2026 Employee Benefits

Benefit Plan Year: January 1, 2026 through December 31, 2026

For More Information, Contact:

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OR

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GSH
GOOD SAMARITAN
HOSPITAL

Good Samaritan Hospital is pleased to provide you with our Employee Benefits Guide.

Each year at Open Enrollment you have the opportunity to review the benefits offered and to decide which plans will best fit your needs over the coming year. This guide briefly highlights the benefits offered to all eligible employees and dependents. Important contact information and enrollment information can also be found in the following pages.

Newly hired employees working 30 or more hours per week are eligible for benefits on the 1st of the month following 60 days of employment.

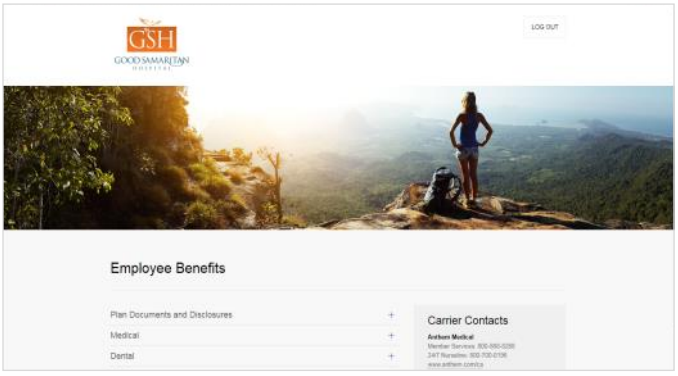
Important: *This guide provides you with an overview of our benefit plans, but in all cases, the plans will be administered in accordance with the governing plan documents. Refer to the Summary of Benefits and Coverage (SBC) documents for more detailed medical plan information.*

Online Enrollment via Employee Benefits Website

We are pleased to provide you with our benefits website! This website is an online destination where you can find benefits information and make your benefit elections. This site, which is available anytime and anywhere you have internet access, allows you to quickly access the information you need to make your enrollment decisions and to make the most of those benefits throughout the year.

Logging on to the site is easy.

Simply go to **goodsamaritan.benefitsmap.com**. Enter the username **goodsamaritan** and the password **benefits**. After entering the site, you can review your benefit plan options, find important plan documents, phone numbers, websites and email addresses, and download our carrier flyers. If you have any questions as you navigate our benefits website, please contact the Good Sam Benefit Service Center. When you are ready to make your benefit selections, use the link to our online enrollment system Paylocity, which is located on the home page of our benefits website.



If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. See page 8 for details.

Please review the CHIP notice on page 11. It includes information on how you can contact your state to check if you are eligible for premium assistance under Medicaid or Children's Health Insurance Program (CHIP) and how to apply for the programs.

Medical Insurance with Blue Shield and Kaiser

We are pleased to offer you the choice of four medical plans: two HMO plans and one PPO plan with Blue Shield, and one HMO plan through Kaiser. Please refer to the plans' Summary of Benefits and Coverage documents (SBCs) and/or benefit summaries for more detailed benefit information.

The **Blue Shield Trio HMO and Access+ HMO** plans provide comprehensive medical coverage to you and your family. Under these plans, you must choose a Primary Care Physician (PCP) and medical group. All of your care must be provided or authorized through your PCP, who will coordinate your care with the medical group's doctors and affiliated hospitals.

The **Blue Shield PPO** plan provides benefits both in and out of the PPO network. However, you can reduce your out-of-pocket costs by visiting a PPO provider, where richer benefits and negotiated fees stretch your health care dollars farther. You may also receive care outside the PPO network; however, you will have higher out-of-pocket expenses and you are responsible for filing claims with the insurance company.

The **Kaiser HMO** plan utilizes an integrated managed care approach where most services such as office visits, diagnostic x-ray, lab and pharmacy services can be found at each facility. Under this plan, all of your care must be directed through a Kaiser provider. You will receive benefits only if you use the Kaiser doctors, clinics and hospitals.

	Kaiser HMO	Blue Shield Trio HMO	Blue Shield Access+ HMO	Blue Shield PPO	
	In-Network Only	In-Network Only	In-Network Only	In-Network	Out-of-Network
Deductible (Member/Family)	None	None	None	$1,000 / $3,000	$3,000 / $9,000
Office Visit Copay	$30 PCP $50 Specialist	$25 PCP $25 Trio Specialist	$25 PCP, $40 Access+ Specialist	$35 PCP $40 Specialist	40% after deductible
Emergency Room	$250 per visit, waived if admitted	$150 per visit, waived if admitted	$150 per visit, waived if admitted	$150 + 20%	
Hospital	$500 copay per day	$750 per admit	$750 per admit	20% after deductible	40% up to $600/ day after deductible
Prescription Drug Coverage	Deductible: None	Deductible: None	Deductible: None	Deductible: None	Deductible: None
Generic/Tier 1	$15	$10	$10	$10	$10 Copay + 25%
Brand Formulary/Tier 2	$35	$30	$30	$30	$30 Copay + 25%
Brand Non Formulary/Tier 3	N/A	$50	$50	$50	$50 Copay + 25%
Specialty/Tier 4	30% up to $250	20% up to $250	20% up to $250	30% up to $250	30% up to $250 + 25%
Out-of-Pocket Maximum (Member/Family)	$3,500 / $7,000	$2,500 / $5,000	$2,500 / $5,000	$5,500 / $11,000	$10,000 / $20,000

Please refer to your carrier Summaries of Benefits and Coverage (SBCs) for more detailed benefit information. Plan documents will govern.

Dental Insurance with Blue Shield

We partnered with Blue Shield to offer you two dental plans: a Dental HMO (DHMO) plan and a PPO plan. Please refer to the plans' benefit summaries for more detailed benefit information.

The **Blue Shield DHMO** plan provides quality dental benefits at an affordable cost. Under this dental plan, you must select a Primary Care Dentist (PCD) who will provide all of your covered dental care and arrange for any care by a specialist. Please refer to the plan's Description of Benefits and Copayments for a list of covered services and the required copays.

Tip: Enrolling in the DHMO plan? Bring your Description of Benefits and Copayments to your dental appointment and ask your dentist for a cost estimate before starting treatment.

Blue Shield DHMO Plan	
	In Dental HMO Network Only
Calendar Year Deductible	None
Calendar Year Benefit Max	Unlimited
Preventive Services	No Charge
Basic Services	See the plan benefit summary and Description of Benefits and Copayments
Major Services	
Orthodontia (Adult/Children)	$1,975 copay / $1,775 copay

Vision Insurance with Blue Shield

Whether your vision is 20/20 or less than perfect, everyone needs to receive regular vision care. The **Blue Shield PPO** vision plan offers you professional vision care and high quality lenses and frames through Blue Shield's network of private practices and retailers. Similar to a PPO medical or dental plan, you maximize your benefits by receiving services from in-network eye care providers.

Blue Shield PPO Vision Plan		
VSP Choice Network	**In Network**	**Out of Network**
Frequency Exam Lenses Frames	Once every 12 Months Once every 12 Months Once every 12 Months	
		Reimbursement:
Exam	$10 Copay	Up to $60
Standard Lenses	$25 Copay	Up to $75
Frames	$150 Allowance	Up to $100
Contact Lenses (instead of glasses)	$150 Allowance	Up to $100

The **Blue Shield PPO** dental plan gives you the freedom to receive covered dental care from any licensed dentist. However, you can maximize your benefits by seeing a dentist in the Blue Shield Dental Network. If you visit an out-of-network dentist, you may need to file your claims with Blue Shield on your own and you will be responsible for any remaining amount owed after the insurance has paid out.

Tip: Enrolling in the PPO dental plan? Before you receive any major dental work, ask your dentist to submit a Dental Treatment Plan to Blue Shield. Blue Shield will then issue a report showing what services will or will not be covered by your dental plan, as well as how much you will pay for those services.

Blue Shield PPO Plan		
	In Network	**Out of Network**
Calendar Year Deductible[1]	$50 Individual $150 Family	
Calendar Year Benefit Max[2]	$2,000 per Member	
Preventive Services	No Charge	No Charge
Basic Services	You pay 10% after Deductible	You pay 20% after Deductible
Major Services	You pay 40% after Deductible	You pay 50% after Deductible
Provider Reimbursement	Fee Schedule	UCR
Orthodontia	You pay 50% $1,000 Individual Annual Orthodontia Benefit Maximum	

[1] Deductible payments cross accumulate, regardless of in or out of networks.
[2] Benefit payments cross accumulate toward the Max, regardless of in or out of networks.

Basic Life and AD&D Insurance

with MetLife

At **no cost to you**, Good Samaritan Hospital is pleased to provide our benefit-eligible, non-management employees with term life insurance equal to 1 x annual earnings up to $150,000. We also provide a matching amount of accidental death and dismemberment (AD&D) insurance. (coverage is reduced at age 65) These valuable benefits are provided through **MetLife**, and **Good Samaritan Hospital pays 100% of the cost** for these coverages.

Managers, please contact Human Resources for your Life and AD&D insurance amounts.

Tip: Keep your beneficiary designation up-to-date, to ensure any death benefits are paid as you intend for them to be paid.

Generally, you can name anyone with whom you have a relationship as your beneficiary. However, naming minor children or someone other than your spouse may require additional paperwork. You may wish to contact an attorney or financial professional for guidance with this consideration.

Voluntary Life and AD&D Insurance with MetLife

Voluntary term life and AD&D insurance through **MetLife** offers additional financial protection to you and your family. You may enroll yourself, your spouse or domestic partner, and your eligible children. You must enroll in the plan in order to purchase coverage for your dependents. If you enroll in this insurance, you will pay for your coverage through convenient payroll deductions.

- It is important for all employees to select and verify coverage in the enrollment system.
- Remember, you must purchase coverage for yourself in order to purchase coverage for your spouse/DP or children.
- Guarantee Issue: This is the amount of coverage you may elect when first eligible for the plan without answering health questions.
    - Employee Guarantee Issue Amount: $100,000
    - Spouse/DP Guarantee Issue Amount: $25,000
    - Child Guarantee Issue Amount: $10,000
- A Medical Questionnaire must be completed if you or your spouse/DP wish to enroll in a benefit greater than the Guarantee Issue amount, or if you choose to enroll after your initial eligibility date. To request coverage over the Guarantee Issue amount, or enroll late, please contact the Benefits Service Center for the medical questionnaire.
    - Employee Overall Benefit Maximum: $500,000
    - Spouse/DP Overall Benefit Maximum: $100,000
    - Child Overall Benefit Maximum: $10,000

How to Find an In-Network Provider

BLUE SHIELD

Medical Trio HMO

1. Go to **blueshieldca.com/networktriohmo**
2. Choose Primary Care Physician and Enter your Zip Code
3. Relevant results will be displayed.

Medical Access+ HMO

1. Go to **blueshieldca.com/networkhmo**
2. Choose Primary Care Physician and Enter your Zip Code
3. Relevant results will be displayed.

Medical PPO

1. Go to **blueshieldca.com/pponetwork**
2. Enter your Zip Code, Select Specialty to search.
3. Relevant results will be displayed.

Dental DHMO

1. Go to **blueshieldca.com/dentalhmo**
2. Enter your Zip Code, Select Specialty to search
3. Relevant results will be displayed.

Dental PPO

1. Go to **blueshieldca.com/dentalppo**
2. Enter your Zip Code, Select Specialty to search
3. Relevant results will be displayed.

Vision

1. Go to **www.blueshieldca.com/fad/home**
2. Click Vision Care
3. Choose Continue as a Guest
4. Enter your Zip Code
5. Under Plan Year, choose 2026. Under Plan Type, choose Vision- all other
6. Select Specialty to search
7. Relevant results will be displayed.

KAISER PERMANETE

Medical

1. Go to **www.kp.org**
2. Enter User ID and Password to login and search for Kaiser providers.

Legal Assistance and Identity Theft Protection with LegalShield and IDShield

LegalShield gives you the ability to talk to an attorney on any legal matter, no matter how trivial or traumatic, without worry about high hourly costs. You may purchase a Legal Services Membership for you and your family members through convenient payroll deductions, and your membership includes:

- Legal advice
- Trial defense including trial representation
- IRS audit assistance
- Contract and document review
- Will and Healthcare Power of Attorney preparation

IDShield is also available for purchase by payroll deductions, and membership includes:

- Identity recovery services
- Privacy monitoring
- 24/7/365 live support
- Security monitoring, including credit score tracking and financial activity alerts

Need more information? Contact LegalShield representative Christa Aufdemberg at (714) 904-6501 or christa@legalidbenefits.com, or visit our employee benefits website at **goodsamaritan.benefitsmap.com**.

Supplemental Benefits with Unum

Unum's supplemental benefit programs can provide you and your family with peace of mind and financial security when you need it most. We offer several options, paid by you through convenient payroll deductions:

- **Accident** - Cash payments if injured or hospitalized *Includes a wellness benefit!
- **Hospital Indemnity** - Cash payments for ER and hospital care
- **Critical Illness** - Cash payments for specified serious illnesses

For more information, visit our employee benefits website at **goodsamaritan.benefitsmap.com**.

NEW! Enhanced Employee Assistance Program (EAP) with Health Advocate

Health Advocate is here to help you and your family with any health or well-being issues. You get access to experts who will do the work to ensure that you get the right information and assistance at the right time. We're here to help with anything you need anytime you need it, in the language and communication channel you're most comfortable using.

Access confidential support for mental and emotional health needs

Find long-term help virtually, by phone, or in-person from qualified health professionals and treatment centers.

Build skills to better cope with the challenges in your life

Work through issues that impact your life and well-being and develop a plan to feel happier, healthier, and more in control.

Get resources to help you better balance work and life

Locate the right resources for help, including childcare, eldercare, relocation support, time management, and more. You also have access to guidance from specialists for legal and financial issues.

Get help anytime and anywhere online or through our mobile app

Connect with an advocate in real time and explore webinars, online courses, and articles about mental and emotional health topics.

To get started call (866) 799-2485 or visit **HealthAdvocate.com/goodsamhospital** (Registration Code: GOODSAM).

NEW! Pet Insurance with Pet Partners

Take the Stress Out of Unexpected Vet Bills. Pet insurance reimburses you for the cost of accidents and illnesses throughout your pet's life.

- Visit any vet
- Enjoy great perks such as Rx discounts, 24/7 live vet & more
- Pre-existing condition coverage*
- Prior Coverage Credit
- Simple, straightforward pricing
- Premiums paid through payroll deduction

Log in to Paylocity to enroll. Questions about coverage, claims, or your policy? We're here to help. Contact PetPartners Customer Care: Email us at **mypolicy@petpartners.com** or call (800) 956-2495.

*"Pre-Existing Condition" means any injury or illness that started or showed symptoms before your pet insurance coverage began or during the 12-month waiting period.

Enrollment

Who Can Enroll?

To be eligible to enroll in benefits you must be a regular full-time employee, have satisfied the waiting period, and work the minimum hour requirements. You may also enroll your spouse or domestic partner, and your children up to age 26, regardless of student or marital status.

How Do I Enroll?

After reviewing your options, whether during annual Open Enrollment or during your New Employee Enrollment Period, use the online enrollment link from our benefits website (www.goodsamaritan.benefitsmap.com) by the deadline given to you. All new employees must enroll in or waive (decline) each available coverage. The 2026 open enrollment window is passive. If you do not wish to make any changes, you do not need to do anything. Any changes you do make must be made in Paylocity during the open enrollment window.

Tip: Print and retain the confirmation screen for your records.

Important: If you waive (decline) any coverage, you may not enroll in that coverage until the next annual Open Enrollment, unless you or a dependent have a Qualified Family Status Change.

When Can I Enroll or Make a Change to My Enrollment?

Annual Open Enrollment - You have the opportunity, once each year before the beginning of the benefit plan year, to make changes to your current enrollment, including enrolling yourself or a dependent in a plan for the first time.

New Employee Enrollment Period - Check with Human Resources to find out when you are eligible for benefits.

Qualified Family Status Change - If you or a dependent experience a status change, you have 30 days from the date of the status change to make any changes to your benefit elections.

Qualified family status changes include:

- Change of marital status, including marriage, divorce, or legal separation
- Termination or commencement of employment
- Birth or adoption of a child
- Reduction or increase in hours of employment, including a switch between part-time and full-time status

This list is not complete; please contact Human Resources for more information.

Important: If you or a dependent have a qualified family status change and you wish to enroll or make changes to your benefit elections, please contact Human Resources immediately. If you do not update or change your coverage within 30 days of the status change, you must wait until the next annual Open Enrollment.

Contact Information

Blue Shield - Medical, Dental, and Vision

www.blueshieldca.com
HMO/PPO Medical Member Services: (888) 256-1915
Retail Pharmacy: (800) 393-6130
24-Hour Nurseline: (877) 304-0504 [TTY: 711]
Dental HMO/PPO Member Services: (888) 256-1915
Vision Member Services: (888) 256-1915

Kaiser - Medical

www.kp.org
Member Services: (800) 464-4000

MetLife - Basic Life & AD&D, Vol Life & AD&D

www.metlife.com
Member Services: (800) GET-MET8

Unum - Accident, Hospital, & Critical Illness

Claims & Customer Service: (800) 635-5597
Fax Number: (800) 447-2498

LegalShield and IDShield

www.legalshield.com
Legal Shield Customer Service: (800) 526-8585
www.idshield.com
Identity Theft Customer Service: (800) 494-8519
Christa Aufdemberg, Senior Vice President: (714) 904-6501
or christa@legalidbenefits.com

Pet Partners - Pet Insurance

Phone: (800) 956-2495

Health Advocate

Phone: (866) 799-2485
www.HealthAdvocate.com/goodsamhospital
(Registration Code: GOODSAM)

Paylocity - Online Enrollment System

www.goodsamhospital.bswift.com

Good Sam Benefits Service Center and Benefits Website

Phone: (833) 214-5098
Email: GoodSamBenefits@sullicurt.com
Goodsamaritan.benefitsmap.com
Username: goodsamaritan / Password: benefits

Medicare Notice of Creditable Coverage

Important Notice from Good Samaritan Hospital About Your Prescription Drug Coverage and Medicare

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

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

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. Good Samaritan Hospital has determined that the prescription drug coverage offered by the Anthem Blue Cross Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Good Samaritan Hospital coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Good Samaritan Hospital coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Good Samaritan Hospital 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
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Nakei Kemp, Human Resources
901 Olive Dr., Bakersfield, CA 93308
Phone: (661) 215-7777
Email: nkemp@goodsamhospital.com

Other Important Notices and Disclosures

The Women's Health and Cancer Rights Act of 1998—Important Notice

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

Reconstruction of the breast on which the mastectomy has been performed;
Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
Prosthesis and treatment of physical complications in all stages of mastectomy, including lymphedemas.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

HIPAA Privacy Notice—Important Notice about Your Health Information

The HIPAA Notice of Privacy Practices applies to Protected Health Information associated with the Group Health plan provided to our employees, employee's dependents and, as applicable, retired employees. The Notice describes that Good Samaritan Hospital may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide individuals covered under our group health plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of the Notice so long as it remains in effect. We reserve the right to change the terms of the Notice as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all policyholders then covered by the Group Health plan. Copies of our current Notice may be obtained by contacting:

Nakei Kemp, Human Resources
901 Olive Dr., Bakersfield, CA 93308
Phone: (661) 215-7777
Email: nkemp@goodsamhospital.com

Newborns' and Mothers Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Patient Protection Disclosure

Blue Shield and Kaiser health plans generally requires/allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Blue Shield and Kaiser designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Blue Shield HMO at (888) 256-1915 or Kaiser at (800) 464-4000.

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

You do not need prior authorization from Blue Shield or Kaiser or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Blue Shield HMO at (888) 256-1915 or Kaiser at (800) 464-4000.

HIPAA Special Enrollment Rights

If you are declining for yourself or your dependent (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependent's other coverage). However, you must request enrollment within 30 days after your or your dependent's other coverage ends (or after the employer stops contributing towards the other coverage). Note: if the change is due to Medicaid/CHIP eligibility, there is a **60 day** window for Medicaid/CHIP eligibility changes only.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an innetwork facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services - If you have an emergency medical condition and get emergency services from an out-ofnetwork provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center - When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **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, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

CALIFORNIA – Medicaid

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

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecover y.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

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

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MINNESOTA – Medicaid

Website:https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

PENNSYLVANIA – Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for- medicaid-health-insurance-premium-payment-program- hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

VERMONT– Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs- services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OREGON – Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VIRGINIA – Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium- assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium- assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and- eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
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
1-877-267-2323, Menu Option 4, Ext.61565

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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 and reference the OMB Control Number 1210-0137.

Control Number 1210-0137 (expires 1/31/2026)

DISCLAIMER

This summary provides an overview of your benefit plan choices. It is for informational purposes only. It is not intended to be an agreement for continued employment; neither is it a legal plan document. If there is a disagreement between this summary and the plan documents, the plan documents will govern. In addition, the plans described in this summary are subject to change without notice. Continuation of any benefit plan or coverage is at the company's discretion and in accordance with federal and state laws. If you need additional information or have any questions please contact Human Resources.