2021 CAREGIVER BENEFITS GUIDE

FULL-TIME & PART-TIME

York Hospital

LOVING KINDNESS

Disclaimer. This booklet is a brief overview of the benefit plans and polices available to you as an caregiver of York Hospital. The booklet is only a summary. It does not include all of the details of your plan coverage. If there is a conflict between this Caregiver Benefits Guide and the Summary Plan Descriptions, Plan Documents or Certificates of Coverage, the terms of the Summary Plan Descriptions, Plan documents or Certificates of Coverage will govern. Please note that the benefits described in this guide may be changed at any time, and do not represent a contractual obligation on the part of the employer.

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Overview

Providing caregivers with a comprehensive benefits package is an important priority of York Hospital. This document provides an overview of your caregiver benefits and how to make the most of your coverage.

Don't miss out!
Open enrollment is the only time of the year that you can make changes to certain benefit elections unless you have a qualifying event.

Eligibility

York Hospital offers its caregivers and their dependents a generous benefits package that includes:

- Health Insurance (including vision and prescription coverage)
- Dental Insurance
- Vision Insurance
- Flexible Spending Account (FSA)
- Basic Life Insurance
- Voluntary Life & AD&D Insurance
- Short Term Disability Insurance
- Long Term Disability Insurance
- Permanent Life Insurance
- Critical Illness Insurance
- Retirement Benefit
- Tuition Assistance Plan
- Earned Time*
- Pet Insurance

Some benefits are available to all York Hospital caregivers regardless of how many hours you are scheduled to work. They include:

- Caregiver Support Program
- Anthem Wellness offerings

You can learn more about these benefits throughout this manual.

Dependents are defined as:

- Spouse
- Children under the age of 26
- Domestic partner, which may include partners of either same sex or opposite sex. Caregivers and their domestic partners must sign an affidavit of domestic partnership. Please see Human Resources for this document.

* Earned Time will be offered with limits to per diem, temporary and limited part-time employees affective 1/1/21 in accordance to the Maine Paid Leave Act.

Caregivers at York Hospital are eligible for benefits as outlined in the following chart.

Benefit	Minimum Hours Worked to Be Eligible for Coverage	Benefits Begin
• Medical Insurance • Dental Insurance • Vision Insurance • Basic Life • Supplemental Life • Flexible Spending Accounts • Short Term Disabiliy • Long Term Disability • Pet Insurance	20 hours per week	30 days of continuous active employment in a benefits-eligible position

If you were employed prior to January 1, 2010 in a limited, part-time capacity, your benefit eligibility may differ. In accordance with Maine Paid Leave Act, per diem, temporary, and limited part-time caregivers are eligible for up to 40 hours of earned time per year. Please contact Caregiver Experiences for further information.

There are a few opportunities to enroll in benefits:

New hire. When you first start working at York Hospital, you will be eligible for benefits after 30 days of continuous active employment in a benefits-eligible position. You will have 30 days from your date of hire to make benefit elections.

Change in status. If your employment status at York Hospital changes, you may become eligible for additional benefits and you will have 30 days from the date of the status change to make benefit elections.

Open enrollment. During open enrollment, caregivers can make changes to their benefit elections or enroll in new benefit programs. Information will be sent to all caregivers prior to the open enrollment dates that provide detailed instructions.

Qualified Life Event. If you experience a change in your life, you can make changes to certain benefits within 31 days of the event (or within 60 days if qualifying for Medicare or CHIP). Examples of qualified life events include:

- Marriage, divorce, or death of a spouse
- Birth or adoption of a child
- Change in your or your spouse's enrollment status (e.g., full-time to part-time)
- Your spouse gains or loses coverage
- Turning 26 and losing health coverage on a parent's plan

How to Enroll

To enroll in benefits, you will need to Log in to Dayforce to make changes to the applicable benefits. Please contact Caregiver Experiences to obtain additional information.

MEDICAL BENEFITS

Health Plan Comparison

Highest Level of Benefits

A PPO Plan is also known as a Preferred Provider Organization plan. In order to receive the highest level of benefits under this plan, you must receive care from a York Hospital provider.

Second Highest Level of Benefits

The next higher level of benefits will be paid for services received from providers at Massachusetts General Hospital (MGH). **This applies to all inpatient and outpatient services performed at the main campus and Danvers location of Massachusetts General Hospital.**

Third Highest Level of Benefits

The third highest level of benefits will be paid for services received from providers in the Anthem network.

You can search for a York Hospital, MGH, or Anthem network provider by logging on to www.anthem.com. Select "Log In" in the top right corner, then select "For Members" and "Log In." Then follow the prompts to create your secure online account. Once you have created your account, you may then search for a provider.

You may choose to receive services from providers who are not part of the York Hospital, MGH, or Anthem networks; however, benefits for those services will be paid at a lower level of coverage, and you will be responsible for more of the out-of-pocket costs for those services.

Important Information about the PPO Plans

- You are not required to choose a primary care provider (PCP) to manage your care. However, it is strongly recommended that you form a relationship with a personal doctor who will be able to assist you in managing your care.
- You are not required to obtain referrals in order to see specialty health care providers.
- You can receive care from any licensed health care provider, including providers who are part of the plan's networks of doctors, hospitals and other healthcare providers, as well as providers who do not participate in the plan's networks. Benefits paid at the out-of- network level will generally result in more out-of-pocket cost for you.
- For those services that are paid subject to the deductible, you will be responsible for meeting the deductible each calendar year before any benefits will be paid.
- Deductibles, coinsurance, and copays (but not prescription drug copays) will all accrue toward the annual out-of-pocket maximum. There is a separate out-of-pocket maximum for prescription drug copays.

Continued...

- Expenses that apply towards your deductible or coinsurance for services that you receive from York Hospital or MGH Providers will apply towards your deductible for services received from Anthem providers, and vice versa. However, expenses that apply towards your deductible or coinsurance for services that you receive from Non-Participating providers will not apply towards your deductible for services received from either York Hospital, MGH, or Anthem providers, and vice versa. This cross-accumulation policy applies for all of the York Hospital health plans. **This year, York has added a third health plan. It is a High Deductible Health Plan.**

Please note: The following charts are only summaries; not all plan provisions or restrictions are listed here (for example, benefits for physical therapy, speech therapy, occupational therapy, and chiropractic care are all subject to calendar year maximums). For a complete outline of the York Hospital health plans, please contact Caregiver Experiences.

Know the lingo!
You can find explanations of important terms in the glossary section of this benefits guide.

Comparison of In-Network Benefits

OPTION 1				
Benefit	**York Hospital / YHO Provider**	**Mass General Hospital**	**Anthem**	**Non-Participating Providers**
Deductible	$500 single / $1,000 family	$750 single / $1,500 family	$2,500 single / $5,000 family	$4,000 single / $8,000 family
Coinsurance % *Member Paid*	20%	25%	30%	40%
Out-of-Pocket Maximum	$2,000 single / $4,000 family	$4,000 single / $8,000 family	$6,000 single / $12,000 family	$7,500 single / $15,000 family
Preventive Care	No Charge	25% after deductible	30% after deductible	40% after deductible
Office Visit - PCP	$25	25% after deductible	30% after deductible	40% after deductible
Office Visit - Specialist	$40	25% after deductible	30% after deductible	40% after deductible
Hospital - Outpatient	20% after deductible	25% after deductible	30% after deductible	40% after deductible
Hospital - InPatient	20% after deductible	25% after deductible	$500 Copay + 30% after deductible	$500 Copay + 50% after deductible
Emergency Room	$150	$150	$150	$150
Urgent Care	$40	25% after deductible	30% after deductible	40% after deductible
Ambulance	N/A	25% after deductible	30% after deductible	40% after deductible
Diagnostic X-Ray & Lab	20% after deductible	25% after deductible	30% after deductible	40% after deductible
High-Tech Imaging	20% after deductible	25% after deductible	30% after deductible	40% after deductible
Chiropractice Manipulation	N/A	25% after deductible	30% after deductible	40% after deductible
Speech, Physical & Occ. Therapy	$25/	25% after deductible	30% after deductible	40% after deductible
Skilled Nursing Facility	20% after deductible	25% after deductible	30% after deductible	40% after deductible
Behavioral Health - Outpatient	$25	$25	$25	40% after deductible
Behavioral Health - Inpatient	N/A	25% after deductible	30% after deductible	$500 Copay + 40% after deductible

Comparison of In-Network Benefits

OPTION 2				
Benefit	**York Hospital / YHO Provider**	**Mass General Hospital**	**Anthem**	**Non-Participating Providers**
Deductible	$1,000 single / $2,000 family	$1,750 single / $3,500 family	$3,000 single / $6,000 family	$5,000 single / $10,000 family
Coinsurance % *Member Paid*	20%	25%	40%	50%
Out-of-Pocket Maximum	$2,500 single / $5,000 family	$5,000 single / $10,000 family	$6,000 single / $12,000 family	$7,500 single / $15,000 family
Preventive Care	No Charge	25% after deductible	40% after deductible	50% after deductible
Office Visit - PCP	$25	25% after deductible	40% after deductible	50% after deductible
Office Visit - Specialist	$40	25% after deductible	40% after deductible	50% after deductible
Hospital - Outpatient	20% after deductible	25% after deductible	40% after deductible	50% after deductible
Hospital - InPatient	20% after deductible	25% after deductible	$500 Copay + 40% after deductible	$500 Copay + 50% after deductible
Emergency Room	$150	$150	$150	$150
Urgent Care	$40	25% after deductible	40% after deductible	50% after deductible
Ambulance	N/A	25% after deductible	40% after deductible	50% after deductible
Diagnostic X-Ray & Lab	20% after deductible	25% after deductible	40% after deductible	50% after deductible
High-Tech Imaging	20% after deductible	25% after deductible	40% after deductible	50% after deductible
Chiropractice Manipulation	N/A	25% after deductible	40% after deductible	50% after deductible
Speech, Physical & Occ. Therapy	$25/	25% after deductible	40% after deductible	50% after deductible
Skilled Nursing Facility	20% after deductible	25% after deductible	40% after deductible	50% after deductible
Behavioral Health - Outpatient	$25	$25	$25	50% after deductible
Behavioral Health - Inpatient	N/A	25% after deductible	40% after deductible	$500 Copay + 50% after deductible

PRESCRIPTIONS FOR OPTION 1 & OPTION 2

Both of the York Hospital health plans include prescription drug coverage. The amount you pay depends upon which tier the medication is in, as well as upon where you choose to purchase your prescription. For a current listing of medications by tier, visit www.Express-Scripts.com.
You have two options when filling a prescription:

- Fill the prescription at the York Hospital Pharmacy. Your out-of-pocket costs will be lower if you choose this option.
- Fill your prescription at any other pharmacy. Your prescriptions will be subject to an annual deductible if you choose this option.

There is an annual Out-of-Pocket Maximum for your prescription drug costs, of $2,150 single and $4,300 family. However, pharmacy deductible and coinsurance expenses for prescriptions filled at a pharmacy other than the York Hospital Pharmacy will not apply toward this out-of- Pocket Maximum.

Here is how your prescription drug costs will be covered under both of the York Hospital health insurance plans. Please also review the information on the incentive based $0 prescription drug copay for certain conditions, found in the Appendix to this booklet.

	Cost
Prescription Drug Calendar Year Out-of-Pocket Maximum (York & Retail)	Single: $2,150 Family: $4,300
York Hospital Pharmacies - Retail Pharmacy *(up to a 30-day supply)*	Generic Drugs - $20 Preferred Brand - $50 Non-Preferred Brand - $100 Specialty Drugs - max $200 (40% coinsurance)
York Hospital Pharmacies - Retail Pharmacy *(up to a 90-day supply)*	Generic Drugs - $40 Preferred Brand - $100 Non-Preferred Brand - $200 Specialty Drugs - N/A
For prescriptions filled at a Non-York Hospital Pharmacy: RxBenefits A separate $250 Individual / $500 Family pharmacy deductible applies then the greater of:	
Non-York Hospital Pharmacies Retail Pharmacies *(up to a 30-day supply)*	Generic Drugs - $20 minimum (20% coinsurance) Preferred Brand - $50 minimum (30% coinsurance) Non-Preferred Brand - $100 minimum (40% coinsurance) Specialty Drugs - $200 minimum (40% coinsurance)
Out-of-Network Pharmacy	Not Covered

Comparison of In-Network Benefits

OPTION 3 - New HDHP Plan with HSA				
Benefit	**York Hospital / YHO Provider**	**Mass General Hospital**	**Anthem**	**Non-Participating Providers**
Deductible	$2,800 single / $5,600 family	$3,250 single / $6,500 family	$4,000 single / $8,000 family	$6,000 single / $12,000 family
Deductible Type	Embedded	Embedded	Embedded	Embedded
Coinsurance % *Member Paid*	20%	30%	40%	50%
Out-of-Pocket Maximum	$3,500 single / $7,000 family	$5,000 single / $10,000 family	$6,000 single / $12,000 family	$10,000 single / $20,000 family
Preventive Care	No Charge	30% after deductible	40% after deductible	50% after deductible
Office Visit - PCP	20% after deductible	30% after deductible	40% after deductible	50% after deductible
Office Visit - Specialist	20% after deductible	30% after deductible	40% after deductible	50% after deductible
Hospital - Outpatient	20% after deductible	30% after deductible	40% after deductible	50% after deductible
Hospital - InPatient	20% after deductible	30% after deductible	40% after deductible	50% after deductible
Emergency Room	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Urgent Care	20% after deductible	30% after deductible	40% after deductible	50% after deductible
Ambulance	N/A	30% after deductible	40% after deductible	50% after deductible
Diagnostic X-Ray & Lab	20% after deductible	30% after deductible	40% after deductible	50% after deductible
High-Tech Imaging	20% after deductible	30% after deductible	40% after deductible	50% after deductible
Chiropractice Manipulation	N/A	30% after deductible	40% after deductible	50% after deductible
Speech, Physical & Occ. Therapy	20% after deductible	30% after deductible	40% after deductible	50% after deductible
Skilled Nursing Facility	20% after deductible	30% after deductible	40% after deductible	50% after deductible
Behavioral Health - Outpatient	20% after deductible	30% after deductible	40% after deductible	50% after deductible
Behavioral Health - Inpatient	N/A	30% after deductible	40% after deductible	50% after deductible

PRESCRIPTIONS FOR OPTION 3

The York HDHP w/HSA Plan includes prescription drug coverage. The drug coverage is subject to the medical deductible. The amount you pay depends upon which tier the medication is in, as well as upon where you choose to purchase your prescription. For a current listing of medications by tier, visit www.Express-Scripts.com.

If you fill your prescription at the York Hospital Pharmacy, your deductible and out-of-pocket costs will be lower.

Here is how your prescription drug costs will be covered under the York HDHP w/HSA Plan. Please also review the information on the incentive based $0 prescription drug copay for certain conditions, found in the Appendix to this booklet.

	York Hospital Pharmacies	**All Other Participating Pharmacies**	
Deductible	Combined with Medical	Combined with Medical	
Out-of-Pocket Maxiumum	Combined with Medical	Combined with Medical	
Preventive Drug Benefit*	Deductible Waived	N/A	
30-Day Supply		Coinsurance after Ded.	Minimum Copay per Script
- Tier 1 (Most Generics)	$20	20%	$20
- Tier 2 (Preferred Brand)	$50	30%	$50
- Tier 3 (Non-Preferred Brand)	$100	40%	$100
- Tier 4 (Specialty)	40% to $200	40%	$200

* Preventive Rx: Deductible is waived and applicable copay will apply. To determine if a specific medication is on the preventive list of medication, please visit customercare@rxbenefits.com.

Health Savings Account (HSA)

The Health Savings Account (HSA) accompanies the Option 3 High Deductible Health Plan. This account is offered thru Empower. Combining a medical plan with a health savings accounts for pre-tax contributions to help with qualified Medical Expenses.

- Including Out-of-pocket medical, dental and vision expenses and are tax-free.
- You can save HSA funds for future expenses as unused funds are not forfeited at year end

	Employer Monthly Contribution
Employee	$41.67
Employee Child(ren)	$62.50
Family	$83.33

In addition to the deposits made by York Hospital associated with your health coverage, you can also contribute your own pre-tax funds into this plan, and you can change your contribution amount at any time during the year. Under IRS rules, the maximum that can be deposited into your HSA in 2021 is $3,600 if you have employee only coverage or $7,200 if you have family coverage. Employees who are at least 55 years of age at any point in 2021 can deposit an additional $1,000. These totals include money from all sources, which means the deposits UNE makes to your account accumulate toward the maximums. **If you have a health savings account, you cannot have other coverage, including Medicare Part A.**

HSA Eligibility Requirements:

- Must be enrolled in an HSA qualified High Deductible Health Plan, such as Option 3.
- Must NOT be enrolled in any non-qualified health plan such as that of spouse's employer.
- Must NOT be enrolled in Medicare, TRICARE or Medical Flexible Spending Account (including a spouse's Medical Flex Spending Account.

Understanding Your HSA:

- HSA contribution made through York Hospital are pre-tax
- HSA interest/earnings are tax deferred
- You can invest HSA funds exceeding a $2,000 cash balance in mutual funds
- Post tax contribution deposited outside of payroll are tax deductible up to maximum contribution amounts
- Qualified distributions are tax-free
- Non-qualified distributions are taxable and subject to 20% penalty
- At age 65, Non-qualified distributions are not subject to penalty
- Enrollment in Medicare disqualifies HSA contributions but does not prevent continued use of HSA funds for qualified distributions
- Qualified distributions include Medicare & COBRA premiums

PRICING FOR HEALTH INSURANCE

Below you will find pricing information for all the benefit offerings described in this booklet. Note that the costs below reflect the deductions for each payroll period unless otherwise noted.

Full Time (36-40 Hours/Week) - Bi-Weekly

Hourly Wage		Option 1	Option 2	Option 3
< $20.01	Caregiver Only Caregiver + Child(ren) Family	$28.62 $142.77 $204.05	$15.00 $112.70 $165.69	$13.32 $100.08 $147.13
$20.01 - $48.08	Caregiver Only Caregiver + Child(ren) Family	$41.39 $142.77 $204.05	$33.06 $112.70 $165.69	$29.36 $100.08 $147.13
$48.09 - $96.15	Caregiver Only Caregiver + Child(ren) Family	$50.35 $169.46 $241.43	$40.56 $134.12 $196.37	$36.02 $119.10 $174.38
$96.16 or more	Caregiver Only Caregiver + Child(ren) Family	$57.21 $192.56 $274.35	$46.09 $152.41 $223.15	$40.93 $135.34 $198.16

Part Time (20-35 Hours/Week) - Bi-Weekly

Hourly Wage		Option 1	Option 2	Option 3
< $20.01	Caregiver Only Caregiver + Child(ren) Family	$28.62 $254.83 $409.92	$15.00 $202.34 $330.54	$13.32 $179.68 $293.52
$20.01 - $48.08	Caregiver Only Caregiver + Child(ren) Family	$116.22 $254.83 $409.92	$95.35 $202.34 $330.54	$84.67 $179.68 $293.52
$48.09 - $96.15	Caregiver Only Caregiver + Child(ren) Family	$138.26 $301.08 $483.29	$113.74 $239.43 $390.04	$101.00 $212.61 $346.36
$96.16 or more	Caregiver Only Caregiver + Child(ren) Family	$157.11 $342.14 $549.19	$129.25 $272.08 $443.23	$114.77 $241.61 $393.59

Option 3 - Employer Contributions to HSA

	Monthly
Caregiver	$41.67
Caregiver + Child(ren)	$62.50
Family	$83.33

HEALTH & WELLNESS BENEFITS

Caregiver Support Program

For many caregivers, the Caregiver Support Program can be the key to recovering from a traumatic event such as divorce, death in the family, anxiety or depression, work issues, or financial difficulties. York Hospital provides its caregivers and their dependents with access to Caregiver Support Program, which provides counseling and referrals, at no cost to you or your family members.

Caregiver Support Program services are available to all caregivers and their dependents, starting on the caregiver's date of hire. You are eligible to receive up to five (5) free visits with York Hospital's Caregiver Support Program provider. All services are completely confidential.

The Caregiver Support Program, also known as Guidance Resources, is offered through ComPsych. This program includes up to five (5) in-person confidential sessions with a counselor, per occurrence. Legal and financial assistance is available by telephone, as is assistance with referrals for such services as child and elder care, moving and relocation, and college planning.
A Caregiver Support Program can help you through life's challenges in a number of ways, including:

- Emotional and work-life counseling for a wide range of topics, such as stress, family or marital conflicts, major life changes, depression, effective parenting, chronic illness, and child and elder care;
- Legal assistance for such legal concerns as buying a home, divorce, or adoption;
- Financial planning support in areas including retirement planning, budgets, saving for college, debt, and more.

With the Caregiver Support Program offered through York Hospital, not only can you access face-to-face and telephone counseling, you will also have access to a number of online resources. These resources include online "Ask the Experts" Q&A sessions, and hundreds of articles on personal health topics. The Caregiver Support Program can also refer you to resources and services in your own area, including self-help groups, senior centers, Certified Financial Planners, and advocacy programs.

Access the Caregiver Support Program online at: www.guidanceresources.com. Your company ID is GEN311. You may also contact the Caregiver Support Program by phone, toll-free at 1-800-311-4327

Caregiver Support Program offers unlimited, confidential, 24/7 services to all caregivers as well as their dependents, parents, and parents-in-law.

Vision Reimbursement Benefit

York Hospital in conjunction with its preferred providers York Eye and Kittery Eye are offering a $100 vision reimbursement benefit for hardware. Caregivers are responsible for the full cost of their vision hardware, however, when purchased at York Eye or Kittery Eye, York members are eligible for up to $100 reimbursement per calendar year. Members will need to submit the reimbursement claim form with a receipt to Anthem for reimbursement.

Anthem Additional Wellness & Discount Offerings

Well being is at your finger tips.

Anthem Digital Platform integrates benefits plans, claims, transparency tools, and wellbeing solutions.

- **Sydney Health Mobile** keeps your health care information in one place. Here you can access your medical benefits, view your integrated clinical program & well being tools.
- **Anthem Health Guide**: Specifically trained customer service agents who work directly with health care clinicians to connect you to the programs and support you need, help you make good health care decisions and even remind you when you've missed a routine exam.
- **24/7 Nurseline** - The line is staffed by registered nurses to talk to about your general health issues. They can help you determine if you can treat your issue at home, if you need to make an appointment to see your doctor, or if you should head to urgent care or the emergency room.
- **MyHealth Advantage** looks at your health information to see if there are gaps in care, find ways to improve your health, and suggest ways to avoid serious health problems. Through personalized messages sent to you and care reminders sent to your doctor, MyHealth Advantage helps you follow best practices for your health care.
- **Future Moms** - A program that can answer your questions around pre and post-natal care and any questions you may have about your pregnancy.
  - Sign up as soon as you know you're pregnant. Just call us toll free at 800-828-5891. One of our registered nurses will help you get started.
  - You'll get: A toll-free number so you can talk to a nurse coach 24/7,about your pregnancy. A nurse may also call you from time to time to see how you're doing.
  - The Mayo Clinic Guide to a Healthy Pregnancy book that shows changes you can expect for you and your baby during the next nine months.
  - A booklet with tips to help keep you and your new baby safe and well.
  - Other helpful information on labor and delivery, including options and how to prepare.
- **MyStrength** – Access myStrength, a free online and mobile program that supports your emotional health and well-being. The program's tools and resources can help you and your eligible dependents manage addiction, anxiety, chronic pain, depression, problems with sleep, and stress.
- **As an Anthem member you qualify for discounts on products and services that promote better health and well-being.**
  - Glasses.com™ and 1-800-CONTACTS® — Shop for the latest brand-name frames at a fraction of the cost for similar frames at other retailers. You are also entitled to an additional $20 off orders of $100 or more, free shipping and free returns.
  - EyeMed — Take 30% off a new pair of glasses, 20% off non-prescription sunglasses and 20% off all eyewear accessories.
  - Premier LASIK — Save $800 on LASIK when you choose any "featured" Premier LASIK Network provider. Save 15% with all other in-network providers.
  - TruVision — Save up to 40% on LASIK eye surgery at more than 1,000 locations.
  - Nations Hearing — Receive hearing screenings and in-home service at no additional cost. All hearing aids start at $599 each.
  - Hearing Care Solutions — Digital instruments start at $500, and a hearing exam is free. Hearing Care Solutions has 3,100 locations and eight manufacturers, and offers a three-year warranty, batteries for two years and unlimited visits for one year.
  - Amplifon — Take 25% off, plus an extra $50 off one hearing aid; $125 off two.
  - ProClear™ Aligners — Take $1,200 off a set of custom aligners. You can improve your smile without metal braces and time-consuming dental visits. Your order is 50% off and comes with a free whitening kit.
- **Fitness & Health** - Receive discounts of programs and porducts from a variety of companies, such as FitBit, Garmin, Jenny Craig, ChooseHealthy, and more.

DENTAL BENEFITS

Dental insurance provides coverage for expenses related to your oral health, such as teeth cleaning and fillings. York Hospital offers dental coverage through Delta Dental.

Description of Coverage

- With the dental plan, you can see any dentist, but you will save money by going to a provider that is in-network.
- Preventive dental care (such as cleanings, x-rays, and oral cancer screenings) are covered at 100% with in-network providers.
- Basic services are covered at 80% with in-network providers.
- Major services are covered at 50% with in-network providers.
- Orthodontia is covered at 50%, up to a $1,500 lifetime maximum
- Your dental plan has an annual deductible of $50 per person with a maximum annual deductible of $150 per family.
- Your dental plan will pay a maximum of $1,500 in benefits per person per calendar year.

Summary of In-Network Dental Coverage

Benefit	Examples of Services	In-Network Plan Pays:
Diagnostic and Preventive Services	Cleanings, x-rays, sealants, fluoride	• 100%
Basic Services	Fillings, periodontics, oral surgery	• 80% • Deductible (combined for Basic and Major Care) is $50 per person/$150 per family, per calendar year
Major Services	Crowns, dentures, bridges, implants	• 50% • Deductible (combined for Basic and Major Care) is $50 per person/$150 per family, per calendar year
Orthodontia	Correction of malposed (crooked) teeth for both adults and children	• 50% • Lifetime maximum benefit $1,500

Contributions for 2021

	Full Time (36-40 Hrs/Wk) Deduction	Part Time (20-35 Hrs/Wk) Deduction
Caregiver Only	$4.04	$9.09
Employee + One	$22.60	$28.77
Family	$28.43	$34.57

VISION BENEFITS - HARDWARE BENEFIT

Vision insurance provides coverage for expenses related to your vision, such as lenses and frames, and contacts. York Hospital offers vision coverage through Delta Dental.

Description of Coverage

- DeltaVision is supported by an EyeMed Vision Care network with over 88,000 providers at over 27,000 locations nationwide.
- Caregivers receive a $180 frame or contact lenses allowance
- Caregivers pay a $10 copay for single vision, bifocal, or trifocal lenses

Summary of Vision Coverage

Benefit	In-Network	Non-Network
Frames every 12 months	$180 allowance, then 20% off balance	$90
Standard Plastic Lenses every 12 months Single Vision / Bifocal / Trifocal Lenses	Member pays $10, plan pays balance	$25 / $40 / $55
Lens Options • UV coating/tint/standard scratch resistance • Standard polycarbonate • Standard anti-reflective coating • Standard progressive • Premium progressive • Other add-ons and services	 • Member copay $15 each • Member copay $40 • Member copay $45 • Member copy $75 • $75 copay; 80% of charge less $120 allowance • 20% off retail price	N/A
Contact Lenses every 12 months Conventional	$180 allowance then 15% off balance	$144
Disposable	$180 allowance, member pays balance	$144
Medically necessary	Paid in full	$200

	Full Time (36-40 Hrs/Wk) Deduction	Part Time (20-35 Hrs/Wk) Deduction
Caregiver Only	$4.13	$4.13
Employee + One	$7.08	$7.08
Family	$12.67	$12.67

FLEXIBLE SPENDING ACCOUNT

A Flexible Spending Account (FSA) allows you to save money on a pre-tax basis for eligible medical or dependent care expenses. York Hospital offers a medical savings account, and a dependent care savings account. All of the FSAs are managed by Group Dynamic, Inc. (GDI). NOTE: If you enroll in the HDHP w/HSA plan, you are NOT eligible to participate in the medical FSA.

Description of Benefit – Medical FSA

- You can contribute up to $2,750 per year a pre-tax basis.
- This is a use-it-or lose it benefit. You can only carry over $550 from year-to-year.
- Funds in this account can only be used for qualified medical expenses (which includes dental and vision).
- The medical FSA offers a 90 day runout. Caregivers are permitted to submit claim expenses incurred in 2019 for 90 days following the end of the plan year.
- The CARE Act of 2020 allows over-the-counter drugs and medicine to be purchased without a prescription using FSA funds.

When can I use my medical FSA?

Examples of qualified medical expenses include:

- Acupuncture
- Chiropractic care
- Contact lenses and glasses (including readers)
- Diabetic testing supplies
- Eye exams
- Dental expenses
- Health plan co-payments and deductibles
- Hearing aids
- Medical monitoring & testing devices
- Orthopedic and surgical supports
- Prescription medications
- Walking aids and wheelchairs

For the complete list of eligible medical expenses, visit: https://www.irs.gov/publications/p502

Description of Benefit – Dependent Care FSA

A Dependent Care FSA can reimburse you for care provided to a dependent in order for you - and your spouse if you are married - to work or attend school.

- You can contribute up to $5,000 per year on a pre-tax basis.
- If you're married, filing single you can only contribute up to $2,500.
- This is a use-it-or lose it benefit.
- The dependent care FSA offers a 90 day runout. Caregivers are permitted to submit claim expenses incurred in 2019 for 90 days following the end of the plan year.

A dependent is defined as:

- A child under 13 that you claim on your federal tax return.
- A child over the age of 13 who is mentally or physically incapable of self-care.
- A parent who is unable to care for him/herself physically or mentally, needs full-time care, and depends on your financial support.

How do FSAs work?

FSA accounts are easy to use:

- Make contributions to your FSA through pre-tax payroll deductions.
- Specify any amount you wish to deduct on a per-payroll-period basis but note that it cannot be changed during the benefit year.

To get reimbursed from your Medical FSA account:

- Pay for the qualified expense at the time of service and then submit your claim to GDI to be reimbursed.
- Use the York Hospital Medical Debit Card and funds will be deducted directly from your FSA account.
- Pay out-of-pocket and submit your claim to GDI to receive reimbursement.

To get reimbursed from your Dependent Care FSA account:

- Pay for the qualified expense at the time of service and get a receipt.
- Submit your claim to GDI to receive reimbursement.
- You must submit any claims for reimbursement within three months of the date of service.

Fund your account wisely.
Your reimbursement requests from your FSA request cannot exceed the balance in your account.

DISABILITY INSURANCE

York Hospital offers two types of disability insurance through Prudential: short-term disability (STD) and long-term disability (LTD). Disability insurance replaces part of your income if you are unable to work for an extended period of time due to illness or injury.

Description of Coverage – Short-term Disability (STD)

STD is an insurance program that replaces a portion of your weekly income should you have a non-occupational sickness or injury and are unable to work. STD also provides a benefit for pregnancy-related claims. Once your claim is approved, benefits will begin after your elimination period and will continue through your plan's maximum duration. For further details and plan provisions, please refer to your Plan Summary.

- If you will be out of work for an extended period of time due to illness or injury, the first 7 consecutive days is considered an elimination period. During this time, you can use earned time or take unpaid leave.
- Following the elimination period, you are eligible for short-term disability (STD). STD insurance provides 60% of your income for up to 12 weeks.
- You are eligible for long-term disability (LTD) when the STD benefit expires.

Summary of STD Coverage

	Coverage Details
Elimination Period	7 consecutive days due to illness or injury
Maximum Benefit	60% of your weekly pre-disability earnings, less deductible sources
Benefit Duration	12 weeks

Do I pay taxes on the STD Disability Benefits?
Your participation in the STD program is paid by you. As a result, your STD plan is considered to be provided to you on a contributing basis with after tax dollars, and benefits are considered non-taxable.

Description of Coverage – Long-term Disability (LTD)

LTD is an insurance program that replaces a portion of your monthly income should you have a non-occupational sickness or injury and are unable to work. LTD is designed to begin once you have exhausted your short-term disability benefits. Once your claim is approved, benefits will begin after your elimination period and may continue through your plan's maximum duration. For further details and plan provisions, please refer to your Plan Summary.

- LTD insurance provides 60% of your income until retirement age.

Summary of LTD Coverage

	Coverage Details
Elimination Period	90 days
Maximum Benefit	60% of income to a maximum of $12,500
Benefit Duration	Benefits will be paid until you reach retirement age (according to Social Security)
Pre-Existing Condition Limitations	3/3/12*
Definition of Disability	**First 24 months** – Unable to perform the material and substantial duties of your regular occupation or you have a 20% or more loss in your monthly earnings and are under the care of a doctor **After 24 months** - Unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience and you are under the regular care of a doctor

**A pre-existing condition is a disability that begins within 12 months of your coverage effective date and is due to a pre-existing condition unless you were treatment free for 3 months after the coverage effective date. A pre-existing condition is an injury or sickness for which you received medical treatment, consultation, diagnostic measures, prescribed drugs or medicines, or for which you followed treatment recommendations during the 3 months prior to your effective date.*

Do I pay taxes on the LTD Disability Benefits?
Your participation in the LTD program is paid for by your employer. As a result, the LTD premium is not taxed and therefore, any benefit payment you receive under the LTD plan would be taxable.

LIFE INSURANCE/AD&D

Life insurance pays out a sum of money to your beneficiary(ies) in the event of your death. Accidental Death & Dismemberment (AD&D) is a limited form of life insurance that pays out in the event that the insured's death is an accident.

Basic AD&D pays you and your beneficiary a benefit for the loss of life or other injuries resulting from a covered accident - 100% for loss of life and a lesser percentage for other injuries. Injuries covered may include loss of sight or speech, paralysis, and dismemberment of hands or feet. Basic AD&D benefits are paid regardless of other coverage you may have.

York Hospital offers two types of life insurance: basic life insurance with AD&D and voluntary supplemental life insurance. This insurance is offered through Prudential.

Description of Benefit – Basic Life Insurance & AD&D

Caregivers who are regularly scheduled to work more than 20 hours per week are automatically enrolled in basic life insurance at no cost to the caregiver.

- Basic life insurance covers 1 times the equivalent of your annual earnings up to a maximum benefit of $50,000.
- This benefits includes an equal amount for AD&D coverage

Although you are enrolled automatically, you will still need to specify a beneficiary. Contact Caregiver Experiences for more information.

Basic Life & AD&D Insurance Benefits

Benefit	Amount
Basic Life and AD&D Insurance - Caregiver Paid for by York Hospital	• Benefit equal to one times annual earning, to a maximum of $50,000 • Increments of $1,000 • Includes an equal amount of accidental death & dismemberment (AD&D) coverage.

Note: Upon termination of employment you may be eligible to take your Basic Life coverage with you through the portability or conversion benefit feature. Please see your Plan Summary for additional information.

Description of Benefit - Voluntary Life Insurance

You can purchase additional life insurance for yourself, your spouse, or your child(ren). Below are the details of the coverage.

Benefit	Amount
Voluntary Life Insurance - Caregiver Elected and paid for by caregiver	• Up to 5 times salary, in increments of $10,000. • **Evidence of Insurability required for amounts in excess of $150,000 and for late entrants.** • Not to exceed $500,000, or 5 times your annual income.
Voluntary AD&D Insurance - Caregiver Elected and paid for by caregiver	• Up to 5 times salary, in increments of $10,000. • Not to exceed $500,000, or 5 times your annual income. • May be purchased whether or not caregiver purchases the Supplemental Life coverage.
Voluntary Life Insurance - Spouse/ Partner Elected and paid for by caregiver	• **Up to 100% of caregiver amount, in increments of $5,000.** • Not to exceed $500,000. • **Evidence of Insurability required for amounts in excess of $50,000 or late entrants.** • Benefits paid to caregiver. • May only be purchased if the caregiver has also purchased Life coverage for him/herself.
Voluntary AD&D Insurance - Spouse/ Partner Elected and paid for by caregiver	• Up to 100% of caregiver amount, in increments of $5,000. • Not to exceed $500,000. • Benefits paid to caregiver. • May only be purchased if the caregiver has also purchased Life and/or AD&D coverage for him/ herself.
Voluntary Life Insurance - Child Elected and paid for by caregiver	• Up to 100% of caregiver amount, in increments of $2,000, not to exceed $10,000. • Maximum benefit for child between the ages of live birth and six months is $250. • Benefits paid to caregiver. • May only be purchased if the caregiver has also purchased Life coverage for him/herself.
Voluntary AD&D Insurance - Child Elected and paid for by caregiver	• Up to 100% of caregiver amount, in increments of $2,000, not to exceed $10,000. • Maximum benefit for child between the ages of live birth and six months is $250. • Benefits paid to caregiver. • May only be purchased if the caregiver has also purchased Life and/or AD&D coverage for him/ herself.

[1] Note that you cannot elect more coverage for your spouse or child than yourself. [2] If you want to be insured for an amount greater than guaranteed issue, you must demonstrate evidence of insurability.

VOLUNTARY LIFE/AD&D PRICING

Caregivers enrolled in voluntary life insurance may increase up to $50,000 of additional caregiver coverage during the annual enrollment period without completing Evidence of Insurability. No medical questions will be asked. Pricing is based on age. More information about costs can be found in the Benefit Plan Pricing section.

Take it with you!
Your Basic Life and Voluntary Life insurance may be portable, meaning that you may be able keep the coverage even if you are no longer employed with York Hospital.

Voluntary Life Insurance Pricing

The table below shows the payroll deductions for voluntary life coverage for each payroll period. Rates shown are the monthly premiums. Your rate will increase as you move to the next age band.

Voluntary Life Insurance Monthly Deductions*

Age Band	Caregiver per $1,000	Spouse per $1,000	Child per $1,000
0-24	$0.052	$0.052	$0.02
25-29	$0.061	$0.061	Applies to all covered children. The premium paid for child coverage is based on the cost of coverage for one child, regardless of how many children you have.
30-34	$0.083	$0.083	
35-39	$0.127	$0.127	
40-44	$0.185	$0.185	
45-49	$0.295	$0.295	
50-54	$0.462	$0.462	
55-59	$0.697	$0.697	
60-64	$1.043	$1.043	
65-69	$1.761	$1.761	
70-74	$3.132	$3.132	
75+	$3.132	$3.132	

**PLEASE NOTE: A Spouse's age band is based on the age band of the caregiver. It is not based on the spouses age band.*

You can calculate your Voluntary Life premium by using the following formula:

1. Find your age bracket in the chart above.
2. Find your rate per $1,000 of in the “Caregiver per $1,000” column for your age band.
3. Divide the amount of coverage you would like to purchase by 1,000 to determine the number of units you need.
4. Calculate your monthly premium by multiplying the rate per $1,000 by the number of units.
5. Calculate your annual premium by multiplying the monthly premium by 12.
6. Calculate your payroll deduction by dividing your annual premium by the number of pay periods in a year. If you have a bi-weekly payroll, you divide by 26.

How do I calculate what my life insurance will cost?
If you are 42 years old and you wish to purchase $100,000 worth of coverage, the calculation would be as follows:

- Age band is 40-44
- Rate per $1,000 is $0.185 based on the Caregiver Price per $1,000 column for that age band
- Number of units needed is $100,000 / $1,000 = 100
- Monthly premium would be 100 x $0.185 = $18.50
- Deductions for a bi-weekly payroll would be $222/26 = $8.54

Voluntary AD&D Insurance Pricing

Rates shown are your biweekly deduction.

	AD&D Cost Per	Monthly Rate
Caregiver	$1,000	$0.01
Spouse	$1,000	$0.01
Child	$1,000	$0.01

For Supplemental AD&D rates, simply divide the amount of Supplemental AD&D coverage you wish to purchase by 1,000, multiply that number by the Monthly Rate of $0.01. For the payroll deduction, times that number by 12 and divide by 26. Example below for $100,000 in AD&D coverage.

$100,000/$1,000=100 units x 0.01=$1.00 per month for $100,000 in coverage
$1.00 X 12/26=0.46 per pay period for $100,000 in coverage

RETIREMENT BENEFITS

401(k) Retirement Benefit

York Hospital provides caregivers with access to a 401(k) Retirement Plan. This plan allows you to make voluntary tax deferred contributions to your retirement plan. Your retirement plan funds – both interest and principal – will compound pre-tax. **You are eligible to enroll in this benefit on the first of the month following your eligibility date with York Hospital.** You can enroll at any time after that date. A post-tax (Roth) deferral option is also available.

There are many investment options available to you under York Hospital's 401(k) plan. The federal maximum contribution limit for 2021 is $19,500 per year. If you are age 50 or older, or will turn 50 by the end of the year, you may make additional "catch-up" contributions. Catch-up contributions allow you to save above the normal annual IRS limit on a pretax basis. If you take advantage of these catch-up, the total maximum contribution for 2021 is $26,000. You may also roll over contributions from most other plans.

Once your 401(k) plan has been established, you may be eligible to borrow against the funds on deposit. You may take no more than one (1) loan from the account at one time.

Employer Match

York Hospital will provide the following matching contributions into your 401(k) plan:

- At 2 years of service, the Hospital matches 25% of the first 6% of pay.
- At 5 years of service, the Hospital matches 50% of the first 6% of pay.
- At 15 years of service, the Hospital matches 50% of the first 7% of pay.

Sign Up Today!

To take advantage of contributing to York Hospital's 401(k), please go to www.empower-retirement.com to register for a user login. You also have available resources through Empower Retirement for individualized guidance and education. Go to https://eiseverywhere.com//ehome/184830 to sign up for a session. Please contact Caregiver Experiences and/or the Retirement Plan Document for more details.

EARNED TIME

York Hospital provides its eligible caregivers with the opportunity to use accrued Earned Time. This benefit is available for all eligible caregivers as of date of hire. Eligible caregivers are defined as those caregivers who are scheduled to work 20 or more hours per week. Per Diem, temporary, and limited part-time caregivers are eligible for limited earned time (ET).

ET is calculated based on your number of hours worked, plus any Earned Time that you have claimed, excluding overtime. Earned Time accumulates in your personal ET "bank", to be used as necessary. You may use your accumulated ET for vacation, holidays, sick time, and personal time away from work.

The most that you are allowed to accumulate in your current accruing ET bank is 320 hours. York Hospital does not require that you maintain a minimum balance in your ET bank.
Cash-in eligibility will be limited to two times per year, on the following dates:

- First pay date in April, cash-in to a maximum of 40 hours
- First pay date in November, cash-in to a maximum of 40 hours

Both banks of "old" and "new" ET are eligible for cash in each pay date listed above, to a total cash in of 80 hours. Cash In amounts will be paid as follows:

- Cash in of New, currently accruing bank will be paid out at the time of cash-in at 75% of current rate of pay
- Cash in of Old, non-accruing bank will be paid out at the time of cash-in at 100% of current rate of pay

Earned Time for eligible caregivers accrues throughout the year. The accrual rate increases with your length of service, as shown in the chart below:

Years of Service	Accrual Rate
0 to 2 years of service	0.081
2 to 10 years of service	0.100
10 or more years of service	0.120
25 years or more	0.1315

ET for Per Diem, Limited Part-Time, Temporary and Seasonal Caregivers

Developed in accordance to the Maine Paid Leave Act (effective 1/1/2021)

Rate	0.02/hr worked regardless of seniority
Max Bank	40 hrs
Limitations	No donation or cash-in Earned Time. ED, Walk-in and Hospitalist providers are excluded from accrual give ability to work a set number of shifts/yr and maintain regular earnings.

Note: Earned Time cannot be used over and above an employee's regular weekly hours. For example, a 36 hour per week employee that works 24 hours within a week can use up to 12 hours of Earned Time for that week.

ADDITIONAL BENEFITS

Holiday Pay

In addition, as an eligible caregiver, if you are an hourly paid Caregiver, you will receive premium pay if you work on the following holidays (please refer to York Hospital's Shift Differential policy for more details):

Holiday	Hours	Paid At
New Year's	5pm 12/31 - 5pm 1/1	Time and One Half
Memorial Day	9pm Sun. - 9pm Mon.	Time and One Half
Independence Day	9pm 7/3 - 9pm 7/4	Time and One Half
Labor Day	9pm Sun. - 9pm Mon.	Time and One Half
Thanksgiving	9pm Wed. - 9pm Thur.	Time and One Half
Christmas	5pm 12/24 - 7am 12/26	Double Time

Permanent Life Insurance

During the first enrollment after your initial eligibility date, you may enroll in coverage up to the stated limits, without having to answer medical questions or provide any evidence of insurability. If you do not enroll when you are first eligible, however, and you wish to do so in the future, evidence of insurability may be required. Family coverage is available for you, your spouse or domestic partner, and your eligible children.

Once enrolled, you hold this coverage at the same rate for your lifetime. The policy will build cash value.

Critical Illness Insurance

During the first enrollment this plan will pay lump sum dollars upon your diagnosis for covered conditions, such as heart attack, end-stage kidney (renal) failure, major organ failure, stroke, coronary artery disease, and cancer. You, your spouse, and your eligible children may be covered.

Benefits are paid directly to you to use however you wish (mortgage, groceries, bills, etc.). In addition, a wellness benefit is payable each year for preventive cancer screenings.

For more information, please contact The Farmington Company 1-800-621-0067. Additional details are available online at: www.farmingtonco.com. Under "Employees", click "Wish to Participate?" Click where indicated to log in. User ID: yor01 and Password: yor2009

Pet Insurance

Employees may purchase voluntary pet insurance through Nationwide. My Pet Protection from Nationwide offers flexibility allowing you to choose the plan that is best for you. Features include:

- You can see the vet of your choice, there isn't a network
- Pay the fee at point of service and remit invoice for reimbursement
- $250 annual deductible
- Annual maximum of $7,500
- The cost is based on pet species and zip code, not the age or breed
- Easy enrollment process

To learn more, go to PetInsurance.com/yorkhospital.

Section 529 Plan

A Section 529 Plan, or a NextGen account, is a college savings plan, operated by a state or educational institution. Section 529 Plans are regulated by the Internal Revenue CodeService (IRS). The goal of a Section 529 plan is to make it easier to save for college and other post-secondary training for a designated beneficiary, such as a child or grandchild.

What is NextGen?

The NextGen College Investing Plan is Maine's Section 529 Plan, with special benefits for Maine residents. It is used by thousands of Maine families to help plan and pay for higher education. Opening a NextGen account for your child (or yourself) is a real investment in the future. NextGen offers special benefits to Maine residents, including a one-time $200 Initial Matching Grant, a one-time $100 Automated Funding Grant and a NextStep Matching Grant up to $300 per year!

Withdrawals, including any earnings from a NextGen account, are federal and Maine state income tax-free, when used for qualified higher education expenses.

What can a NextGen account be used for?

NextGen account funds can be used to pay for qualified higher education expenses (as defined in the Internal Revenue Code) at any U.S.-accredited post-secondary school eligible to participate in federal student assistance programs. This may include graduate schools, trade schools, and some foreign institutions that participate in federal financial aid programs. Eligible post-secondary schools include two-year degrees (Associate's), four-year degrees (Bachelor's), and some certificate programs.

Who can open a NextGen account?

Any U.S. resident aged 18 and older may open a NextGen account on behalf of any future student. For example, a parent or grandparent can open an account on behalf of a child or grandchild. Adults can even open an account for themselves to start or continue their own education.

Are there other grants available?

Yes! The NextStep Matching Grant provides a 50% match on contributions, up to a $300 match per year to eligible Maine accounts. There is no lifetime maximum. The Automated Funding Grant is a one-time $100 grant for eligible Maine accounts that make at least six consecutive contributions through an automated funding option such as payroll deduction or a checking or savings account.

For more information and to learn how to open an account visit www.NextGenforME.com. Section 529 accounts are available as an option for direct deposit. Please log into www.dayforcehcm.com to add an account.

Tuition Assistance

York Hospital will provide eligible caregivers with financial support for taking college accredited courses. This benefit is available for all eligible caregivers as of date of hire. Eligible caregivers are defined as those members scheduled to work 20 or more hours per week. Per Diem and Temporary caregivers are not eligible for this benefit.

York Hospital will pay the tuition cost for eligible courses directly to the caregiver upon completion of the course. (Please note, however, that fees and books are not eligible for reimbursement under this program.) Courses taken must be either work related and/or bring value to the caregiver's current position and to the organization. Courses eligible for tuition reimbursement are subject to review by your Leader. Caregivers should complete the Tuition Reimbursement Request Process & Application which can be obtained by contacting Caregiver Experiences.

Procedure:

1. Complete Continuing Education Reimbursement Application - include specific on course and send to leader for approval - it is the Leader's responsibility to ensure the course falls under the policy guidelines.
2. Leader will send approved application to Human Resources for processing.
3. Upon complete of course, caregiver should submit final grade to Human Resources for reimbursement. If no grade is received or a grade of "D" or lower is received, the caregiver is responsible for payment as outline on application.

Caregivers are eligible for the following benefits under York Hospital's Tuition Assistance Plan:

Full Time Caregiver Benefit Amount (36 – 40 hours per week)

- $1,000 each six months or $2,000 per year
  - January – June
  - July – December

Part Time Caregiver Benefit Amount (20 – 35 hours per week)

- $500 each six months or $1,000 per year
  - January – June
  - July – December

For more information about York Hospital's Tuition Assistance Plan, please contact Caregiver Experiences or staff@yorkhospital.com.

GLOSSARY

Beneficiary – The person(s) who receive the proceeds from a life insurance policy or a retirement account upon the death of the insured. See also “contingent beneficiary.”

Caregiver - An eligible employee or staff member of York Hospital.

Co-insurance – The percent of a claim the insured pays until the out-of-pocket maximum is reached.

Contingent Beneficiary – The person(s) who receive the proceeds from a life insurance policy or a retirement account upon the death of the insured if the primary beneficiary is unable to receive them.

Co-payment or Co-pay – A fixed out-of-pocket amount the insured must pay for certain services, such as doctor’s office visits or medications.

Deductible – The amount of money that the insured must pay out of pocket before an insurance company will pay a claim.

Elimination Period – With disability insurance, this is the time period between an injury and the receipt of benefit payments. In other words, it is the length of time between the beginning of an injury or illness and receiving benefit payments from an insurer.

Flexible Spending Account (FSA) - A special account into which you can put pre-tax money in to pay for certain out-of-pocket health care costs.

Health Maintenance Organization (HMO) – A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. With an HMO, the primary care physician typically coordinates your healthcare services. For most HMO plans, you’ll need a referral from your primary care physician to see any other healthcare provider (except in an emergency) for the services to be covered by the health plan.

Health Reimbursement Arrangement (HRA) – An employer-funded health benefit that helps employees pay for medical expenses.

Health Savings Account (HSA) – A type of savings account that can be used with a designated high-deductible health plan (HDHP) that lets you set aside money on a pre-tax basis to pay for qualified medical expenses.

High-deductible Health Plan (HDHP) – A health insurance plan in which the insured is responsible for covering a greater portion of medical expenses in exchange for lower premiums.
In-network Provider – A provider network is a list of the doctors, other healthcare providers, and hospitals with which a plan has contracted to provide medical care to its members. These providers are called “network providers” or “in-network providers.”

Out-of-network Provider – A provider network is a list of the doctors, other healthcare providers, and hospitals with which a plan has contracted to provide medical care to its members. Providers that are not part of this network are considered "out-of-network." Most (but not all) health plans offer out-of-network coverage, but out-of-pocket costs are higher.

Out-of-pocket Maximum – The out-of-pocket maximum is the most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.

Point-of-service (POS) – A type of managed care health insurance plan that combines characteristics of the health maintenance organization (HMO) and the preferred provider organization (PPO).

Pre-existing Condition – Any condition for which the patient has already received medical advice or treatment prior to enrollment in a new medical insurance plan. Health insurers can no longer charge more or deny coverage to you or your child because of a pre-existing health condition.

Preferred Provider Organization (PPO) – A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network.

Prescription Formulary – A drug formulary is a list of prescription drugs, both generic and brand name, used by practitioners to identify drugs that offer the greatest overall value. With most health plans, you will pay less out of pocket in co-pays or co-insurance to use medications that are included on the formulary. Prescription coverage is sometimes referred to in "tiers."

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – 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)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN–Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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, 2020, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy.

If WHCRA applies to you and you are receiving benefits in connection with a mastectomy and you elect breast reconstruction, coverage must be provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.

This law applies to two different types of coverage:

1. Group health plans (provided by an employer or union);
2. Individual health insurance policies (not based on employment).

Group health plans can either be "insured" plans that purchase health insurance from a health insurance issuer, or "self-funded" plans that pay for coverage directly. How they are regulated depends on whether they are sponsored by private employers, or state or local ("non-federal") governmental employers. Private group health plans are regulated by the Department of Labor. State and local governmental plans, for purposes of WHCRA, are regulated by CMS. If any group health plan buys insurance, the insurance itself is regulated by the State's insurance department.

Contact your employer's plan administrator to find out if your group coverage is insured or self-funded, to determine what entity or entities regulate your benefits. Health insurance sold to individuals (not through employment) is primarily regulated by State insurance departments.

WHCRA requires group health plans and health insurance companies (including HMOs), to notify individuals regarding coverage required under the law. Notice about the availability of these mastectomy-related benefits must be given:

1. To participants and beneficiaries of a group health plan at the time of enrollment, and to policyholders at the time an individual health insurance policy is issued; and
2. Annually to group health plan participants and beneficiaries, and to policyholders of individual policies.

Contact your State's insurance department to find out whether additional state law protections apply to your coverage if you are in an insured group health plan or have individual (non-employment based) health insurance coverage.

WHCRA does not apply to high risk pools since the pool is a means by which individuals obtain health coverage other than through health insurance policies or group health plans.

WHCRA does NOT require group health plans or health insurance issuers to cover mastectomies in general. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.

Note: A non-Federal governmental employer that provides self-funded group health plan coverage to its employees (coverage that is not provided through an insurer) may elect to exempt its plan (opt out) from the requirements of WHCRA by following the "Procedures & Requirements for HIPAA Exemption Election" posted on the Self-Funded Non-Federal Governmental Plans webpage at http://cms.gov/cciio/resources/files/hipaa_exemption_election_instructions_04072011.html. This includes a requirement to issue a notice of opt-out to enrollees at the time of enrollment and on an annual basis. For a list of plans that have opted out of WHCRA, go to http://cms.gov/cciio/resources/other/index.html#nonfed and click on "List of HIPAA Opt-out Elections for Self-funded Non-Federal Governmental Plans."

If you have concerns about your plan's compliance with WHCRA, contact our help line at 1-877-267-2323 extension 6-1565 or at phig@cms.hhs.gov.

NOTICE OF CREDIBLE COVERAGE

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

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

York Hospital has determined that the prescription drug coverage offered by the Health Plan Option 1 and Option 2 plan's deductible is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

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

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your coverage with York Hospital will not be affected.

If you keep the prescription drug coverage offered under York Hospital Plan, you will continue to receive all the medical and prescription drug benefits available under the plan.

If you drop the prescription drug coverage provided through York Hospital Plan, coverage of your other medical benefits under the Plan will also be terminated since these benefits are provided on a combined basis.

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

When Will You Pay A Higher Premium (Penalty) To Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with York Hospital and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage…
See below for further information. 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 York Hospital changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage: Visit www.medicare.gov
- Call your State Health Insurance Assistance Program
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	January 1, 2021
Name of Entity/Sender:	York Hospital
Contact—Position/Office:	Matt Bennett- Caregiver Experiences MBennett@yorkhospital.com or (207) 351-2228

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Employer is committed to protecting the privacy of personal and health information (as defined below) maintained by the Group Health Plans it sponsors for the benefit of its employees and the employees of its affiliates and subsidiaries (collectively referred to as the "Plan").

This Notice of Privacy Practices describes how personal and health information may be used and disclosed. It also describes your rights to access and control your information.

The Plan is required by law to protect the privacy of personal and health information and to provide you with a copy of this notice which describes the Plan's privacy practices. If you have any questions about this notice or would like further information, please contact your Employer's Privacy Officer.

The Plan may make a change to this notice at any time, as long as the change is consistent with applicable state and federal law. If the Plan makes an important change to this notice, the Plan will notify you by mail or electronically as permitted by applicable law. The Plan may also post the revised notice on its web site.

This notice is effective December 1, 2020 and supersedes the notice dated September 16, 2013.

WHAT IS PERSONAL AND HEALTH INFORMATION?

Personal and Health Information (referred to as 'information' elsewhere in this notice) includes protected health information (PHI) and individually identifiable information like your name and social security number. PHI is health information related to your physical or behavioral health condition used in providing health care to you or for payment for health care services. The Plan protects all forms of information including electronic, written and verbal information.

TO WHOM WILL THE PLAN DISCLOSE MY INFORMATION?

The Plan may disclose information to:

- The Plan's Business Associates and Business Partners:
  - The Plan may contract with other organizations to provide services on the Plan's behalf (e.g., a third party administrator of your health benefits). In these cases, the Plan will enter into an agreement with the organization explicitly outlining the requirements associated with the protection, use and disclosure of your information. These agreements are referred to in this notice as "Business Associate Agreements".

- Your Family and Others:
  - When you are unavailable to communicate, such as during an emergency
  - When you have previously indicated an individual is your personal representative
  - When the information is clearly relevant to their authorized involvement with your health care or payment for health care. For example, the Plan may confirm a claim has been received or paid if an individual has prior knowledge of the claim.
  - When sharing information about Plan benefits available or your Plan identification number with a spouse or close personal friend who wishes to provide this information to a medical health care professional administering your case.
  - When sharing a minor's information with parents who have custodial rights when the information is not further restricted by pertinent state or federal law. Information related to any care a minor may seek and receive without parental consent remains confidential unless the minor authorizes disclosure.

- Your Providers and Others Involved in Your Care:
  - The Plan may share information with those involved in your care for quality initiatives, safety concerns and coordination of care. Examples include state-mandated quality improvement initiatives, results of laboratory tests not otherwise restricted by law, and clinical reminders sent to your primary care provider.
  - Your Plan's third party claims administrator
  - When providing certain portions of your information to your Employer as the sponsor of the Plan, for purposes related solely to the Plan's administration. The Employer shall not use any Plan-related information for any purposes unrelated to Plan administration, including without limitation for employment-related actions or decisions. The Employer may only disclose your information to third parties, such as to consultants or advisors, if the Employer has first obtained a Business Associate Agreement from the person or organization receiving your information.

HOW WILL THE PLAN USE AND DISCLOSE MY INFORMATION?

In order to provide coverage for treatment and to pay for those services, the Plan needs to use and disclose your information in several different ways. The following are examples of the types of uses and information disclosures the Plan is permitted to make without your authorization:

FOR PAYMENT

The Plan will use and disclose your information to administer your Plan benefits. This may involve the determination of eligibility, claims payment, utilization review activities, medical necessity review, coordination of benefits, appeals and external review requests.

Examples include:

- Paying claims under the Plan for services received by participants
- Sending information to an external medical review company to determine the medical necessity or experimental status of a treatment
- Sharing information with other insurers to determine coordination of benefits or settle subrogation claims
- Providing information to the Plan's utilization review company for precertification and utilization management services
- Providing information in the billing, collection and payment of premiums and fees to Plan vendors

FOR HEALTH CARE OPERATIONS

The Plan may use and disclose your information for operational purposes, such as care management, coordination of care, quality assessment and improvement, cost analyses, and underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. Examples include:

- Assessing the quality of care and outcomes for Plan participants
- Conducting quality assessment studies to evaluate the Plan's performance or the performance of a particular network or vendor
- The use of information in determining the cost impact of benefit design changes
- The disclosure of information to underwriters for the purpose of calculating premium rates and providing reinsurance quotes to the Plan (The Plan will not use or disclose any genetic information it might otherwise receive for underwriting purposes.)
- The disclosure of information to stop-loss or reinsurance carriers to obtain claim reimbursements to the Plan
- Disclosure of information to Plan consultants or brokers who provide legal, actuarial and auditing services to the Plan
- Use of information in general data analysis used in the long term management and planning for the Plan
- Engaging in wellness programs, preventive health, early detection, disease management, health risk assessment participation initiatives, case management and coordination of care programs, including sending preventive health service reminders
- Facilitating transition of care from and to other insurers, health plans or third party administrators
- Other general administrative activities, including data and information systems management, risk management, auditing and detection of unlawful conduct

FOR TREATMENT

Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. It also includes but is not limited to consultations and referrals between one or more of your providers. The Plan may disclose your information to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers) in connection with your treatment. The Plan does not provide treatment. On occasion, the Plan may be required to provide information about you to your providers in order to facilitate treatment.

For example, prior to providing a health service to you, your doctor may ask the Plan for information concerning whether and when the service was previously provided to you.

FOR OTHER PERMITTED PURPOSES

The Plan may use or disclose your information for the following permitted purposes:

- For research subject to certain conditions
- To comply with laws and regulations related to Workers' Compensation.
- For public health activities such as assisting public health authorities with disease prevention or control and with injury or disability control. This can include data collection by state government-mandated or -sponsored consortiums or public health authorities. The Plan may also disclose your information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits the Plan to do so.
- For health oversight activities data may be submitted to a government agency authorized to oversee the health care system or government programs, or to its contractors. Examples include the U.S. Department of Health and Human Services (HHS), a state insurance department or the U.S. Department of Labor for activities authorized by law, such as audits, examinations, investigations, inspections and licensure activity.
- In response to a court order or an administrative tribunal and, in certain cases, in response to a subpoena, discovery request or other lawful process.
- To funeral directors or coroners so they can carry out their lawful duties. The Plan may also disclose information about a decedent to the executor, administrator or other person with authority to act on behalf of the decedent's estate.

OTHER REQUIRED USES AND DISCLOSURES

The Plan may use and disclose information about you as required by law. Examples of such situations include:

- To report information related to victims of abuse, neglect or domestic violence
- To prevent serious threat to your health or safety or that of another person
- To authorized federal officials for national security purposes. In addition, under certain conditions, the Plan may disclose your information if you are or were a member of the Armed Forces, for those activities deemed necessary by appropriate military authorities.
- For inmates, to a correctional institution or a law enforcement official having lawful custody, if the provision of such information is necessary to provide you with health care, protect your health and safety, and that of others, or maintain the safety and security of the correctional institution.

WILL THE PLAN USE OR DISCLOSE MY INFORMATION IN WAYS NOT DESCRIBED IN THIS NOTICE?

Other than the uses previously listed, your information will only be used or disclosed with your written authorization. You may revoke such an authorization at any time in writing, except to the extent the Plan has already taken an action based on a previously executed authorization.

To authorize the Plan to use or disclose any of your information to a person or organization for reasons other than those described in this notice, please contact your Employer's Privacy Officer to obtain and complete an authorization form.

The Plan will not use or disclose your information for marketing without your written authorization. Marketing means a communication to encourage you to purchase or use a product or service. Marketing does not include communications about refill reminders or drugs you currently use, case management or care coordination, descriptions about your plan of benefits and related information, and information about treatment alternatives. The Plan will not sell your information without your written authorization.

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

WHAT RIGHTS DO I HAVE REGARDING MY INFORMATION?

- **Access and Control of Your Information**.- The Plan must provide you certain rights with respect to access and control of your information. You have the following rights to access and control your PHI:

    - **Access and receive copies of your information** - You have the right to receive a copy of your information, once you provide the Plan with specific information to fulfill your request. You may ask for an electronic copy of your information and the Plan will provide it if the information is maintained electronically. Information will be provided in the form and format you request, if it is readily producible in such form and format; or if not, in a readable hard copy form or such other form and format as agreed to by you and the Plan. The Plan reserves the right to charge a reasonable fee for the cost of producing and mailing copies of such information.

    - **Amend your information** - If you believe your information is incorrect or incomplete, you have the right to ask the Plan to amend it. In certain cases, the Plan may deny your request and provide you with a written explanation. For example, the Plan may deny a request if the Plan did not create the information, as is often the case for medical information that was generated by a provider, or if the Plan believes the current information is correct.

    - **Confidential communications** - The Plan recognizes you have the right to receive communications regarding your information in a manner and at a location that you feel is safe from unauthorized use or disclosure. To support this commitment, the Plan will permit you to request your information by alternative means or at alternative locations. The Plan will attempt to accommodate reasonable requests.

    - **Accounting of disclosures** - You have the right to request an accounting of those instances in which the Plan or our Business Associates have disclosed your information, during the 6 years prior to the date of your request, for purposes other than treatment, payment or health care operations, or other permitted or required purposes. The Plan will require specific information needed to fulfill your request. If you request an accounting more than once in a 12-month period, the Plan may charge you a reasonable fee.

    - **Restrictions** - You have the right to ask the Plan to place restrictions on the way it is permitted to use or disclose your information. The Plan is not, however, required by law to agree to these requested restrictions. If the Plan does agree to a restriction, the Plan will abide by the restriction unless it is related to an emergency.

- **Personal Representatives** - You have the right to name a personal representative who may act on your behalf to control the privacy of your information. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your information or allowed to take any action for you. Proof of such authority may take one of the following forms:
    - a power of attorney for health care purposes, notarized by a notary public;
    - a court order of appointment of the person as the conservator or guardian of the individual;
    - or an individual who is the parent of a minor child.

In addition, you will be required to complete a form to name a personal representative. Please contact your Employer's Privacy Officer for assistance.

- **Notice of Privacy Practice** - You have the right to receive a paper copy of this Notice of Privacy Practices upon request at any time, even if you have already received it electronically or have previously agreed to receive it electronically.

- **Rights under state law** - You may be entitled to additional rights under state law to the extent state law applies to the Plan. The privacy laws of a particular state might impose a privacy standard under which the Plan will be required to operate.

- **Right to be notified of a breach** - You have the right to be notified of a breach of your unsecured information.

- **How do I exercise my rights?**
  You can exercise all of your privacy rights by contacting your Employer's Privacy Officer. To the extent that the Plan has provided all of your information to a Business Associate (e.g., a third party administrator of your health benefits) you must request access directly from such Business Associate. Please contact your Employer's Privacy Officer for assistance with a request from a Business Associate.

- **What do I do if I feel my rights have been violated?**
  If you believe your privacy rights have been violated, you may file a written complaint with your Employer's Privacy Officer.

You may also notify the Secretary of the Department of Health and Human Services (HHS). Send your complaint to:

Medical Privacy, Complaint Division Office for Civil Rights (OCR)
U.S. Department of Health and Human Services 200 Independence Avenue SW
Room 509F, HHH Building Washington, DC 20201.

You may also call OCR's Voice Hotline at
(800) 368-1019 or you can find more information at www.hhs.gov/ocr.

The Plan will not take retaliatory action against you for filing a complaint.

PRIVACY NOTICES

Health Insurance Portability and Accountability Act (HIPAA) Privacy

York Hospital will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations, and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of York Hospital.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan, your insurer, or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Newborns' and Mother's 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).

Mental Health and Addiction Equity Act

Under a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), many health plans and insurers must make sure that there is "parity" between mental health and substance use disorder benefits, and medical and surgical benefits. This generally means that treatment limits applied to mental health and substance use disorder benefits must be at least as generous as the treatment limits applied to medical and surgical benefits. In other words, treatment limits cannot be applied to mental health and substance use disorder benefits unless those limits are comparable to limits applied to medical and surgical benefits. The types of limits covered by parity protections include:

- Financial requirements – such as deductibles, copayments, coinsurance, and out-of-pocket limits;
- Treatment limits– such as limits on the number of days or visits covered, or other limits on the scope or duration of treatment (for example, being required to get prior authorization to get treatment).

The medical benefits offered through the York Hospital are compliant with state and federal mental health parity.

Health Insurance Marketplace Notice of Coverage Options

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Caregiver Experiences (207-351-2228 or staff@yorkhospital.com).

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

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

CONTACT INFORMATION

Medical
Anthem. - 833-678-1093
www.anthem.com

Prescription Drug
RxBenefits – 800-334-8134
www.express-scripts.com

Dental
Delta Dental - 800-832-5700
www.nedelta.com

Vision
Delta Dental (EyeMed) - 866-723-0513
www.eyemedvision.com

Flexible Spending Accounts
Group Dynamic, Inc. - 800-626-3539
www.gdynamic.com

Life Insurance & Long-Term Disability Insurance
The Prudential – 800-598-5671
www.Prudential.com

Short-term Disability
For claim initiation or claim status, please contact Prudential at 1-800-842-1718.
For benefit payment information, please contact Caregiver Experiences at 207-351-2228 or staff@yorkhospital.com.

Caregiver Support Program
ComPsych - 800-311-4327
www.guidanceresources.com

Retirement Plans
Empower Retirement - 800-338-4015
www.empower-retirement.com

Pet Insurance
Nationwide - 877-738-7874
www.petinsurance.com/yorkhospital

Permanent Life & Critical Illness
The Farmington Company - 800-621-0067
www.farmingtonco.com

HSA
Empower - 800-331-5455
www.empowermyretirement.com

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