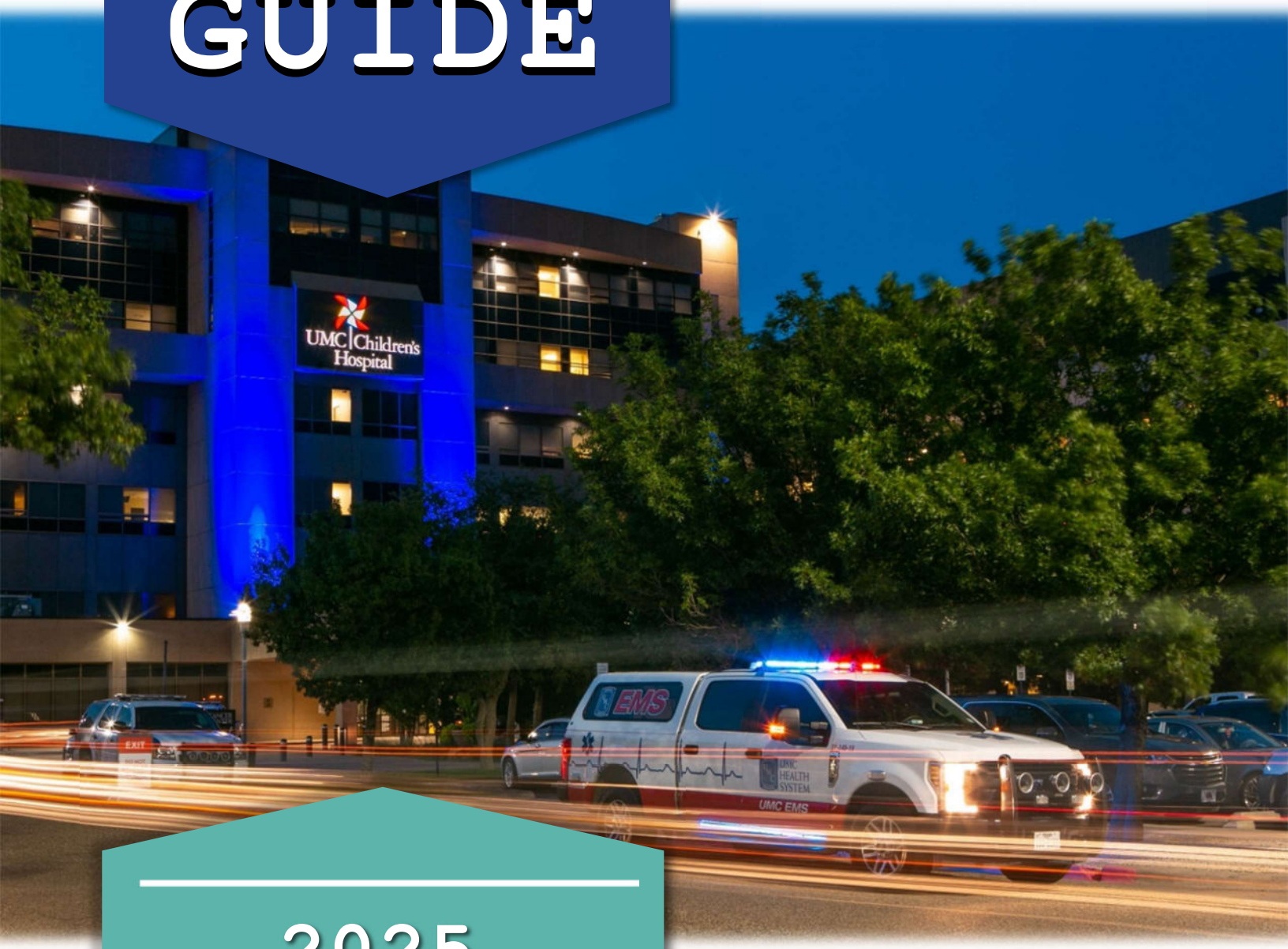
EMPLOYEE BENEFITS GUIDE

UMC HEALTH SYSTEM



2025 PLAN YEAR

This benefit guide summarizes the benefit plans that are available to UMC Health System eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

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Welcome

At UMC Health System, we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all our employees. This benefit guide will help you choose the type of plan and level of coverage that is right for you.

You can also view overviews of our benefit plans online at www.umchealthsystem.com.

Sincerely,

Human Resources

Contact Information

USI Mobile App

UMC Health System is pleased to offer on-the-go access to key benefit information through the **USI Mobile App**, MyBenefits2GO. Download in the App Store or Google Play Store and enter code F66102 in the app to access your benefit highlights.

USI Benefit Resource Center

We encourage you to contact the **USI Benefit Resource Center** (BRC) Team. The Benefit Specialists at USI are experienced professionals, and their primary responsibility is to assist you! They can answer many of the benefits questions you have, or they will help you find an answer.

Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time
Phone: 855-874-0110
Email: BRCSouthwest@usi.com

Carrier Customer Service

	Carrier	Phone Number	Website
Medical EPO	UMC Health Plan	(806) 775-8793	www.umchealthsystem.com
Dental PPO	SunLife	(800) 247-6875	www.sunlife.com/us
Vision	SunLife	(800) 877-7195	www.vsp.com
Life and AD&D	SunLife	(800) 247-6875	www.sunlife.com/us
Voluntary Life and AD&D	SunLife	(800) 247-6875	www.sunlife.com/us
Short Term Disability (STD)	SunLife	(800) 247-6875	www.sunlife.com/us
Long Term Disability (LTD)	SunLife	(800) 247-6875	www.sunlife.com/us
Voluntary Critical Illness	Aflac	(800) 433-3036	www.aflacgroupinsurance.com
Voluntary Hospital Indemnity	Aflac	(800) 433-3036	www.aflacgroupinsurance.com
Voluntary Accident	Aflac	(800) 433-3036	www.aflacgroupinsurance.com
Flexible Spending Accounts	Pension Concepts	(806) 745-9781	www.pensionconcepts.org
Online Will Preparation	Estate Guidance	N/A	www.EstateGuidance.com Promo code: SLF4VAS
Mental Health Support	ComPsych EAP Texas Tech EAP	(888)-475-3827 (806) 743-1327	www.compsych.com www.ttuhsc.edu/eap

Additional information regarding benefit plans can be found in Workday. Contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

Eligibility

Who is Eligible

You may enroll in the UMC Health System Employee Benefits Program if you are a full- or part-time employee scheduled to work at least 20 hours per week.

When Coverage Begins

The effective date for your benefits is January 1, 2025. Newly hired employees and dependents will be effective in UMC Health System's benefits programs on their date of hire. All elections are in effect for the entire plan year and can only be changed during Open Enrollment, unless you experience a family status event.

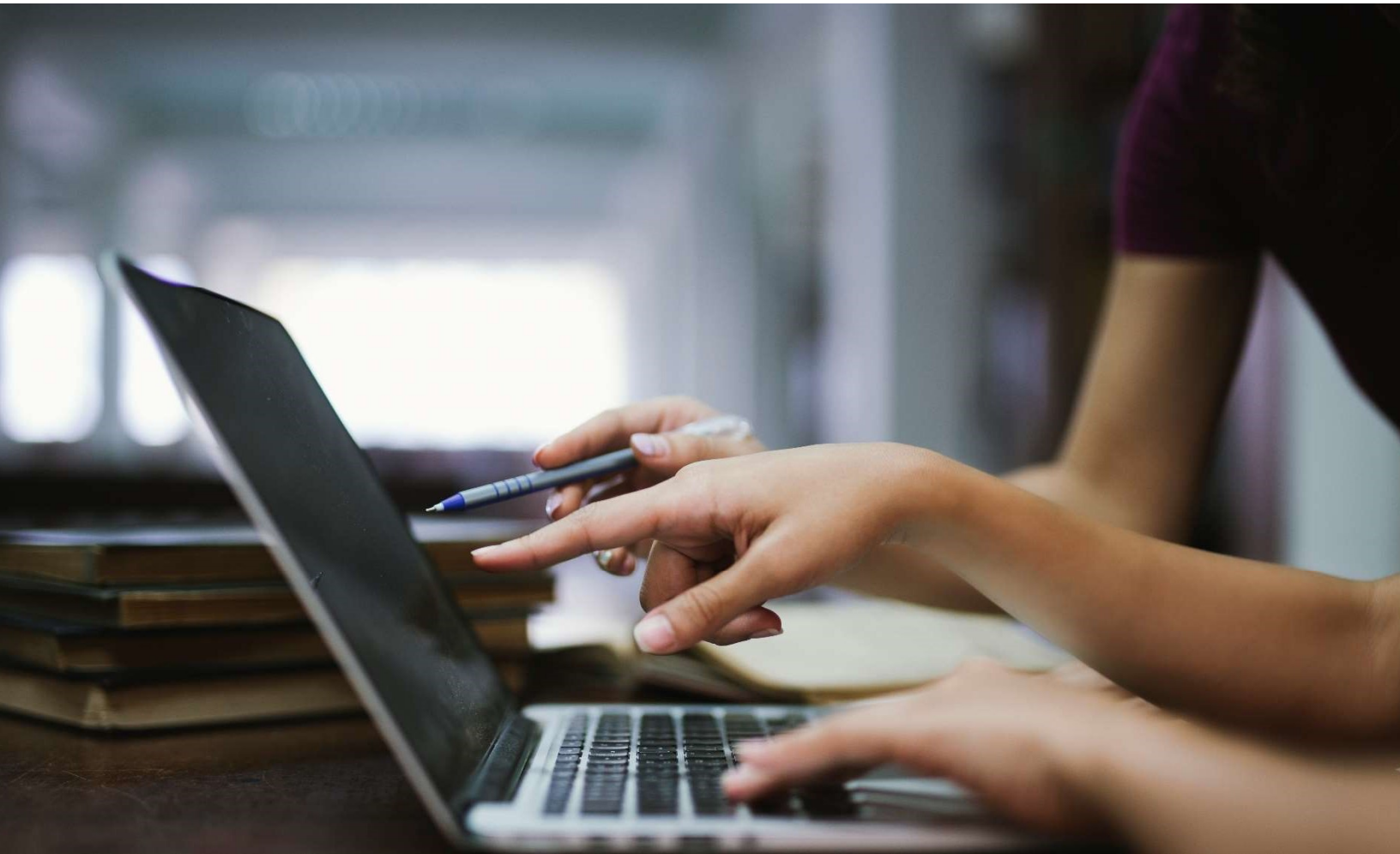
Eligible Dependents

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your:

- Legal spouse or domestic partner
- Children up to age 26 including natural, adopted, stepchildren and children obtained through court-appointed legal guardianship, as well as children of same sex state-registered domestic partners.
    - If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided.

How to Enroll

All employees will select benefits, add dependents, and review beneficiary information in Workday. Contact Human Resources if you have questions about accessing or updating Workday.



Medical Insurance

The UMC Health System is pleased to offer a comprehensive medical plan to our employees. Below is a summary of your benefits. To find an in-network provider, go to www.team-choice.com. For more information, please reference your Summary Plan Description.

EPO Medical Plan		
Benefits	In-Network	Out-of-Network
Calendar Year Deductible Individual	$750	N/A
Coinsurance	20%	N/A
Out of Pocket Maximum Individual Family	$9,200 $18,400	N/A
Physician Visits Primary Care Specialist Express Care Clinic Rx Perks Clinic MyTeamCare Now Telemedicine	$30 Copay $60 Copay $10 Copay $0 Copay $20 Copay	Not Covered
Preventive Services	Covered at 100%, Ded. Waived	Not Covered
Diagnostic Lab & X-Ray	Covered at 100%, Ded. Waived	Not Covered
Advanced Imaging CT, MRI PET Scans	$300 Copay 20% after Deductible	Not Covered
Emergency Room	$600 Copay (waived if admitted)	
Urgent Care Center	$30 Copay	Not Covered
Inpatient Hospital	$600 copay per day up to $3,000	Not Covered
Outpatient Hospital	$500 per admission	Not Covered
Pharmacy Benefits (UMC Outpatient Pharmacy & MedImpact)		
■ **Generic** ■ **Brand Name Formulary** ■ **Brand Name Non-Formulary** ■ **Specialty Drugs**	$35 Copay Greater of $55 or 20% Greater of $75 or 20% $0 Copay if prescribed at hospital discharge or through RXP Program	

*Out of network services are allowed only for prescription drug coverage and emergency services. The Participant may be responsible for any balances billed by the Out-of-Network Provider for emergency services that are in excess of the Plan's responsibility. The Participant is responsible for contacting UMC Health Plan Operations (806-775-8793) if the Participant resides outside of the usual TeamChoice service area in order to obtain In-Network benefits, other than emergency services, through the approved out-of-area provider network.

Medical Insurance Rates

2025 Bi-Weekly Premiums		
	Base Premium Rates*	**Discounted Premium Rates***
Staff earning $18/hour or less		
Employee Only – Full Time	$74.00	$49.00
Employee Only – Part Time	$164.00	$139.00
Employee & Child(ren) – Full Time	$229.00	$204.00
Employee & Child(ren) – Part Time	$310.00	$285.00
Employee & Spouse – Full Time	$304.00	$279.00
Employee & Spouse – Full Time	$405.00	$380.00
Employee & Family – Full Time	$374.00	$349.00
Employee & Family – Part Time	$459.00	$434.00
Staff earning $18.01/hour or more	**Base Premium Rates***	**Discounted Premium Rates***
Employee Only – Full time	$82.00	$57.00
Employee Only – Part Time	$186.00	$161.00
Employee & Child(ren) – Full Time	$261.00	$236.00
Employee & Child(ren) – Part Time	$356.00	$331.00
Employee & Spouse – Full Time	$347.00	$322.00
Employee & Spouse – Part Time	$464.00	$439.00
Employee & Family – Full Time	$429.00	$404.00
Employee & Family – Part Time	$526.00	$501.00

Retiree & Active UMC Board Members	**Base Premium Rates***	**Discounted Premium Rates***
Insured Only	$671.00	$617.00
Insured & Child(ren)	$1,322.00	$1,268.00
Insured & Spouse	$2,260.00	$2,206.00
Insured & Family	$2,329.00	$2,275.00

*To be eligible for the premium discount employees must comply with the requirements of UMC's Nicotine Policy. See your summary plan document for additional information.

Flexible Spending Accounts (FSA)

A Flexible Spending Account (FSA) helps you pay for health care or dependent care costs using tax-free dollars. Your contribution is deducted from your paycheck on a pretax basis and is put into the FSA. When you incur expenses, you can access the funds in your account to pay for eligible expenses. This chart below shows the eligible expenses for each FSA and how much you can contribute each year. Each of these options reduces your taxable income.

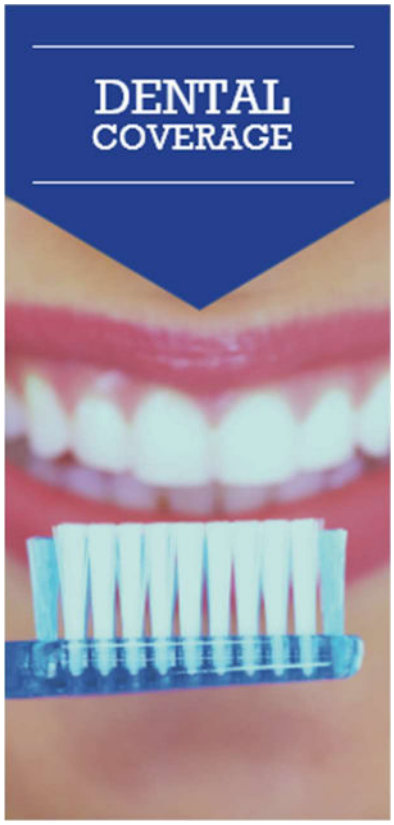
Account Type	Eligible Expenses	Annual Contribution Limits
Health Care FSA	Most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses, and prescriptions)	Minimum contribution is $195 per year. Maximum contribution is $3,300 per year. Funds are deducted throughout the year, but all funds are available on January 1.
Dependent Care FSA	Dependent care expenses (such as day care, after school programs or elder care programs) for children under age 13 or elder care so you and your spouse can work or attend school full-time	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns).

- Reimbursement set up: debit cards, direct deposit, and/or paper checks
- Online claims submission
- 24/7 member portal access to track claims submission, reimbursement totals, and balance information

For more information, go to www.pensionconcepts.org or call (806) 745-9781.

Important information about FSAs

Your FSA elections are effective from January 1st through December 31st each year. FSA elections do not automatically continue from year to year; you must actively enroll each year. Claims for reimbursement of services received from January 1st through February 28th must be submitted by March 31st of the following year. All unused funds will be forfeited. This is known as the "use it or lose it" rule and it is governed by IRS regulations.



Dental Insurance

UMC Health System offers two Dental plans through SunLife. The Base Plan covers preventive services as well as a limited number of basic services. The Enhanced Plan provides coverage for preventive, basic, and major dental services as well as orthodontia for children. Go to www.sunlife.com/sunlifedentalnetwork to find an in-network dentist.

Preventive Care

(Available on either Plan)

- Exams
- Cleanings
- Routine X-rays
- Fluoride Treatments

Major Care

(Available on Enhanced Plan only)

- Caps and Crowns
- Bridgework
- Dentures
- Implants

Basic Care

(Available on either Plan)

- Fillings
- Periodontal Maintenance
- Space Maintainers (for children under 19)

Orthodontic Care

(Available on Enhanced Plan only)

- Covers children under age 19
- $1,000 Lifetime Maximum

	SunLife Dental PPO	
Benefits Coverage	Base Plan	Enhanced Plan
Annual Deductible		
Individual	$50	$50
Family	$150	$150
Waived for Preventive Care?	Yes	Yes
Annual Maximum		
Per Person / Family	$1,000	$1,500
Preventive	100%	100%
Basic	80%	80%
Major	Not Covered	50%
Orthodontia		
Benefit Percentage	Not covered	50%
Adults (and Covered Full-Time Students, if Eligible)		Not covered
Dependent Child(ren)		Covered
Lifetime Maximum		$1,000

Employee Contributions (Bi Weekly 26 per yr)		
Employee	$5.85	$11.69
Employee & Spouse	$11.44	$21.94
Employee & Child(ren)	$14.67	$29.63
Family	$21.30	$42.04

Vision Insurance

UMC Health System provides Vision Insurance through SunLife and uses the VSP Network.

	SunLife Vision
Copay	
Routine Exams (Annual)	$10 copay
Vision Materials	
Materials Copay	$25 copay
Lenses	Benefit varies by type of lens. Covered every 12 months
Contacts Covered in lieu of frames. Medically necessary contacts may be covered at a higher benefit level	$60 for contact lens fitting and evaluation Elective contacts covered $130 allowance every 12 months
Frames	Covered at 100% to $130 allowance; 20% off amount over allowance every 24 months

Employee Contributions (Bi-Weekly)	
Employee	$2.64
Employee & Spouse	$5.23
Employee & Child(ren)	$5.13
Family	$7.80

Using your vision plan:

1. Review your plan information
2. Find an eye doctor – Create an account or log in at www.vsp.com before you search to make sure you find a doctor in your network. You'll get more and save more in-network!
3. Make an appointment and let the office know you are a VSP member.

Life and AD&D

UMC Health System provides Basic Life and AD&D benefits to eligible employees. The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan.

SunLife Life and AD&D	
You	
Benefit Maximum	$50,000
Guaranteed Issue	$50,000
Your Spouse	
Benefit Maximum	Not covered
Guaranteed Issue	Not covered
Your Child	
Benefit Maximum	Not covered
Guaranteed Issue	Not covered

The above benefits will begin to decrease at age 65.

Important Reminder!

Be sure to update your beneficiary in Workday to ensure your assets are distributed according to your wishes.

Voluntary Life and AD&D Insurance

In addition to the employer paid Basic Life and AD&D coverage, you have the option to purchase additional voluntary life insurance to cover any gaps in your existing coverage that may be a result of age reduction schedules, cost of living, existing financial obligations, etc. Your election, however, could be subject to medical questions and evidence of insurability.

You may purchase additional Life/AD&D insurance with SunLife if you want more coverage. Your contributions will depend on your age and the amount of coverage you elect. Refer to Workday for more information.

DISABILITY COVERAGE

Long-Term Disability

UMC Health System offers Full-Time Employees long-term income protection through SunLife in the event you become unable to work due to a non-work-related illness or injury. This benefit covers 60% of your monthly base salary up to $10,000. Benefit payments begin after 90 days of disability. See Certificate of Coverage for benefit duration. Please see the summary plan description for complete plan details.

Voluntary Short-Term Disability

Short-Term Disability Insurance

UMC Health System offers Full-Time Employees a short-term disability option through SunLife. This benefit covers 60% of your weekly base salary up to $2,000 per week. The benefit begins after 7 days of injury or illness and lasts up to 12 weeks. Refer to Workday for more information.

Supplemental Health Plans

The following supplemental health products are available through Aflac. All coverage is 100% employee paid. Refer to Workday for more information.

Accident & Injury

No one plans to have an accident. But it can happen at any moment throughout the day, whether at work or at play. Most major medical insurance plans only pay a portion of the bills. Our policy can help pick up where other insurance leaves off and provide cash to cover the expenses. Our accident coverage helps offer peace of mind when an accidental injury occurs.

Critical Illness

The signs pointing to a critical illness are not always clear and may not be preventable, but our coverage can help offer financial protection in the event you are diagnosed. group voluntary critical illness coverage provides a lump-sum cash benefit to help you cover the out-of-pocket expenses associated with a critical illness.

Hospital Indemnity

Even a minor trip to the hospital can present you with unexpected expenses and medical bills. Even with major medical insurance, your plan may only cover a portion of your stay. Hospital Indemnity coverage can provide financial assistance to enhance your current coverage by helping with expenses like transportation, time away from work, and meals for family members.

Claimant Support Services

Getting the help you need to face life's challenges and planning ahead to protect your loved ones can go a long way. These services are free and confidential to all employees who are eligible for the Basic Life and AD&D benefits.

Online Will Preparation

SunLife offers Online Will Preparation through Estate Guidance. A will is the cornerstone of any estate plan and can protect your assets and loved ones. Through an easy-to-use secure website, you and your spouse can now create and download a will in about 20 minutes. This service includes the following:

- Step-by-step guidance and customization for your unique situation, glossary of legal definitions,
- Ability to name an executor to carry out your wishes and a guardian(s) to care for your children,
- Ability to create a living will (for an additional fee), and
- Ability to create a final arrangements document (for an additional fee).

www.EstateGuidance.com Promo code: SLF4VAS

Mental Health Support

SunLife offers Mental Health Support through ComPsych. Losing a loved one or becoming disabled can be overwhelming to say the least. With Claimant Support Services, you have access to no-cost, objective financial planning, legal information, and emotional support, if you or your family member has filed a claim with us. You can receive the following:

- Up to five telephonic professional counseling sessions per claim for legal, financial, and emotional assistance,
- 24/7 access to counseling provided by ComPsych's on-staff professionals, including clinicians, licensed attorneys, CPAs, CFPs, and other financial experts,
- Assistance with topics such as inheritance taxes, loss of income, creditors, and probate, and
- Support dealing with trauma, loss, and adjusting to a reduced quality of life, and other concerns.
- ComPsych's professionals do not sell financial products and do not receive commissions, so you can rest assured that you will receive the information you need to help during a difficult time.

www.compsych.com (888)-475-3827

Employee Assistance Program

The Counseling Center is provided by the Texas Tech University Health Sciences Center. UMC Health System employees qualify for up to 12 counseling sessions per year. Counseling is free and confidential for you and others in your household (spouse, partner, or minor child). Individual, couple, and family counseling is offered. Daytime (M-F) and evening (M-Th) appointments are available via Telehealth (Zoom) or in-person. Counselors are licensed and have the knowledge and experience to assist you with a variety of issues, including:

- Better couple communication
- Excessive stress or anxiety
- Managing family conflict
- Alcohol or drug abuse
- Healing from trauma
- Workplace issues
- Grief and loss
- Depression

The Counseling Center
3601 4th Street
Lubbock, TX

(806) 743-1327
www.ttuhsc.edu/eap
counselingcenter@ttuhsc.edu

Legal Notices

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, 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;
- Prostheses; 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.

NEWBORNS ACT DISCLOSURE – FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF 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, 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 toward your or your dependents' other coverage). However, you must request enrollment within 30 days 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.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 30 days from the loss of coverage or the date you become eligible for premium assistance. To request special enrollment or obtain more information, contact the person listed at the end of this summary.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Health Plan Operations
(806) 775-8793
healthplanoperations@umchealthsystem.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully****.*
Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- 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.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

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.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person 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.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html**.**
- We will not retaliate against you for filing a complaint.

Your Choices

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, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, 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
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
  Marketing purposes
  Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are 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.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- 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

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here 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.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

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 (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Effective Date of this Notice: 1/1/2025
- Name or title of the privacy official (or other privacy contact) and his/her email address and phone number:

  UMC Health System
  (806) 775-8793
  healthplanoperations@umchealthsystem.com

Important Notice from UMC Health System 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 UMC Health System 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. UMC Health System has determined that the prescription drug coverage offered by the UMC Health Plan for the plan year 2025 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, the following options may apply:

- You may stay in the UMC Health Plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose UMC Health Plan creditable coverage.
- You may stay in the UMC Health Plan and also enroll in a Medicare prescription drug plan. The UMC Health Plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the UMC Health Plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the UMC Health Plan, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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 UMC Health System 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 UMC Health System 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).

Date:	January 1, 2025
Name/Entity of Sender:	UMC Health System
Contact Position/Office:	Health Plan Operations
Address:	309 North Slide Road Lubbock, TX 79416
Phone Number:	(806) 775-8793

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
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
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (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
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.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
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
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

KANSAS – Medicaid

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

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 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

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)

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

MASSACHUSETTS – Medicaid and CHIP

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

MINNESOTA – Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsphttps://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3739

MISSOURI – Medicaid

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

MONTANA – Medicaid

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

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 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 JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

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

NORTH DAKOTA – Medicaid

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

OKLAHOMA – Medicaid and CHIP

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

OREGON – Medicaid and CHIP

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

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)

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 CAROLINA – Medicaid

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

SOUTH DAKOTA – Medicaid

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

TEXAS – Medicaid

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

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 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/

VERMONT – Medicaid

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

VIRGINIA – Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/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, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
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

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 and reference the OMB Control Number 1210-0137.

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution – as well as your employee contribution to employment-based coverage – is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender:	UMC Health System
Contact--Position/Office:	Health Plan Operations
Address:	309 North Slide Road Lubbock, TX 79416
Phone Number:	(806) 775-8793

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit 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

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 UMC Health System		4. Employer Identification Number (EIN) N/A
5. Employer address 309 North Slide Road		6. Employer phone number (806) 775-8793
7. City Lubbock	8. State TX	9. ZIP code 79416
10. Who can we contact about employee health coverage at this job? Health Plan Operations		
11. Phone number (if different from above)	12. Email address healthplanoperations@umchealthsystem.com	

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

- As your employer, we offer a health plan to all eligible employees. Eligible employees are Full and Part Time employees scheduled to work 20 or more hours per week.
- With respect to dependents, we do offer coverage. Eligible dependents are Spouses, domestic partners, children up to age 26 including natural, adopted, stepchildren and children obtained through court- appointed legal guardianship, as well as children of same sex state-registered domestic partners, and for child(ren) mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided.

[x] 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** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?

_____

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly