Tri-City Medical Center

ADVANCED HEALTH CARE...FOR YOU

MEDICAL - VISION - DENTAL - EAP - FSA - LIFE/AD&D - LTD - LEGAL - RETIREMENT - VOLUNTARY

2019 BENEFITS GUIDE

This benefits guide provides a brief overview of some of the benefit plans available to you as a Tri-City Medical Center employee. While every effort was made to accurately report your benefits, discrepancies or errors are always possible. In case of a discrepancy between this guide and the actual plan documents and/or insurance contracts, the plan documents and insurance contracts will prevail. The benefits described in this guide may be changed at any time and do not represent a contractual obligation on the part of Tri-City Medical Center. If you have any questions about information contained in this guide, please contact Human Resources.

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At Tri-City Medical Center (TCMC), our signature is health and wellness. Caring hands are our symbol and our promise. In our culture of excellence, we understand that Making A Difference means touching lives and always giving our best. It means keeping our patients, their families and our community at the heart of everything we do. Making A Difference is also about reaching out to you, our valued employees, and providing tools and programs for your good health and financial security. With that, we are proud to provide you with a comprehensive and affordable benefits package that offers peace of mind and protection when you need it most.

Our benefits are designed to make a positive difference in your life, just as you make a difference in the lives of those you serve at Tri-City Medical Center. We review our benefits program annually to ensure that it continues to align with our mission and meet your needs in ways that are cost effective and market competitive. We continually draw upon the feedback we receive from our TCMC colleagues regarding the adequacy of the benefits and the quality of service provided. During annual open enrollment, you have the opportunity to change your benefits to best meet your personal needs for the new plan year.

This benefits guide provides you with an overview of the benefits available to you as a TCMC employee. More detailed information is provided in the summary of plan descriptions posted on the Tri-City Intranet under Human Resources. Additional resources are available by contacting providers directly either online or by phone. Please refer to page 21 for provider websites and phone numbers or contact the Benefits Department at (760) 940-7998.

At Tri-City Medical Center, we are committed not just to hiring, but to retaining the best talent in the industry. Signature Benefits is our way of saying thank you for providing excellence in every aspect of your work and supporting our mission to advance the health and wellness of those we serve.

Medical	UnitedHealthcare Signature Value Advantage HMO UnitedHealthcare Select Plus PPO
Pharmacy	OptumRx
Vision (with medical plan)	VSP PPO Vision Plan
Dental	DeltaCare USA DHMO Delta Dental PPO
Flexible Spending Accounts	Contribute up to $2,650 to Health Care Account Contribute up to $5,000 to Dependent Care Account
Life & AD&D Insurance	One time basic annual salary + $5,000 $105,000 benefit max for Life and AD&D
Long Term Disability	Coverage determined by NSRP status Voluntary coverage available
Retirement Plans	National Security Retirement Program Deferred Compensation Plan Money Accumulation Pension Plan
Other Valuable Benefits	Time Away from Work Tuition Reimbursement Program Employee Assistance and Work/Life Programs Voluntary Benefits

Enrollment & Waiver Option

LIMITED TIME TO ENROLL!

To ensure you have the benefits that you and your dependents need, it's important you decide upon and enroll in the TCMC benefits program options that are right for you.

- If you are an existing employee who wishes to change benefit elections for 2019, you must enroll by the annual enrollment deadline or you will continue with your current 2018 elections, except for Flexible Spending Accounts which require re-enrollment each year.
- If you are a new employee, you must enroll within 30 days of employment. If you do not enroll by the enrollment deadline, you will NOT have Medical, Vision or Dental coverage and you will not be able to add coverage until the next annual open enrollment period unless you have a qualifying event (refer to "Qualifying Events" on page 5).
- All part-time and full-time benefit eligible employees will be automatically enrolled in the Basic Life and AD&D benefit equal to one times annual salary + $5,000 up to $105,000 - at no cost to you.

WAIVER OPTION

If you have coverage elsewhere, you can waive TCMC's medical and dental benefits and receive $75 per month if you are full-time, or $20 per month if you are part-time benefits eligible. These dollars will be included in your paycheck. You must complete your enrollment form and provide proof of other medical coverage within 30 days of employment or status change. Although only proof of other medical coverage is required, you must waive both medical and dental benefits in order to receive this option. **If you elected this option in 2018, you do not need to re-enroll in 2019.**

WHO IS ELIGIBLE?

You are eligible to participate in TCMC's flexible benefits program if you are a benefited employee, regularly scheduled to work 48 or more hours per pay period. When you enroll your benefits coverage is effective the 1st of the month following 30 days of employment.

Your eligible dependents may be enrolled in medical/vision, dental, and/or dependent life coverage. Your eligible dependents include:

- Your legal spouse
- Your children to age 26
- Your unmarried children of any age who are physically or mentally disabled and who are financially dependent upon you, if the disability began prior to attainment of limiting age and you provide proof of the disability.

You may also enroll qualifying same sex domestic partners and their dependent children in medical, vision, dental and supplemental life coverage. For more information regarding domestic partner coverage, and the tax consequences, contact the Benefits Representative in Human Resources.

Dependent children for the purpose of health insurance eligibility need not be financially dependent, reside with parent, be a student, be unmarried or be unemployed.

Eligibility Verification

In the face of increasing health care costs, we are always looking for innovative ideas to help preserve your highly competitive benefits program. As a result, Tri-City Medical Center verifies the eligibility of dependents in our health care plan. This process will lower our costs, but leave your health care benefits untouched.

To cover dependents on our health care plan, you will need to send the appropriate documentation to HR no later than 10 business days from your date of hire/Qualifying Event or Online Open Enrollment. If you fail to do so, you will not be able to cover dependents for health care coverage at this time and will have to wait until the next Open Enrollment in 2019 for coverage effective January 1, 2020. Please contact the Benefits Department at (760) 940-7998 to obtain the Dependent Eligibility packet, or download from the TCMC Intranet.

ENROLLMENT CHANGES

MAKING CHANGES

You may change your benefit elections (change or drop your coverage, add or remove dependents from coverage, etc.) during the Plan Year ONLY if a qualifying event occurs in your life or in your employment or status.

QUALIFYING EVENTS

If you have a qualifying event and want to change your benefit elections, **you must submit the appropriate benefit change forms to Human Resources-Benefits within 30 days of the qualifying event.** The changes you make in your benefit elections must be consistent with the qualifying event. Qualifying events include:

- Marriage, legal separation, or divorce
- Addition of a dependent (such as the birth or adoption of a child or a change in child custody or qualified medical child support order)
- Death of your spouse or a dependent
- Significant change in the benefit offerings available to you, your spouse, or your dependent due to employment
- Change in status of you or your spouse from benefits eligible to benefits ineligible or vice-versa
- You or your spouse takes or returns from a leave of absence
- Change in your (or your spouse's or dependent's) employment status
- You, your spouse, or a dependent becomes eligible for Medicare or Medicaid coverage
- Dependent reaches plan's age limit or becomes eligible for health coverage through their employer

Employee Contributions

Your contributions for medical and dental coverage and flexible spending accounts are deducted from your pay before federal income, Social Security, and most state and local income taxes are calculated. Your contributions to NSRP and Deferred Compensation are deducted from your pay before federal and most state and local income taxes are calculated. You pay your share of the cost for these benefits with tax-free dollars, so you save by paying less in taxes. Your contributions for supplemental life and dependent life insurance, voluntary long-term disability (if you are enrolled in Social Security) and the Money Accumulation Pension Plan are deducted from your pay after taxes.

TCMC has 26 pay periods each year. Deductions for insurance benefits and flexible spending accounts are taken out of the first two paychecks each month (24 pay periods). Your contributions to your retirement programs are taken out of all 26 paychecks.

What TCMC Pays

- Full cost of full-time, employee only HMO medical, PPO vision and dental coverage
- Most of the cost of part-time employee and dependent medical and dental coverage
- Full cost of Basic Life and AD&D insurance
- Matching contributions to retirement savings in NSRP and MAPP
- Long-Term Disability and Survivor Income Benefit (if you are a benefited employee enrolled in NSRP)
- Tuition Reimbursement
- Paid Time Off
- Employee Assistance and Work/Life Programs

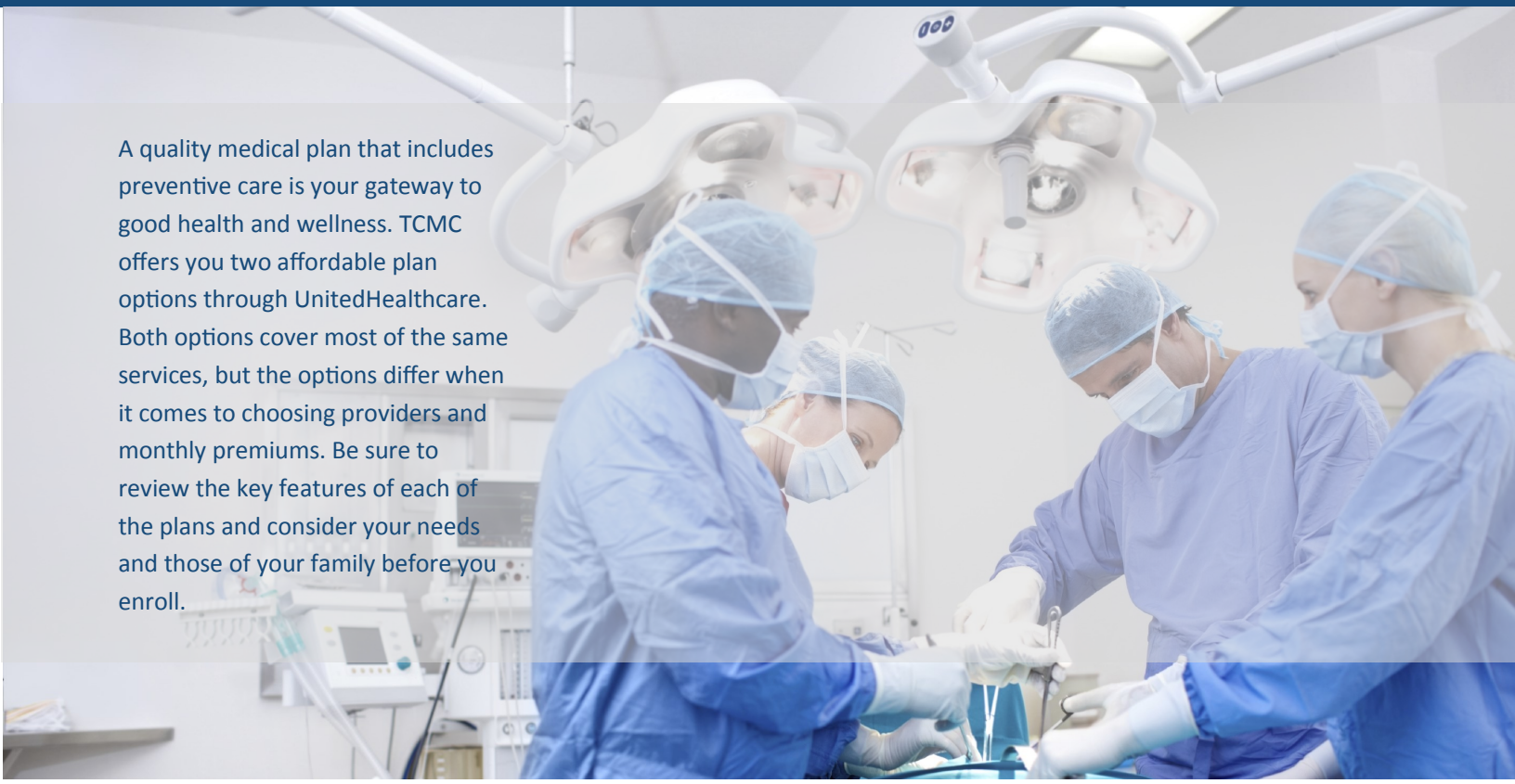
MEDICAL, DENTAL AND VISION COVERAGE

(These rates do not include Domestic Partner coverage. Please contact HR-Benefits for Domestic Partner rates.)

	UnitedHealthcare Signature Value Advantage HMO + Vision	UnitedHealthcare Select Plus PPO + Vision	DeltaCare USA Dental HMO	Delta Dental PPO	Flex Dollars
FULL-TIME					
Employee Only	$0.00	$112.92/month $56.46/pay period	$.0.00	$0.00	$75.00/month $37.50/pay period
Employee + 1	$267.78/month $133.89/pay period	$467.06/month $233.53/pay period	$5.01/month $2.50/pay period	$29.96/month $14.98/pay period	N/A
Employee + 2 or more	$377.80/month $188.90/pay period	$667.22/month $333.61/pay period	$11.37/month $5.69/pay period	$37.11 month $18.55/pay period	N/A
PART-TIME					
Employee Only	$126.96/month $63.48/pay period	$266.16/month $133.08/pay period	$4.57/month $2.28/pay period	$29.62/month $14.81/pay period	$20.00/month $10.00/pay period
Employee + 1	$374.67/month $187.33/pay period	$622.73/month $311.36/pay period	$12.11/month $6.05/pay period	$36.96/month $18.48/pay period	N/A
Employee + 2 or more	$528.61/month $264.31/pay period	$889.64/month $444.82/pay period	$16.16/month $8.08/pay period	$50.34/month $25.17/pay period	N/A
TWO TRI-CITY EMPLOYEES					
Employee + 1	$119.01/month $59.51/pay period	$204.85/month $102.43/pay period	$3.07/month $1.53/pay period	$14.17/month $7.09/pay period	N/A
Employee + 2 or more	$171.02/month $85.51/pay period	$292.18/month $146.09/pay period	$4.77/month $2.38/pay period	$20.05/month $10.03/pay period	N/A

VOLUNTARY PLANS

For Supplemental Life Insurance—see page 15
For Voluntary LTD rates– see page 16
For Critical Illness and Voluntary Accident rates– see page 17



A quality medical plan that includes preventive care is your gateway to good health and wellness. TCMC offers you two affordable plan options through UnitedHealthcare. Both options cover most of the same services, but the options differ when it comes to choosing providers and monthly premiums. Be sure to review the key features of each of the plans and consider your needs and those of your family before you enroll.

KEY MEDICAL TERMS

COINSURANCE: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service.

COPAY: This is the amount that you pay each time you receive certain types of services, such as a physician office visit.

ANNUAL DEDUCTIBLE: This is the amount that you pay each plan year before the medical plan begins to pay benefits for services to which the deductible applies.

ANNUAL OUT-OF-POCKET MAXIMUM: This is the maximum amount that you will pay during the plan year for eligible medical expenses (payments you make for prescription drugs are not included). If you reach this limit, the plan will cover most services at 100% for the rest of the plan year.

PRIMARY CARE PHYSICIAN (PCP): In the Signature Value Advantage HMO Plan, your PCP is the physician you choose from within the United Healthcare Signature Value Advantage Plan network who will provide most of your care and manage any necessary specialized care or hospitalizations. If you enroll in the Signature Value Advantage HMO Plan option, you must use UnitedHealthcare Signature Value Advantage Plan network providers (except in medical emergencies) in order for benefits to be paid by the plan.

IN-NETWORK (PREFERRED PROVIDERS): If you enroll in the UnitedHealthcare Select Plus PPO option, the plan will pay the highest level of benefits if you use Select Plus Preferred Providers.

NON-PREFERRED PROVIDERS: If you use providers who are not part of UnitedHealthcare's Select Plus PPO network, the plan will pay benefits at the non-preferred provider level. Whenever you use out-of-network providers, the services you receive will be covered at lower amounts, and your share of the cost will be higher.

Medical Plan Options

UHC SIGNATURE VALUE ADVANTAGE HMO

The UHC Signature Value Advantage HMO Plan (SVA) option covers services received from physicians, hospitals, and other providers within the UHC Signature Value Advantage Plan network. You must use network providers in order to receive benefits. Except in medical emergencies, services received from providers who are not part of the UHC Signature Value Advantage Plan network will not be covered. As long as you use UHC Signature Value Advantage Plan network providers, you will receive comprehensive benefits (including preventive care) and your out-of-pocket expenses will be lower with no claim forms to submit. If you choose the Signature Value Advantage HMO Plan option, you must choose a Primary Care Physician (PCP) who will provide most of your care and manage any specialized care or hospitalization you may need by referring you to other network providers. Whenever you need health care services, visit your PCP. If you receive services without approval from your PCP, your charges won't be covered by the plan (except in medical emergencies).

UHC SELECT PLUS (PPO)

The PPO option gives you the freedom to use UnitedHealthcare preferred and non-preferred providers and receive benefits. If you use preferred providers, you will pay less for the services that you receive. You will have higher out-of-pocket expenses if you use non-preferred providers.

UnitedHealthcare requires the designation of a primary care provider (PCP) for the UHC Signature Value Advantage HMO plan. 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. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, UnitedHealthcare designates one for you. You have the option of changing your PCP at any time by contacting UnitedHealthcare at (800) 624-8822. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact UnitedHealthcare at the phone number on the back of your medical I.D. card. You do not need prior authorization from UnitedHealthcare 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 preapproved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact UnitedHealthcare at the phone number on the back of your medical I.D. card.

Pharmacy Benefits

Looking for an easier and more affordable way to refill your prescription maintenance medications? The Mail Service program through Optum RX eliminates frequent trips to the pharmacy. You can receive a 90-day supply of your medication for 2 copays (or the maximum supply indicated in your pharmacy member materials) by mail, rather than just a 30-day supply from your local pharmacy. You can order refills by mail, by phone at 1-855-505-8107 or over the Internet at www.optumrx.com.

*If filling a prescription through a Retail Pharmacy, please be sure and use your Optum RX ID card (not your medical ID card) or it will not go through.

MEDICAL PLAN OPTIONS AT-A-GLANCE

The table below highlights your medical plan options. For more detailed information, visit the Tri-City Intranet under Human Resources-Benefit Plan Information. You may also log on to UnitedHealthcare's website at **www.myuhc.com,** or you may contact the Benefits Department or Human Resources directly.

MEDICAL OPTIONS AT-A-GLANCE			
FEATURES	**UHC HMO**	**UHC SELECT PLUS PPO**	
	SIGNATURE VALUE ADVANTAGE HMO PLAN (SVA) NETWORK ONLY	IN-NETWORK PREFERRED PROVIDERS	OUT-OF-NETWORK NON-PREFERRED PROVIDERS
Annual Deductible	None	$250 per individual Maximum of 3 individual deductibles per family	$500 per individual
Annual Out-of-Pocket Maximum	$1,000 per individual	$2,000 per individual Maximum of 3 individual maximums per family	$5,000 per individual
Lifetime Maximum Benefit	Unlimited	Unlimited	
OUTPATIENT SERVICES			
Office Visit PCP/Specialist	$20/$40 copay	$20/$40 copay*	50% coinsurance**
Well-Baby Care	Paid in full	Paid in full*	Not covered
Preventive Care	Paid in full	Paid in full*	Not covered
X-Ray & Lab Services	$15 copay	20% coinsurance**	50% coinsurance**
Outpatient Surgery	$100 copay	20% coinsurance**	50% coinsurance**
Emergency & Urgent Care Services			
Emergency Room Visit	$100 copay	$100 copay*	$100 copay*
	Note: Emergency room copay is waived if admitted as inpatient		
Urgent Care Visit	$20 copay	$20 copay*	50% coinsurance**
Mental Health Services			
Office Visit	$20 copay	$20 copay*	50% coinsurance**
Intensive Outpatient Treatment	Paid in full	20% coinsurance**	50% coinsurance**
Chiropractic Services			
Office Visit	$20 copay	$20 copay*	50% coinsurance**
Maximum Visits Per Year	20	24 (combined in and out of network)	
INPATIENT SERVICES *(including Mental Health Facilities)*			
Hospital Services	$250 copay (copay waived if admitted to TCMC)	20% coinsurance**	50% coinsurance**
Physician Services	Paid in full	20% coinsurance**	50% coinsurance**
PRESCRIPTION DRUG PLAN *(Prescriptions must be filled at a participating OptumRx pharmacy or through the mail order program)*			
Retail - 30 day supply			
Generic	$15 copay	$15 copay*	
Brand	$35 copay	$35 copay*	
Mail Order - 90 day supply			
Generic	$30 copay	$30 copay*	
Brand	$70 copay	$70 copay*	

*No deductible, **After Deductible

VSP VISION

If you and your dependents enroll in either medical plan, you also receive vision coverage through VSP's PPO Vision Plan. Your vision plan provides you and your family with substantial discounts on prescription eyewear whether you use preferred or non-preferred providers. If covered services and/or materials are provided by a nonparticipating provider, charges will be paid by the plan based on a schedule of allowances. The certificate of coverage provides the detailed schedule of allowances.

The vision plan provides benefits for covered services and/or materials when you use a participating provider as follows:

VISION PLAN OPTIONS			
Benefit	**Description**	**Copay**	**Frequency**
Your coverage with a VSP Provider			
WellVision Exam	Focuses on your eyes and overall wellness	$0	Every 12 months
Presciption Glasses			
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amounts over your allowance • $70 Costco frame allowance	$0	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	$0	Every 12 months
Lens Enhancements	• Scratch-resistant coating • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$0 $55 $95-$105 $150-$175	Every 12 months
Contacts			
Contacts (instead of glasses	• $105 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months

Annual vision exams not only correct vision problems, they can also reveal warning signs of more serious health issues, such as hypertension, cardiovascular disease and diabetes. To find a VSP PPO Vision Plan provider, log on to www.vsp.com.

DELTA DENTAL

Delta smiles begin with regular dental checkups. You and your eligible dependents may choose between two dental options that provide comprehensive coverage. Refer to the chart for plan highlights. It is recommended that you request a treatment plan for Basic, Major and Orthodontia services.

If you choose the DeltaCare USA DHMO option, you must choose a DeltaCare USA DHMO network provider as your assigned dentist and obtain dental services through that provider. Except in dental emergencies, services obtained from a provider other than your assigned dentist will not be covered. As long as you use your DeltaCare USA DHMO network provider, you will receive comprehensive dental benefits (including preventive care) and your out-of-pocket expenses will be lower with no claim forms to submit.

If you choose the Delta Dental PPO option, you may go to any dentist for services; you will be reimbursed for those services at a higher percentage when you use a Preferred Provider.

DENTAL PLAN OPTIONS

FEATURES OR TREATMENT	DeltaCare USA DHMO	Delta Dental PPO Plan 1	
		IN-NETWORK	OUT-OF-NETWORK
Annual Deductible (Ind/Fam)	None	$50/$150	$50/$150
Annual Benefit Maximum	None	$2,000	$2,000
Preventive & Diagnostic			
(Office visits, x-rays, cleanings, etc.)	Many services paid in full; co-pay schedule applies to others (see DeltaCare USA Plan 11B Summary for a more complete schedule of benefits)	100%**	80%**
Basic			
(Fillings, root canals, oral surgery, etc.)	Many services paid in full; co-pay schedule applies to others (see DeltaCare USA Plan 11B Summary for a more complete schedule of benefits)	80%*	60%*
Major			
(Crowns, bridges, dentures, etc.)	Many services paid in full; co-pay schedule applies to others (see DeltaCare USA Plan 11B Summary for a more complete schedule of benefits)	60%*	50%*
Orthodontia			
Orthodontic Coverage	Comprehensive Orthodontic Treatment— $1,700 copay*** - child or adolescent to age 19 $1,900 copay *** - adult, including covered dependent adult children	50%/50%*	50%/50%*
Lifetime Maximum		$2,000	$2,000
		Covered for dependent children to age 26 only	

* After Deductible

** No Deductible

*** Additional copays may apply for full treatment

FLEXIBLE SPENDING ACCOUNTS (FSA)

If you have health care and/or dependent care expenses that you typically pay out-of-pocket, participation in the Flexible Spending Accounts can save you money. The contributions you make to these accounts are deducted from your pay BEFORE federal income, Social Security, and most state and local income taxes are calculated. The end result is that you decrease your taxable income and increase your spendable income. You can save hundreds or even thousands of dollars a year.

You may use the Health Care Flexible Spending Account, the Dependent Care Flexible Spending Account, or both.

Before you enroll, decide how much you anticipate spending in the next plan year (January 1, 2019 through December 31, 2019) for eligible expenses and then calculate how much you will contribute to your Flexible Spending Accounts for the upcoming year. You may contribute:

- Up to $2,650 per year to a Health Care Flexible Spending Account.
- Up to $5,000 per year to a Dependent Care Flexible Spending Account; if you and your spouse file separate tax returns, the most each of you can contribute to this account is $2,500 a year.

Your contributions are deducted from your paychecks (24 pay periods) and deposited in your designated account(s). As you incur eligible expenses, you file claims and are reimbursed from your account(s) with tax-free money. For more information, go to: www.tri-ad.com/fsa.

WHAT EXPENSES ARE REIMBURSABLE?

Your Health Care FSA may be used to pay for eligible health care expenses that are not paid by any of your medical/vision or dental plans. Examples include plan deductibles and copays, other out-of-pocket costs, transportation expenses incurred to receive health care, and expenses that exceed plan limits (such as braces). Expenses incurred by any person who qualifies as a dependent on your income tax return are eligible for reimbursement through your Health Care Flexible Spending Account.

*For a full list of eligible expenses, go to: www.tri-ad.com/FSA

Your Dependent Care Flexible Spending Account may be used to pay for expenses incurred that are necessary to allow you and your spouse, if you are married, to work or attend school full-time. Day care or other dependent care services for children 12 or under, or for dependents of any age that are physically or mentally incapable of self care, are eligible expenses for reimbursement from the Dependent Care Account.

HOW DO I RECEIVE PAYMENTS FROM MY ACCOUNTS?

When you incur expenses, submit a completed claim form and documentation of the expense to the plan administrator (Tri- Ad). Claim forms are available in Human Resources or on the TCMC Intranet. Your expenses will be reimbursed as follows:

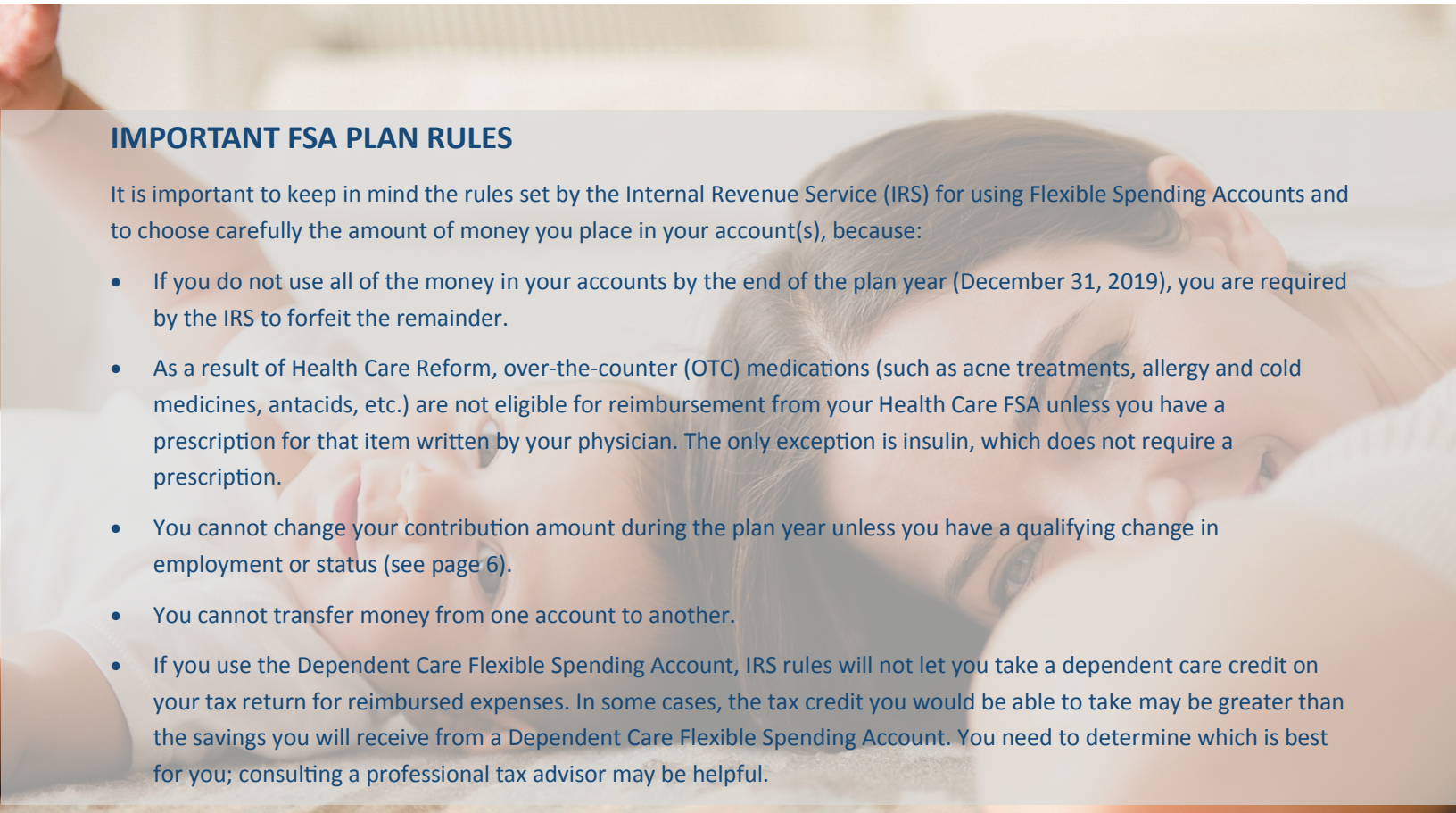
Health Care Flexible Spending Account – (HFSA)

The total amount of the eligible expense will be reimbursed, up to the total annual contribution amount less any expenses for which you have already been reimbursed, regardless of how much you have actually deposited into your account at the time your claim is submitted.

Dependent Care Flexible Spending Account – (DFSA)

Dependent care covers childcare for children 12 or under and dependent parents. The amount of your eligible expense will be reimbursed up to the balance in your account at the time of your claim. If the amount of your claim is greater than your account balance, a partial payment will be made to you based on the funds available. As deposits continue to be made from your payroll deductions, you will be automatically reimbursed the remaining claim amounts.

The deadline for submitting claims for expenses incurred through the end of the plan year (December 31, 2019) is March 31 of the following year.



IMPORTANT FSA PLAN RULES

It is important to keep in mind the rules set by the Internal Revenue Service (IRS) for using Flexible Spending Accounts and to choose carefully the amount of money you place in your account(s), because:

- If you do not use all of the money in your accounts by the end of the plan year (December 31, 2019), you are required by the IRS to forfeit the remainder.
- As a result of Health Care Reform, over-the-counter (OTC) medications (such as acne treatments, allergy and cold medicines, antacids, etc.) are not eligible for reimbursement from your Health Care FSA unless you have a prescription for that item written by your physician. The only exception is insulin, which does not require a prescription.
- You cannot change your contribution amount during the plan year unless you have a qualifying change in employment or status (see page 6).
- You cannot transfer money from one account to another.
- If you use the Dependent Care Flexible Spending Account, IRS rules will not let you take a dependent care credit on your tax return for reimbursed expenses. In some cases, the tax credit you would be able to take may be greater than the savings you will receive from a Dependent Care Flexible Spending Account. You need to determine which is best for you; consulting a professional tax advisor may be helpful.

LIFE/AD&D AND LONG TERM DISABILITY

LIFE/AD&D INSURANCE

For your peace of mind and added financial security for those who depend on you, TCMC pays the full cost to provide you with basic life insurance. If your death or dismemberment is the result of an accident, accidental death and dismemberment (AD&D) coverage provides additional financial protection. All or a portion of your AD&D benefit (depending on the nature of your injury) may also be payable to you if you are seriously injured in an accident.

FOR YOURSELF

TCMC automatically provides you with basic life insurance equal to one times your base annual salary plus $5,000, up to a $105,000 max. TCMC also automatically provides you with AD&D insurance and pays the full cost. The amount of basic AD&D coverage equals one times your base annual salary plus $5,000 ($105,000 maximum).

You may purchase supplemental life insurance in amounts equal to one, two, three, four, or five times your base annual salary ($500,000 maximum). Evidence of insurability is required if you apply for over $270,000 or three, four or five times your pay in supplemental life coverage when you are initially benefits-eligible. If you are required to provide evidence of insurability, you will need to complete an online medical history questionnaire and may be required to provide medical records and/or undergo medical testing. Based upon the results of your evidence of insurability, the insurance company may deny coverage. Life and AD&D benefits reduce at age 65. Please refer to your plan document for more information.

Employee Supplemental Life Rates/$1,000 of Benefit		
Age	**MONTHLY**	**PER PAYCHECK**
<30	$0.045	$0.023
30 to 34	$0.071	$0.036
35 to 39	$0.090	$0.045
40 to44	$0.135	$0.068
45 to 49	$0.233	$0.117
50 to 54	$0.342	$0.171
55 to 59	$0.623	$0.312
60 to 64	$0.936	$0.468
65 to 69	$1.522	$0.761
70+	$2.718	$1.359

Spousal Supplemental Life Premiums		
AMOUNT	**MONTHLY**	**PER PAYCHECK**
$5,000	$1.65	$0.82
$10,000	$3.30	$1.65
$15,000	$4.94	$2.47
$20,000	$6.59	$3.29
$25,000	$8.26	$4.13
Dependent Children Supplemental Life Premiums		
AMOUNT	**MONTHLY**	**PER PAYCHECK**
$5,000	$0.98	$0.49
$10,000	$1.96	$0.98

LONG TERM DISABILITY (LTD)

If you are ill or injured and unable to work, the last thing you should have to worry about is losing your income. TCMC's disability benefits provide important income replacement in the event that you become disabled.

Benefited employees who are enrolled in NSRP are automatically enrolled in long-term disability insurance that is paid for by TCMC (since NSRP is an alternative to Social Security, NSRP participants do not participate in the disability components of Social Security).

Benefited employees who are not enrolled in NSRP participate in the disability components, as well as the retirement components of Social Security. In addition, you may purchase voluntary LTD coverage through payroll deduction. In both of the above scenarios, LTD benefits begin after 180 days of total disability and are paid monthly. The monthly benefit is 60% of base pay up to a maximum monthly benefit of $6,000 for the NSRP LTD plan, or $3,000 per month for the Voluntary LTD plan.

LIFE INSURANCE FOR YOUR SPOUSE AND DEPENDENTS

If you elect supplemental life insurance for yourself, you may elect to purchase supplemental life insurance for your spouse and dependent children. If you have more than one child, each child is covered for the same insurance amount and you are charged only one premium regardless of the number of children covered.

You may choose the life insurance maximums of $10,000 (not to exceed 50% of your supplemental life insurance) for your spouse and $10,000 for your dependent children when you are initially benefits-eligible without evidence of insurability. If you do not purchase spouse and/or dependent life coverage when you are initially benefits-eligible, evidence of insurability will be required for all levels of coverage if you elect it during a subsequent annual enrollment period. In the event of the death of your insured spouse or dependent(s), the life insurance benefit will be paid to you.

LIFE/AD&D - HOW BENEFITS ARE PAID

At your death—Your beneficiaries receive your life insurance. If you die as a result of an accident, your beneficiaries are paid the full amount of your AD&D insurance in addition to your basic life insurance benefit.

If you're seriously injured in an accident– All or part of your AD&D benefit is paid to you. The amount payable depends on the nature of your injury.

Voluntary LTD Employee Rates/$1,000 of Benefit

Age	MONTHLY	PER PAYCHECK
<25	$0.17	$0.085
25 to 29	$0.20	$0.100
30 to 34	$0.28	$0.140
35 to 39	$0.42	$0.210
40 to 44	$0.71	$0.355
45 to 49	$1.17	$0.585
50 to 54	$1.64	$0.820
55 to 59	$2.12	$1.060
60 to 64	$2.01	$1.005
65+	$1.79	$0.895

CRITICAL ILLNESS & ACCIDENT INSURANCE

HARTFORD—CRITICAL ILLNESS

Critical Illness coverage, offered through Hartford, helps employees and their families prepare for life altering, often unexpected, illnesses by offering ancillary benefits after a positive diagnosis. This coverage helps to provide financial support during these critical periods. This voluntary program is available for you and your dependents and will pay a lump sum benefit for the covered person diagnosed with any of the covered illnesses listed in your plan summary.

COVERAGE AMOUNTS	DESCRIPTION
Employee Coverage Amount	$10,000
Spouse Coverage Amount	$5,000
Child(ren) Coverage Amount	$5,000
Guaranteed Issue Amount(s)	Employee: $10,000; Spouse and/or Child(ren): $5,000
Reduction Due To Age	50% Reduction for each covered person when the employee reaches age 70

Rates are based on the attained age of the Employee and increases as he/she enters each new age category.

PER PAYCHECK				
Age	Employee	Employee & Spouse	Employee & Child	Family
18-24	$1.74	$2.84	$3.53	$4.92
25-29	$2.08	$3.34	$3.73	$5.26
30-34	$2.31	$3.70	$3.71	$5.33
35-39	$2.92	$4.62	$4.19	$6.09
40-44	$4.11	$6.43	$5.24	$7.76
45-49	$6.31	$9.85	$7.41	$11.14
50-54	$8.73	$13.60	$9.80	$14.86
55-59	$11.85	$18.46	$12.92	$19.71
60-64	$16.58	$25.79	$17.63	$27.02
65-69	$22.72	$35.15	$23.77	$36.38
70-74	$15.36	$23.85	$16.10	$24.71
75-79	$19.99	$30.88	$20.73	$31.74

PER MONTH				
Age	Employee	Employee & Spouse	Employee & Child	Family
18-24	$3.48	$5.67	$7.06	$9.84
25-29	$4.15	$6.68	$7.45	$10.52
30-34	$4.61	$7.39	$7.42	$10.66
35-39	$5.84	$9.23	$8.37	$12.17
40-44	$8.21	$12.86	$10.48	$15.51
45-49	$12.61	$19.69	$14.82	$22.28
50-54	$17.45	$27.20	$19.60	$29.71
55-59	$23.70	$36.92	$25.83	$39.41
60-64	$33.16	$51.58	$35.26	$54.04
65-69	$45.43	$70.29	$47.54	$72.75
70-74	$30.72	$47.70	$32.19	$49.42
75-79	$39.97	$61.76	$41.45	$63.48

HARTFORD—ACCIDENT INSURANCE

The Voluntary Accident plan, offered to you through Hartford, pays a scheduled benefit for treatment, injury or services incurred by a covered person who is injured in an accident. This plan is available to you and your dependents and covers off-the-job accidents. Emergency, Hospital & Treatment Care Packages, as well as specified Injury & Surgery Benefit Packages are offered. Please refer to your schedule of benefits for a complete list of reimbursement amounts.

COVERAGE	PER PAYCHECK	PER MONTH
Employee Only	$3.83	$7.66
+Spouse	$6.10	$12.20
+Child(ren)	$6.39	$12.77
+Family	$10.08	$20.16

EMPLOYEE ASSISTANCE AND WORK/LIFE PROGRAMS

The Employee Assistance Program offered through Magellan provides convenient, confidential short-term counseling and referral services to help you and your family members deal with life's challenges. Resources are also available to help you balance the demands of today's hectic lifestyle and enhance your quality of life.

A CONFIDENTIAL & IMPORTANT RESOURCE

Your program provides useful tools and resources that can help make the most out of your day or guide you through a difficult time. All confidential and at no cost to you. Some of the topics we can help with include:

- Resiliency—overcoming stress and crisis at home and at work.
- Emotional Wellness—addiction, depression, anxiety and assistance with other emotional wellness issues.
- Workplace success—career goals, team conflict, crisis, management support.
- Wellness and balance—work-life balance, stress, relaxation, personal well-being.
- Personal and family goals—relationship, children and teen or aging loved ones. Changes in finances or personal situations.

Your program includes up to 8 counseling sessions for you and your eligible dependents or household members at no cost to you.

ADDITIONAL RESOURCES AND INFORMATION

HEALTH AND WELLNESS PROGRAM

Our program makes it easy to bring healthy habits into your busy life. You can set daily goals and track progress online, via mobile app and through integration with fitness trackers. You can even get help and motivation from health coaches and peers.

WORK-LIFE SERVICES

You have access to tools, resources and experts who ca help with may of the day-to-day things that can happen in life. You also have access to the LifeMart® discount center which offers valuable discounts on things such as travel, clothing, restaurants, and more.

LEGAL & FINANCIAL CONSULTATION

Your program offers you quick and confidential access to help with legal or financial questions and services you may need. Legal and financial experts are available to help with any questions you may have, or access the online library for helpful tools and resources.

1-800-424-1747

www.magellanassist.com

GROUP AUTO, HOME AND RENTERS INSURANCE

MetLife Auto & Home's group insurance program is available to you as a voluntary benefit through TCMC. This program is underwritten by MetLife Auto & Home and offers special discounts to employees of participating groups.

Maximize your company benefits today and start saving:

- Save up to an additional 10% right away with our Welcome Discount for NEW customers.
- Qualify for a group discount of up to 15% off your policy.
- Earn an additional discount when you pay your premium through automatic payroll/bank account deduction.
- Receive extra savings if you've been with TCMC for a long time.
- Save more with our superior driver discount.
- Earn multi-vehicle savings when you insure more than one vehicle with us.
- Make the most of our multi-policy discounts when you insure both your home and auto with MetLife Auto & Home.

FOR MORE INFORMATION ON GROUP AUTO, HOME, RENTERS AND PET INSURANCE:

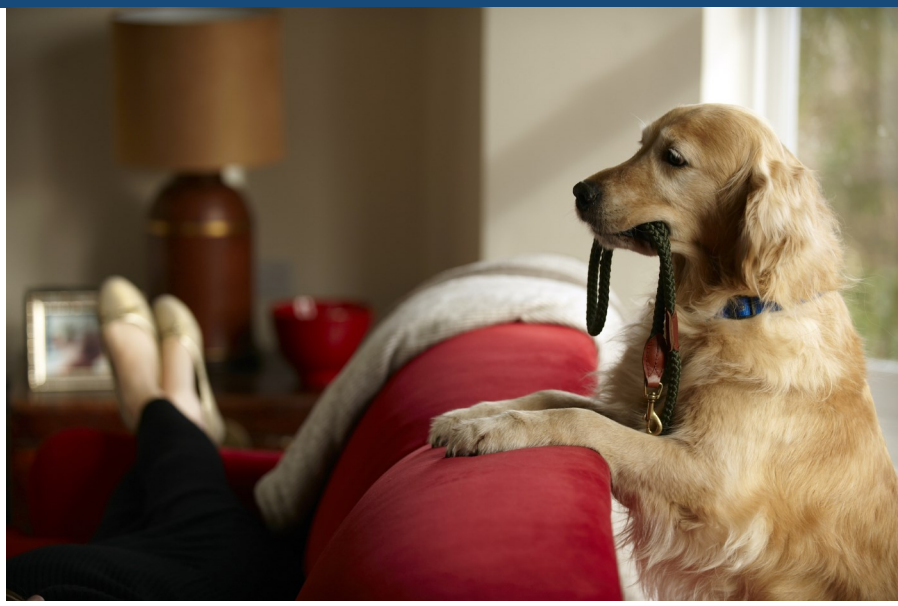
CALL: 1-800-GET-MET 8 (1-800-438-6388)

OR VISIT: www.metlife.com/mybenefits

PET INSURANCE & PREPAID LEGAL PLAN

PET INSURANCE

You have you and your family's health covered, but what about your furry family members? Pet insurance provides a financial safety net for unexpected veterinary expenses. Nationwide, through MetLife, may provide coverage for chronic and recurring conditions (that are not pre-existing) at no out-of-pocket cost. Benefits also include protection to assist members with cost associated with pet expenses that may not be directly related to a pet's condition.



You can choose from one of three plans:

	Major Medical Plan comprehensive℠ + Pet Wellness Plan Plus³ everyday care℠	Major Medical Plan comprehensive℠	Pet Wellness Plan Plus³ everyday care℠
Use any vet	✓	✓	✓
Accidents, including poisonings, cuts and broken bones	✓	✓	
Common illnesses, including ear infections, rashes, vomiting and diarrhea	✓	✓	
Serious/chronic illnesses, including cancer, diabetes and allergies	✓	✓	
Hereditary conditions	✓	✓	
Procedures/services, including surgeries, Rx meds and hospitalization	✓	✓	
Wellness services, including exams, vaccinations and flea/heartworm preventives	✓		✓
Annual Deductible	$250 for medical claims $0 for wellness claims		

PREPAID LEGAL PLAN - Covers employee, spouse and dependents)

- Preparation of living wills and trusts
- Unlimited telephone advice and office consultations on any personal legal matter
- Preparation of powers of attorney, deeds, demand letters, notes and mortgages
- Document review
- Representation for tenant negotiations and eviction defense, debt collection, identity theft, tax audits and real estate matters

OTHER BENEFITS

MEMBERSHIP BANKING* through San Diego County Credit Union

DISCOUNT PROGRAMS

- Over-the-Counter Drug & Supply Discounts through Employee Health*
- Cafeteria Discounts*
- Hundreds of Discounts through www.workingadvantage.com and www.TicketsAtWork.com
- Membership Discounts Through Tri-City Wellness Center*

*Benefit is available to all employees.

TUITION REIMBURSEMENT PROGRAM

Your individual development and continued learning are important, which is why TCMC helps pay to further your education. Eligible benefited and non-benefited employees may receive tuition reimbursement, depending upon the type of educational program. Additional information is available from the Education Department.

TIME AWAY FROM WORK

All of us need time away from work occasionally for rest and relaxation, illness, a holiday, to care for a sick child, to attend to personal business, and for many other reasons. To ensure you can take time off and still be paid, TCMC provides benefited employees with a generous, flexible Paid Time Off (PTO) program in which you accrue hours each pay period. The Administrative Policy Manual on the TCMC Intranet includes more detailed information regarding our Paid Time Off program. See the chart below or contact the Payroll Department at 760-940-7390.

PAID TIME OFF (PTO) ACCRUAL RATE

FULL-TIME EMPLOYEES			80% TIME EMPLOYEES 64-69 HOURS PER PAY PERIOD			60% TIME EMPLOYEES 48-63 HOURS PER PAY PERIOD		
Years of Tenure[1]	Annual Days	Annual Hours	Years of Tenure[1]	Annual Days	Annual Hours	Years of Tenure[1]	Annual Days	Annual Hours
0-3	24	192	0-3	19	153.6	0-3	14	115.2
4-9	29	232	9-Apr	23	185.6	4-9	17	139.2
10-14	34	272	14-Oct	27	217.6	10-14	20	163.2
15-19	35	280	15-19	28	224	15-19	21	168
20+	36	288	20+	29	230.4	20+	22	172.8

[1] Tenure is defined as the number of years worked since the most recent benefit eligibility date.

Saving for the future is a basic element of sound financial planning. To help you save, TCMC offers you three different retirement plans. The three plans are:

NATIONAL SECURITY RETIREMENT PROGRAM

All employees are eligible for NSRP. This program, to which both you and TCMC contribute, is an alternative to Social Security. You contribute 6.7% of your pay to the program instead of contributing to the Social Security retirement fund. The money you contribute is deducted from your paychecks and credited to your personal account prior to the deduction for federal/state income taxes. This reduces your current taxable income and you save by paying less in current taxes.

TCMC contributes 4.5% (.045) of pay for benefited employees and .8% (.008) of pay for non-benefited employees. The contributions made by both you and TCMC are always 100% vested, which means you own the money, regardless of how long you remain a TCMC employee.

You decide how to invest the money in your account (both your contributions and TCMC's). The plan offers a wide variety of investment funds and you may allocate the money in your account among a number of options. Taxes on the investment earnings on your account are deferred until you withdraw the money, which helps your savings grow faster.

SOCIAL SECURITY

TCMC contributes 6.2% of your pay and you contribute 6.2% to this U.S. government-sponsored retirement program. You may opt to participate in either Social Security or in the National Security Retirement Program (NSRP); however, you cannot participate in both plans at the same time.

If you are a new employee and want to enroll in NSRP, your enrollment form must be completed and returned to Human Resources within your first 90 days of employment. If not, you must wait for open enrollment and you are limited to a total of three changes during your TCMC career.

DEFERRED COMPENSATION PLAN

TCMC's Deferred Compensation Plan offers you an opportunity to set aside pre-tax dollars for your retirement years while saving tax dollars now. All employees are eligible for this plan immediately upon employment.

- You decide how much you save, up to the maximum annual amount set by the federal government. The money you contribute is deducted from your paychecks and credited to your personal account before federal/state income taxes are deducted. This reduces your current taxable income and you save by paying less in current taxes.
- Saving is easy through regular, convenient payroll deductions.
- You decide how to invest the money in your account. The plan offers a wide variety of investment funds and you may allocate the money in your account among a number of options. Taxes on any investment earnings are deferred until you withdraw the money, resulting in a faster accumulation of your savings.
- You may stop or change the amount of your contributions at the beginning of any pay period and you may change your investment choices or transfer money between investments on a daily basis.

Money Accumulation Pension Plan (MAPP)

If you elect to participate in a MAPP, both you and TCMC contribute to your plan as explained below. You are eligible to participate in the plan if you are a benefited employee who has completed one year of service.

- To participate, you make an after-tax contribution equal to 2% of your pay, and TCMC contributes 6% of your pay.
- You may also make additional voluntary after-tax contributions.
- You decide how to invest the money in your account. The plan offers a wide variety of investment funds and you may allocate the money in your account among a number of options. Taxes on any investment earnings are deferred until you withdraw the money, resulting in a faster accumulation of your savings.
- If you leave TCMC, you may take your vested account balance with you. You are always vested (which means you own the money) in the contributions you make to the plan and any investment earnings on those contributions. You become vested in TCMC's matching contributions and any investment earnings gradually over five years of service with TCMC.

Separate enrollment packets include more detailed information about NSRP, Deferred Compensation, and MAPP. Please study this information carefully before enrolling, but don't delay. The earlier you start to save, the faster your savings will grow, and the better prepared you will be for your retirement!

For more information on the Tri-City Retirement Program or to enroll in any of the plans, please contact Dená Baker at 760-940-5636 or stop by the on-site Prudent Investor office, across the hall from the cafeteria.

PLAN	WEBSITE	PHONE NUMBER
Medical Plans		
United Healthcare Signature Value Advantage HMO Plan	www.myuhc.com	800-624-8822
United Healthcare Select Plus PPO		800-741-8786
Prescription Drugs		
OptumRx	www.optumrx.com	855-505-8107
Chiropractic		
OptumHealth—Physical Health of California	www.myoptumhealthphysicalhealthofca.com	800-428-6337
Behavioral Health Plan		
Optum Health — HMO	www.liveworkwell.com	800-999-9585
PPO	www.myuhc.com	800-741-8786
Dental		
DeltaCare USA DHMO	www.deltadental.com	800-765-6003
Delta Dental PPO		
Vision		
VSP PPO Vision Plan	www.vsp.com	800-877-7195
Employee Assistance Program		
Magellan EAP	www.magellanassist.com	800-424-1747
Flexible Spending Account		
Administered by Tri-AD	www.tri-ad.com/fsa	888-844-1372
Life, AD&D and Long Term Disability Insurance		
Hartford	TCMC Intranet	800-331-7234
Critical Illness & Accident Insurance		
Hartford	www.thehartford.com/benefits/myclaim	866-547-4205
Legal Plan		
Hyatt Legal Plans	www.legalplans.com	800-821-6400
Retirement Plans		
National Security Retirement Program	TCMC Intranet/HR/Retirement	Dená Baker (PIA) - 760-940-5636
Deferred Compensation Plan	www.LincolnFinancial.com	800-234-3500
Money Accumulation Pension Plan (MAPP)		
MetLife Voluntary Benefits		
Pet Insurance, Auto and Home	www.metlife.com/mybenefits	800-438-6388
TCMC Human Resources/Benefits		
	TCMC Intranet/HR/Benefits	760-940-7998
BB&T Benefits Advocate		
	benefitsadvocate@bbandt.com	800-914-5096

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).

CHIP REAUTHORIZATION ACT (CHIPRA) OF 2009

Effective April 1, 2009, employees and dependents who are eligible for coverage under the medical plan, but are not enrolled, will be permitted to enroll in the plan if they lose eligibility for Medicaid or CHIP coverage or become eligible for a premium assistance subsidy under Medicaid or CHIP.

Individuals must request coverage under the plan within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy. CHIPRA allows states to offer eligible low-income children and their families a premium assistance subsidy to help pay for employer-sponsored coverage. Some states offer a premium assistance subsidy. Included with this notice is a list of potential opportunities available for premium assistance. You should contact your State for further information on eligibility.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) CONTINUATION

COBRA gives you and your dependents the right to continue health care coverage for a specific time if your employer-sponsored coverage ends. In accordance with COBRA, you (and/or your covered dependents) have a right to continue your health care coverage in the event you (or your dependents) are no longer eligible for coverage through the employee benefits program. There are several instances in which COBRA continuation is available; these instances are referred to as "qualifying events."

Generally, COBRA coverage is available to your for up to 18 months (an additional 18 months may be available in certain circumstances). To receive this coverage, you must enroll for benefits in a timely manner and pay the required premium. The amount charged can be equal to the full premium plus a 2% administration fee. If a qualifying event occurs and your employer is aware of it or notified, the COBRA administrator will send you the required COBRA enrollment materials. For qualifying events that your employer may not be aware of, such as a divorce or birth of a child, it is your responsibility to report the event within 60 days.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) COMPLIANCE STATEMENT OF RIGHTS

As a participant in the group insurance plan you are entitled to certain rights and protections under the ERISA of 1974. ERISA provides that all Plan participants shall be entitled to:

Receive Information about You Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for copies.
- Receive a summary of the Plan's annual financial report, if the plan administrator is required by law to file a Form 5500. The plan administrator may be required by law to furnish each participant with a copy of this summary annual report.

GRANDFATHERED PLAN STATUS NOTICE

This group health plan is **NOT** a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA). As permitted by the Affordable Care Act (ACA), a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the plan may not include certain consumer protections of the ACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the ACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Human Resources. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace.

What is the Health Insurance Marketplace?

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

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan.

However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or call your plan administrator.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.HealthCare.gov for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) NOTICE OF PRIVACY PRACTICES

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.

Our Pledge to You: This notice is intended to inform you of the privacy practices followed by the Benefit Plan (the Plan) and the Plan’s legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective as of July 1, 2009.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. It is required that all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information: Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information: Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

- *Payment.* We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits

with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

- *Health Care Operations.* We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

- T*reatment.* Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

- *As permitted or required by law.* We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

- *Pursuant to your Authorization.* When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

- T*o Business Associates.* We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

- *To the Plan Sponsor.* We may disclose protected health information to certain employees for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights:

- *Right to Inspect and Copy.* In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

- *Right to Amend.* If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the Risk Management Department. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

- *Right to an Accounting of Disclosures.* You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made

  1. for purposes of treatment, payment or health care operations;
  2. to you;
  3. pursuant to your authorization;
  4. to your friends or family in your presence or because of an emergency;
  5. for national security purposes; or
  6. incidental to otherwise permissible disclosures.

  Your request for an accounting must be submitted in writing to Human Resources. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

- *Right to Request Restrictions.* You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

- Your request for restrictions must be submitted in writing to Human Resources. We will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

- *Right to Request Confidential Communications.* You have the right to receive confidential communications containing your health information. Your request for confidential communications must be submitted in writing to Human Resources. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

- *Right to be Notified of a Breach.* You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

- *Right to Receive a Paper Copy of this Notice.* If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact Human Resources.

Our Legal Responsibilities

We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice.

We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time from Human Resources. For more information about our privacy practices, if you have any questions or complaints, please contact Human Resources.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Human Resources. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. Human Resources can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

This notice is being provided to make certain that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive health insurance coverage at this time.

Loss of Other Coverage
If you are declining coverage 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).

Example: You waived coverage under this plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth, or Adoption
If you have a new dependent as a result of a 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, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP
If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

To request special enrollment or obtain more information, please contact Human Resources.

Note: If you or your dependents enroll during a **special enrollment period**, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a preexisting condition exclusion period of more than 12 months. Any preexisting condition exclusion period will be reduced by the amount of your prior creditable health coverage. **Effective for plan years beginning on or after January 1, 2014, health plans may not impose pre-existing condition exclusions on any enrollees.**

MEDICARE PART D NOTICE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare 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. **The prescription drug coverage offered by your employer is 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 15 through December 7.

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

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 under the group health plan 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 19 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 November to join.

For More Information about This Notice or Your Current Prescription Drug Coverage
Contact Human Resources 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 IMS 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.
- all 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).

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA) NOTICE

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

OVER-THE-COUNTER (OTC) DRUG REIMBURSEMENTS FOR FSAS/HSAS

Under the Health Care Reform law (PPACA), the cost of an OTC medicine or drug cannot be reimbursed from the account unless a prescription is obtained. The change does not affect insulin, even if purchased without a prescription, or other health care expenses such as medical devices, eyeglasses, contact lenses, co-pays and deductibles. The new standard applies only to purchases made on or after January 1, 2011.

A similar rule is in effect for Health Savings Accounts (HSAs). The IRS has also posted a questions and answers section on its website http://www.irs.gov/newsroom/article/0,,id=227308,00.html concerning these provisions.

PATIENT PROTECTION NOTICE

Our plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, the medical carrier designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the medical insurance carrier at the number listed on your identification card.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the medical insurance carrier 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 the 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 the medical insurance carrier at the number listed on your identification card.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A 1993 amendment to the Employee Retirement Income Security Act (ERISA) requires employment-based group health plans to extend health care coverage to the children of a parent-employee who is divorced, separated or never married when ordered to do so by state authorities.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

Under the ACA, health insurers and group health plans provide consumers with a document detailing, in plain language, simple and consistent information about health plan benefits and coverage. This summary document is intended to help consumers better understand the coverage they have and allow them to easily compare different coverage options. SBCs summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

WELLNESS PROGRAM NOTICE OF REASONABLE ALTERNATIVE STANDARD

Your employer is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under a wellness program, you might qualify for an opportunity to earn the same reward by different means. We will work with you (and if you wish, your doctor) to find a wellness program activity with the same reward that is right for you in light of your health status. Contact Human Resources for more information.

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

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the 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. If you would like more information on WHCRA benefits, call your plan administrator.

Tri-City Medical Center

ADVANCED HEALTH CARE...FOR YOU

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer and the insurance carriers. The text contained in this booklet was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the booklet and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this booklet, contact Human Resources.

Prepared by:

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