Regional One Health

2025 Benefits Guide

MY ONE LIFE

EMPLOYEE HEALTH AND WELL-BEING

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Caring for the health and wellbeing of our plan members is a privilege, and the Regional One Health Benefits Plan is designed with you in mind. In these pages, you will find an extensive list of options to help enhance your life – both at work and beyond.

This benefit enrollment guide is only intended to highlight some of the major benefit provisions of the company plan and should not be relied upon as a complete detailed representation of the plan. Please refer to the Plan's Summary Plan Descriptions for further detail. Should this guide differ from the Summary Plan Descriptions, the Summary Plan Descriptions prevail.

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Now More Than Ever, Benefits with YOU in Mind

Dear Regional One Health Employees,

At Regional One Health, we are proud to care for a community that relies on our ability to specialize in tomorrows for their own health and healing. As we continue to grow and move closer to realizing our vision of a new academic medical center, we are reminded every day that our strength lies in the dedication of the people who do this important work. You are the heart of this organization, and together, we're shaping a stronger future.

Just as we provide compassionate care to our patients, we are committed to providing you with the support you need to thrive. The benefits offered to you reflect our desire for you to be healthy, fulfilled, and supported—both in your personal and professional life. Whether it's through our healthcare services, wellness programs, or supplemental offerings, we aim to help you build your own "tomorrow" with the resources and security you deserve. We have enhanced our benefits with a program called LifeBalance, available for all employees to help you enjoy savings on caregiving services, exercise, adventure, healthy eating, stress and relaxation management and more. And this year, we are proud to share that there will be no rate increase for the exceptional plan offerings available.

As we look ahead, we're on this journey together — growing, innovating, and creating a better tomorrow not just for our patients, but for each of you as well. Please take the time to review this year's benefits guide carefully so you can make the best decisions for yourself and your family. While there are some updates to our plans, we've worked hard to ensure that these changes continue to prioritize your well-being and minimize any financial impact.
Thank you for your ongoing dedication to Regional One Health and the incredible care you provide every day. We are committed to supporting you in all that you do, and I'm excited for what we will accomplish together as we continue to build a brighter future for our community and for ourselves.

With sincere gratitude and a shared commitment to tomorrow,

Dr. Reginald Coopwood
President and CEO

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Glossary of Insurance Terms

Benefits can be confusing. This Glossary of Insurance Terms includes key terms you'll find alongside Health and Life insurance products. Familiarizing yourself with the insurance language before you enroll will help you make better benefits decisions for you and your family, be financially prepared for the unexpected, and use your benefits more effectively.

Beneficiary

Person to whom the proceeds of a life or accident policy are payable when the insure dies.

Cash Value

The equity amount of savings accumulated in a permanent life policy.

Dependent

A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction.

Guarantee Terms

If you apply for insurance, you're not required to answer health questions to quality for coverage up to a certain amount.

Elimination Period

The period of time an insured must wait before recieving benefits.

Enrollment Period

Period which new employees can sign up for coverage under a group insurance plan without proof or insurability.

Estate

All the money and property owned by a particular person, especially at death.

Lapse

Termination of a policy upon the policymaker's failure to pay the premium by the end of the grace period.

Pre-Existing Condition

An illness or medical condition that existed before a policy's effective date.

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Options to Consider

COBRA

Extends group health coverage to an employee who loses their job. Coverage may also be extended for family members who lose coverage for various reasons such as death or divorce.

Non-Preferred Provider

A provider who does not have a contract with your insurance carrier or plan to provide services to you. You'll pay more to see a non-preferred provider. (i.e. "out-of-network").

Portability

If you leave your employer, you can keep your coverage and pay the insurance company directly.

Preferred Provider Organization (PPO)

Health care providers, such as doctors and hospitals, who agree to provide health care to members of a particular group at a discounted rate.

Costs to Understand

Deductible

The dollar amount the insured is responsible for paying before the insurance plan starts to pay.

Coinsurance

The insured's share of the cost of a service (usually a percentage) after paying the plan's deductible.

Copayment

A fixed dollar amount for things such as a doctor visit or prescription drug you must pay at the time you receive the service.

Out-of-Pocket Maximum

The limit or the most you'll pay out of your own pocket for services during the insurance plan period.

Premium

The amount you pay for your insurance plan each month.

Knowing the insurance terms will help you understand what is being offered to you. Enrolling in the benefits that are the right fit for you and your family helps support your health and financial future.

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Eligibility & Enrollment

Benefits are an important part of your overall compensation package. Regional One Health offers you the opportunity to enroll in many different plans. You may decide what is important for you and your family and choose the plan(s) that meet your benefits needs.

Who Can Enroll?

ELIGIBILITY

All full-time and critical part-time employees and their eligible dependents may participate in the benefits program. **Eligible dependents include:**

- **Your spouse, if eligible** (please refer to our spouse affidavit to determine eligibility)
- **You or your spouse's children under age 26** including natural, legally adopted, and step-children as well as children for whom you or your spouse are the legal guardian.
- **You or your spouse's children of any age who depend on you for financial support because of a physical or mental disability.** This must have been established prior to age 18 or while an eligible dependent.

Note: If you are covered by another plan outside of Regional One Health and do not want to enroll in the Regional One Health medical plan, please provide documentation of your medical insurance to your HR department.

QUALIFYING LIFE EVENTS (QLE)

Qualifying Life Events (QLE) are determined by the IRS and could allow you to enroll in health insurance or change your benefit elections outside of annual Open Enrollment. Some of the most common include:

- **Change in your marital status:** Marriage, divorce, or legal separation (based on state law)
- **Change in your number of dependents:** Birth, adoption, or if a child is no longer eligible as a dependent
- **Change in your employment status:** Resulting in loss or gain of coverage
- **Change of address** that results in a change in coverage
- Eligibility for coverage through the Marketplace
- Entitlement to **Medicare or Medicaid**

Note: When a QLE occurs, you have 30 days to request changes to your coverage. Keep in mind your change in coverage must be consistent with your change in status. Additionally, supporting documentation is required for QLE approval.

NEW HIRE ENROLLMENT

Welcome to our team! As an employee, you play a tremendous part in our company's success. This is why a core tenant of our business strategy is to ensure you are offered an attractive and competitive benefits package. This benefits guide provides a summary of all the health and welfare benefits offered to you. As a new employee, **the effective date for coverage is the first of the month following your hire date. If you do not enroll in benefits during your new hire period (30 days from start date), you will not be eligible to enroll in benefits until open enrollment unless you experience a qualifying life event.**

Eligibility & Enrollment (cont.)

Benefits are an important part of your overall compensation package. Regional One Health offers you the opportunity to enroll in many different plans. You may decide what is important for you and your family and choose the plan(s) that meet your benefit needs.

How to Enroll

Self-Enroll

Follow these steps to access your account and enroll on your own.

- Visit **https://www.chc-now.com/roh** or scan the QR code to access the benefits enrollment portal.
- You will log in with **your social security number as your username.** Your PIN is the **last 4 digits** of your social security number plus the **last 2 digits** of your birth year.
- Once logged in, you will confirm personal information and add dependents. Then you may begin enrolling in your benefits.

Virtual - Benefits Coach

Benefits Coaches are available by phone to guide you through your benefits package.

- **Schedule a 30-minute phone call** with a Benefits Counselor by scanning the QR code or by visiting:
- If you are **enrolling dependents** have supporting documentation ready. Adding a dependent requires their SSN card and Birth Certificate. You will have to confirm their information with the following documents as applicable:
- Social Security Card – SSN
- Marriage License
- Birth Certificate
- Adoption Papers
- Court order
- Grandchild Affidavit Verification Document
- Disabled Dependent Verification Document

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Know B4 You Go!

If you only read one page of this guide, make it this one!

What does it mean to **"know B4 you go?"** It means that by carefully reviewing your medical care and coverage options, you are ensuring to spend as little of your own money as possible, while getting the best possible care for yourself and your family.

Search for providers here:

- https://www.regionalonehealth.org/provider-search/
- https://www.regionalonehealth.org/ut-regional-one-physicians-search/
- https://bcbst..com

Regional One Health Network

The no-cost physician visits are available to you, as outlined on page 9. Visit Regional One Health for care and services **with no deductible, coinsurance, or copay charges** to you (ER and some pharmaceutical copays may apply). **Services must be provided by Regional One Health "in-network" providers** to be eligible. For 2025 – prescriptions written by external providers will incur a small copay even if filled at an ROH pharmacy. Additionally, the in-patient Urgent Care Clinic and Health & Wellness Clinic are now a part of the ROH Network.

Health & Wellness Clinic Now Open on the Main Campus
901-515-4991
Monday-Thursday 7:30 a.m. - 4:30 p.m.
Friday – 7:30 a.m. - 12:00 p.m.

Teladoc Virtual Care

For medical plan enrollees only. The telemedicine option outlined on page 15. This benefit provides you the luxury of visiting with a doctor from the comfort of your own home. Let's say your child becomes sick on Saturday morning. You can log in and use your smart phone or other webcam device to visit with a doctor before you do anything else. **No line, no waiting, and no cost to you.**

Blue Cross Blue Shield Network

The lower-cost physician visits available to you, as outlined on page 10 of the Medical Benefits summary. If you don't want to use the no-cost services available through ROH, you have a low-cost menu available. **Care or services provided by Blue Cross Blue Shield S Network will have charges applied as in the benefit summary.** Please refer to the plan's Summary Plan Descriptions for further details.

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Filing a Claim

Benefits Coach:
Monday-Friday 9 a.m-5 p.m.
800-884-6617 support@chc-now.com
Scan QR for available appointments

Benefits Coaches are available to assist you with enrollment, activation, and on-going use of your benefits. Additionally, the carrier contact information is listed below to help make filing a claim convenient.

Prudential

Voluntary Term Life • Long Term Disability

Monday-Friday 7AM-5PM CST: 800-842-1718 (LT) 800-524-0542 (Life) 844-455-1002 (Voluntary)

1. Visit the Prudential Benefits Portal https://mybenefits.prudential.com/mybenefits/nonssocontroller/newUserReg.htm
2. Use "**Shelby County Health Care Corp**" as the company name, NOT Regional One Health.
3. Register by using your DOB and SSN.

Trustmark

benefits beyond benefits

Universal Life Insurance with Long-Term Care • Short - Term Disability • Critical Illness • Accident Insurance • Hospital Indemnity

Monday-Friday 7AM-6PM CST: 847-615-1500

1. Visit the Trustmark Benefits Portal https://www.trustmarkbenefits.com/claims
2. Enter your SSN, name, and DOB
3. Include all necessary documentation

Find Your Carrier Here:

BlueCross BlueShield Medical 800-565-9140 Monday-Friday: 7AM - 5PM bcbst.com	**Delta Dental of TN** Dental 800-223-3104 www.DeltaDentalTN.com	**Davis Vision** Monday-Friday: 7AM-10PM Saturday: 8AM-3PM Sunday: 11AM-3PM 800-999-5431 davisvision.com	**Empower** Retirement 800-338-4015 empower-retirement.com	**Pinnacle** Flexible Benefits Plan 888.282.2605 pnfp.com
Trustmark 800-918-8877 customcare@trustmarkbenefits.com	**Transamerica** 888-763-7474 TEBcustrep@transamerica.com	**Prudential** Long Term Disability 800-842-1718 prudential.com	**Spot Pet Insurance** 800-905-1595 https://spotpet.link/regionalonehealth	
Livinti (Southern Scripts) 24/7: 800-710-9341 southernscripts.net	**Supportlinc** 24/7: 888-881-5462 supportlinc.com	**Sustainable Health Index** startshi.com	**3P Risk Strategies** 844-477-7467 3prisk.com	
Matrix Leave of Absence 877-202-0055 matrixabsence.com	**Teladoc Health** 24/7: 1(800)835-2362 teladoc.com	**Memphis Municipal Credit Union** 901-528-2816 mmefcu.org	**Orion Federal Credit Union** Monday-Friday: 8AM-6PM orionfcu.com	

Medical Benefits Summary

of Tennessee

For many of us, nothing is more important than our health and the health of our family members. This is why Regional One Health offers a robust medical insurance program to our employees. Regional One Health has a carrier partnership with BlueCross BlueShield of Tennessee (BCBST). **If you need assistance, call 800-468-9698.**

Provider Network	Regional One Health Provider Network Partnership	PPO Plan; BCBST Network S Baptist Network	Out-of-Network
Annual Deductible		**Embedded**	**Embedded**
Employee Only	**$0**	$1,250	$2,000
Employee + 1	**$0**	$1,750	$3,500
Employee + 2 or more	**$0**	$2,050	$4,400
Annual Out-of-Pocket Maximum		**Includes Deductible**	**Includes Deductible**
Employee Only	$1,000	$2,500	$6,250
Employee + 1	$2,000	$4,500	$12,250
Employee + 2 or more	$2,000	$4,500	$12,250
Preventative Care	Covered 100%	Covered 100%	Deductible plus 50%
Physician Office Visit			
Primary Care	**$0**	$20	Deductible plus 50%
Specialist	**$0**	$50	Deductible plus 50%
Hospital Visits			
Inpatient	**$0**	Deductible plus 20%	Deductible plus 50%
Emergency	$250	$250	$250
Maternity	**$0**	Deductible plus 20%	Deductible plus 50%
Advanced Diagnostic Imaging	**$0**	Deductible plus 20%	Deductible plus 50%
Lab/X-Ray	**$0**	Deductible plus 20%	Deductible plus 50%

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2025 Medical Premiums

of Tennessee

Medical and Rx Premiums (26 pay periods)

Salary <$39,999	Non-Tobacco (non-nicotine) Employee Premium	Tobacco (nicotine) Employee Premium
Employee Only	$69.69	$97.38
Employee + Spouse	$209.54	$237.23
Employee + Child(ren)	$147.69	$175.38
Family	$246.92	$274.62
Salary $40,000 - $84,999	**Non-Tobacco (non-nicotine) Employee Premium**	**Tobacco (nicotine) Employee Premium**
Employee Only	$84.71	$112.40
Employee + Spouse	$254.70	$282.39
Employee + Child(ren)	$179.52	$207.21
Family	$300.14	$327.83
Salary $85,000 - $129,999	**Non-Tobacco (non-nicotine) Employee Premium**	**Tobacco (nicotine) Employee Premium**
Employee Only	$84.71	$112.40
Employee + Spouse	$254.70	$282.39
Employee + Child(ren)	$179.52	$207.21
Family	$300.14	$327.83
Salary >130,000	**Non-Tobacco (non-nicotine) Employee Premium**	**Tobacco (nicotine) Employee Premium**
Employee Only	$96.26	$123.95
Employee + Spouse	$289.43	$317.12
Employee + Child(ren)	$204.00	$231.69
Family	$341.06	$368.75

Note: Premiums are deducted the same month as the benefits coverage.

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Tobacco/Nicotine Cessation Program

In a continuing commitment to promote good health, Regional One Health will reward employees and spouses who do not use tobacco products or products which deliver nicotine and who are enrolled in the medical plan, by offering a lower monthly medical premium.

If you and your spouse currently use tobacco products or products which deliver nicotine and you are unable or it is unreasonably difficult to quit, you may participate in the Blue Cross Blue Shield of Tennessee (BCBST) tobacco cessation program and reduce your monthly medical insurance premium.

Upon completion of the tobacco cessation program, you will be eligible for the lower medical monthly medical insurance premium on the following pay check.

Please note tobacco includes cigarettes, vaporizer pens, e-cigarettes, cigars, pipes, and smokeless chewing tobacco.

Follow these steps below in order to complete the tobacco cessation program and receive non-tobacco rates.

1. **Create a user account on the BCBS website (www.bcbst.com)**
2. **Choose "Managing your Health," Member Wellness Center**
3. **Click on "X" in the corner of the pop-up box to dismiss the Personal Health Assistant**
4. **Click on the icon in top left corner**
5. **Click on "Self-Guided Programs" and Choose *Quitting Tobacco***
6. **Complete the entire six-week program to earn your certificate**
7. **Once you complete your course click on certificates, print or save as a PDF and send to the Benefit Department at benenrollment@regionalonehealth.org**

We can help you live a healthier life.

You can start your journey toward a tobacco-free life today. Log in to BlueAccess℠ and choose **Managing your Health.** Or give us a call. We're here to help. **Call us at 1-866-498-9806 today.**

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Prescription Drug (Rx) Plan

The Rx plan is designed to optimize medication therapy, be a convenient service, and provide the needed medications at a lower cost. The Rx program allows for the purchase of many prescription medications through the on-site retail pharmacy with **no copay if the script was written by an ROH provider.** The plan is designed to provide substantial savings to active employees, spouses, and dependents enrolled in Regional One Health insurance plan. Medications not covered by Regional One Health insurance plan or written by an external provider, as well as certain specialty medications will have a payment due.

Most prescriptions can be filled at the Regional One Health Outpatient Pharmacy. Our team will work diligently to make sure your prescriptions are filled quickly and conveniently.

All specialty medications must be filled at the Regional One Health Outpatient Pharmacy.

ROH PHARMACIES

- Main Campus: 880 Madison Avenue, Ground Floor, 901-545-7970
- East Campus: 6555 Quince Road, Ground Floor, 901-515-5656
- Primary Care Specialists: 3109 Walnut Grove Road, 901-515-3430
- South 3rd Street (*Inside Cash Saver*): 1977 South 3rd Street, 901-515-4646,

Souther Scripts/Liviniti Pharmacy

- Liviniti is Regional One Health's prescription drug vendor. You will receive a separate pharmacy card.
- Liviniti: 800-552-6694

Mail Order Pharmacy

- Postal Prescription Services (PPS): 800-552-6694

To qualify, Regional One Health employees and eligible dependents must do the following:

- Have health insurance coverage through Regional One Health
- Prescription must be covered by Regional One Health Plan
- Qualifying employees and dependents are eligible for prescriptions with NO copayment when filled in the outpatient pharmacy; and when the script is written by an ROH provider. Scripts written by external providers or filled elsewhere will incur a copay

New Prescriptions can be dropped off at the Regional One Health outpatient pharmacy or E-Prescribed by your physician.

Participating Pharmacies:

- **First Choice Network: Kroger, Walmart, CVS/Target, Rite Aid (based on location), Sam's, Publix, KMart, Freds, Winn-Dixie, and many more.**
- **Standard Network: Walgreens, Costco, Rite aid (based on location)**

Prescription Drugs

LIVINITI™ formerly Southern Scripts

	ROH Pharmacy-ROH Provider	ROH Pharmacy-External Provider	Liviniti Pharmacy Network-1st Choice Provider	Standard Pharmacy Network	Out-of-Network
30-Day Supply					
Generic	**$0**	$10	$25	$40	Not covered
Preferred Brand	**$0**	$15	$60	$110	Not covered
Non-Preferred Brand	**$0**	$20	$110	$210	Not covered
Speciality*	**$0**	$25	Not covered	Not covered	Not covered
Maintenance	**$0**	$10	$40	$70	Not covered
90-Day Supply					
Generic	**$0**	$15	$30	$50	Not covered
Preferred Brand	**$0**	$30	$70	$130	Not covered
Non-Preferred Brand	**$0**	$45	$150	$290	Not covered
Maintenance	**$0**	$15	$50	$90	Not covered
Prescription Out-of-Pocket-Maximum					
Prescription Out-of-Pocket Maximum	N/A	Included in medical	Included in medical	Included in medical	Included in medical

Mobile Rx Management - Download the App today! "Southern Scripts (Liviniti)" on the App Store! Store!Members of Livinti need convenient and straightforward access to important pharmacy information, like your Member ID, prescription lists, and pharmacy locations. That's why we created a simple way for members to track and manage their prescriptions - freely available on IOS and Android.

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TelaDoc

Teladoc® HEALTH

Talk to Doctors When You Need Them.

1) What is TelaDoc?

TelaDoc utilizes technology to give you and your family affordable and convenient access to medical and behavioral health services online for those enrolled in the health plan.

You can use TelaDoc Health for:

> General Medical: See a doctor for allergies, colds, fever, flu, and more.
> Mental Health: Talk to an expert for anxiety, depression, and other issues.
> Dermatology: Get treatment for skin conditions by uploading pictures.
> Nutrition Counseling: Get a nutrition plan from dietitians.
> Back & Joint Care: Work with a health coach to manage your pain.
> Tobacco Cessation: Talk to a doctor about enrolling in this program.

2) How Does TelaDoc Work?

Use Teladoc™ Health to talk to a doctor by phone or video chat. It's available 24/7 for non-emergencies. And it typically costs less than you'd pay for an office visit or urgent care trip.

You'll need to register an account by answering a few quick questions. Make sure to have your Member ID card ready when you register.

To get started:

> Log in to the BCBSTN app and choose Talk to a Doctor Now, or
> Visit **bcbst.com/Teladoc**, or
> Call **1-800-TELADOC** (1-800-835-2362).

Our Telehealth Program is available at NO OUT-OF-POCKET COST for you and your family! We are pleased to announce that you and your family now have access to TelaDoc – your new telehealth service. TeleDoc allows you to reach a medical provider or therapist by phone, app or webcam when access to your regular doctor is not available.

Questions To Consider:

Can I get a prescription? Yes. When appropriate, they can write a prescription and send it to your pharmacy. However, they can't write prescriptions for controlled substances and some other drugs.

How do I register for Teladoc Health?
You can get started by logging in to our free **BCBSTN app** and choosing **Talk With a Doctor Now**, or by visiting **bcbst.com/Teladoc**. You can also register by phone at **1-800-TELDOC**

Who is eligible to use Teladoc? Any family member on your medical plan can register. Anyone 18 and older will need to register themselves as described above.

Will I see a quality provider? Yes. Medical care is provided by our team of US-licensed, board-certified physicians, nurse practitioners, and physician assistants. Licensed therapists provide talk therapy.

Do I need an email address? Yes. An email address is required to create a profile for patients over the age of 18.

Is this service confidential? Yes. Teladoc Health Virtual Care services are HIPAA compliant and completely confidential.

How much does using Teladoc Health cost? You'll typically pay less than you would for a visit to the office or urgent care clinic. Refer to your Evidence of Coverage or employer benefit materials for cost information. Once you're registered, you can also go to My Account/Cost Overview in your Teladoc Health account to see the cost for any products available to you.

Do I need a code to register? No, you don't need a code to register your account. You can skip this field during registration.

What health concerns can Teladoc help treat?

Medical

- Abrasions and bruises
- Colds, flu and fever
- Bites and stings
- Urinary tract infections
- Some medication refills
- Diarrhea
- Vomiting, nausea
- Sore throat, cough, congestion
- Allergies, hive, skin infections
- Minor headaches, body aches, arthritic pains
- Eye infections, conjunctivitis

Behavioral

- Addiction
- Anxiety, depression
- Grief/loss, divorce, relationships
- Domestic violence
- Bipolar disorder, mood swings
- Eating disorders

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Regional One Health | Hinge Health

Join the Women's Pelvic Health Program

Hinge Health now offers pelvic floor care — available **at no additional cost to you**.

What's your pelvic floor and why should you care?
Your pelvic floor is the group of muscles and tissues attached to the bottom of your pelvis. It supports your pelvic organs, controls your bladder, and more. And it's one of the hardest working muscle groups in your body.

Why join?

- Get personalized, virtual exercise therapy for pregnancy and postpartum, bladder control, pelvic muscle strengthening, or pelvic muscle relaxation.
- Work 1-on-1 with a clinical care team that specializes in pelvic floor care.
- Exercise from the privacy of your own home, on your schedule.

Scan the QR code to learn more or apply at
hinge.health/regionalonehealth-wph
or call (855) 902-2777

Participants must be 18+ and enrolled in a BlueCross BlueShield of Tennessee medical plan through Regional One Health. BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association.

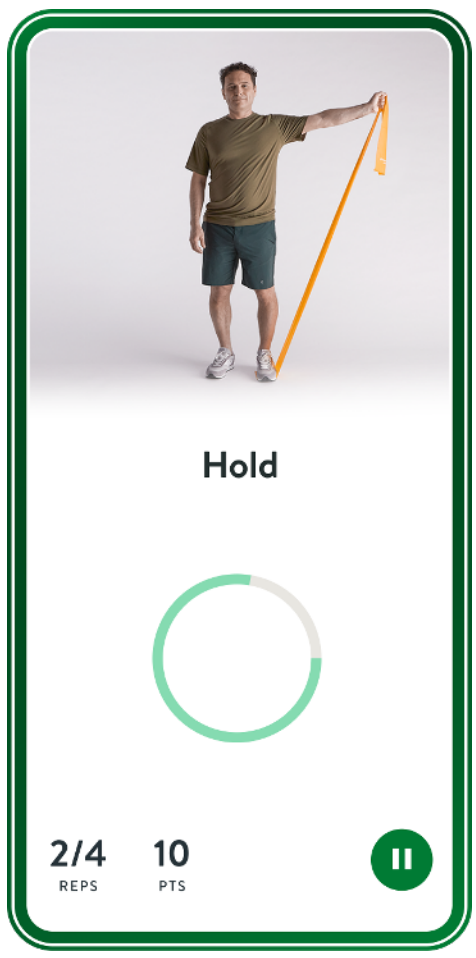
Regional One Health | Hinge Health

Personalized pain care that gets you moving

Relieve joint and muscle pain with virtual exercise therapy **at no cost to you**. On average, participants reduce their pain by 68%.[1]

- **Virtual sessions anytime, anywhere**
- **Unlimited 1-on-1 health coaching**
- **Motion-tracking technology for instant form correction**

Your family may be eligible, too!



To learn more and apply, scan the QR code or visit

hinge.health/regionalonehealth

Questions? Call (855) 902-2777

Hinge Health está disponible en español
Alivia los dolores articulares y musculares y previene las lesiones con tus beneficios de salud gratuitos. Únete ahora.

Participants must be 18+ and enrolled in a BlueCross BlueShield of Tennessee medical plan through Regional One Health. BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association.

[1]After 12 weeks, in a study of chronic knee and back program participants. Bailey JF, et al. Digital Care for Chronic Musculoskeletal Pain: 10,000 Participant Longitudinal Cohort Study. J Med Internet Res 2020;22(5):e18250.

MY ONE LIFE
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delivers

SUSTAINABLE HEALTH INDEX

Are you ready to start the small but mighty steps to a healthier you?

Maybe you've even started to consider some lifestyle changes? Making changes to live a healthier life can be hard. We know many are ready to make meaningful changes, but don't always have the resources to support them.

The Sustainable Health Index – It's time to be the best version of you

As a full-time, part-time critical skill or weekender employee enrolled in the Regional One Health medical plan, you have FREE access to the Sustainable Health Index. SHI, offered thru My One Life, is a health and well-being platform that helps identify risks and obstacles to optimal health, then invites users into a Health Hub that delivers a series of fun and entertaining health adventures.

The process starts with some basic questions covering five key health domains, so the platform can calculate your total health score. Then, SHI will deliver a map of your current health coordinates right to your dashboard, inviting you into relevant adventures where you will earn monetary rewards for missions and milestones completed.

If you are an eligible employee and you need the email with your unique log-in resent, please email support@sustainablehealthindex.com.

SCAN ME

When we start small, we can win big.

Dental Insurance

DELTA DENTAL®

Regional One Health offers two dental plan options for you and your family through Delta Dental of Tennessee. You may visit any Delta Dental dental provider. You must meet an annual deductible before the plan pays a percentage of expenses which are reasonable and customary. **If you need assistance, call 800-223-3104.**

Calendar Year Deductible	Base Option	Buy Up Option
Individual	$50	$50
Family	$150	$150
Calender Year Maximum		
	$1,000	$1,500
Dental Service Type		
Diagnostic & Preventive	**100% Coinsurance No Deductible** • Exams • Cleanings • X-Rays • Fluoride treatment • Space Maintainers	**100% Coinsurance No Deductible** • Exams • Cleanings • X-Rays • Fluoride treatment • Space Maintainers
Basic Services	**80% Coinsurance after Deductible** • Fillings • General anesthesia • Simple Extractions • Periodontic Therapy • Endodontic Therapy • Complex Oral Surgery	**80% Coinsurance after Deductible** • Fillings • General anesthesia • Simple Extractions • Periodontic Therapy • Endodontic Therapy • Complex Oral Surgery
Major Services	**10% Coinsurance after Deductible** Complex Restorations & Related Services • Crowns • Bridges • Dentures • Implants	**50% Coinsurance after Deductible** Complex Restorations & Related Services • Crowns • Bridges • Dentures • Implants
Orthodontia		
Deductible	N/A	$50 Individual /$150 Family
Coinsurance	N/A	50% after deductible
Lifetime Maximum	N/A	$1,500
Benefits Applies To	N/A	Children 18 and under
Rates Per Pay Period		
26 Pay Periods	**Base Option**	**Buy Up Option**
Employee Only	$9.17	$13.85
Employee + Spouse	$15.22	$24.39
Employee + Child(ren)	$14.63	$23.41
Family	$20.68	$33.36

DELTA DENTAL

More Options, Lower Costs

The power of two networks

When it comes to pearly whites, everyone wants to save a little green. Delta Dental offers two provider networks to help cover your smile while keeping costs as low as possible. The **Delta Dental PPO℠ Network** provides maximum cost savings, while the **Delta Dental Premier® Network**—which is the largest network in Tennessee—provides a safety net for additional access when you need it.

Delta Dental PPO	→ More than 269,000 office locations nationwide → Average savings of 30% on submitted fee → No balance billing and no paperwork to file
Delta Dental Premier	→ More than 339,000 office locations nationwide → Average savings of 18% on submitted fee → No balance billing and no paperwork to file
Out-of-Network	→ May need to file your own claims → May be balance billed → No discounts

Save when you see a network dentist

*Example: You have met your deductible and visit a dentist for a Basic Service, which your plan covers at 80%. The estimated charge for the service is $120.^*

Set by Delta Dental

NETWORK	ESTIMATED CHARGE	MAXIMUM ALLOWED FEES	AMOUNT DELTA DENTAL PAYS	AMOUNT YOU PAY
Delta Dental PPO	$120	$84 x 80% =	$67.20	$16.80
Delta Dental Premier	$120	$113 x 80% =	$90.40	$22.60
Out-of-Network Dentist	$120	$100 x 80% =	$80	$40.00

Best Deal!

^This example is an estimate. Fees and reimbursments can vary by state.

20% + $20 balance billing

What is balance billing?

Our network dentists agree to accept maximums on what they charge for each service. An out-of-network dentist hasn't agreed to those maximums. When you visit a Delta Dental network dentist, you won't have to pay the difference between what the dentist charges and what Delta Dental will pay, *aka balance billing*.

As you can see, it pays to visit Delta Dental network dentists - especially those in our PPO network. To find a Delta Dental network dentist near you:

- → Visit **DeltaDentalTN.com,** click on "FIND A DENTIST," and then choose your network.
- → Download our free **Delta Dental mobile app**, available for Apple and Android devices.
- → Call toll-free **(800) 223-3104.**

DELTA DENTAL

Smile More, Save More

Preventive Care and Pre-Treatment Estimates

One word explains why dental benefits work: prevention. Regular dental visits help keep your smile healthy and prevent the development of serious oral health problems. However, when a special procedure is needed, it's good to know how much a procedure will cost before a commitment is made. Delta Dental makes it easy for you to find out whether a proposed dental treatment is covered, what amount the plan will pay, and your out-of-pocket costs.

Preventive Benefits of Dental Coverage

Cover Preventive Care

Many dental plans cover all or most of the cost for routine dental checkups, including cleanings, x-rays, and exams. Deductibles do not usually apply to these services.

Prevent Costly Dental Problems and Improve Overall Health

At a routine checkup, your dentist can diagnose and treat dental disease early on, saving you from more costly and time-consuming dental procedures down the road. Also, serious diseases such as diabetes, and even some cancers have symptoms that can be detected early during a routine oral exam. However, in the event your dentist recommends a special prodedure, getting a **pre-treatment estimate** is a great way to manage costs.

Know Before You Go — Getting a Pre-treatment Estiment

What is a pre-treatment estimate?

A pre-treatment estimate is a voluntary, optional service in whice Delta Dental issues a written estimate of benefits that may be available under your plan for your proposed dental treatment. Your dentist submits the proposed dental treatment to Delta Dental **before** providing the treatment. This service is free for Delta Dental members and usually takes less than 10 business days for processing.

When should I request a pre-treatment estimate from my dentist?

You can request a pre-treatment estimate at any time; however, specific instances when you may want to request one include:

- If your dentist is recommending extensive treatment.
- If you need information on benefit coverage and plan limitations.
- If you would like an estimate of how much you may have to pay.

Note: *Pre-treatment estimate is provided for informational purposes only and is not required before you receive any dental care. It is not a prerequisite or condition for approval of future dental benefits payment. You will receive the same benefits under your plan whether or not a pre-treatment estimate is requested. The benefits estimate provided on a pre-treatment estimate notice is based on benefits available on the date the notice is issued.* ***A pre-treatment estimate is NOT a guarantee of future dental benefits or payment.*** *When the services are complete, Delta Dental will calculate its payment based on your current eligibility, remaining maximum and any deductible requirements.*

Availability of benefits at the time your treatment is completed depends on several factors such as, but not limited to, your continued eligibility for benefits, your available annual or lifetime maximum payments, any coordination of benefits, the status of your plan and the dentist, your plan's limitations and any other plan provisions. A request for a pre-treatment estimate is not a claim for benefits or a preauthorization, precertification or other reservation of future benefits.

DELTA DENTAL

Find the dentist that's right for you at Delta Dental of Tennessee

Choosing a dentist from the Delta Dental PPO℠ network will help you save money and get the most from your benefits. You also have the option to visit any licensed dentist. Not sure if your dentist is a member of our network? Follow these simple steps to find the dentist that's right for you.

Two Options to Find a Dentist in Your Delta Dental Network

1

Visit Our Website

Go to www.DeltaDentalTN.com and click "Find a Dentist."

- Choose a specialty from the drop down menu labeled "Specialty" and select your plan from the drop down menu labeled "Your Plan."
- Choose "yes" or "no" to utilize GPS optimization. If you choose "no," you will be prompted to manually type in your zip code or address. If you choose "yes," you may be prompted to give permissions to access device location.
- Click "Find dentists."
- You will be offered a list of dental health providers in the area. Dental specialties, plans, distance and sorting preferences can be changed to suit your needs.

2

Download the Delta Dental App

To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental. You will need an internet connection in order to download and use most features of our free app.

- From the app home screen, select "Find a Dentist."
- Select your plan from the drop down menu labled "All Plans" or leave on the default setting of "All Plans."
- Choose a dental specialty from the drop down menu labled "General Dentist" or leave on the default setting of "General Dentist."
- Choose "Search by Address" to manually type in your zip code and select "Search by Address" **OR** select "Search by Current Location" to utilize GPS optimization. You may be prompted to give permissions to access device location.
- You will be offered a list of dental health providers in the area.

Still Need Help? Call us.

You can reach Delta Dental of Tennessee when you call (800) 223-3104 Monday–Friday, 7 a.m. to 5 p.m. CT

You can also call anytime and use our automated system, to access information about your eligibility, benefits, claim status, and listings for nearby dentists.

Vision Insurance

The vision plan provides coverage for you and your eligible dependents and is provided by Davis Vision Benefits. **A listing of network providers and retail locations may be accessed at www.davisvision.com or you may call 800.999.5431 and enter client code 3413.**

Download the Davis Vision app to keep your plan information at your fingertips!

Davis Vision Network	PPO	Out-of-Network
Copay		
Exam	$10	Up to $40 reimbursement
Lenses		
Single	$25	Up to $40 reimbursement
Bifocal	$25	Up to $60 reimbursement
Trifocal	$25	Up to $80 reimbursement
Lenticular	$25	Up to $100 reimbursement
Frames		
Davis collection frames covered in full ($160 value), any other provider frames up to $130 allowance and an additional 20% off Frequency = 12/12/24		Up to $105 reimbursement
Contacts		
Collection contacts covered in full, or non collection contacts covered up to $130 retail allowance plus 15% off balance		Up to $105 reimbursement

Services (In-Network)	Frequency
Exam	12 Months
Frames	24 Months
Lenses or Contact Lenses	12 Months

Rates Per Pay Period (26 pay periods)	Davis Vision Network
Employee Only	$3.02
Employee + Spouse	$6.04
Employee + Child(ren)	$5.28
Family	$8.29

MY ONE LIFE
EMPLOYEE HEALTH AND WELL-BEING

Basic Life Insurance &
Accidental Death & Dismemberment

Regional One Health provides life insurance through Prudential. Life insurance provides a source of income for your beneficiary in the event of your death, helping them cover immediate or long-term expenses.

Regional One Health provides life insurance through Prudential. Life insurance provides a source of income for your beneficiary in the event of your death, helping them cover immediate or long-term expenses.

Accidental Death and Dismemberment (AD&D) insurance pays for death related to an accident or for the loss of a limb, eyesight, hand, or foot related to an accident.

All full-time employees receive basic life and AD&D insurance coverage equal to one times their base annual earnings up to $600,000. The benefit amount reduces to 67% at age 65 and 50% at age 70 or more.

If you need assistance filing a claim, find the appropriate number below.

Life	Voluntary Term Life	Accidental Death & Dismemberment
800-524-0542	844-455-1002	800-842-1718

Remember to add beneficiaries to your policy! It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

Voluntary Term Life &
Accidental Death & Dismemberment

Voluntary Accidental Death and Dismemberment (AD&D)

Voluntary accidental death and dismemberment insurance covers the unintentional death or dismemberment of the insured. Dismemberment includes the loss, or the loss of use, of body parts or functions (e.g., limbs, speech, eyesight, and hearing).

Voluntary AD&D can be added up to **5x your salary with no medical questions asked.**

Voluntary Term Life

For employees: If you are a new hire, Voluntary term life insurance is offered at up to **2x your salary or a maximum of $300,000 with no medical questions.** Employees can elect up to 5x your salary to a maximum of $1,000,000 after completing Medical Underwriting.

For Employee's Spouse: Employees can elect Voluntary Term Life for their spouse in $5,000 increments, up $250,000

For Employee's Child: Employees can elect a $10,000 benefit amount to cover their dependent child.

This is a great opportunity for life insurance while you are employed at Regional One.

Premiums come out on a monthly basis for this product only.

Long-Term Disability

Long Term Disability is **paid for by Regional One Health** for all full-time employees and pays 60% of your salary with a 180-day Elimination Period.

Long-Term Disability	
Employee Eligibility	32 hour per week, first of the month following 90 days
Pre-Existing Conditions	3-month look back, 12-month wait
Benefit Percentage	60%
Monthly Benefit Maximum	$10,000
Benefit Elimination Period	180 days
Benefit Duration	Social Security Normal Retirement Age
Definition of Disability	You are considered disabled when, because of injury of sickness, you are under the regular care of a doctor, you are unable to perform the material and substantial duties of your regular occupation and your disability results in a loss of income of at least 20%
Benefit Limitations	None
Mental/Nervous	24 months
Self-Reported	24 months
Earnings Definition	**For Trauma Radiology Employees:** Your gross monthly income, including a 10% TIC adjustment pay, from your Employer in effect just prior to your disability date. **For Blood Bank Employees:** Your gross monthly income, including a 6% TIC. **For all other Employees:** Gross weekly income from your Employer in effect just prior to your date of disability. Does not include income from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than your Employer.
Taxibility	Yes

Short-Term Disability (Paycheck Protect)

Trustmark

Short Term Disability will pay up to **60% of your base salary** if you're out of work due to an injury or illness, **up to $4,000 a week**. There are 4 options available to employees.

Benefit Period	Accident/Sickness Elimination Period
3 Months	7 days
6 Months	
3 Months	14 days
6 Months	

Possible Benefits	
Maternity	A disability due to pregnancy is covered the same as any other sickness when it begins 10 months after the effective date. (6 weeks for natural birth / 8 weeks for cesarean section)
6 Months	After 90 days of total disability or the elimination period, whichever is greater, premium will be waived for as along as the disability continues, but not beyond the maximum benefit period.
3 Months	Helps insured gradually return to work with a 50% benefit up to 6 months (or less if the benefit period is less than that) if insured returns to work part time after receiving benefits for 30 days.

You can keep your coverage to age 70 or for 5 years if purchased between ages 66 and 70. **Guaranteed Issue Underwriting is available for new hires only** in $100 monthly increments up to 60% of base earnings, less any other disability coverage in-force at time of application.

Trustmark
Universal Life w/ LTC

This coverage provides permanent life insurance protection with a **premium that never increases** due to age or a specified term. Life Insurance is a promise to your family to help protect their future. The death benefit can be used any way you or your family sees fit.

Plan Features

- **Fully portable** - You can keep this policy should you change jobs or retire.
- The policy builds cash value and accrues interest
- Rate stability and benefit stability -- **your rate will never increase due to age**
- Guarantee Renewable
- Employees up to 75 years of age can apply
- **Long Term Care Benefit** -- Pays monthly benefit equal to 4% of your death benefit for up to 50 months.
- **Benefit Restoration** -- Restores the death benefit that is reduced to pay Long Term Care, so your family receives the full death benefit amount when they need it most
- Accelerated Death Benefit for Terminal Illness. Pays 75% of death benefit when life expectancy is 24 months or less
- Spouse and dependent coverage available without purchase of employee policy (Modified Guaranteed Issue)

Benefit Amounts

Employee Age (18-64)	
Guaranteed Issue ***No Medical Questions - This enrollment only***	**Up to $50,000**
Simplified Issue	Up to $300,000
Spouse Age (18-64)	
Guaranteed Issue	If Employee applies for coverage: Amount purchased by **$3/week or $25,000**
Simplified Issue	Up to $300,000
Child(ren) (Under the age of 23)	
Guaranteed Issue	Amount purchased by $3.48 through $4.73 per week

MY ONE LIFE
EMPLOYEE HEALTH AND WELL-BEING

Transamerica Cancer Insurance

Cancer insurance helps those diagnosed with cancer to stay focused on recovery by alleviating some of the financial burden associated with the cost of cancer treatment.

Benefits		Low Plan	High Plan
Initial Diagnosis		$2,000	$5,000
Annual Cancer Screening (1 per person per calendar year)		**$100**	**$100**
Treatment Benefits			
Radiation/Chemotherapy (per 12-month period; pays actual charges)		$10,000	$20,000
Blood, Plasma, Blood Components, Bone Marrow and Stem Cell Transplant (per 12-month period; pays actual charges)		$10,000	$20,000
New or Experimental Treatment (per 12-month period; pays actual charges for drugs and chemical substances approved by FDA)		$10,000	$20,000
Surgery Benefits			
Surgery	**Inpatient** **Outpatient**	$1,000 $1,500	$5,000 $7,500
Anesthesia		25%	25%
Prosthesis		$500	$2,500
Reconstructive Surgery	Breast Cancer- Simple or total mastectomy Breast Cancer - Radical mastectomy Cancers of the male or female genitalia Cancer of the head, neck, or oral cancers	$120 $170 $170 $250	$600 $850 $850 $1,250
Skin Cancer	One removal Per additional removal	$75 $35	$375 $175
Hospital Benefits			
Hospital Confinement (per day of covered confinement)		$100	$100
Attending Physician (per day while hospital confined)		$20	$20
Private Duty Nurse (per day while hospital confined)		$100	$100

Rates - Per Pay Period			
	Employee	Employee and Children	Family
Low Plan	$8.52	$9.86	$15.72
High Plan	$16.30	$18.42	$29.36

Trustmark Accident Insurance

Trustmark

Benefits for 24 Hour Coverage

Accident/Injury	Benefit Amount
Concussion Benefit	$400
Laceration Benefit	$50 to $400
Dislocation Benefit	$200 to $6,000
Prosthetic Device or Artificial Limb Benefit One More than one	 $1,000 $1,500
TrekCheck – Lodging (per night up to 30 days)	$200
TrekCheck – Transportation (50 miles up to three trips)	$400
Surgical Care Benefit	$100 to $2,000
Burn Benefit	$100 to $10,000
Skin Graft Benefit	25% of burn benefit
Eye Injury Benefit	$300
Emergency Dental Benefit Crown Extraction	 $300 $150
Fracture Benefit	$1,000 to $3,000
Catastrophic Accident Benefit Employee Spouse Child	$20,000
Organized Sports Benefit When injuries are sustained as the result of participating in an organized amateur sport.	Additional 25% of base benefit
Wellness Benefit **Routine Visit Flex Wellness Screening** **Diagnostic Test Screening**	**$50**

Most benefits are paid once per person per covered accident per plan year.

MY ONE LIFE
EMPLOYEE HEALTH AND WELL-BEING

Trustmark Accident Insurance

Trustmark

Benefits for 24 Hour Coverage

Accident/Injury	Benefit Amount
Hospital First Day Stay Benefit Paid for each additional day spent in the hospital (standard, step- down unit or ICU stay).	$1,000
Hospital First Day Stay Benefit – ICU Paid in addition to the Hospital First Day Stay Benefit when admission is to the ICU.	$1,000
Hospital Daily Stay Benefit (per day up to 365 days) Pays for each additional day of confinement (standard or ICU admission).	$200
Hospital Daily Stay Benefit – ICU (per day up to 15 days) Paid in addition to the Hospital Daily Stay Benefit when stay is in the ICU.	$200
Inpatient Rehabilitation Benefit (per day up to 60 days)	$200
Blood, Plasma, Platelets Benefit	$500
Coma Benefit	$10,000
Pain Management/Epidural Benefit	$100
Initial Doctor's Office Visit Benefit (Including Walk-In Clinic & Telemed)	$200
Urgent Care Benefit	$200
Emergency Room Treatment Benefit	$200
Ambulance Benefit • Air • Ground / Water	 $5,000 $300
Major Diagnostic Testing Benefit	$200
X-Ray Benefit	$100
Accident Follow-Up Treatment Benefit (per visit, up to six visits)	$75
Physical Therapy Benefit (per visit, up to ten visits) Physical, occupation or speech therapy	$50
Appliance Benefit Major appliance Minor appliance	 $100 $200

MY ONE LIFE
EMPLOYEE HEALTH AND WELL-BEING

Trustmark Accident Insurance

Trustmark

Wellness Benefit – Routine Visit Flex

Eligible tests include:

- Routine Physical
- Low-dose mammography or routine mammogram
- Biometric screening
- Blood test for triglycerides
- Fasting blood glucose test
- Lipid panel
- Serum cholesterol test for HDL and LDL
- Immunization
- Sport physical
- Pap smear (for women over age 18)
- Chest x-ray
- Invasive Colonoscopy
- Noninvasive colon screening, including CT colonoscopy
- Electrocardiogram (EKG/ECG)
- Human papillomavirus (HPV) vaccination
- Vision test

Rates - Per Pay Period

	Employee	Employee and Spouse	Employee and Children	Family
Rate	$5.74	$8.25	$9.72	$14.68

Covered Accident

A sudden and unexpected event which occurs without the Covered Person's intent which:

- Results in an Injury to the Covered Person which is independent of disease or infirmity;
- Has a specific time and place of its occurrence;
- Occurs after the Certificate Effective Date;
- Occurs while this Certificate is in force; and
- Is not excluded by name or description in this Certificate

Elimination Period

The period of time after the date of a covered accident for which catastrophic accident benefits are not payable.

Injury or Injuries

An accidental bodily injury which resulted from a Covered Accident. It does not include Sickness, disease or bodily infirmity. Overuse syndromes, typically due to repetitive or recurrent activities, such as osteoarthritis, carpal tunnel syndrome or tendonitis, are considered to be a Sickness and not an Injury for purposes of this Certificate.

Trustmark
Critical Illness

Benefit Amounts		
Benefit Amounts		$10,000 $20,000 $30,000
Guaranteed Issue	**Employee** **Spouse** *(employee must apply)* **Child** *(employee must apply)*	$30,000 $30,000 $15,000
Wellness Benefit Routine Visit with Immunizations, Physicals, & Vision Tests		$50

Benefit Amounts	Critical Illness		
100% Benefit	**Cancer** • Multiple Myeloma • Leukemia • Stage 2 involving lymph node involvement, or any Stage 3 or 4 of any cancer		• Stage 2 or higher Melanoma • Stage 1 or higher: pancreas, liver, lung, esophagus, biliary tract, head and neck, lymphoma
	Coronary Artery Disease • Heart Attack • Sudden Cardiac Arrest	**Cerebral Vascular Disease** • Stroke with at least 30 days impairment	
	End Stage Renal Failure and Major Organ Failure • When dialysis or kidney transplant is needed • Failure of the liver, lung, pancreas or heart		
50% Benefit	**Cancer** • Melanoma Stage 1 • Stage 1 or 2 of any localized cancer without lymph node involvement	**Cerebral Vascular Disease** • Stroke with less than 30 days impairment • Stroke when clinically diagnosed	**Coronary Artery Disease** • Coronary artery obstruction • Heart attack (clinically diagnosed) • Thoracic Aorta or Valve Surgery
10% Benefit	**Cancer** • Invasive squamous or basel cell skin cancer • In-situ cancers • Benign tumors of the Cnetral Nervous System		**Coronary Artery Disease** • Initial Diagnosis

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Critical Illness (cont.)

Additional Benefits

Infectious Disease and Rare Illness Benefit: Built-In

- 50% coverage for Addison's Disease, Budd-Chiari Syndrome, Systemic Sclerosis and Walter Payton's Disease-Primary Sclerosing Cholangitis
- 10% coverage for any infectious disease requiring hospital admissions, including but not limited to: AIDS, Babesiosis, Brucellosis, Cerebrospinal Meningitis, Cholera, Coronavirus Disease 2019 (COVID-19), Diphtheria, Eastern Equine Encephalitis (EEE), Histoplasmosis, Legionnaires' Disease, Leptospirosis, Lyme Disease, Malaria, Necrotizing Fasciitis, Osteomyelitis, Rocky Mountain Spotted Fever, Poliomyelitis, Rabies, Reyes Syndrome, Tetanus, Tuberculosis, Typhoid Fever, Tularemia, West Nile.

Pediatric Illness Benefit: Built-In

50% coverage for metabolic/genetic, structural, congenital heart illnesses, and autism spectrum disorder (level 2 & 3 diagnoses).

Specified Illness Benefit: Built-In

The Specified Illness Rider expands the list of covered illnesses

- Tiered benefits for additional illnesses. Each illness is eligible for a benefit once per covered person per lifetime, no separation period is required between illnesses.
- Depending on the diagnosis, benefit payment may be 100%, 50%, or 10% of the selected benefit amount, subject to the annual maximum available for the calendar year in which the diagnosis occurs.
- Dementia.
- Post Dramatic Stress Disorder (PTSD) when diagnosed by a Physician, this benefit helps a covered person get treatment they need from a licensed clinician

100% Benefit

- **Permanent blindness**
- **Complications of diabetes requiring lower-limb amputation**
- **Irreversible loss of hearing**
- **Occupational Human Immunodeficiency Virus (HIV)**
- **Permanent Paralysis**
- **Lou Gehrig's Disease (ALS)**

50% Benefit

- **Central nervous condition**
  - **Lupus**
  - **Sarcoid**
  - **Central nervous infection of the brain**
- **Neurologic Diseases, such as Huntington's Disease, Multiple Sclerosis, Parkinson's Disease**
- **Dementia, such as Alzheimer's Disease**

10% Benefit

- **Complications of diabetes requiring hospitalization for hyperglycemia, dehydration**
- **Stem cell/bone marrow transplant**
- **Acute Respiratory Distress Syndrome**
- **Coma**
- **Epilepsy**
- **Rheumatoid Arthritis**
- **Type 1 Diabetes**
- **Post-Traumatic Stress Disorder (PTSD)**

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Hospital Indemnity

Hospital indemnity **pays you directly in the event of hospitalization** for any reason, such as illness, injury, or birth. Hospital stays are often unexpected and can be expensive, which comes with emotional and financial stress. Hospital indemnity can help offset out-of-pocket costs so that you can focus on getting better.

Hospital Indemnity		
	High Plan	**Low Plan**
Hospital Admission (2 stays) Provides one lump-sum benefit upon the first day of confinement in a hospital or when confined to an observation unit of a hospital for more than 20 hours.	$1,500	$500
Hospital Confinement (30 days) Pays for each additional day of confinement. For proposed days of confinement and benefit amounts see rate section.	$200	$100
ICU Admission (2 stays) Paid in addition to the First Day Stay Benefit upon the first day of ICU confinement in a hospital ICU.	$1,500	$500
ICU Confinement (30 days) Paid in addition to the Daily Stay Benefit when confined to ICU.	$200	$100
Mental Wellness and Addiction Recovery Benefit When hospitalized, admissions for these reasons are treated as normal triggers for the base benefit.		
Normal Childbirth Admissions for normal childbirth are included in the base benefit. Complications of pregnancy and delivery are always covered.		

Rates - Per Pay Period				
	Employee	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
Low Plan	$3.71	$6.52	$5.22	$8.50
High Plan	$9.66	$16.78	$13.57	$22.00

MY ONE LIFE
EMPLOYEE HEALTH AND WELL-BEING

Digital Protection Plan

Device Protection
Comprehensive device protection against physical or liquid damage, mechanical breakdown, loss, or theft. Unlike a traditional carrier, reimbursement for a replacement device is available to you.

Register any phone purchased in the last 5 years to get coverage. No diagnostics required – provide your phone number, and serial or IMEI number. **You receive cash gift cards to purchase a replacement phone or for its repair.**

****Coverage is for one (1) device only****
Deductible - $75 Damage/ $125 Loss or Theft

Identity Protection
We will cover up to $25,000 in expenses that arise from identity theft - these can include legal fees, lost wages, costs for child or elder care, costs of obtaining credit and other reports, loan fees, and more!

Call in and speak with a specialist to handle the claim process for you.

Legal Protection
The nationwide network of attorneys provides expert legal services with a 25% discount from their customary rates. Speak with an account manager to find an attorney to handle your case.

Why might you need an attorney?

- Debt Issues
- Home & Real Estate
- Estate Planning
- Cars & Driving
- Family
- Civil Lawsuits

If you need assistance, please email
customer.service@3prisk.com
1-844-477-7467

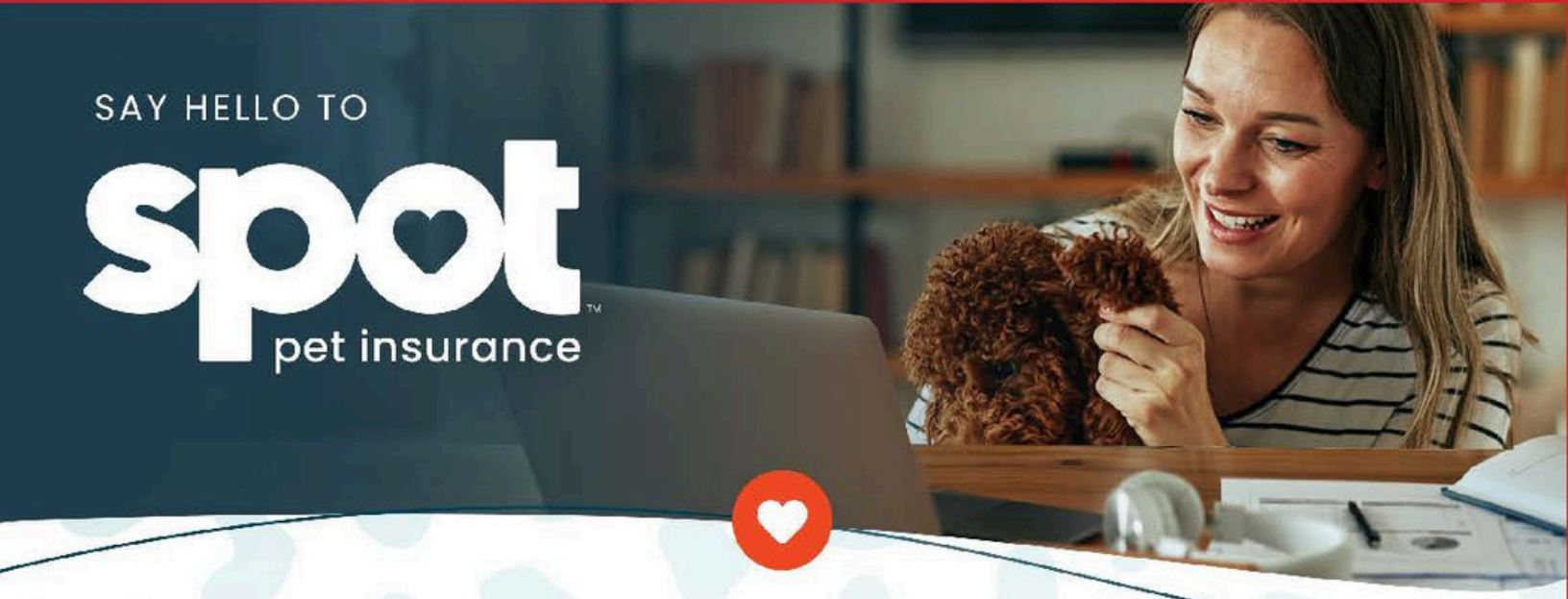
3P Risk Strategies, LLC
a Texas series LLC

For more details visit
3prisk.com/dpp

MY ONE LIFE
EMPLOYEE HEALTH AND WELL-BEING

SAY HELLO TO

spot™ pet insurance



your new pet insurance benefit

Save on Vet Bills with **America's Favorite Pet Insurance**

Cap off your benefits with pet insurance from Spot and get reimbursed on eligible vet bills for accidents, illnesses, and more.

- Up to 90% Cash Back
- Preventative Care Add-Ons
- 24/7 Pet Telehealth Line

How **Spot Pet Insurance** Works

Visit any licensed vet or specialist.

Submit your claim online.

Get reimbursed fast & easily.

Special Offer Just for You: Up to 20% Off

Regional One Health

Save With Your Discount! https://spotpet.link/regionalonehealth

When Calling, Use Priority Code: EB_ROH | **800.905.1595**

*10% employee discount. 10% multi pet discount for additional pets added. Limitations apply. For terms and conditions, visit spotpetins.com/sample-policy. Insurance plans are underwritten by United States Fire Insurance Company produced by Spot Insurance Services, LLC. EB.0.23

Employee Assistance Program

Regional One Health has a sincere interest in helping employees to be successful. Problems or incidents sometimes occur which may interfere with their ability to function effectively, either at work or at home. If and when this happens, it is important to have a place to turn for help.

The Regional One Health employee assistance program (EAP) is a confidential program designed to help resolve personal problems. The EAP can help with the following:

- **Family issues/marital/relationship difficulties**
- **Alcohol/drug abuse assessment**
- **Anxiety or depression/improving self-esteem**
- **Grieving the loss of a loved one/managing the stress of everyday life**
- **Major life events such as job loss, relocation, serious illness**
- **Coping with violence**
- **Elder and childcare referrals**

Employee's participation in the EAP is completely confidential. To make help readily accessible while still protecting your privacy, Regional One Health has contracted with the SupportLinc Employee Assistance Program to provide services to employees and their eligible family members.

The program is staffed with trained professionals to provide counseling and referrals for additional counseling as needed. SupportLinc upholds strict confidentiality standards. No one, including your employer, will know who has accessed the program unless you specifically grant permission or express a concern that presents us with a legal obligation to release information.

SUPPORT LINC
EMPLOYEE ASSISTANCE PROGRAMS

These benefits offer emotional wellbeing and work-life balance resources for you and your family.

supporlinc.com
888-881-5462

MY ONE LIFE
EMPLOYEE HEALTH AND WELL-BEING

Flexible Spending Account

Flexible spending accounts (FSAs) enable you to set aside some of your pay, on a pre-tax basis, into an account to pay for eligible health or dependent care expenses. By setting aside money pre-tax, which you would normally be spending post-tax, you save between 25 percent and 40 percent on your everyday expenses.

There are two types of FSAs. The health care FSA covers copays, deductibles, coinsurance, prescriptions, dental care, eye exams, and other eligible healthcare expenses. The dependent care FSA covers childcare expense while you are at work for children under age 13 or other dependents who are incapable of self-care. **For assistance, please call Pinnacle at 888.282.2605.**

Make contributions. You set aside pre-tax money through payroll deductions up to IRS limits. For a health care FSA, you must contribute at least $150 (not to exceed **$3,200**). Health care FSA funds are available to use as of January 1. For a dependent care FSA, you must contribute no more than $5,000. Please note, if you are married and file a separate income tax return, the maximum you can contribute is $2,500.
Dependent care FSA funds are available after they've been deducted from your paycheck.

Use your funds. You can pay for eligible expenses out-of-pocket and reimburse yourself from your FSA savings at a later date or, you can pay with a convenient FSA debit card. View a complete list of eligible funds at www.irs.gov.

Don't lose your funds. The money you set aside must be used during the plan year – it will not roll over into your account. Any money left in the account will be forfeited. **You have until March to turn in receipts for reimbursement.**

Important Considerations:

- Your elections cannot be changed during the plan year, unless you experience a qualifying life event.
- If you have an open HSA, you are not eligible for an FSA.
- You need to keep your receipts as proof that your expenses were eligible for IRS purposes.

Planning For Retirement

A consistent savings plan throughout your career is the foundation for security during your retirement years. According to financial experts, company sponsored plans may provide approximately ⅔ of the necessary retirement income.

Participation in this benefit can be at any time during the year. You do not enroll through the benefits portal, but by calling Empower at 800-338-4015.

ROH/UTROP 's 403(b) plan is designed to help you reach your investment goals. The plan offers tax advantages as well as a generous company matching contribution. It is a great way to build up a solid retirement fund through your working years.

Less Than Two Years	0%
Two Years	20%
Three Years	50%
Four Years	75%
Five Years	100%

- You are eligible to participate and contribute to the plan immediately upon hire and can join anytime.
- You will be eligible for the employer's match after completing one year of employment and clocking 1,000 hours if you are at least 21 years old. Employees must clock 1,000 hours each year to advance in the vesting schedule.
- You can contribute up to the maximum tax-deferred amount allowed by the Internal Revenue Service. ROH/UTROP will match 100% of up to 4% maximum of contributions after completing one year of employment and 1,000 hours of service.
- Match contributions made by ROH/UTROP or credited interest earnings become the employee's, according to a vested interest schedule.
- Participant statements are issued on a quarterly basis.
- The plan is administered under a gradual vesting schedule.
- Participation is voluntary and you may change or stop your contribution at any time.
- You must contact Empower to begin contributing.

To enroll in 403(b):
www.empower-retirement.com
800-338-4015

Tuition Reimbursement

Joining our team has its perks, especially when it comes to continuing your education. This has never been more important than now, with college costs on the rise. As a member of Regional One Health, you may be eligible for Tuition Reimbursement. That's right – our Tuition Reimbursement Program can help you out on approved education costs.

If you are investing in your education, we want to invest in you!

Program Requirements:

- Active Full-time employee continuously for 1 year or more
- Associate's, Bachelor's, or Master's degree-seeking
- Accredited Institution

Frequently Asked Questions

Is the program for employees only or dependents too?
Tuition Reimbursement is for employees only.

Is there a form for the reimbursement?
Yes, the application is on the Internet.

Where do I go to get reimbursed?
After approval, checks can be picked up from our AP Dept. or mailed to your home address.

How do I submit tuition application and checklist?
Via email, in person, or you can fax to HR Benefits Department.

How long does it take to get reimbursed?
Up to two weeks after submitting final grades and other required documents.

How many classes/courses can be applied for at a time?
Up to 4 courses per application.

BUY NOW, PAY LATER.

Regional One Medical employees can now make purchases interest-free through payroll deductions.

You now have access to a unique voluntary benefit platform that will make purchasing quality, brand-name items simple & manageable.

The BenefitsMe platform allows you to utilize payroll deductions to shop now and make payments over time without interest! You can shop items & services such as laptops, electronics, appliances, furniture, skin care, home improvement, travel & more at shop.benefitsme.com!

Let's Cover The Basics...

WHAT DO I NEED TO PARTICIPATE?

- An active Employee ID
- Basic contact and banking information
- Create an account at shop.benefitsme.com

HOW DO I GET A SPENDING LIMIT?

Access your spending limit by creating a BenefitsMe account. It's that simple. Go to My Account at any time to view your spending limit, available balance, and order details.

CAN I BUY MORE THAN ONE ITEM AT A TIME?

Absolutely, you have the flexibility to purchase any number of products or services, as long as the total cost does not exceed your available spending limit.

SHOP.BENEFITSME.COM

LifeBalance

Experience LifeBalance

Explore savings on caregiving services, exercise, adventure, healthy eating, stress & relaxation management, and more!

Regional One Health

With LifeBalance, you can enjoy more of the things we all love -- fun family time, health, fitness, travel, electronics, apparel, the great outdoors, and above all, a good deal. Discounts are available year-round for you and your family members, and can be accessed by visiting **RegionalOneHealth.LifeBalanceProgram.com**. Find savings on brands like these:

AAA · Memphis Rock n Soul Museum · Wyndham Hotels & Resorts · planet fitness · Apple

Samsung · The Farmer's Dog · Six Flags · Basecamp Fitness · sam's club

KinderCare Learning Centers · Expedia · Regal · Brookdale Senior Living · Memphis Music Hall of Fame

Brands and offers are subject to change at any time. To view the offers listed above and more, please visit **RegionalOneHealth.LifeBalanceProgram.com** and create or login to your account.

p: 888.754.5433 e: info@LifeBalanceProgram.com

Spousal Healthcare Verification

Regional One Health Group Health Plan requires spouses of covered employees and retirees to enroll in their employer's group medical plan where such availability to coverage exists.

ROH Employee Information

Employee Name_____ Employee ID_____

Spousal Information
(To be completed by your spouse regarding his/her employer healthcare plan)

Spouse Full Name_____Last four of Spouse SSN_____

(Please Print)

Verification Criteria - Please select the correct statement regarding your spouse

_____My spouse works and has elected to take his/her employer's group health plan
_____My spouse does not work or is self employed
_____My spouse works for an employer who does not offer health coverage to their employees
_____My spouse works for an employer who offers health coverage to their employees, but my spouse is not eligible to participate in their employer's health plan
_____My spouse if covered by Medicare/Disability

Acknowledgement

I hereby certify that the information provided above is correct. I understand that my misrepresentation in the information I have provided above will permit Regional One Health to terminate my spouse's coverage and seek any legal remedies available including possible prosecution for insurance fraud. **If applicable, I authorize the release of the health care plan coverage information requested below and authorize its use in accepting the application for Regional One Health Group Health Plan coverage.** If my spouse's employment status changes in the future, I understand that I am responsible for completing a new enrollment form and this affidavit within **30 days** of the employment status change. I understand that failure to notify Regional One Health of my spouse's employment change or falsifying his/her employment status is fraud and could result in financial penalty, loss of coverage and/or possible termination of employment. **I understand that my spouse will not be added to medical coverage and coverage will not be effective until this form is fully executed, and proper documentation returned. I understand for Qualifying Life Event changes the effective date of spouse's coverage will start the beginning of the next month following approved coverage.**

Employee Signature_____ Date_____

Spouse Signature_____ Date_____

Spouse's Employer

Employer Name_____ Employer Phone Number_____

Employer Address_____

Tobacco (Nicotine) User/Non-tobacco (Non-nicotine) User Certification

Employee Information	
Employee Name	Today's Date
Spouse Name	Plan Year

Non-Tobacco (Nicotine) User Certification	
❒ Employee	I certify I currently do not use tobacco products or products which deliver nicotine and am eligible for lower monthly medical insurance premium.
❒ Spouse	I certify my spouse currently does not use tobacco products or products which deliver nicotine and am eligible for lower monthly medical insurance premium.

Tobacco (Nicotine) User Certification - Participation in Tobacco Cessation Program	
❒ Employee	I certify I currently use tobacco products or products which deliver nicotine and will enroll in the tobacco cessation program. I understand I will pay higher monthly medical insurance premium for employee only coverage until I complete the tobacco cessation program. I understand I must complete the program, or work with the benefits department to identify an alternative program, to earn the lower medical insurance premium. I understand upon completion of the tobacco cessation program or alternative program, I will be eligible for the lower medical insurance premium after certification is signed and dated.
❒ Spouse	I certify my spouse currently uses tobacco products or products which deliver nicotine and will enroll in the tobacco cessation program. I understand I will pay higher monthly medical insurance premiums for employee/spouse coverage until my spouse completes the tobacco cessation program. I understand my spouse must complete the program, or work with the benefits department to identify an alternative program, to earn the lower medical insurance premiums. I understand upon completion of the tobacco cessation program, or alternative program, I will be eligible for the lower medical insurance premium after certification is signed and dated.

Tobacco User Non-Disclosure	
❒ Employee	I choose not to disclose my status as it relates to using tobacco products or products which deliver nicotine. I understand by not making an election, I will pay a higher monthly premium rate.
❒ Spouse	I choose not to disclose my spouse's status as it relates to using tobacco products or products which deliver nicotine. I understand by not making an election, I will pay a higher monthly premium rate.

Signature	
Employee Name (print)	Employee Signature
Date	

How to File an FMLA Claim

Regional One Health understands the importance of income protection for you and your family.

Family Medical Leave (FML) Benefits

You may qualify for FML benefits if you or a family member has a serious health condition that is disabling. To be eligible, you must have been employed a total of 12 months (excluding any 7 year gap in employment) and have worked at least 1,250 hours in the 12 months preceding your leave start date. You are allowed to take up to 12 weeks of unpaid leave for yourself or if you:

- Are caring for a family member
- Have an approved intermittent leave of absence
- Are approved for a military exigency leave
- Have an approved leave of absence for the purposes of baby bonding with a newborn/placed/adopted child.

If available, Family Medical Leave may be applied "after a period of incapacity lasting more than three consecutive calendar days."

Matrix makes it easy for you to file a claim 24 hours a day, 7 days a week.

877-202-0055

To file a claim, download the Matrix eServices Mobile App by searching Matrix eServices Mobile on your smartphone or tablet's app store (iOS or Android).

Information You Will Need to Report a Leave of Absence

Depending on the type of leave, you will be asked to provide some basic information. Having the following information readily available when you report your absence to Matrix will speed up the process:

- **Personal Information:** Name, address, telephone number, and the last four digits of your Social Security Number.
- **Job Information:** Job title and description, workplace location and address, work schedule, supervisor's name and telephone number, date of hire, and last day worked.
- **Provider Information:** Name, address, telephone number, and fax number for each treating provider.

Authorizing the Release of Your Medical Information

The release of your medical information to Matrix is critical for the evaluation of your request for Family Medical Leave. With the convenient wallet card below, Matrix has made it easier for your physician to share the required information to ensure prompt claims processing and timely payment.

To use, sign the attached wallet card and present it to your treating licensed physician, medical practitioner, hospital, clinic, or other medically related facility. If we need any additional medical information to process your benefits payment, your signature will authorize the release of that information to Matrix.

Reliance Standard Life Insurance Company is licensed in all states (except New York), the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. In NewYork, Insurance products and services are provided through First Reliance Standards Life Insurance Company, Home Office: New York, NY.

2025 Annual Notices Appendix

Medicare Part D Notice

Important Notice from Regional One Health About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Regional One Health has determined that the prescription drug coverage offered by Liviniti 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 Regional One Health coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Liviniti is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage
If you do decide to join a Medicare drug plan and drop your Liviniti prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

Medicare Part D Notice (cont.)

Important Notice from Regional One Health About Your Prescription Drug Coverage and Medicare

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 Regional One Health and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Regional One Health changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: January 1, 2025
Name of Entity/Sender: Nila Carrington
Contact-Position/Office: Director of Benefits & Wellbeing
Phone Number: 901.545.7372

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: in-network individual deductible $1,250/$1,750 family, 80% in-network coinsurance. If you would like more information on WHCRA benefits, call your plan administrator (901) 545-7372.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (901) 545-7372.

HIPAA Notice of Special Enrollment Rights

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

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31-day timeframe, coverage will be effective the date of birth, adoption, or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Regional One Health's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

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

Notice of Choice of Providers

The BlueCross BlueShield of Tennessee generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Nila Carrington at (901) 545-7372.

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

You do not need prior authorization from BlueCross BlueShield of Tennessee or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Nila Carrington at (901) 545-7372.

Michelle's Law

The BlueCross BlueShield of Tennessee plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school—or change in school enrollment status (for example, switching from full-time to part-time status)—starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, Nila Carrington in writing as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid, http://www.myalhipp.com Phone: 1-855-692-5447
ALASKA – Medicaid, http://myakhipp.com/, 1-866-251-4861, Customer Service@MyAKHIPP.com
ARKANSAS – Medicaid, http://myarhipp.com/, 1-855-692-7447
CALIFORNIA – Medicaid, http://dhca.gov/hipp, 916-445-8322, hipp@dhcs.ca.gov
COLORADO – Medicaid and CHP+ , https://www.healthfirstcolorado.com/, 1-800-221-3943, CHP+, https://www.colorado.gov/hcpf/child- health- plan-plus, 1-800-359-1991
FLORIDA – Medicaid, https://www.flmedicaidtplrecovery.com/hipp/index.html, 1-877-357-3268
GEORGIA – Medicaid, https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp 678-564-1162 4
INDIANA – Medicaid, http://www.in.gov/fssa/hip/, 877-438-4479 or https://www.in.gov/medicaid/, 800-457-4584
IOWA – Medicaid and CHIP, https://dhs.iowa.gov/ime/members : 1-800-338-8366 , Hawki: http://dhs.iowa.gov/Hawki, 1-800-257-8563 HIPP https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp, 1-888-346-9562
KANSAS – Medicaid, https://www.kancare.ks.gov/ , 1-800-792-4884
KENTUCKY – Medicaid https://chfs.ky.gov/agencies/dms/member/Pages/kihi pp.aspx, 1-855-459-6328, KIHIPP.PROGRAM@ky.gov, : 1- 877-524-4718, https://chfs.ky.gov
LOUISIANA – Medicaid www.medicaid.la.gov or www.ldh.la.gov/lahipp, : 1-888-342-6207 or 1-855-618-5488 (LaHIPP)

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

MAINE – Medicaid, https://www.maine.gov/dhhs/ofi/applications-forms, or 1-800-442-6003 TTY: Maine relay 711
MASSACHUSETTS - Medicaid and CHIP http://www.mass.gov/MassHealth, or 1-800-462-1120
MINNESOTA – Medicaid: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/other-insurance or 1-800-657-3739
MISSOURI – Medicaid, http://www.dss.mo.gov/mhd/participants/pages/hipp.htm or 573-751-2005
MONTANA – Medicaid, http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP or 1-800-694-3084
NEBRASKA – Medicaid, http://www.ACCESSNebraska.ne.gov or 1-855-632-7633
NEVADA – Medicaid, http://dwss.nv.gov/, Medicaid 1-800-992-0900
NEW HAMPSHIRE – Medicaid, https://www.dhhs.nh.gov/oii/hipp.htm or 603-271-5218
NEW JERSEY - Medicaid and CHIP, Medicaid http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid 1-609-631-2392, CHIP http://www.njfamilycare.org/index.html or 1-800-701-0710
NEW YORK – Medicaid https://www.health.ny.gov/health_care/medicaid/ or 1-800-541-2831
NORTH CAROLINA - Medicaid http://www.ncdhhs.gov/dma or 919-855-4100
NORTH DAKOTA – Medicaid, http://www.nd.gov/dhs/services/medicalserv/medicaid/ or 1-844-854-4825
OKLAHOMA - Medicaid and CHIP http://www.insureoklahoma.org or: 1-888-365-3742
OMAHA - 402-595-1178
OREGON –Medicaid http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html:or 1-800-699-9075
PENNSYLVANIA - Medicaid, https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx or 1-800-692-7462
RHODE ISLAND - Medicaid and CHIP, www.eohhs.ri.gov or 401-462-5300
SOUTH CAROLINA - Medicaid http://www.scdhhs.gov or 1-888-549-0820
SOUTH DAKOTA - Medicaid http://dss.sd.gov or 1-888-828-0059
TEXAS – Medicaid, http://www.gethipptexas.com/ 1-800-440-0493
UTAH - Medicaid and CHIP, Medicaid https://medicaid.utah.gov/, CHIP http://health.utah.gov/chip 1-877-543-7669
VERMONT- Medicaid, http://www.greenmountaincare.org/, Phone: 1-800-250-8427
VIRGINIA - Medicaid and CHIP, https://www.coverva.org/en/famis-select .https://www.coverva.org/en/hipp or Medicaid 1-800-432-5924, CHIP 1-800-432-5924
WASHINGTON - Medicaid, https://www.hca.wa.gov/ 1-800-562-3022
WEST VIRGINIA-Medicaid and CHIP, https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid 304-558-1700, CHIP 1-855-MyWVHIPP (1- 855-699-8447)
WISCONSIN – Medicaid and CHIP, https://www.dhs.wisconsin.gov/badgercareplus/p- 10095.htm or 1-800-362-3002
WYOMING – Medicaid, https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ or 1-800-251-1269

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

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

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

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

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

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

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

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

REGIONAL ONE HEALTH
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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

This notice is provided to you on behalf of:

Regional One Health's Health Plan*

*This notice pertains only to healthcare coverage provided under the plan.

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of healthcare to you, or payment for the healthcare is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request(ask your Human Resources representative, or contact the Plan's PrivacyOfficial, described below), and will be posted on any website maintained by Regional One Health that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

REGIONAL ONE HEALTH
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES (CONT.)

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations

- **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to them in order to allow it to more effectively provide treatment to you.
- **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
- **Health Care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

Other Uses and Disclosures of Your PHI Not Requiring Authorization. The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

- **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Regional One Health) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and dis-enrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.
- **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
- **Required by Law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
- **For PublicHealth Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
- **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

REGIONAL ONE HEALTH
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES (CONT.)

- **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **ForResearch Purposes:** In certain circumstances, and under strict supervision of a privacy board, thePlan may disclose PHI to assist medical and psychiatric research.
- **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.

REGIONAL ONE HEALTH
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES (CONT.)

- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is:
  - (i) correct and complete;
  - (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or
  - (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S.Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired, or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Persons for Information or to Submit a Complaint

If you have questions about this notice, please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, or breach notification process, please contact the PrivacyOfficial or an authorized Deputy Privacy Official.

REGIONAL ONE HEALTH
IMPORTANT NOTICE
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Privacy Official

The Plan'sPrivacy Official, the person responsible for ensuring compliance with this notice,is:

Nila Carrington
Director of Benefits & Wellbeing
(901) 545-7372

Effective Date

The effectivedate of this notice is: January 1, 2025

Health Insurance Marketplace Coverage Options and Your Health Coverage

Part A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

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

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

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

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

*An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefitcosts covered by the plan is no less than 60 percentof such costs. For purposes of eligibility for the premiumtax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospitalservices and physician services.

Health Insurance Marketplace Coverage Options and Your Health Coverage (cont.)

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

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

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

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid orChildren's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is **offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

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

What About Alternatives to Marketplace Health Insurance Coverage

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage.

Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan throughSeptember 8, 2023.Confirm the deadline with your employer or your employment-based health plan.

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

Health Insurance Marketplace Coverage Options and Your Health Coverage (cont.)

How Can I Get More Information?

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

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

Part B: Information About Health Coverage Offered By Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name		4. Employer Identification Number (EIN)
5. Employer Address		6. Employer Phone Number
7. City	8. State	9. ZIP Code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email Address	

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid- year, or if you have other income losses, you may still qualify for a premium discount.

Health Insurance Marketplace Coverage Options and Your Health Coverage (cont.)

If you decideto shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

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

Notes

Regional One Health

MY ONE LIFE

EMPLOYEE HEALTH AND WELL-BEING