual mandates.

To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as coverage from a State or Federal Health Insurance Exchange.

For information regarding Health Care Reform and the Individual Mandate, please contact Human Resources or visit [www.cciio.cms.gov](http://www.cciio.cms.gov).

You may elect to "waive" medical/dental/and/or vision coverage if you have access to coverage through another plan. To waive coverage, please log into DayForces. It is important to note that if you waive our medical coverage, you must maintain medical/health coverage through another source. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be in November 1, 2022 or if a qualifying status change occurs.



# Medical

## What are my options?

Use the chart below to compare medical plan options and determine which would be the best for you and your family.

	<b>PPO</b>	<b>HDHP</b>
	<b>UMR</b>	<b>UMR</b>
<b>Required to select and use a Primary Care Physician (PCP)</b>	No	No
<b>Seeing a Specialist</b>	No referral required	No referral required
<b>Deductible Required</b>	Yes, in most cases Embedded: Yes	Yes Embedded: Yes
<b>Claims Process</b>	PPO providers will submit claims You submit claims for other services	PPO network providers will submit claims. You submit claims for other services.
<b>Compatible with your Health Savings Account (HSA)</b>	No, unless PPO is also a HDHP	Yes
<b>Other Important Tips</b>	<ul style="list-style-type: none"> <li>You may choose in or out-of-network care, however in-network care provides you a higher level of benefit.</li> <li>Emergencies covered worldwide.</li> <li>Out-of-network providers will bill the balance to the member for amounts not covered</li> </ul>	<ul style="list-style-type: none"> <li>You may choose in or out-of-network care, however in-network care provides you a higher level of benefit.</li> <li>Emergencies covered worldwide.</li> <li>Out-of-network providers will bill the balance to the member for amounts not covered by UMR</li> <li>Although this plan has a higher deductible than most plans, it requires lower payroll deductions.</li> <li>The HSA account provides a tax-favored vehicle to help you manage your out-of-pocket expenses.</li> </ul>

Please note, the above examples are used for general illustrative purposes only. Please consult with your Human Resources department for more specific information as it relates to your specific plan. For a detailed view of your medical plan summaries, visit [www.umar.com](http://www.umar.com).

TIP

### Medical Services Covered in Full

The federal Health Care Reform law now requires insurance companies to cover preventive care services in full, saving you money and helping you maintain your health. Preventive services may include annual check-ups, well-baby and child visits and certain immunizations and screenings.

To confirm that your preventive care services are covered, refer to your plan documents.

## USING A PPO

In-Network or Out-of-Network



Primary Care Physician

or



Specialist

## USING A HDHP

In-Network or Out-of-Network



HSA Funds



Primary Care Physician

or



Specialist

## Plan Highlights

	HDHP		Base Plan PPO		Buy-Up Plan PPO	
	El Rio Facilities	UHC Network	El Rio Facilities	UHC Network	El Rio Facilities	UHC Network
<b>Annual Deductible (Calendar Year)</b>						
Individual	\$2,000	\$2,500	\$1,000	\$2,000	\$750	\$1,500
Family	\$4,000	\$4,500	\$2,000	\$3,500	\$1,500	\$2,500
<b>Maximum Out-of-pocket <sup>(1)</sup></b>						
Individual	\$2,000	\$5,000	\$1,000	\$6,000	\$750	\$5,000
Family	\$4,000	\$9,500	\$2,000	\$11,500	\$1,500	\$9,500
<b>Professional Services</b>						
Primary Care Physician (PCP)	0% after deductible	10% after deductible	No Charge	\$30 copay	No Charge	\$25 copay
Specialist	0% after deductible	10% after deductible	No Charge	\$60 copay	No Charge	\$50 copay
Preventive Care Exam	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Diagnostic X-ray and Lab	0% after deductible	10% after deductible	No Charge	20% no deductible	No Charge	10% no deductible
Complex Diagnostics (MRI/CT Scan)	N/A	10% after deductible	N/A	20% after deductible	N/A	10% after deductible
Chiropractic Services	N/A	10% after deductible	N/A	\$60 copay	N/A	\$50 copay
<b>Hospital Services</b>						
Inpatient	N/A	10% after deductible	N/A	20% after deductible	N/A	10% after deductible
Outpatient Surgery	N/A	10% after deductible	N/A	20% after deductible	N/A	10% after deductible
Urgent Care	N/A	10% after deductible	N/A	\$75 copay	N/A	\$75 copay
Emergency Room	N/A	10% after deductible	N/A	\$300 copay	N/A	\$300 copay
<b>Mental Health &amp; Substance Abuse</b>						
Inpatient	N/A	10% after deductible	N/A	20% after deductible	N/A	10% after deductible
Outpatient	N/A	10% after deductible	N/A	20% after deductible	N/A	10% after deductible
<b>Prescription Drugs (31-day supply)</b>						
Tier 1	Covered 100%	\$15 copay	Covered 100%	\$15 copay	Covered 100%	\$15 copay
Tier 2	\$10 copay	\$40 copay	\$10 copay	\$40 copay	\$10 copay	\$40 copay
Tier 3	\$20 copay	\$80 copay	\$20 copay	\$80 copay	\$20 copay	\$80 copay
Tier 4 - Specialty	\$50 copay	\$125 copay	\$50 copay	\$125 copay	\$50 copay	\$125 copay
<b>Prescription Drugs - Mail Order (93-day supply)</b>						
Tier 1	Covered 100%	\$30	Covered 100%	\$30	Covered 100%	\$30
Tier 2	\$10 copay	\$80	\$10 copay	\$80	\$10 copay	\$80
Tier 3	\$20 copay	\$160	\$20 copay	\$160	\$20 copay	\$160

<sup>(1)</sup> Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

# Prescription Drug Coverage

Many FDA-approved prescription medications are covered through the benefits program. Important information regarding your prescription drug coverage is outlined below:

- The Navitus plan covers generic formulary, brand-name formulary, non-formulary brand, and specialty drugs.
- Generic drugs are required by the FDA to contain the same active ingredients as their brand-name counterparts.
- A brand-name medication is protected by a patent and can only be produced by one specified manufacturer.
- Although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company's preferred formulary list.
- Specialty medications most often treat chronic or complex conditions and may require special storage or close monitoring.

For a current version of the prescription drug list(s), visit [ibenefits](#).

## WHY PAY MORE?

There are a few ways you can save money when using the Prescription Drug Plan:



### Utilize El Rio Pharmacies

Save time and money by utilizing El Rio pharmacies. El Rio pharmacies offer the lowest cost for scripts over other in-network pharmacies. It is a convenient and cost saving way to fill your prescriptions. Did you know El Rio is also able to fill your specialty medications?



### Mail Order

Save time and money by utilizing a mail order service for maintenance medications. A 90-day supply of your medication will be shipped to you, instead of a typical 30-day supply at a walk-in pharmacy.



### Shop Around

Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others may. By calling ahead, you may determine which pharmacy provides the most competitive price.



### Explore Over-the-Counter Options

For common ailments, over-the-counter drugs may provide a less expensive option that serves the same purpose as prescription medications.

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# How to Find a Provider

## UnitedHealthcare Network Via UMR.

**When you choose a plan available through UMR, you are choosing to have access to the UnitedHealthcare Choice Plus network, one of the nation's largest health care networks.**

1. Go to [www.myuhc.com](http://www.myuhc.com)
2. Select "Find a Doctor"
3. Select "Medical Directory"
4. Select "All UnitedHealthcare Plans"
5. Scroll down and select your health plan network - "Choice Plus" Network
6. Search current location or Change Location.
7. Enter Doctor, Specialty, Facility, Clinic, or Medical Group Name or select Find Health Care By Category. .



If you do not have a member login you can view providers by visiting:

1. [www.choiceplus.welcometouhc.com/find-a-doctor](http://www.choiceplus.welcometouhc.com/find-a-doctor)
2. Select Search the network: "The Choice Plus Plan"

**Remember, if you don't log in or create an account, you may get search results showing healthcare facilities and professionals that are not in your plan's network.**



# Spending Accounts

## Health Savings Account (HSA)

### What is it?

By enrolling in the El Rio high-deductible health plan, you will have access to a Health Savings Account (HSA), which provides tax advantages and can be used to pay for qualified health care expenses, such as your deductible, copayments, and other out-of-pocket expenses.

### What are the benefits?

Administered by Optum Bank, an HSA accumulates funds that can be used to pay current and future health care costs.

- You can contribute to your HSA on a pre-tax basis, for federal tax purposes, or you can contribute on a post-tax basis and take the deduction on your tax return.
- Generally, HSA funds can grow on a tax-free basis, subject to state law.<sup>1</sup>
- An HSA reduces your taxable income and may allow you to make tax-free withdrawals from the account when paying for qualified health care expenses (tax regulations vary by state).
- Because you own the HSA, there are no “Use it or Lose it” provisions, so unused HSA funds roll over from year-to-year, and can be used to reimburse future eligible out-of-pocket expenses.
- You may enjoy lower monthly premium payments as compared to traditional PPO medical plans.
- Because you own the HSA, the money in your account is yours to keep if you leave the company.
- El Rio Health contributes \$50 per pay period to your HSA for employee-only coverage, and \$100 per pay period for an employee covering dependents.

### How do I qualify for an HSA?

The IRS has guidelines regarding who qualifies for an HSA. You are considered eligible if:

- You are covered under a qualified medical plan.
- You are not enrolled in non-qualified health insurance outside of El Rio Health’s HSA plan.
- You are not enrolled in Medicare.
- You are not claimed as a dependent on someone else’s tax return (excluding a spouse).
- You are not enrolled in a general Health Care Flexible Spending Account (Health FSA) or general Health Reimbursement Arrangement (HRA).

<sup>(1)</sup> Please consult your tax advisor for applicable tax laws in your state.

## A few rules you need to know:

- For 2022, the maximum contribution limit for employee and employer contributions in an employee's HSA account is \$3,650 if you are enrolled in the HSA-PPO for employee-only coverage, and \$7,300 for employees with dependent coverage.
- It's important to monitor your contributions to avoid going over the IRS limit, as contributions in excess of the IRS limit are subject to standard income tax rates, plus a 6% excise tax.
- There is a 20% penalty for using HSA funds on non-qualified health care expenses if you are under age 65. For more details about what are considered qualified health care expenses, visit [www.irs.gov](http://www.irs.gov), publication 969.
- You may not be able to contribute to your HSA if you are entitled to Medicare. However, funds accumulated before Medicare entitlement may be used to reimburse your qualified medical expenses.
- You may not contribute to your HSA if you are covered under any medical benefits plan which is not an HSA-qualified high deductible medical plan (e.g., a spouse's non-HDHP medical plan, a general purpose Health Care FSA, or Medicare). However, you may be covered by a Limited Purpose Health Care FSA, or an FSA which can be used after your HDHP deductible is met.
- Typically, the maximum amount an employee is eligible to contribute to an HSA per calendar year is based upon a **pro-rata** portion of the number of months an employee is eligible to contribute to an HSA. For example, an employee would normally be able to contribute 4/12 of the maximum annual limit in his/her first year of enrollment into the HSA plan, if the employee first joins the HSA plan on September 1. However, under the full contribution rule, an employee is allowed to contribute the maximum annual amount, regardless of the number of months he/she was eligible to contribute to an HSA in the first year, if he/she is eligible to contribute to an HSA on December 1 of the first year and continues to be eligible to contribute to an HSA until December 31 of the following year (i.e., for the entire subsequent year).

### TIP

#### How do I manage my HSA?

- **The most convenient way to pay for qualified expenses is to utilize the debit card**
- **You can also use your own cash or a personal credit card and reimburse yourself through your online HSA account**
- **It is recommended that you keep receipts of HSA purchases, should you ever be audited by the IRS**
- **View the status of your claims and check your HSA balance at [www.optumbank.com](http://www.optumbank.com)**

## WHAT TO KNOW ABOUT YOUR HEALTH SAVINGS ACCOUNT



You own your HSA



Your money rolls over year after year



You choose how much to contribute  
(max. amounts apply)



Paired with a high-deductible health plan



You receive a triple tax advantage

# Flexible Spending Accounts (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible health care and dependent care expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA Type	Detail
 Health Care FSA	<ul style="list-style-type: none"><li>• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance.</li><li>• Maximum contribution for 2022 is \$2,750.</li></ul>
 Limited Purpose FSA	<ul style="list-style-type: none"><li>• Option for employees enrolled in a Health Savings Account (HSA) eligible plan.</li><li>• Use this FSA to reimburse for eligible preventive care, dental and vision expenses.</li><li>• Maximum contribution for 2022 is \$2,750.</li></ul>
 Dependent Care FSA	<ul style="list-style-type: none"><li>• Can be used to pay for a child's (up to the age of 13) child care expenses and/or care for a disabled family member in the household, who is unable to care for themselves.</li><li>• Maximum contribution for 2022 is \$5,000.</li></ul>

## What are the benefits?

- Your taxable income is reduced and your spendable income increases!
- Save money while keeping you and your family healthy.

## How do I use it?

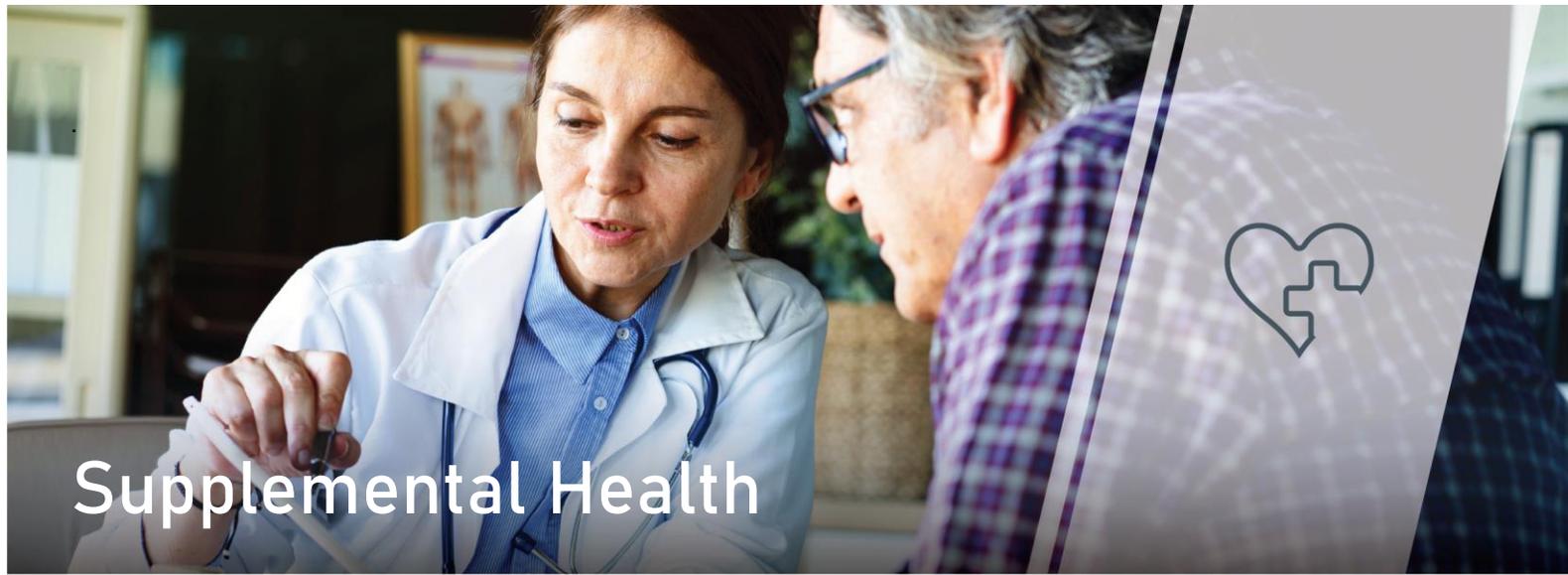
You must enroll in the FSA program within 30 days of your hire date or during annual open enrollment. At this time, you must establish an annual contribution amount within the maximum limit. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status, and more. Visit [www.umar.com](http://www.umar.com) to access UMR's online portal.

## A few rules you need to know:

- You may carryover up to \$550 from your 2021 Health FSA to the 2022 plan year.

For more details about using an FSA, contact UMR/Human Resources.





# Supplemental Health

## Critical Illness Coverage

Critical Illness coverage offered on a voluntary basis through Reliance Standard pays you a lump sum benefit if you are diagnosed with a covered illness or condition. All benefits are paid directly to you and you may use the funds as you see fit.

### What can Critical Illness coverage pay for?

- Medical expenses, such as copays, deductibles or co-insurance.
- Lost Income.
- Everyday expenses such as groceries and utilities.
- Alternative treatments.
- Lodging and travel to a specialist

### What are examples of covered illnesses or conditions?

- Cancer.
- Heart Attack.
- Stroke
- Alzheimer's.
- Kidney Failure.
- Organ Transplant.

### Here's an example of how Critical Illness coverage can help support you

Denise is 45 years old and had a heart attack. She was out of work for a couple of months recovering and although she had disability insurance, it didn't cover all of her lost income and medical bills. Thankfully, Denise had a \$10,000 Critical Illness policy. She filed her claim and received her cash benefit so that she could pay her bills and medical expenses. With her Critical Illness policy, Denise had peace of mind and was able to focus on improving her health.

Please note the above is an illustration only and does not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.

### 100% Employee-paid

If you elect the voluntary Critical Illness plan, 100% of the cost is deducted through payroll deductions. Monthly post-tax rates are available to be viewed in Dayforce.

### Benefit options

Election	Benefit Amounts & Guaranteed Issue
Employee	\$5,000 to \$10,000 in \$1,000 increments
Spouse	\$5,000 to \$10,000 in \$1,000 increments (not to exceed 100% of approved employee amount)
Child(ren)	Children are covered at 25% of approved employee amount up to a maximum of \$2,500

### Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. To learn more or to obtain a full schedule of benefits please see Human Resources.

# Accident Insurance Plan

Accident Insurance offered on a voluntary basis through Reliance Standard provides coverage for specific injuries and treatments resulting from a covered accident. The amount of the benefit paid depends on the type of injury and care received.

## How can Accident Insurance help?

Since benefits are paid directly to you, you choose how to use them, such as paying medical bills, subsidizing lost income, or covering everyday expenses.

## What are some common covered benefits?

- Emergency room visit.
- Ambulance
- Doctor visits.
- Hospital admission.
- Surgery.
- Medical equipment.
- Outpatient therapy.
- Diagnostic imaging.

Covered Event/Injury	Benefit Amount
Ambulance (ground)	\$300
Emergency room care	\$150
Physician follow-up (\$75 x 2)	\$150
X-ray	\$50
Concussion	\$150
Broken tooth (repaired by crown)	\$300
<b>Total benefit paid by Kathy's Accident Plan</b>	<b>\$1,100</b>

## Here's an example of how Accident Insurance can help support you

Kathy's daughter, Molly, plays soccer. During a recent game, she collided with a player, was knocked unconscious and taken to the emergency room (ER) by ambulance. The ER doctor diagnosed a concussion and a broken tooth. He ordered an x-ray scan to check for facial fractures due to swelling. Molly was released to her primary care physician for follow-up treatment and her dentist repaired her broken tooth with a crown. Thanks to Accident Insurance, Kathy will receive \$1,100 to help pay for Molly's expenses associated with her accident.

Please note the above is an illustration only and does not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.

## 100% Employee-paid

If you elect the voluntary Accident Insurance plan, 100% of the cost is deducted through payroll deductions. Monthly post-tax rates are outlined below:

Election	Per Pay Period Contribution for Plan A	Per Pay Period Contribution for Plan C
Employee Only	\$7.06	\$8.44
Employee + Spouse	\$11.27	\$13.80
Employee + Child(ren)	\$12.82	\$15.82
Family	\$17.23	\$21.38

# Hospital Protection

Planned or unplanned, a trip to the hospital can be unsettling, especially if your primary medical insurance doesn't cover the majority of your costs. Hospital Insurance offered on a voluntary basis through Reliance Standard pays out cash to you or your family to offset both medical and non-medical bills resulting from a hospital stay.

## How can Hospital insurance help?

The cash benefits can be used to pay for services or expenses your traditional medical plan might not cover. Since benefits are paid directly to you, you choose how to use them. Here are a few examples:

- Copayments.
- Deductibles.
- Transportation expenses.
- Child care.
- Lodging expenses for a companion.
- Lost income.

## Here's an example of how Hospital Insurance can help support you

Meet Trevor. Trevor had some complications from gallbladder removal surgery, which resulted in a 5-day hospital stay. Through his primary medical insurance, Trevor owed a \$500 deductible and \$3,000 in co-insurance. With the help of his Hospital Insurance coverage, which paid a \$1,000 admission benefit plus \$150 for each additional day, he was only out of pocket \$1,900 instead of \$3,500.

Out-of-Pocket Expenses	Hospital Indemnity Plan Benefits
\$500 deductible	\$1,000 admission benefit
\$3,000 co-insurance	\$150/day x 4 additional days = \$600
<b>Total: \$3,500</b>	<b>Total benefits paid to Trevor: \$1,600</b>

Please note the above is an illustration only and does not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.

## 100% Employee-paid

If you elect the voluntary Hospital Insurance plan, 100% of the cost is deducted through payroll deductions. Monthly post-tax rates are outlined below:

Election	Per Pay Period Contribution
Employee Only	\$11.17
Employee + Spouse	\$19.69
Employee + Child(ren)	\$16.19
Family	\$24.53

# Dental Plan



## Your Dental PPO Plan

You and your eligible dependents have the opportunity to enroll in a Dental Preferred Provider Organization (PPO) plan offered by Delta Dental of AZ.

## Using the Plan

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists.

## Plan Highlights

## Base Plan

## Buy-Up Plan

	El Rio Providers	Delta Premier & PPO Dentists	El Rio Providers	Delta Premier & PPO Dentists
Calendar Year Deductible				
Individual	No Deductible	\$50	No Deductible	\$50
Family	No Deductible	\$150	No Deductible	\$150
Annual Maximum	\$1,000		\$2,000	
Preventive	No Charge		No Charge	
Basic Services	10% after deductible	20% after deductible	10% after deductible	20% after deductible
Major Services	40% after deductible	50% after deductible	40% after deductible	50% after deductible
Orthodontia Services				
Child up to age 19	Not Available	50% after deductible	Not Available	50% after deductible
Lifetime Maximum		\$1,000		\$1,500

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

**TIP**

### Choose your Primary Care Dentist

When using a Dental PPO plan, you can receive services from dental providers both in and out of your insurance network. However, you'll receive better coverage when you use an in-network dentist. To determine whether your dentist is in or out of your insurance network, go to [www.deltadentalaz.com](http://www.deltadentalaz.com) and search the provider network, or call Delta Dental of AZ.

# Vision Plan



Vision coverage is offered by Avesis as a Preferred Provider Organization (PPO) plan. As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount. To locate an in-network vision provider, visit [www.avesis.com](http://www.avesis.com).

## Plan Highlights

## Base Vision PPO

## Buy Up Vision PPO

	In-Network	In-Network
Exam – Every 12 months		
Materials Copay	\$0 copay	\$10 copay
Lenses – Every 12 months		
Single	\$0 copay	\$0 copay
Bifocal	\$0 copay	\$0 copay
Trifocal	\$0 copay	\$0 copay
Frames	Every 24 months	Every 12 months
Frames	\$150 Allowance, 10% discount above \$150	\$175 Allowance, 10% discount above \$175
Additional Pairs of Glasses	10% discount	10% discount
Contacts – Every 12 months, in lieu of lenses & frames		
Medically Necessary	Covered in Full	Covered in Full
Elective	\$150 Allowance	\$175 Allowance

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

### TIPS

### Five tips for having an excellent view

Don't underestimate your eyes! The following tips can help you keep your eyes healthy:

- Eat lots of dark green leaves and blackberries.
- Get regular eye exams.
- Allow your eyes to rest from the computer screen.
- Wear sunglasses to protect your eyes from bright light.
- Wear safety goggles whenever necessary.



# Life and Disability

## Basic Life and AD&D

In the event of your passing, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Paid for in full by El Rio Health, the benefits outlined below are provided by Reliance Standard:

- Basic Life and AD&D Insurance of 2x annual earnings up to \$500,000.
- Please note, benefits may reduce when you reach age 65.

IRS Regulation: Employees can receive employer paid life insurance up to \$50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of \$50,000 will trigger taxable income for the “economic value” of the coverage provided to you.

## Voluntary Life and AD&D

If you would like to supplement your employer paid insurance, additional Life and AD&D coverage for you and/or your dependents is available for purchase on a payroll deduction basis through Reliance Standard.

- **For employees:** Increments of \$10,000 up to a \$500,000 maximum, not to exceed 5x your base annual earnings. With a guarantee issue benefit of \$200,000 if you enroll in the plan within your initial eligibility.
- **For your spouse:** Increments of \$10,000 up to a \$250,000 maximum with a guarantee issue benefit of \$30,000 if you enroll in the plan within your initial eligibility.
- **For your child(ren):** Coverage begins at 6 months old up to age 26, and is available in flat amounts of \$5,000 or \$10,000.
- **Voluntary AD&D:** Coverage is available for purchase in the same amounts as voluntary life insurance amounts above.

Any amounts of insurance over the guarantee issue benefit are subject to review of good health by the insurance company. Insurance amounts subject to review will not be effective until the insurance company approves.

If you do not enroll in the plan within the initial enrollment period, **any** amount of supplemental life insurance will require proof of good health, which is subject to approval by the insurance company before the insurance is effective. For more information regarding this plan, review the plan summary detail.

Please note: Benefits coverage may reduce when you reach age 75. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.



### Required! Are Your Beneficiaries Up to Date?

**Beneficiaries are individuals or entities that you select to receive benefits from your policy.**

- **You can change your beneficiary designation at any time.**
- **You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.**
- **To select or change your beneficiary, visit DayForce or contact Human Resources.**

# Employer Paid Short & Long Term Disability

## Added protection

Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings.

## Your Plans

## Coverage Details

### Short Term Disability (STD)

- Administered by Reliance Standard, STD coverage provides a benefit equal to 60% of your earnings.
- Base plan option is up to \$2,500 per week for a period up to 19 weeks. Benefits begin after 44 days of consecutive disability.
- Buy-Up plan option is up to \$2,500 per week for a period up to 24 weeks. Benefits begin after 14 days of consecutive disability.

### Long Term Disability Coverage (LTD)

- If your disability extends beyond days, the LTD coverage through Reliance Standard can replace 60% of your earnings, up to maximum of \$8,500 per month.
- Your benefits may continue to be paid until you reach social security normal retirement age as long as you meet the definition of disability.

## Long Term Care (LTC) Coverage

In the event that you, your spouse/ domestic partner, parents, parents-in-law, grandparents or grandparents-in-law are unable to perform activities of daily living such as bathing or dressing, voluntary LTC could provide assistance. Administered by UNUM, the policy will continue to pay benefits for an amount of time, or until the insured no longer needs care. Coverage may help pay for adult daycare, assisted living, nursing home care, services received in your own home, and skilled care, such as physical, occupational, respiratory or speech therapy.

### Base Plan: 100% Employer Paid

- \$1,000 monthly benefit, 100% Facility/50% Professional Home Care, 3 year benefit duration, 90 day elimination period. Employees have the option to purchase additional insurance for themselves or plans for qualified dependents:

### Buy-Up Options Include:

- \$2,000 - \$8,000 monthly benefit, 6 Year or Lifetime benefit duration, Total Choice Home Care, Simple Inflation Option. Certain buy-up options require medical underwriting.

If purchased after initial eligibility period, all buy-up options require medical underwriting. If you do not enroll when you first become eligible, you will be required to complete a health questionnaire for the buy-up plan. All eligible dependents will be asked to complete the health questionnaire, regardless of when they enroll. Contact the Benefits Help Desk for additional information.

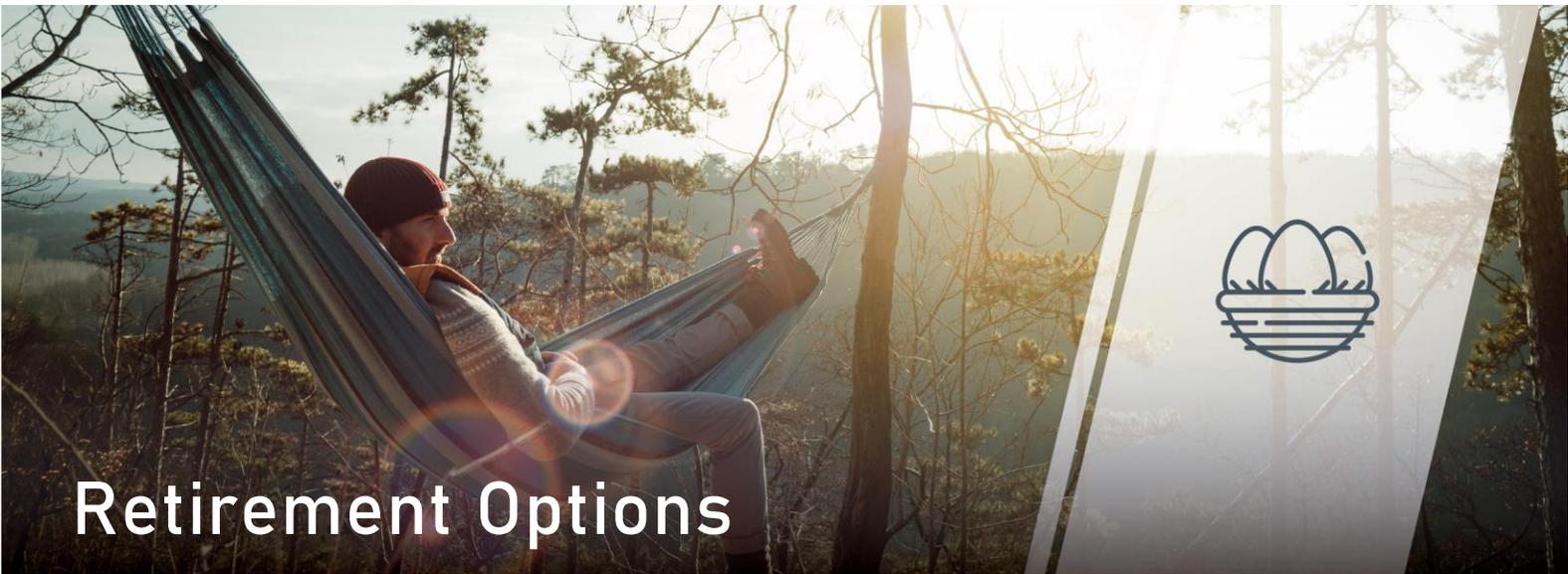


# Employee Assistance Program (EAP)

El Rio Health understands that you and your family members might experience a variety of personal or work-related challenges. Through the EAP, you have access to resources, information, and counseling that are fully confidential and paid for in full by El Rio Health.

## Program Component Coverage Details

Number of Sessions	6 sessions per year per member per incident
How to Access	Call 855.205.9185
Topics May Include	<p>Mental Health Support:</p> <ul style="list-style-type: none"> <li>• Marital, relationship or family problems.</li> <li>• Bereavement or grief counseling.</li> <li>• Substance abuse and recovery.</li> </ul> <p>Community Support:</p> <ul style="list-style-type: none"> <li>• Childcare and eldercare.</li> <li>• Legal services and Identity theft.</li> <li>• Financial support.</li> <li>• Educational materials.</li> </ul>
Who Can Utilize	All employees, dependents of employees, and members of your household



# Retirement Options

## Your 403(b) Plan Option

Administered by The Standard, the 403(b) plan allows you to plan for your future by investing a portion of each paycheck. Once you become eligible, you may elect to have a percentage of your paycheck withheld and invested in your 403(b) account, subject to federal law and plan guidelines. See Human Resources to confirm eligibility and enrollment dates.

## Enrollment & Account Access

- To enroll in the 403(b) plan, please visit [www.standard.com](http://www.standard.com) to enroll online or contact Human Resources - Benefits Team at [benefitshelpdesk@elrio.org](mailto:benefitshelpdesk@elrio.org) or 520.309.2428/520.309.3775 to receive instructions on accessing Dayforce.
- Check your 403(b) account balance, view your contributions, change your investments and more by visiting [www.standard.com](http://www.standard.com). For login or password assistance, please contact The Standard at 800.858.5420.

## Additional 403(b) Information

**Contribution Limits:** For 2022, the IRS annual contribution limits are \$20,500 for everyone under age 50 or \$26,500 for anyone that is age 50 or over prior to December 31, 2022. If you have multiple employers during the year, these limits are combined for all plans that you contribute to during the year. Restrictions may apply to these limits based on plan documents and annual testing requirements.

**Contribution Changes:** Check with Human Resources - Benefits Team for frequency and process for changing your contributions. You may also stop your contribution entirely at any time. Requests to change or stop your contributions must be made through Dayforce.

**Employer Contributions:** Check with Human Resources - Benefits Team for current status of any employer contributions to the plan.

**Loans & Hardship Withdrawals:** If allowed by the plan document, please see Human Resources - Benefits Team for information and requirements for either option.

**Rollover Contributions:** If you have an outside qualified retirement plan or account such as a 401(k), 403(b), 457(b) or IRA, you may be able to transfer that account into your new plan. Please contact The Standard or Human Resources - Benefits Team for additional information.

**Termination of Employment:** Upon termination of employment from our organization, regardless of reason, you will be entitled to request a full distribution of your vested account balance. This may be done as a rollover to another plan or IRA. You may also request a lump-sum cash payment to yourself. Please be aware of possible taxes and penalties which may apply to any payment other than a rollover.

Marsh & McLennan Insurance Agency LLC does not serve as advisor, broker-dealer or registered investment advisor for this plan. All of the terms and conditions of your plan are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

# Costs, Directory, and Required Notices

## Cost Breakdown

The rates below are effective January 1, 2022 – December 31, 2022.



### Coverage Level

### Bi-Weekly Payroll Deduction

	Part Time (20 - 29 hours)	Full Time (30+ hours)
<b>UMR High Deductible Health Plan</b>		
Employee Only	\$13.16	\$0.00
Employee and Spouse/ Domestic Partner	\$122.08	\$99.02
Employee and Child(ren)	\$118.53	\$95.80
Employee and Family	\$209.83	\$178.72
<b>UMR Base Plan PPO</b>		
Employee Only	\$40.53	\$25.33
Employee and Spouse/ Domestic Partner	\$180.11	\$152.22
Employee and Child(ren)	\$175.57	\$148.09
Employee and Family	\$292.45	\$254.36
<b>UMR Buy-Up Plan PPO</b>		
Employee Only	\$73.61	\$58.42
Employee and Spouse/ Domestic Partner	\$254.53	\$226.54
Employee and Child(ren)	\$248.55	\$221.07
Employee and Family	\$399.95	\$361.86
<b>Delta Dental AZ Base Plan</b>		
Employee Only	\$0.83	\$0.00
Employee and Spouse/ Domestic Partner	\$8.56	\$7.57
Employee and Child(ren)	\$13.01	\$12.20
Employee and Family	\$17.60	\$16.45
<b>Delta Dental AZ Buy-Up Plan</b>		
Employee Only	\$8.47	\$5.84
Employee and Spouse/ Domestic Partner	\$24.19	\$19.10
Employee and Child(ren)	\$30.94	\$24.40
Employee and Family	\$42.41	\$33.42
<b>Avesis Vision Base Plan</b>		
Employee Only		\$3.94
Employee and Spouse/ Domestic Partner		\$6.90
Employee and Child(ren)		\$8.22
Employee and Family		\$10.25
<b>Avesis Vision Buy Up Plan</b>		
Employee Only		\$4.65
Employee and Spouse/ Domestic Partner		\$8.14
Employee and Child(ren)		\$9.70
Employee and Family		\$12.09

# Directory & Resources

Below, please find important contact information and resources for El Rio Health.

Information Regarding	Group / Policy #	Contact Information	
<b>Enrollment &amp; Eligibility</b>			
Human Resources:			
• Benefits		520.309.2428 520.309.3775	<a href="mailto:benefitshelpdesk@elrio.org">benefitshelpdesk@elrio.org</a>
Online Enrollment Vendor:			
• DayForce			
<b>Medical Coverage</b>			
UMR			
• Base Plan PPO	76-412578	800.207.3172	<a href="http://www.umar.com">www.umar.com</a>
• Buy-Up Plan PPO			
• High Deductible Health Plan			
<b>Dental Coverage</b>			
Delta Dental of AZ			
• Base Plan	31281	800.352.6132	<a href="http://www.deltadentalaz.com">www.deltadentalaz.com</a>
• Buy-Up Plan			
<b>Vision Coverage</b>			
Avesis			
• Vision Base Plan	30781	800.828.9341	<a href="http://www.avesis.com">www.avesis.com</a>
• Vision Buy-Up Plan			
<b>Life, AD&amp;D and Disability</b>			
Reliance Standard			
• Life and AD&D	161515		
• Voluntary Life and AD&D			
• Short Term Disability	167315		
• Long Term Disability	131556	800.351.7500	<a href="http://www.rsli.com">www.rsli.com</a>
• Accident Insurance	827487		
• Critical Illness	802261		
• Hospital Indemnity			
<b>Flexible Spending Accounts</b>			
UMR		800.207.3172	<a href="http://www.umar.com">www.umar.com</a>
<b>Health Savings Account</b>			
Optum Bank		800.791.9361	<a href="http://www.optumbank.com">www.optumbank.com</a>
<b>403(b) Retirement Plan Adviser</b>			
The Standard		800.858.5420	<a href="http://www.standard.com">www.standard.com</a>
<b>Employee Assistance Plan</b>			
OptumEAP	ELRIO	855.205.9185	<a href="http://www.liveandworkwell.com">www.liveandworkwell.com</a>
<b>Benefits Broker / Benefit Questions</b>			
Lovitt & Touché, A Marsh & McLennan Insurance Agency LLC			
Claims Advocate - Catherine Nault		520.722.7155	<a href="mailto:cnault@lovitt-touche.com">cnault@lovitt-touche.com</a>

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## Guidelines/Evidence of Coverage

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

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The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

# Medicare Part D notice

## Important Notice about Your Prescription Drug Coverage and Medicare

### Model Individual CREDITABLE Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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 prescription 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:

1. 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.
2. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, 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 15 to December 7. 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 prescription drug plan.

### What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area.

If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

**Please contact Human Resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.**

Your medical benefits brochure contains a description of your current prescription drug benefits.

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

### For More Information about This Notice or Your Current Prescription Drug Coverage...

Contact your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer 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'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember:** Keep this Creditable Coverage notice. If you decide to join one of the Medicare prescription 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).

# Legal Information Regarding Your Plans

## REQUIRED NOTICES

### Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Protheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Your plans comply with these requirements.

### Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

### Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

"HIPAA Special Enrollment Opportunities" include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage <sup>(1)</sup>
- Acquisition of a new spouse or dependent through marriage <sup>(1)</sup>, adoption <sup>(1)</sup>, placement for adoption <sup>(1)</sup> or birth <sup>(1)</sup>
- Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) <sup>(1)</sup>
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

### "Change in Status" Permitted Midyear Election Changes

- Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved "change in status" as defined by the IRS.
- Examples of permitted "change in status" events include:
  - Change in legal marital status (e.g., marriage <sup>(2)</sup>, divorce or legal separation)
  - Change in number of dependents (e.g., birth <sup>(2)</sup>, adoption <sup>(2)</sup> or death)
  - Change in eligibility of a child
  - Change in your / your spouse's / domestic partner's employment status (e.g., reduction in hours affecting eligibility or change in employment)
  - A substantial change in your / your spouse's domestic partner's benefits coverage
  - A relocation that impacts network access
  - Enrollment in state-based insurance Exchange
  - Medicare Part A or B enrollment
  - Qualified Medical Child Support Order or other judicial decree
  - A dependent's eligibility ceases resulting in a loss of coverage <sup>(3)</sup>
  - Loss of other coverage <sup>(2)</sup>
- Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage
- You enroll, or intend to enroll, in a Qualified health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

You must notify Human Resources within 30 days of the above change in status, with the exception of the following which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

## IMPORTANT INFORMATION ON HOW HEALTH CARE REFORM AFFECTS YOUR PLAN

### Prohibition on Excess waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan.

### Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended

## CONTINUATION COVERAGE RIGHTS UNDER COBRA

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

<sup>(1)</sup> Indicates that this event is also a qualified "Change in Status"

<sup>(2)</sup> Indicates this event is also a HIPAA Special Enrollment Right

<sup>(3)</sup> Indicates that this event is also a COBRA Qualifying Event

## CONTINUATION COVERAGE RIGHTS UNDER COBRA (CONTINUED)

### What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [enter name of employer sponsoring the Plan], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

### 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;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to any person covered under the plan who is a spouse, dependent child, or any other person eligible for COBRA continuation coverage under the plan.

### How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

#### Disability extension of 18-month period of COBRA continuation coverage

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

#### How is COBRA continuation coverage provided? (Continued)

#### Second qualifying event extension of 18-month period of continuation coverage

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

### Are there other coverage options besides COBRA Continuation Coverage?

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

### Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

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

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

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

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

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

### If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

### Keep your Plan informed of address changes

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

### Plan contact information

El Rio Health  
Attention: George Toy  
Chief Human Resources Officer  
450 W. Paseo Redondo  
Tucson, AZ 85701  
520.640.3909

## EMPLOYEE RIGHTS & RESPONSIBILITIES UNDER THE FAMILY MEDICAL LEAVE ACT

### Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

### Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness<sup>(1)</sup>; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.<sup>(2)</sup>

### Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

### Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months<sup>(3)</sup>, and if at least 50 employees are employed by the employer within 75 miles.

<sup>(1)</sup> <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

<sup>(2)</sup> The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition"

<sup>(3)</sup> Special hours of service eligibility requirements apply to airline flight crew employees

**Definition of Serious Health Condition**

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

**Use of Leave**

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

**Substitution of Paid Leave for Unpaid Leave**

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

**Employee Responsibilities**

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

**Employer Responsibilities**

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

**Unlawful Acts by Employers**

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

**Enforcement**

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TTY: (877) 889-5627 [www.wagehour.dol.gov](http://www.wagehour.dol.gov)

**UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT NOTICE OF 1994, NOTICE OF RIGHT TO CONTINUED COVERAGE UNDER USERRA**

**Right to Continue Coverage**

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

**How to Continue Coverage**

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

**What Happens if You do not Elect to Continue Coverage?**

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

**Premium for Continuing Your Coverage**

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

**Length of Time Coverage Can Be Continued**

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

**Reporting to Work / Applying for Reemployment**

Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible
31-180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible
181 days or more	Submit an application for reemployment within 90 days after completion of your service
Any period if for purposes of an examination for fitness to perform uniformed service	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

**Definitions**

For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency
- "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

# HIPAA PRIVACY NOTICE

## Notice of Health Information Privacy Practices

**This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.**

This notice is EFFECTIVE: **1/17/2022**

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to provide information about the legal protections that apply to your health information. HIPAA includes numerous provisions that are designed to maintain the privacy and confidentiality of your Protected Health Information (PHI). PHI is health information that contains identifiers (such as your name, address, social security number, or other information that identifies you) and information related to your past, present or future health condition and treatments.

This notice is for participants in the Company Health & Welfare Plan (referred to as the "Plan"), including its component plans.

### Required by Law

- The Plan must make sure that health information that identifies you is kept private.
- The Plan must give you this notice of our legal duties and privacy practices with respect to health information about you.
- The Plan must obtain written authorization from you for the use and disclosure of your PHI related to psychotherapy notes; when for purposes of marketing; and/or for disclosures constituting a sale of PHI.
- The Plan must follow the terms of the notice that are currently in effect.

### Permitted Plan use of Your Health Information

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact the Plan Privacy Officer.

You have both the right and choice to tell us to: share information with your family, close friends, or others involved in payment for your care; share information in a disaster relief situation; and contact you for fundraising efforts.

If you are not able to tell us your preference, for example if you are unconscious, the Plan may go ahead and share your information if it believes it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety.

The Plan will never share your information unless you give us written permission for: marketing purposes and the sale of your information.

**Treatment:** The Plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the Plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

**Regular Operations:** We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees. We may also use and disclose your information to run our organization and contact you when necessary. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. The Plan is also not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

**Payment for Health Services and Administration of the Plan:** The Plan can use and disclose your health information when paying for your health services. For example, the Plan may share information about you with your dental plan to coordinate payment for your dental work. The Plan may disclose your health information to your health plan sponsor for plan administration. For example, where your company contracts with an insurer to provide a health plan, and the Plan provides your company with certain statistics to explain the premiums charged.

**Business Associates:** There are some services provided in our organization through contracts with business associates. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy rules and HIPAA security rules.

**As Required by Law:** We will disclose health information about you when required to do so by federal, state or local law (this includes the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law).

**To Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director:** We may share health information about you with organ procurement organizations; and may share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Workers' Compensation:** We may release health information about you for workers' compensation programs or claims or similar programs. These programs provide benefits for work-related injuries or illness.

**Law Enforcement and other Government Requests:** We may disclose your health information for law enforcement purposes or with a law enforcement official, in response to a valid subpoena or other judicial or administrative request/order, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services.

**Public Health and Research:** We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation). Additionally we may share health information about you when: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety or for purposes of health research.

### Your Rights Regarding Your Health Information

**Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:**

- Request a restriction on certain uses and disclosures of your information where concerning a service already paid for.
- Obtain a paper copy of the notice of health information practices promptly (even if you have agreed to receive the notice electronically) by requesting it from the Plan Privacy Officer.
- Ask to see or get a copy of your health and claims records and other health information we have about you. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Inspect and obtain a copy of your PHI contained in a "designated record set." A designated records set includes medical and billing records; enrollment, payment, billing, claims adjudication

and case or medical management record systems; or other information used in whole or in part by or for the covered entity to make decisions about individuals. A written request to access your PHI must be submitted to your company Privacy Officer. Requested information will be provided within 30 days if maintained on site or 60 days if maintained off site.

- Request an amendment/correction to your health information: you can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- **Obtain an accounting of disclosures of your PHI during the preceding six years, who we shared it with, and why, with the exception of disclosures made for purposes of treatment, payment or health care operations, and certain other disclosures (such as any you asked us to make); made to individuals about their own PHI; or, made through use of an authorization form. A reasonable fee may be charged for more than one request per year.**
- **Request confidential communications of your health information be sent in a different way (for example, home, office or phone) or to a different place than usual (for example, you could request that the envelope be marked "confidential" or that we send it to your work address rather than your home address). We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.**
- **Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.**
- **Receive notification within 60 days (5 day for California residents) for any breaches of your unsecured PHI.**
- **Assign someone as your medical power of attorney or your legal guardian, who can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.**

### Plan Responsibilities

**The Plan is required to maintain the privacy of PHI and to comply with the terms of this notice. The Plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you within 60 days of the effective date of any material change to the rights and duties listed in this notice. The Plan is required to:**

- **Maintain the privacy and security of your health information.**
- **Make reasonable efforts not to use, share, disclose or request more than the minimum necessary amount of PHI needed to accomplish the intended purpose, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**
- **Follow the duties and privacy practices described in this notice with respect to information we collect and maintain about you and provide you a copy of the notice.**
- **Abide by the terms of this notice.**
- **Notify you if we are unable to agree to a requested restriction, amendment or other request.**
- **Notify you of any breaches of your protected health information that may have compromised the privacy or security of your information within 60 days (5 days for California residents).**
- **Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.**

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA. The plan is prohibited from using or disclosing PHI that is genetic information of an individual for any purposes, including underwriting.

For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html)

### Your Right to File a Complaint

If you believe your privacy rights have been violated, you can file a formal complaint with the Plan Privacy Officer; or with the U.S. Department of Health and Human Services (by mail or email). We will not retaliate against you and you will not be penalized for filing a complaint.

### Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

### Contact Person

If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the Plan Privacy Officer. All requests must be submitted in writing to the address shown below.

El Rio Health  
Attention: George Toy  
Chief Human Resources Officer  
450 W. Paseo Redondo  
Tucson, AZ 85701  
520.640.3909

# HIPAA Wellness Program Reasonable Alternative Standards Notice

Your group health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Human Resources 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 in light of your health status.

## ADA Wellness Program Notice

### **NOTICE REGARDING WELLNESS PROGRAM**

El Rio Health wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease).

However, employees who choose to participate in the wellness program will receive an incentive. Although you are not required to complete the activities or participate, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources

### **Protections from Disclosure of Medical Information**

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and El Rio Health may use aggregate information it collects to design a program based on identified health risks in the workplace, El Rio will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources.

# 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](http://www.healthcare.gov).

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or [www.insurekidsnow.gov](http://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](http://www.askebsa.dol.gov) or call 1-866-444-EBSA (3272).

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –**

<p><b>ALABAMA – Medicaid</b></p> <p>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447</p>	<p><b>COLORADO – Health First Colorado (Colorado's Medicaid Program) &amp; Child Health Plan Plus (CHP+)</b></p> <p>Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: <a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus</a> CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): <a href="https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program">https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program</a> HIBI Customer Service: 1-855-692-6442</p>
<p><b>ALASKA – Medicaid</b></p> <p>The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></p>	<p><b>FLORIDA – Medicaid</b></p> <p>Website: <a href="https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html">https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html</a> Phone: 1-877-357-3268</p>
<p><b>ARKANSAS – Medicaid</b></p> <p>Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)</p>	<p><b>GEORGIA – Medicaid</b></p> <p>Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162 ext 2131</p>
<p><b>CALIFORNIA – Medicaid</b></p> <p>Website: Health Insurance Premium Payment (HIPP) Program <a href="http://dhcs.ca.gov/hipp">http://dhcs.ca.gov/hipp</a> Phone: 916-445-8322 Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a></p>	<p><b>INDIANA – Medicaid</b></p> <p>Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a> Phone 1-800-457-4584</p>
<p><b>IOWA – Medicaid and CHIP (Hawki)</b></p> <p>Medicaid Website: <a href="https://dhs.iowa.gov/ime/members">https://dhs.iowa.gov/ime/members</a> Medicaid Phone: 1-800-338-8366 Hawki Website: <a href="http://dhs.iowa.gov/Hawki">http://dhs.iowa.gov/Hawki</a> Hawki Phone: 1-800-257-8563 HIPP Website: <a href="https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a> HIPP Phone: 1-888-346-9562</p>	<p><b>MONTANA – Medicaid</b></p> <p>Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084</p>
<p><b>KANSAS – Medicaid</b></p> <p>Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a> Phone: 1-800-792-4884</p>	<p><b>NEBRASKA – Medicaid</b></p> <p>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a> Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
<p><b>KENTUCKY – Medicaid</b></p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a> Phone: 1-855-459-6328 Email: <a href="mailto:KIHIPPPROGRAM@ky.gov">KIHIPPPROGRAM@ky.gov</a></p> <p>KCHIP Website: <a href="https://kidshealth.ky.gov/Pages/index.aspx">https://kidshealth.ky.gov/Pages/index.aspx</a> Phone: 1-877-524-4718</p> <p>Kentucky Medicaid Website: <a href="https://chfs.ky.gov">https://chfs.ky.gov</a></p>	<p><b>NEVADA – Medicaid</b></p> <p>Medicaid Website: <a href="http://dhcnp.nv.gov">http://dhcnp.nv.gov</a> Medicaid Phone: 1-800-992-0900</p>
<p><b>LOUISIANA – Medicaid</b></p> <p>Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a> Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p><b>NEW HAMPSHIRE – Medicaid</b></p> <p>Website: <a href="https://www.dhhs.nh.gov/oi/hipp.htm">https://www.dhhs.nh.gov/oi/hipp.htm</a> Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>
<p><b>MAINE – Medicaid</b></p> <p>Enrollment Website: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a> Phone: 1-800-442-6003 TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage: <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a> Phone: -800-977-6740. TTY: Maine relay 711</p>	<p><b>NEW JERSEY – Medicaid and CHIP</b></p> <p>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Medicaid Phone: 609-631-2392 CHIP Website: <a href="http://www.nifamilycare.org/index.html">http://www.nifamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710</p>
<p><b>MASSACHUSETTS – Medicaid and CHIP</b></p> <p>Website: <a href="https://www.mass.gov/info-details/masshealth-premium-assistance-pa">https://www.mass.gov/info-details/masshealth-premium-assistance-pa</a> Phone: 1-800-862-4840</p>	<p><b>NEW YORK – Medicaid</b></p> <p>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a> Phone: 1-800-541-2831</p>
<p><b>MINNESOTA – Medicaid</b></p> <p>Website: <a href="https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp">https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp</a> Phone: 1-800-657-3739</p>	<p><b>NORTH CAROLINA – Medicaid</b></p> <p>Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a> Phone: 919-855-4100</p>
<p><b>MISSOURI – Medicaid</b></p> <p>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005</p>	<p><b>NORTH DAKOTA – Medicaid</b></p> <p>Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a> Phone: 1-844-854-4825</p>

<b>OKLAHOMA – Medicaid and CHIP</b> Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a> Phone: 1-888-365-3742	<b>UTAH – Medicaid and CHIP</b> Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a> CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a> Phone: 1-877-543-7669
<b>OREGON – Medicaid</b> Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a> <a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a> Phone: 1-800-699-9075	<b>VERMONT– Medicaid</b> Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a> Phone: 1-800-250-8427
<b>PENNSYLVANIA – Medicaid</b> Website: <a href="https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx">https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx</a> Phone: 1-800-692-7462	<b>VIRGINIA – Medicaid and CHIP</b> Website: <a href="https://www.coverva.org/en/famis-select">https://www.coverva.org/en/famis-select</a> <a href="https://www.coverva.org/en/hipp">https://www.coverva.org/en/hipp</a> Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
<b>RHODE ISLAND – Medicaid and CHIP</b> Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a> Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	<b>WASHINGTON – Medicaid</b> Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a> Phone: 1-800-562-3022
<b>SOUTH CAROLINA – Medicaid</b> Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a> Phone: 1-888-549-0820	<b>WEST VIRGINIA – Medicaid</b> Website: <a href="http://mywvhpp.com/">http://mywvhpp.com/</a> Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
<b>SOUTH DAKOTA - Medicaid</b> Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059	<b>WISCONSIN – Medicaid and CHIP</b> Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a> Phone: 1-800-362-3002
<b>TEXAS – Medicaid</b> Website: <a href="http://gethiptexas.com/">http://gethiptexas.com/</a> Phone: 1-800-440-0493	<b>WYOMING – Medicaid</b> Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a> Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)  
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email [ebsa.opr@dol.gov](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

# Notice Regarding Availability of Health Insurance Exchange



## New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved  
OMB No. 1210-0149  
(Expires 6-30-2023)

### PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

#### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

#### 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 coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

#### Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.83% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.<sup>1</sup>

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 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.

#### How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

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The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](http://HealthCare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

### PART B: Information About Health Coverage Offered by Your Employer

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<sup>1</sup> An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name El Rio Health Center		4. Employer Identification Number (EIN) 86-0285857	
5. Employer address 839 W. Congress		6. Employer phone number 520.670.3909	
7. City Tucson	8. State AZ	9. ZIP Code 85745	
10. Who can we contact about employee health coverage at this job? Human Resources			
11. Phone number (if different from above) Click here to enter text.		12. Email address HRDepartment@elrio.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

- All employees. Eligible employees are:

- Some employees. Eligible employees are:

Employees scheduled to work 20 hours per week or more.

- With respect to dependents:

- We do offer coverage. Eligible dependents are:

Your legal Spouse or domestic partner, and dependent eligible children (up to age 26) or older who are or become disabled and dependent upon the employee.

- We do not offer coverage.

- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

\*\* Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.



