



2026

Employee Benefits Guide

Where Your Benefits Take Center Stage



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MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.



Welcome to Your Benefits Guide

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, PIH Health supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, and additional benefits.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

The benefits in this summary are effective January 1, 2026, through December 31, 2026.

IMPORTANT NOTE: This is a summary overview and does not provide a complete description of all benefit provisions. While we've made every effort to make sure that this overview is comprehensive, it cannot provide a complete description of all benefits. Specific details and limitations are provided in the plan documents, such as the Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC), etc. Plan documents contain relevant provisions and determine how benefits are paid. If the information in this overview differs from the plan documents, the plan documents prevail.

Who is Eligible?

You are eligible if you are an active employee working a minimum of 40 hours per pay period (.5 FTE) in a benefit eligible status.

Full-time employees are those working a minimum of 60 hours per pay period (.75 FTE).

The following dependents are eligible for benefits:

- Legally married spouse (including a same-sex spouse)
- California Registered Domestic Partner if you have filed a Certificate of Domestic Partnership with the State of California – Certificate must be submitted to Human Resources (HR). The IRS requires that you pay taxes for your domestic partner coverage. Any premiums for your domestic partner paid for by PIH Health are taxable income and will be included on your paycheck. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO)

Members who are NOT eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings

Termination of Employment

All plans remain intact until the end of the month with the exception of the Flexible Spending Account (FSA). **Flexible Spending Accounts term on the last day of employment.**



When you can enroll

New Hire Enrollment	New hire coverage or coverage for an employee who has transferred to a benefit eligible status begins on the first of the month following 30 days.
Open Enrollment	The one time each year that you can make changes to your benefits for any reason.
Qualifying Life Event	A qualifying life event is a significant change in your life that allows you to make changes to your benefits outside of open enrollment. See the next page for more information.

Changing Your Benefits

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

Any change you make must be consistent with the change in status. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

You must submit your change within 30 days after the event.



The Easy Way To Get Benefits Info

MyBenefits.Life® gives you all your benefits information in one place

You can do just about anything online these days. Why should accessing your benefits information be any different? MyBenefits.Life® is a website that gives you access to the benefits information you need, when you need it.

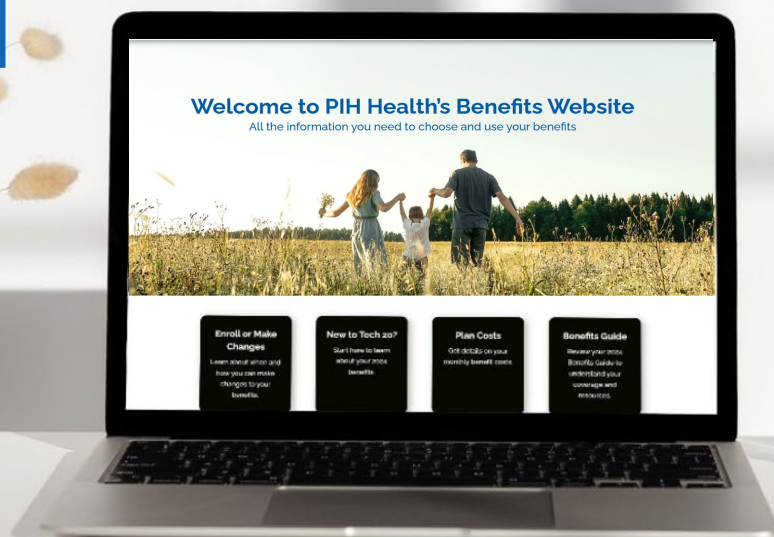
Here's what you'll find on MyBenefits.Life®

Benefits	See benefit details and costs for all plans you're eligible for.
Articles & Video Library	Increase your benefits IQ with short articles and videos.
Documents	Read important benefit plan notices ("the fine print").
Contacts	Find HR, benefits, and carrier contacts.

Visit PIHHealth.MyBenefits.Life for 24/7 access to your important benefits information.

Want quick access via your mobile device?

Open the link on your device, select the **Share** option, then select **Add to Home Screen**.



Have Questions About Your Benefits?



Get help from a Benefit Advocate

Are you getting married and not sure how and when to add your new spouse to your plan? Is your stepchild eligible for your healthcare plan? Do you need help understanding the difference between an HSA and an FSA? A Benefit Advocate can help answer these questions and more.

Benefit Advocates are trained benefits experts who can help you understand and use your healthcare and other coverage. Contact your Benefit Advocate for issues such as:

- General benefit questions
- Eligibility and coverage
- Finding a network provider
- Healthcare claim or billing issues, when warranted
- Coverage changes due to life events (marriage, new child, divorce, etc.).

Claims assistance

If you need claims assistance, you'll need to complete a HIPAA Authorization Form to grant your Benefit Advocate permission to work with your insurer and/or healthcare provider(s) to resolve your claims issues. Permission is granted on a limited time basis to only the individuals listed on the form. The form is revocable at any time. Your Benefit Advocate will provide the form to you when needed.

Contact Your Alliant Benefit Advocate

Email

PIHHealthBenefits@Alliant.com

Phone

833.714.0229

Hours

5 am to 5 pm PT, Monday through Friday

Click to play video



Enrolling for Benefits

Oracle

All employees will utilize the Oracle system called **MyHRConnect** to enroll in benefits. You will be able to enroll in your benefits from work or home. You can log onto your benefit portal from any computer or device that has internet access.

Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

Getting started

- Log in to Oracle at www.PIHHealth.org/MyHRConnect

Username: PIH Health Employee Number

Password: Your password was self-created. To reset your password, call the Helpdesk at 562.698.0811 Ext. 14160

- Click on “My Benefits”
- Click on “My Benefits (Enrollment)”
- You will arrive on the “People to Cover” page (contacts)
- Enter the following fields: effective start date, hire date, last name, first name, gender, date of birth, relationship, national identifiers – social security number (click on “Add” and follow prompts)
- Click the “Submit” button
- Click on “Back Arrow”
- Click on “Continue” to proceed



Don't miss your enrollment deadline!



Medical

Our medical plans offer comprehensive coverage. Preventive care is fully covered under all plans if obtained in-network. Your costs for other services will depend on which plan you choose.

Medical Plan Overview

This guide serves as a summary of the medical plans. Please review the plan documents before selecting a plan.

What you need to know

PIH Health Plan

Tier 1: PIH Health

Tier 2: Anthem Blue Cross

You are **required** to use the Tier 1 PIH Health providers when available. You are only allowed to use Tier 2 if services are not available at the Tier 1 level. **You must obtain a prior authorization before obtaining the services from the Tier 2.** Refer to the following page for more details on prior authorizations.

Consumer Driven Health Plan (CDHP)

Tier 1: PIH Health

Tier 2: Anthem Blue Cross

Tier 3: Out-of-Network

You can maximize your benefits when you utilize the Tier 1 PIH Health providers. Because this plan consists of a higher deductible, PIH Health offers a Health Savings Account (HSA) when you elect this medical plan. The HSA allows you to contribute into the account and use for healthcare expenses that you may have today or save for future expenses. Refer to the Health Savings Account page for more detailed information.

EPO Plan

Tier 1: PIH Health

Tier 2: Anthem Blue Cross

This plan does not offer out-of-network coverage. There is no deductible when using the Tier 1 PIH Health providers.

Luminare Health Member Benefits

Luminare Health is your medical plan administrator utilizing both the PIH Health Providers Listing and the Anthem BlueCross Network.

Luminare Health Mobile App

Download the myLuminareHealth mobile app to get all the information you need, right when you need it most. With the myLuminareHealth mobile app, you can easily access your benefits portal on the go. The mobile app gives you secure access to valuable benefit and plan information anytime you need it.

Through myLuminareHealth, you can:

- Review eligibility and plan information for you and your covered dependents
- View claims details for you and your dependents
- Access Explanation of Benefits (EOB) documents
- View, print, or download your current ID card or request new ID cards
- Access an electronic summary of benefits and coverages
- Locate participating doctors or hospitals

Create an Account

1. Go to www.myLuminareHealth.com.
2. Under “Plan Participant,” select “Create Your Account.”
3. Enter the required registration fields and click “Next.”
4. Click “I Agree” to accept the consent to electronic signatures and communications and terms and conditions.
5. Enter your contact information in the listed fields. You must enter your email address and at least one phone number.
6. Click “Start” next to the communication method you would like to verify and a code will be sent to your email address or mobile phone number you provided. Enter the verification code in the indicated field. Click “Next” to continue.
7. Create your profile by choosing a username and password. Answer three security questions and click “Next.”

Contact Luminare Health

Phone: 833.944.1713

Website: www.myLuminareHealth.com



Find a Provider

Find a Provider – Luminare Health/ Anthem Blue Cross

Finding a provider is fast and easy. The Anthem Blue Cross “Find a Doctor” tool searches for doctors, hospitals, labs, and other healthcare providers in your Anthem BlueCross plans. By creating an account on the www.myLuminareHealth.com website, you will have direct access to the www.Anthem.com/ca link.

How to Find a Provider (must create an account)

To find a PIH Health participating provider, click on the “PIH Health” icon. Please note that you must create an account in order to find a provider. Please refer to the previous page for step-by-step instructions on how to create an account with Luminare Health.

1. To get started, visit Luminare Health’s website at www.myLuminareHealth.com and log in.
2. Click the “Find a Doctor” link under the “My Links” tab to be sent to Anthem’s “Find Care” page.
3. Scroll to the middle where it says “Use Member ID for Basic Search.”
4. Enter the three-digit prefix **PJH** and click “Continue.” This prefix must be used to find the providers available to your plan.
5. Enter the city, county, or zip code of the area where you are seeking care.
6. Enter the type of provider you are looking for or the provider’s name.
7. The distance/radius search is 20 miles. To expand or narrow the search radius, click the mileage bar to the left of your results.
8. Make your selection.

Visit Luminare Health Today!



Medical Plans

1. PIH Health Plan

The PIH Health Plan consists of two tiers:

Tier 1: PIH Health Providers

Tier 2: Anthem Blue Cross Participating Providers (prior authorization required)

Under the PIH Health Plan, you are required to use the Tier 1 – PIH Health Providers when available. You are only allowed to seek services at the Tier 2 level if services are not available at the Tier 1 level.

You must obtain a prior authorization before obtaining the services from the Tier 2. Please refer to the following page for details on prior authorizations and how to obtain one.

2. Consumer Driven Health Plan

The Consumer Driven Health plan (CDHP) offers 3 tiers of coverage:

Tier 1: PIH Health Providers

Tier 2: Anthem Blue Cross Participating Providers

Tier 3: Out-of-Network Providers

You can maximize your benefits when you utilize the Tier 1 – PIH Health providers. Because this plan consists of a higher deductible, PIH Health offers a Health Savings Accounts (HSA) when you enroll in this medical plan.

The Health Savings Account allows you to contribute funds into the account and use for healthcare expenses that you may have today or future expenses. Refer to the Health Savings Account page for more detailed information on how the HSA works, contribution limits, HSA features, and more.

3. EPO Plan

The EPO plan offers 2 tiers:

Tier 1: PIH Health Providers

Tier 2: Anthem Blue Cross Participating Providers

This plan does not offer out-of-network benefits. However, there is no deductible when using the Tier 1 – PIH Health providers.

Tier 1 Provider Listing

Regardless of which plan you decide to enroll in, you can maximize your benefits by utilizing the Tier 1 – PIH Health providers. You can locate your Tier 1 Provider Listing on the Luminare Health site, Oracle, your MyBenefits.Life site or your communications Bookshelf located [HERE](#).



Prior Authorizations

Prior Authorizations

Prior authorizations are needed before certain medical treatments are started. It is a program designed to determine whether a proposed setting and course of treatment is medically necessary and appropriate, and minimizes the risk of reduced benefits. Some of the medical treatments include, but are not limited to:

- Inpatient services (ex. elective hospital admissions, acute hospital admissions, skilled nursing facility admissions, acute or sub-acute rehab admissions)
- Transplant procedures
- Durable Medical Equipment (ex. insulin pump/artificial pancreas device)
- Prosthetics/Orthotics
- Genetic labs
- Private duty nursing
- Outpatient radiology (ex. MRI, CT MRA, PET Scan) – prior authorization not required at a Tier 1 PIH Health facility
- Mental health/substance abuse inpatient services, partial hospitalization, and/or intensive outpatient services

PIH Health Plan

If you elect the PIH Health Plan, you are required to use a PIH Health provider (Tier 1) whenever services are available.

You can only seek care outside of PIH Health if the services are not provided at PIH Health. In this case, prior to receiving services from a Tier 2 provider, you must first obtain prior authorization (approval).

A benefit will not be eligible for payment if a service is rendered/received outside of the Tier 1 PIH Health provider category before obtaining a prior authorization (approval).

How to Request a Prior Authorization

Your provider will submit a prior authorization request on your behalf via EZ NET or by fax to 562.967.2910.



PIH Health Plan

This table shows member cost share.

	Tier 1: PIH Health Providers	Tier 2: Anthem Blue Cross Participating Providers (available only upon obtaining an authorization)
Annual Deductible		
Individual Coverage	\$0	\$0
Family Coverage	\$0	\$0
Annual Out-of-Pocket Maximum^{1,2}		
Individual Coverage	\$3,000	\$6,000
Family Coverage	\$6,000	\$12,000
Office Visit		
Primary Care	\$20 copay	\$30 copay
Specialist	\$35 copay	\$45 copay
Teladoc Visit	\$20 copay	\$20 copay
Preventive Services	No charge	No charge
Chiropractic (up to 30 visits/year)	\$30 copay/visit	\$30 copay/visit
Urgent Care	\$20 copay	\$30 copay
Emergency Room	\$150 copay (waived if admitted)	\$150 copay (waived if admitted)
Lab and X-Ray	No charge	No charge
Advanced Imaging CT, PET, MRI, etc.	\$100/visit	\$100/visit
Outpatient Surgery	No charge	\$400 copay Mental health/substance abuse: No charge Pediatric facility services not available at PIH Health: no charge (at Choc with a PIH Health provider approved prior authorization)
Inpatient Hospitalization	No charge	\$1,000 admission copay Mental health/substance abuse: No charge Pediatric facility services not available at PIH Health: no charge (at CHOC with a PIH Health provider approved prior authorization)
Durable Medical Equipment	No charge	No charge
PRESCRIPTION DRUGS (MedImpact)		
Annual Deductible	Combined with medical	Combined with medical
Out-of-Pocket Maximum	Combined with medical	Combined with medical
Retail: 30-Day Supply		
Generic	\$6 copay	\$20 copay
Preferred	\$30 copay	\$45 copay
Nonpreferred	\$60 copay	\$100 copay
Specialty	25% up to \$250	25% up to \$250
Retail: 30-90 Day Supply		
Generic	\$12 copay	N/A
Preferred	\$60 copay	N/A
Nonpreferred	\$120 copay	N/A
Specialty	N/A	N/A
Mail Order: 90-Day Supply		
Generic	N/A	\$40 copay
Preferred	N/A	\$90 copay
Nonpreferred	N/A	\$200 copay
Specialty	N/A	N/A

¹This family maximum is embedded, meaning that the plan will cover 100% for a member once they reach their individual maximum.

²All covered expenses, including your medical deductibles and prescription copays, accumulate towards the out-of-pocket maximum.

Consumer Driven Health Plan (CDHP)

This table shows member cost share.

	Tier 1: PIH Health Providers	Tier 2: Anthem Blue Cross Participating Provider	Tier 3: Out-of-Network
Annual Deductible¹			
Individual Coverage	\$1,700	\$2,500	\$4,000
Individual in a Family	\$3,400	\$3,400	\$4,000
Family Coverage	\$3,400	\$5,000	\$8,000
Annual Out-of-Pocket Maximum^{2,3}			
Individual Coverage	\$3,400	\$6,000	\$10,000
Family Coverage	\$6,000	\$12,000	\$20,000
HSA EE Contribution Limit			
Individual		\$4,400	
Family		\$8,750	
Office Visit			
Primary Care	10%*	30%*	50%*
Specialist	10%*	30%*	50%*
Teladoc	10%*	10%*	10%*
Preventive Services			
	No charge	No charge	Not covered
Chiropractic (up to 30 visits/year)			
	10%*	30%*	50%*
Urgent Care			
	10%*	30%*	50%*
Emergency Room			
	20%* (waived if admitted)	20%* (waived if admitted)	20%* (waived if admitted)
Lab and X-Ray			
	10%*	30%*	50%*
Advanced Imaging CT, PET, MRI, etc.			
	10%*	30%*	50%*
Outpatient Surgery			
	10%*	30%*	50%*
Inpatient Hospitalization			
	10%*	30%*	50%*
Durable Medical Equipment			
	10%*	30%*	50%*
PRESCRIPTION DRUGS (MedImpact)			
Annual Deductible			
	Combined with medical	Combined with medical	Combined with medical
Annual Out-of-Pocket Maximum			
	Combined with medical	Combined with medical	Combined with medical
Retail: 30-Day Supply			
Generic	\$6 copay	\$20 copay	\$20 copay + 25%
Preferred	\$30 copay	\$45 copay	\$45 copay + 25%
Nonpreferred	\$60 copay	\$100 copay	\$100 copay + 25%
Specialty	25% up to \$250	25% up to \$250	\$20 copay + 25%
Retail: 30-90 Day Supply			
Generic	\$12 copay	N/A	N/A
Preferred	\$60 copay	N/A	N/A
Nonpreferred	\$120 copay	N/A	N/A
Specialty	N/A	N/A	N/A
Mail Order: 90-Day Supply			
Generic	N/A	\$40 copay	N/A
Preferred	N/A	\$90 copay	N/A
Nonpreferred	N/A	\$200 copay	N/A
Specialty	N/A	N/A	N/A

¹This family deductible is embedded, meaning that the plan begins to make payments for a member once they reach their individual deductible.

²This family maximum is embedded, meaning that the plan will cover 100% for a member once they reach their individual maximum.

³All covered expenses, including medical deductibles and prescription copays, accumulate towards the out-of-pocket maximum.

*After deductible.

Health Savings Account (HSA)

IMPORTANT: You must be enrolled in the Consumer Driven Health Plan (CDHP) to be eligible for an HSA.

A Health Savings Account (HSA) is a powerful tool for managing healthcare costs and saving for the future. This program is administered through WEX, Inc.

How the HSA Works

You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

2026 IRS Contribution Limits

Individual: \$4,400 per year
Family: \$8,750 per year
Are you age 55 or over? You can contribute an additional \$1,000 per year

You are ELIGIBLE for an HSA if:

- You are currently enrolled in the Consumer Driven Health Plan (CDHP).
- You are not enrolled in any other non-HDHP medical coverage.
- You do not have a general-purpose healthcare FSA through your own or your spouse's benefit plan. Limited purpose FSAs, which cover dental and vision expenses only, are allowed.

You are NOT ELIGIBLE for an HSA if:

- You are enrolled in Medicare, Medicaid or Tricare, or if you are someone else's tax dependent.

What about using your HSA for your dependents?

Review this article to learn more:

alliantbenefits.cld.bz/HSA-Eligibility

Unlock the Power of Your HSA

Tax Advantages

Contributions, growth, and eligible withdrawals are all tax-free.*

Rollover Capability

Unused funds roll over from year to year, so you don't lose them.

Retirement Savings

You can use HSA funds for healthcare expenses in retirement.**

Flexibility

Use funds for a wide range of qualified healthcare expenses.

Portability

Keep your HSA even if you change jobs or health plans.

*California and New Jersey tax HSA contributions and interest.

**For more information regarding HSAs, Retirement and Medicare, please contact your tax advisor for advice.

Find out more

- www.wexinc.com
- [Eligible Expenses](#)
- [Ineligible Expenses](#)

Health Savings Account (HSA) – WEX Resources

WEX Website Features

- Interactive HSA savings calculator – visit the Benefits Toolkit in the Insights tab
- Eligible expense list – visit the Benefits Toolkit in the Insights tab
- Manage account
- Manage investments
- Educational tools

WEX Mobile App Features

- Check your balance and view account activity
- Scan an item's barcode to determine if it is an eligible expense
- Easily move funds from your HSA into your bank account to cover eligible expenses
- File a claim and upload documentation
- Report a card lost or stolen

How to set up your online account

1. Visit www.wexinc.com
2. Select “Login”>/Benefit Accounts.
3. Select “HSA, FSA, HRA/Wellness & Commuter.”
4. If this is your first time logging in, select “New User” and fill out the required information.

Your WEX HSA debit card

You will receive two free benefits debit cards when you enroll in the HSA, mailed directly to your home address. To activate your card, you may call the toll-free number on the activation sticker on the front of your card.

You can use the WEX debit card to pay for eligible services and products. When you use the debit card, payments are automatically withdrawn from your HSA, resulting in fewer out-of-pocket costs for you. You can also request a WEX debit card for your dependents and/or spouse. A dependent must be 18 years of age or older to receive a debit card in their own name.

How to file a claim if you pay out of pocket

If you choose to pay for your HSA eligible expenses out of pocket, you can file for a reimbursement.

- Log in to your online account or use your mobile app to request a payment be sent directly to your provider or to you.
- Don't forget about direct deposit! You can set up direct deposit online and allow WEX to deposit reimbursements directly into your bank account.

Save Your Receipts!

We recommend saving itemized receipts and EOBs for tax purposes. At the end of the year, WEX will provide you with the tax forms required to file your taxes. You are responsible for reporting your HSA contributions and distributions at tax time.



EPO Plan

This table shows member cost share.

	Tier 1: PIH Health Providers	Tier 2: Other Participating Providers
Annual Deductible¹		
Individual Coverage	\$0	\$1,000
Individual in a Family	\$0	\$1,000
Family Coverage	\$0	\$2,000
Annual Out-of-Pocket Maximum^{2,3}		
Individual Coverage	\$3,000	\$6,000
Individual in a Family	\$3,000	\$6,000
Family Coverage	\$6,000	\$12,000
Office Visit		
Primary Care	\$20 copay	\$30 copay
Specialist	\$35 copay	\$45 copay
Teladoc Visit	\$20 copay	\$20 copay
Preventive Services	No charge	No charge
Chiropractic (up to 30 visits/year)	\$20 copay/visit	\$20 copay/visit
Urgent Care	\$20 copay	\$30 copay
Emergency Room	\$150 copay (waived if admitted)	\$150 copay (waived if admitted)
Lab and X-Ray	No charge	40%*
Advanced Imaging CT, PET, MRI, etc.	\$100 copay	40%*
Outpatient Surgery	\$100/surgery	40%*
Inpatient Hospitalization	\$250/admission	40%*
Durable Medical Equipment	No charge	No charge
PRESCRIPTION DRUGS (MedImpact)		
Annual Deductible	Combined with medical	Combined with medical
Out-of-Pocket Maximum	Combined with medical	Combined with medical
Retail: 30-Day Supply		
Generic	\$6 copay	\$20 copay
Preferred	\$30 copay	\$45 copay
Nonpreferred	\$60 copay	\$100 copay
Specialty	25% up to \$250	25% up to \$250
Retail: 30-90 Day Supply		
Generic	\$12 copay	N/A
Preferred	\$60 copay	N/A
Nonpreferred	\$120 copay	N/A
Specialty	N/A	N/A
Mail Order: 90-Day Supply		
Generic	N/A	\$40 copay
Preferred	N/A	\$90 copay
Nonpreferred	N/A	\$200 copay
Specialty	N/A	N/A

¹This family deductible is embedded, meaning that the plan begins to make payments for a member once they reach their individual deductible.

²This family maximum is embedded, meaning that the plan will cover 100% for a member once they reach their individual maximum.

³All covered expenses, including medical deductibles and prescription copays, accumulate towards the out-of-pocket maximum.

*After deductible.

Flexible Spending Account (FSA)



IMPORTANT: You must re-enroll in this account each year. Elections do not rollover.

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses. This program is administered through WEX, Inc.

How the FSA Works

You estimate what you and your family's eligible out-of-pocket costs will be for the coming year, expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.

- Use the FSA debit card to pay for eligible services and products. You can also login to your online account or use your mobile app to request a payment be sent directly to your provider or to you.
- Request an itemized receipt for any expenses you plan to pay for with your FSA.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.

2026 IRS Contribution Limits

You can contribute up to \$3,400.

Contributions are deducted from your pay pre-tax.

Deadline To Incur Claims

Expenses must be incurred between 01/01/2026 and 12/31/2026.

Deadline To Submit Claims

Claims must be submitted for reimbursement no later than March 31, 2026.

Rollover

You can rollover up to \$680 to use the following year. Any additional remaining balance will be forfeited.

Are You Eligible?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

Limited Purpose FSA

- If you/your spouse are enrolled in a high deductible health plan (like our Consumer Driven Health Plan), you can only participate in the Limited Purpose FSA for dental and vision expenses.
- All other considerations listed above also apply to the Limited Purpose FSA.

Do You Pay For Dependent Care?

Review the next page for information on tax savings through the Dependent Care FSA.

Find out more

- www.wexinc.com
- [Eligible Expenses](#) – now include more over-the-counter items!
- [Ineligible Expenses](#)

Comparing Tax-Free Health Accounts

These programs are administered through WEX, Inc. Visit www.wexinc.com to learn more.

	Health Savings Account (HSA)	Healthcare Flexible Spending Account (FSA)
Who can participate?	Consumer Driven Health Plan (CDHP) participants	Anyone not enrolled in the Consumer Driven Health Plan (CDHP). You are only allowed a "Limited Purpose FSA" for dental/vision expenses only.
Is the account tax-free?	Contributions, earnings, and withdrawals for qualified healthcare expenses are free from federal tax. *	Contributions and withdrawals for qualified healthcare expenses are tax-free.
Who funds the account?	You can make contributions, up to the annual limit.	FSA accounts are funded by your payroll deductions.
How much can I contribute?	Your contributions can total \$4,400 per individual or \$8,750 per family in 2026, plus \$1,000 if you're over 55.	\$3,400 in 2026, not including 2025 rollover.
Does my unused balance roll over?	100% of balance.	You can roll over up to \$680 from 2025 funds.
What is the deadline to incur claims?	N/A	You have until 12/31/2026 to incur new claims.
What is the deadline to submit claims?	N/A	You have until March 31, 2027, to submit prior year expenses.
What happens if I leave the company?	Your account goes with you. You can use it for future qualified healthcare expenses, even if you no longer have a CDHP health plan.	You may finish your current FSA plan year through COBRA.
Does my account earn interest?	Yes, and you can invest your account balance over a certain amount in investment accounts, just like a 401(k).	No
Can I change my election after open enrollment?	Election can be changed mid-year, and deposits can be made at any time.	Election cannot be changed unless you have a qualifying life event.
When can I spend my funds?	After they are deposited into the account.	Immediately, up to your total annual election.

*California and New Jersey tax HSA contributions and interest.

Additional Tax-Saving Accounts

IMPORTANT: You must re-enroll in this account each year. Elections do not rollover.

Dependent Care Flexible Spending Account (FSA)

Paying For Daycare? Make It Tax-free! A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by WEX, Inc.

How the Dependent Care Flexible Spending Account (FSA) Works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

2026 IRS Contribution limits

You can contribute up to \$7,500 per household per year. If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to \$3,750 each year.

Deadline to incur expenses

Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year.

Rollover

Unspent funds will be forfeited.

You can't change your Dependent Care FSA election amount mid-year unless you experience a qualifying event.



Rula

Finding a therapist just got easier

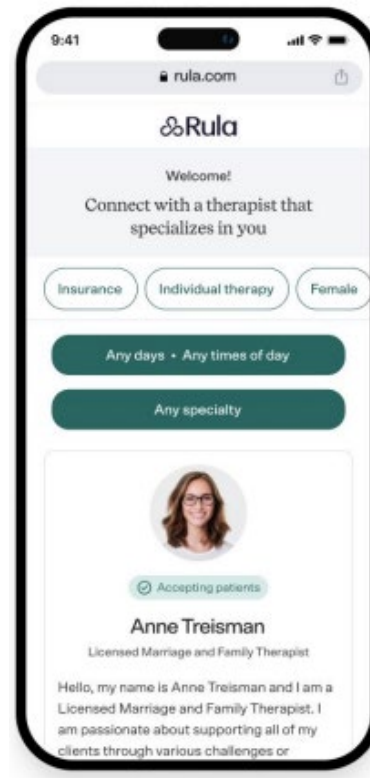
PIH Health partners with Rula to provide PIH Health employees and their families with quick, easy access to high quality therapists and psychiatrists.

1. **Select your therapist:** Tell them your therapist preferences so they can match you with the right provider.
2. **Complete registration:** Register within 12 hours of selecting your therapist. No charges will be made until after your first appointment (you can cancel anytime).
3. **Verify your benefits:** They'll check with your insurance and let you know your payment estimate before your appointment.
4. **Confirm your appointment time:** You'll receive a confirmation notice 1-2 days before your appointment along with a video call link.



PIH Health Employee/Family

We're partnering with PIH Health Employee/Family to help you find a therapist that is covered by your insurance and meets your preferences.



Contact Rula Today!

Phone: 323.205.7088

Therapy: www.rula.com/pih-employee

Psychiatry: www.rula.com/pih-employee-psych



Teladoc Health

Talk to a doctor anytime

Teladoc Health gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone, video, or mobile app visits. It's an affordable alternative to costly urgent care and emergency room (ER) visits.

Meet our doctors

Teladoc Health is simply a new way to access qualified doctors. All Teladoc Health doctors:

- Are practicing primary care physicians, pediatricians, and family medicine physicians
- Average 20 years' experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

Get the care you need

Teladoc Health doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies & sinus problems
- Urinary tract infection
- Respiratory infection
- Skin problems
- And more!

When should you use Teladoc Health?

Teladoc Health does not replace your primary physician. It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care for a non-emergency
- When on vacation, a business trip, or away from home
- For short-term prescription refills

Teladoc Health is just a call or click away!

Call 800-Teladoc or visit [Teladoc.com](https://www.teladoc.com) to get started.



Prescriptions Breaking Your Budget?

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. If you enroll in medical coverage, you will automatically receive coverage for prescription drugs. The medical plan pharmacy benefit is administered by MedImpact. You will use your Ingenio Rx ID card at the pharmacy.

All employees, regardless of their primary care physician (PCP) selection, can fill their prescriptions at a PIH Health pharmacy for a lower out-of-pocket cost. All specialty, compound, and self-injectable medications will be filled through MedImpact's Specialty Pharmacy. Please note that your plan requires you to switch to one of the pharmacies listed on this page to avoid paying full cost.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

IMPORTANT: The following drugs are only available at a PIH Health pharmacy: Consentyx, Enbrel, Humira (and all biosimilars), Jardiance, Mounjaro, Biktarvy, Ozempic, Wegovy, Trulicity, Victoza, Zepbound, Skyrizi, Stelara.

The Formulary Drug Tiers Determine Your Cost

\$ Generic Drug

\$\$ Brand Name Drug

\$\$\$ Specialty Drug



PIH Health Pharmacy Locations:

PIH Health Community Pharmacy

Wells Medical Office Building
12462 Putnam St. #105
Whittier, CA 90602

Phone: 562.789.5412

Hours:

Monday-Friday, 8 am to 7 pm
Saturday and Sunday,
9 am to 5 pm

PIH Health Pharmacy

Bloomfield Medical Office Building
12400 Bloomfield Ave.
Santa Fe Springs, CA 90670

Phone: 562.967.2810

Hours:

Monday-Friday, 9 am to 5:30 pm
Saturday & Sunday, 10 am to 5 pm
(closed for lunch from 1:30 pm to 2 pm)

PIH Health Good Samaritan Hospital Total Care Pharmacy

1245 Wilshire Blvd., Suite 201

Los Angeles, CA 90017
(second floor of the north tower)

Phone: 213.977.4111

Hours:

Monday-Friday,
8 am – 4:30 pm

PIH Health Pharmacy

Downey Medical Office Building
11480 Brookshire Ave., #102

Downey, CA 90241

Phone: 562.904.4455

Hours:

Monday-Friday, 9 am – 5:30 pm (closed for lunch from 1 pm to 1:30 pm, weekends and holiday)

Dental

This table shows member cost share.

	CIGNA DENTAL HMO		CIGNA DENTAL PPO	
	In-Network	In-Network	Out-of-Network	
Network Name				N/A
Annual Deductible	\$0 individual \$0 family	\$25 individual \$75 family	\$50 individual (combined with in-network) \$150 family (combined with in-network)	
Annual Plan Maximum	No dollar maximum	\$1,500 individual	\$1,500 individual (combined with in-network)	
Waiting Period				
Diagnostic & Preventive	0-50%	No charge	No charge	
Basic Services	0-30%	10%*	20%*	
Major Services ¹	0-30%	40%*	50%*	
Orthodontia	50%	50%	50%	
Adults	Covered	Covered	Covered	
Children	Covered	Covered	Covered	
Ortho Lifetime Max	Unlimited	\$1,500	\$1,500	

*Copay or coinsurance listed is after the deductible is met.

¹The coinsurance for fixed and removable restorations (crowns, bridges, implant/abutment supported prosthetics, complete and partial dentures) do not include additional charges for material upgrades such as CAD/CAM services or complex rehabilitation. Any additional allowable charge for these upgrades is the patient's responsibility as specifically outlined in your Patient Charge Schedule.



- **Dental HMO:** Upon enrollment, you will be auto-assigned a DHMO general dentist to manage all your dental care. Contact Cigna if you would like to make a change to your DHMO general dentist. You must receive services from, or coordinated through, the select DHMO network.
- **Dental PPO:** Under this plan, there is no need to select a primary care dentist. The DPPO allows you the flexibility to see any non-network dentists and paying a percentage of the Usual and Customary (U&C) charges. You may also be responsible for paying the difference between the U&C charges and what the dentist bills when utilizing a non-network dentist. An ID card is not provided for this plan. If coverage or billing information is needed, you can print out a paper ID card from www.myCigna.com.

Vision

Your vision checkup is fully covered after your exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below. When you enroll in the EyeMed Vision plan you are also provided with a vision coverage option through PIH Health. EyeMed Vision Care features a broad provider network with substantial access across the United States in a variety of settings. To receive maximum benefits, utilize PIH Health eye care centers.

For questions about your vision benefits, to locate a network provider, or for general assistance, please visit www.eyemed.com or call 866.723.0514.

This table shows member cost share.

EyeMed Vision PPO			
	PIH Health	In-Network	Out-of-Network
Exams	\$10 copay	\$10 copay	Plan pays up to \$49
Frequency	Once every calendar year	Once every calendar year	Once every calendar year
Eyeglass Lenses			
Single Vision	\$10 copay	\$25 copay	Plan pays up to \$45
Bifocal Lens	\$10 copay	\$25 copay	Plan pays up to \$65
Trifocal Lens	\$10 copay	\$25 copay	Plan pays up to \$85
Frequency	Once every calendar year	Once every calendar year	Once every calendar year
Frames	\$120 allowance	\$130 allowance + 20% discount (copay waived)	Reimbursed up to \$49
Frequency	Once every other calendar year	Once every other calendar year	Once every other calendar year
Contacts¹			
Elective	\$120 allowance (copay waived)	\$130 allowance + 15% discount (copay waived)	Reimbursed up to \$105
Frequency	Once every calendar year	Once every calendar year	Once every calendar year

¹In lieu of glasses

Additional charges will apply for added features such as tinting, scratch coating, and progressive (blending and bifocal) lenses. When contact lenses are obtained, you are not eligible for lenses and frames again for one plan year.

PIH Health Eye Care Center Locations:

Eye Care Center La Habra 121 W. Whittier Blvd. La Habra, CA 90631 Phone: 562.694.2500 Hours: Monday – Friday 8 am to 5 pm	Eye Care Center La Mirada 12675 La Mirada Blvd. Suite 301 La Mirada, CA 90638 Phone: 562.967.2870 Hours: Monday – Friday 8 am to 5 pm	PIH Health Whittier Hospital, Optical Shop 12401 Washington Blvd. Suite 100 Whittier, CA 90602 Phone: 562.967.2885 Hours: Monday – Friday 8 am to 5 pm (every 1 st and 3 rd Thursday of each month: 10 am to 7 pm)	Eye Care Center Santa Fe Springs 12400 Bloomfield Ave. Santa Fe Springs, CA 90670 Phone: 562.967.2820 Hours: Monday – Friday 8 am to 5 pm (every 1 st and 3 rd Wednesday of each month: 10 am to 7 pm)
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Employee CashBack and Spousal CashBack

PIH Health offers two types of CashBack

CashBacks are eligible to employees and/or their spouses who have access to other medical coverage outside of PIH Health. You must enroll for CashBack on an annual basis during open enrollment. Failure to do so forfeits this benefit for the entire benefits plan year.

1. Employees who choose to waive out of the Medical Plans will receive \$100 per month (\$46.15 per paycheck) from PIH Health.
2. Employees who choose to waive their spouses only out of the Medical Plans will receive \$100 per month (\$46.15 per paycheck) from PIH Health.

If you are electing CashBack for yourself or spouse, you must complete the CashBack form which can be found on your Benefits Bookshelf or PIHHealth.MyBenefits.Life. You may also contact the Human Resources Department for the form.

If you are covered as a dependent under a PIH Health medical plan, Medi-Cal, Medicare, or other government sponsored programs, you do not qualify for CashBack.

It is your responsibility to check your first paystub (pay period 1) to verify that you are receiving your CashBack.

Retro credits will NOT be applied for CashBack.

By electing either the employee or spousal CashBack, you are acknowledging that you have insurance coverage outside of your PIH Health medical plan. Per the state law, you must have medical coverage.

Please be aware that if you do not have coverage, you will be penalized by the IRS.





Life & Disability

Life, accidental death & dismemberment (AD&D) and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income.

Is your family protected?

Consider what your family would need to cover day-to-day living expenses and medical bills during an illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

Who is covered

Basic Life and AD&D

Employer Paid

- Employee only

Life and AD&D

Voluntary

- Employee, Spouse, Child

Short Term Disability (STD)

Voluntary

- Employee only

Long Term Disability (LTD)

Employer Paid

- Employee only

Long-Term Disability (LTD)

Voluntary

- Employee Only

Your Beneficiary = Who Gets Paid

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Company-Provided Benefits

Company Provided Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage is provided by Unum, and premiums are paid in full by PIH Health.

Life and AD&D Coverage

Employee \$50,000

AD&D Coverage

Employee \$50,000

Note: Benefit amount reduces to 50% if you are age 70 or older. Refer to the plan documents for details. Plan documents can be found on your MBL (MyBenefits.Life) site.

A Note About Taxes

Company-provided life insurance coverage over \$50,000 is considered a taxable benefit. The value of the benefit over \$50,000 will be reported as taxable income on your annual W-2 form.

Company Provided Long-Term Disability

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. Coverage is provided by Unum, and premiums are paid in full by PIH Health.

Unum Core LTD Plan

Monthly Benefit Amount	50% up to a maximum of \$2,000
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Benefits Begin After	360 days of disability
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Maximum Payment Period¹	Later of Required Beginning Date (RBD) or Social Security Normal Retirement Age (SSNRA)
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¹Maximum payment period is based on the first day benefits begin, not the first day you are disabled.

Three Things to Know About LTD

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need (housing, food, medical bills, etc.).
3. Benefits can last a long time – from weeks to even years, if you remain eligible.

Voluntary Life and AD&D Insurance

Protecting those you leave behind

Voluntary Life and AD&D insurance allows you to purchase additional coverage to protect your family's financial security. The Voluntary Life is independent and elected separately from the Voluntary AD&D. Coverage is provided by Unum and available for your spouse and/or child(ren).

Unum Voluntary Life Coverage

Employee Increments of \$10,000 up to the lesser of 5x your annual earnings, up to \$750,000

Guaranteed Issue: \$250,000

Spouse Increments of \$5,000 up to \$250,000, not to exceed 100% of Employee Basic and Voluntary Life amount

Guaranteed Issue: \$75,000

Child(ren) Live birth – 6 months: \$1,000
6 months – 19 years (26 years old for full-time student): \$5,000 or \$10,000

Guaranteed Issue: \$10,000

Note: Benefit amount reduces to 50% at age 70.

Unum Voluntary AD&D Coverage

Employee Increments of \$10,000 up to the lesser of 5x your annual earnings up to \$750,000

Spouse Increments of \$5,000
60% of the employee benefit (when spouse and employee are covered)

Child(ren) Increments of \$5,000 up to 15% of employee benefit (when children and employee are covered)
Spouse + Each Child:
Spouse: 50% of employee benefit
Child: 10% of employee benefit (when spouse, children, and employee are covered)

Evidence of Insurability (EOI)

If you elect Voluntary Life coverage above guaranteed issue (noted on this page), or if you are a late entrant (enrolling more than 31 days after the date you become eligible), you must complete and submit EOI. This can be completed online through Unum. You can find the form at www.unum.com.



Disability Insurance

NEW! Voluntary Group Whole Life Insurance

PIH Health now offers Group Whole Life Insurance! Your cost won't increase as you age and coverage is guaranteed as long as you pay premiums. In addition, Group Whole Life Insurance builds cash value. Coverage is provided by Unum.

Other features of Group Whole Life Insurance:

- When you purchase coverage when first eligible, you qualify for coverage without medical underwriting.
- Premiums will be deducted via payroll deductions.
- Once you purchase coverage, your premium remains the same as long as premiums are paid.
- Coverage is portable, meaning you can take it with you if you terminate employment with PIH Health.

This Group Whole Life Insurance also offers the optional add-on of a Long-Term Care Rider. Please refer to your plan documents for additional information.

Unum Group Whole Life Plan

Employee	Increments of \$10,000 between \$20,000 and \$150,000
Spouse	Increments of \$5,000 between \$20,000 and \$75,000
Child	\$10,000

Voluntary Long-Term Disability Insurance (LTD)

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. You pay the cost of this coverage. Coverage is provided by Unum.

Unum Buy-Up LTD Plan

Monthly Benefit Amount	60% up to a maximum of \$8,000
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Benefits Begin After	180 days of disability
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Maximum Payment Period¹	Later of Required Beginning Date (RBD) or Social Security Normal Retirement Age (SSNRA)
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¹Maximum payment period is based on the first day benefits begin, not the first day you are disabled.

Unum Buy-Up LTD	Rate
Per \$100/total monthly covered payroll	\$0.43

Short-Term Disability Insurance

Voluntary Short-Term Disability Insurance (STD)

Short-Term Disability insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

This plan pays in addition to group disability or California State Disability Insurance (SDI). For the first 12 months after your coverage becomes effective, your plan may not cover a sickness or accidental injury that arose in the three months prior to your participation in the plan. You pay the cost of this coverage. Coverage is provided by Unum.

Plan 1

Weekly Benefit Amount

Plan pays 20% of weekly earnings

Maximum Weekly Benefit

\$1,200

Benefits Begin After

Accident	14 days of disability
Sickness	14 days of disability

Maximum Payment Period¹

26 weeks

Plan 2

Weekly Benefit Amount

Plan pays 20% of weekly earnings

Maximum Weekly Benefit

\$1,200

Benefits Begin After

Accident	7 days of disability
Sickness	7 days of disability

Maximum Payment Period¹

26 weeks

¹Maximum payment period is based on the first day benefits begin, not the first day you are disabled.

Submitting a Claim

If you are disabled due to an illness or accidental injury, unable to work, and under the care of a licensed physician, you are eligible to submit a claim for benefits under this plan. As long as you remain disabled and meet the plan's disability requirements, you will continue to receive a percentage of your earnings until benefits are no longer payable.



Voluntary Health-Related Plans

For more information regarding costs of coverage benefit offerings please visit www.unum.com.

Accident Insurance

Accident Insurance from Unum helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose.

You may even be eligible for a \$100 Be Well Screening Benefit if you receive a covered wellness screening such as blood tests, stress tests, or a chest x-ray.

Hospital Indemnity Insurance

Hospital indemnity insurance from Unum can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit, for paying medical bills, childcare, or for regular living expenses like groceries—you decide.

Things to Consider

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.

You may even be eligible for a \$50 Be Well Screening Benefit if you receive a covered wellness screening such as blood tests, stress tests, or a chest x-ray.

Critical Illness Insurance

Critical illness insurance from Unum can help fill a financial gap if you experience a serious illness such as cancer, heart attack, or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed.

You may even be eligible for a \$200 Be Well Screening Benefit if you receive a covered wellness screening such as blood tests, stress tests, or a chest x-ray.



Additional Benefits

Legal Program

Do you have an attorney on retainer? Most people don't, but our legal program offers you access to legal advice and even representation for an affordable monthly premium. Whether you need assistance reviewing a rental agreement, fighting a traffic ticket, creating a will, buying a house or navigating an IRS audit, legal coverage from MetLife offers reputable attorney assistance for you and your family. You can enroll in this program during open enrollment.

Two different plans are offered:

- MetLife Legal High Plan (Legal and ID Theft Services)
- MetLife Legal Low Plan (Legal Services)

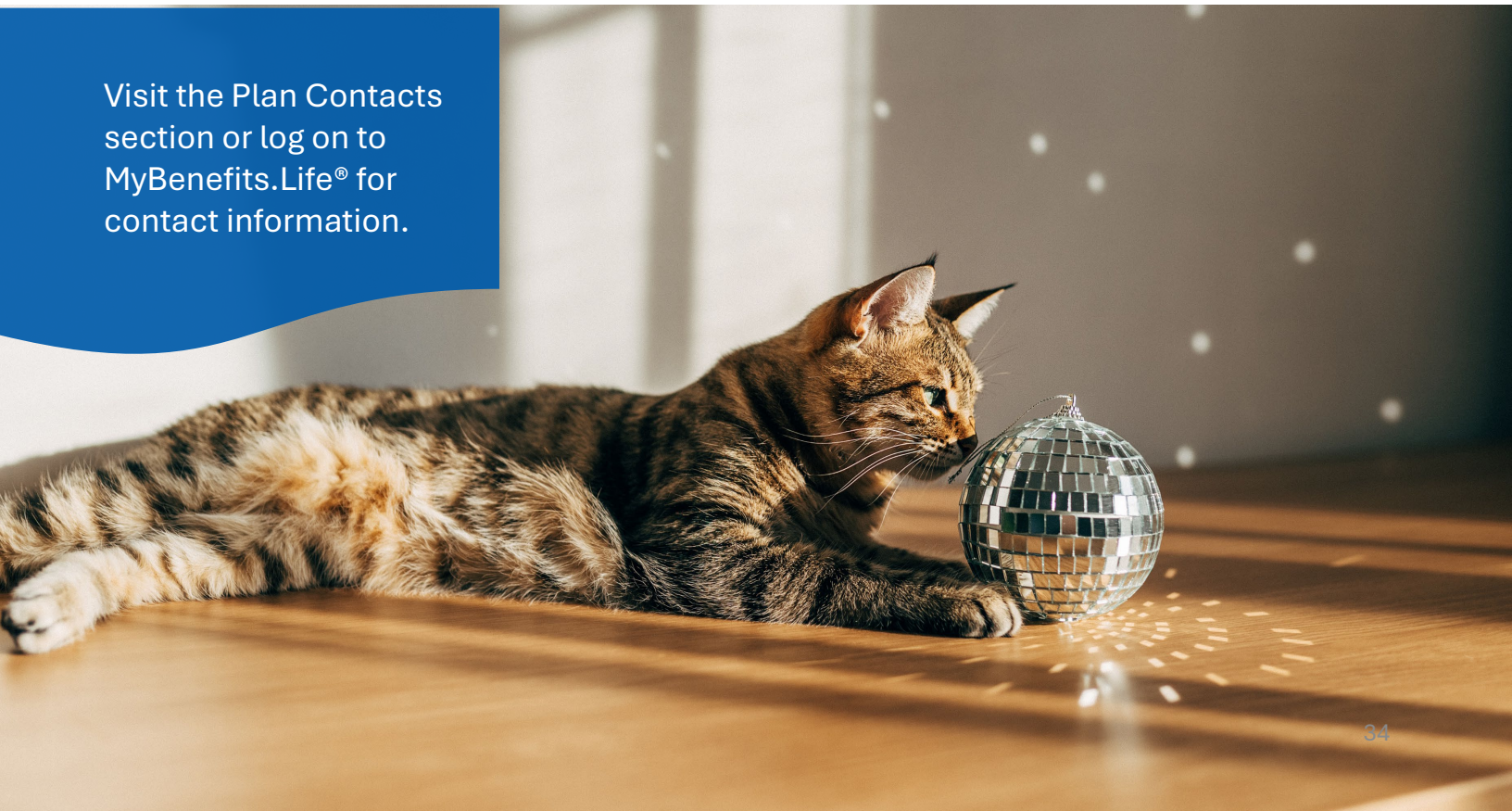
Pet Insurance

Pets are members of the family, too. When your pet gets sick, bills can add up faster than expected. Pet insurance prevents you from needing to weigh your pet's health against your bank account. Most plans offer coverage for costs associated with both accidents and illnesses—even medications.

Two different plans are offered:

- United Pet Care – an alternative to pet insurance offered at a lower cost on a per pet basis.
- Nationwide – is available as the more traditional pet insurance plan. **Premiums are paid directly to the insurance company.**

Visit the Plan Contacts section or log on to [MyBenefits.Life®](https://MyBenefits.Life.com) for contact information.





Wellbeing & Balance

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

A Happier, Healthier You

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

What you need to know

Employee Assistance Program (EAP)

Access resources to manage stress, chemical dependency, mental health, and family issues.

LifeBalance

Access this employee discount program to enjoy a variety of entertainment and attractions.

Important

For immediate assistance in a mental health crisis, please call 911. Or call the National Suicide Prevention Lifeline at 988 for a national network of local crisis centers that provide free and confidential emotional support.

Employee Assistance Program (EAP)

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Concern EAP can help you handle a wide variety of personal issues such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free, and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to five visits per issue
- Unlimited web access to helpful articles, resources, and self-assessment tools

Available Resources

Counseling Benefits

- Difficulty with relationships
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

Parenting & Childcare

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

Financial Coaching

- Money management
- Debt management
- Identity theft resolution
- Tax issues

Legal Consultation

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal injury
- Consumer protection
- Real estate
- Bankruptcy

Eldercare Resources

- Help with finding appropriate resources to care for an elderly or disabled relative

Online Resources

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

Contact the EAP

Phone

800.344.4222

Website

Employees.concernhealth.com

Employer ID: [pihhealth](#)



Discount Program



Get discounts at thousands of businesses focused on your well-being

The LifeBalance Program works like an online coupon book, offering discounts at thousands of participating businesses nationwide. Discounts are available at health clubs, fitness studios, online retailers, sporting goods stores, amusement parks, movie theaters, hotels, ski resorts, and more.

Create an account to access discounts

1. Navigate to PIHHealth.LifeBalanceProgram.com
2. Enter your preferred email address, then click "Let's Get Started"
3. Enter all required info, create a password for your account, answer the prompts, and then click "Sign In"

Once you've set up your account, you can browse the discounts by clicking the "Find Savings By Interest" tile on the home page. You can also use the search box to look for businesses by name or location.

For household members, too!

This benefit is also available to family members in your household, so encourage them to create their free accounts at PIHHealth.LifeBalanceProgram.com.

Questions?

Member Services

888.754.5433

info@LifeBalanceProgram.com





Important Plan Information

In this section, you'll find important plan information, including:

	What you need to know
Important Contacts	Contact information for our benefit carriers and vendors.
Benefits Glossary	A Benefits Glossary to help you understand important insurance terms.
Important Notices	A summary of the health plan notices you are entitled to receive annually, and where to find them.

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify PIH Health if your domestic partner is your tax dependent.

Plan Contacts

PIH Health Benefits Team				
HR Sr. Benefits Specialist	Veronica Rodriguez	562.698.0811 Ext. 12889	Employee.Benefits@PIHHealth.org	
HR Benefits & Retirement Specialist	Adriana Cortes	562.698.0811 Ext. 12427	Adriana.Cortes@pihhealth.org	
HR Benefits Coordinator	Irlanda Valenzuela	562.698.0811 Ext. 12810	Employee.Benefits@PIHHealth.org	
Benefit Advocate				
Alliant Benefit Advocate		P 833.714.0229 F 203.568.8396	PIHHealthBenefits@Alliant.com	
Provider	Plan	Policy	Phone Number	Website
Medical				
Luminare Health	PIH Health Plan	Luminare Group Number: PH0000	833.944.1713	myLuminareHealth.com
Luminare Health	EPO Plan			
Luminare Health	CDHP	Anthem Group Number: L11807		
Teladoc Health	Teladoc		800-Teladoc	Teladoc.com
Pharmacy				
MedImpact	Pharmacy		844.282.5334	medimpact.com
Dental				
Cigna	Dental PPO and HMO	3343006	800.244.6224	MyCigna.com
Vision				
EyeMed	Vision PPO	9731738	866.299.1358	EyeMed.com
Employee Assistance Program (EAP)				
Concern EAP	EAP	pihhealth	800.344.4222	Employees.concernhealth.com

Plan Contacts

Provider	Plan	Policy	Phone Number	Website
Flexible Spending Accounts (FSA)				
WEX, Inc.	Healthcare FSA Dependent Care FSA Limited Purpose FSA		866.451.3399	WEXinc.com/Login/Benefits-Login
Health Savings Account (HSA)				
WEX, Inc.	Health Savings Account (HSA)		866.451.3399	WEXinc.com/Login/Benefits-Login
Basic Life/AD&D, Voluntary Life/AD&D, Long Term Disability (Core and Buy-up)				
UNUM	Basic Life/AD&D, Voluntary Life/AD&D, LTD – <i>Claims, Disability Questions, EOI Questions & Approvals</i>	955994	Life: 800.445.0402 LTD: 800.985.2429	UNUM.com/Employees
Supplemental Benefits				
LifeBalance	EE Discount Program		888.754.5433	PIHHealth.LifeBalanceProgram.com
MetLife	Legal	9904074 High Plan 9904076 Low Plan	800.821.6400	Info.LegalPlans.com
Unum	Group Whole Life Insurance	984541	800.985.2429	Unum.com
Unum	Short-Term Disability	916749	800.985.2429	Unum.com/Employees
Unum	Accident Critical Illness Hospital	Accident: 942741 Critical Illness 942722 Hospital: 942723	800.985.2429	Unum.com
United Pet Care (UPC)	Pet Insurance		877.872.8800	UnitedPetCare.com
Nationwide (Pet)	Pet Insurance		877.738.7874	Benefits.PetInsurance.com/interhealth-Corp
Fidelity Investments	Retirement and Savings Plan		800.343.0860	Fidelity.com/AtWork

Glossary

-A-

AD&D Insurance

An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount

The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)

A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit

A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing

In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is \$100 but the plan's allowable charge is only \$70, an out-of-network provider may bill YOU for the \$30 difference (the balance).

Beneficiary

The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug

A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA

A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim

A request for payment that you or your healthcare provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance

Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment

A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible

The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services. Family coverage may have an **aggregate** or **embedded** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services

Services such as fillings, routine extractions, and some oral surgery procedures.

Dental Diagnostic & Preventive

Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services

Complex or restorative dental work such as crowns, bridges, dentures, inlays, and onlays.

Dependent Care Flexible Spending Account (FSA)

An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for

children under age

13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense

A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service

A service that your health plan doesn't pay for or cover.

-F-

Formulary

A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug

A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor (brand name drug).

Grandfathered

A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA)

An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)

A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP)

A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more healthcare costs (the deductible) before the insurance company starts to pay its share. An HDHP may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

Glossary

-I-

In-Network

In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance

An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance

Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order

A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment

The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network

Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of-network services at all.

Out-of-Pocket Cost

A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA, or HRA.

Out-of-Pocket Maximum

Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care

Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy

A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year

A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug

Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services

Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)

The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance

Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine

A virtual visit to a doctor using video chat on a computer, tablet, or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care

Care for an illness, injury, or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations

Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit

An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

Important Plan Information

Health Plan Notices

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located on Oracle and your MyBenefits.Life site.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **The 'No Surprises' Rules:** Explains rules that protect you from surprise medical bills
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents
- **Nondiscrimination in Health Programs and Activities:** Describes nondiscrimination processes and services available to you
- **Notice of Availability of Language Assistance Services and Auxiliary Aids and Services:** Describes language assistance services available to you

COBRA Continuation Coverage

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

Medicare Part D Notice

Important Notice from PIH Health 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 PIH Health 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. PIH Health has determined that the prescription drug coverage offered by the PIH Health Plan, Consumer Driven Health Plan (CDHP) and EPO Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your PIH Health coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. **Important Note for Retiree Plans:** Certain retiree plans will terminate prescription coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed.

Since the existing prescription drug coverage under the PIH Health Plan, Consumer Driven Health Plan, and EPO Plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your PIH Health prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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

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

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

Date:	September 2025
Name of Entity/Sender:	PIH Health
Contact-Position/Office:	Human Resources
Address:	12401 Washington Blvd. Whittier, CA 90602
Phone Number:	562.698.0811 Ext. 12889

Women's Health and Cancer Rights Act

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. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

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). If you would like more information on maternity benefits, call your plan administrator.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in PIH Health's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in PIH Health's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption, or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in PIH Health's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for PIH Health describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting PIH Health Human Resources.

Affordable Care Act (ACA) Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee-only coverage under our base plan exceeds 8.39% in 2024 (9.02% in 2025) of your modified adjusted household income.

The ‘No Surprises’ Rules

The “No Surprises” rules protect you from surprise medical bills in situations where you can’t easily choose a provider who is in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you’re no longer in need of emergency care. These are called “post-stabilization services.” You shouldn’t get this notice and consent form if you’re getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You are not required to sign the form and should not sign the form if you didn’t have a choice of healthcare provider or facility before scheduling care. If you do not sign, you may have to reschedule your care with a provider or facility in your health plan’s network.

[View a sample notice and consent form](#) (PDF).

This applies to you if you are a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

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

If you or your child(ren) 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 are not eligible for Medicaid or CHIP, you will not 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 dependent(s) 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 dependent(s) 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 are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of **July 31, 2025**. Contact your state for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
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: (800) 403-0864 Member Services Phone: (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: KIHIPPPROGRAM@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: 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: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
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: HSHIPPProgram@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: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
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 Rlte 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 or 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/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Nondiscrimination in Health Programs and Activities

PIH Health complies with all applicable federal civil rights laws, including Section 1557 of the Affordable Care Act (Section 1557). PIH Health does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)) optional (recommended but not required): (or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

In compliance with Section 1557 and other federal civil rights laws, we provide individuals the following in a timely manner and free of charge:

- **Language assistance services.** PIH Health will provide language assistance services for individuals with limited English proficiency (including individuals' companions with limited English proficiency) to ensure meaningful access to our programs, activities, services, and other benefits. Language assistance services may include:
 - Electronic and written translated documents
 - Qualified interpreters
 - Qualified bilingual staff
- **Reasonable modifications.** PIH Health will provide reasonable modifications for qualified individuals with disabilities, when necessary to ensure accessibility and equal opportunity to participate in our programs, activities, services, or other benefits.

If you need these services, please contact Risk Management at 562.698.0811 Ext. 13592. If you believe that PIH Health has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, or sex, please contact 866.368.1901 or <https://pihhealth.ethicspoint.com>. You can file a grievance in person or by mail, fax, or email.

File a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf> or via mail at:

U.S. Department of Health & Human Services
200 Independence Avenue, S.W. – 509F
Washington, D.C. 20201

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles.

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-301-5522.
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-301-5522
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-301-5522.
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-301-5522번으로 전화해 주십시오.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-301-5522.
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-301-5522.
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-301-5522 (رقم هاتف الصم والبكم: 1-xxx-xxx-xxxx).
French Creole (Haitian Creole)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-301-5522.
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-301-5522.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-301-5522.
Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-301-5522.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-301-5522.
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-301-5522 まで、お電話にてご連絡ください。
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-301-5522.
Persian (Farsi)	توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-301-5522 تماس بگیرید.

