2023 BENEFITS GUIDE

Carteret Health Care

Carteret HEALTH CARE

WELCOME TO YOUR 2023 BENEFITS

We are dedicated to providing you with unique benefits that meet the needs of you and your family. We understand the importance of a well-rounded benefits program, and because of that, we offer a range of plans that help protect you in the case of illness or injury. You can learn about the details of these plan options by reading through this Benefit Guide.

Starting with the basics of how to enroll, followed by the details of each plan, this guide is a go-to resource for all things benefits related. Once you better understand the various options we offer, you can make an informed decision on which plans work best for you and your family.

We encourage you to read through this booklet in its entirety. Included you will find details about:

- Who is eligible to participate?
- How to enroll and how to make changes during the year, if applicable
- Each benefit offered and a summary of what is covered under the plan
- The Insurance Companies who administer our benefits and how to contact them if you need assistance
- And much more!

We appreciate the hard work and dedication you bring to our company. For this and many other reasons, we want to offer you competitive and cost effective benefits. It's one way we can say thank you for your contributions.

Sincerely,

Carteret Health Care

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/ Benefits Department.

BENEFITS OVERVIEW

Carteret Health Care is proud to offer a comprehensive benefits package to benefit eligible employees. The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

You share the costs of some benefits (medical, dental, vision), and Carteret Health Care provides other benefits at no cost to you (life, accidental death & dismemberment and long term disability). In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

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ELIGIBILITY

If you are a full-time employee or a part-time employee (working a minimum of 20 hours per week), you and your eligible dependents are eligible to enroll in the benefits as described in this guide. Eligible dependents are your spouse, children to age 26, and/or disabled dependents of any age. ***Please note that if your spouse is eligible for medical coverage through their employer, they are not eligible to enroll in the Carteret Health medical plan.***

If you are enrolling as a New Hire outside of the open enrollment period, benefits are effective October 1, 2023 to September 30, 2024.

Open Enrollment

The open enrollment period is August 31st to September 14th. The benefits you elect during open enrollment will be effective from October 1, 2023 through September 30, 2024.

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 21 for more details.

ENROLLMENT DETAILS

Annual enrollment is a once a year opportunity to enroll or make changes to some benefits unless you have a qualified status change during the year.

If you are currently enrolled in benefits and do not wish to make changes during annual enrollment you must do a pass-through enrollment. With the pass-through enrollment, your benefits will remain at their current level with the following exception: flexible spending account contributions (for healthcare or dependent care) must be elected each year.

HOW TO ENROLL

During Open Enrollment:

1. Review your current benefit elections. Verify your personal information and make changes as needed.
2. Evaluate plan options in Kronos and make your benefit elections.

   ⇒ **Access Kronos Employee Self Service at https://ccgh.kronos.net/wfc/navigator/logon**

3. Complete the Tobacco Certification if you are electing a Medical Plan.

WHEN TO ENROLL

The open enrollment period is **August 31st to September 14th**. The benefits you elect during open enrollment will be **effective from October 1, 2023 through September 30, 2024**.

HOW TO MAKE CHANGES

Unless you have a qualified change in status, you cannot make changes to your benefit elections until next year's open enrollment period. Life events such as marriage, divorce, birth or adoption of a child, change in child's dependent status, death of qualified dependent, change in employment status or change in coverage under another employer-sponsored plan may qualify you for a special enrollment period. Please notify Justin du Mont within **30 days** of your qualifying event.

Questions?

If you have any questions about the employee benefits described herein or would like more information, please refer to your plan documents and insurance booklets or contact Justin du Mont, Benefits Coordinator.

MEDICAL BENEFITS

Administered by Medcost

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

	MEDICAL PLAN B OVERVIEW		
	Carteret Health	In-Network	Out-of-Network
Calendar Year Deductible	$1,000 single $3,000 family	$2,000 single $6,000 family	$3,000 single $9,000 family
Calendar Year Out-of-Pocket Maximum	$4,500 single $13,500 family	$6,000 single $14,700 family	$9,000 single $27,000 family
Coinsurance (You Pay)	10%	30%	50%
DOCTOR'S OFFICE			
Primary Care Office Visit	$5 copay	$15 copay	50%
Specialist Office Visit	$30 copay	$50 copay	50%
Preventive Services	Covered 100%	Covered 100%	50%
PRESCRIPTION DRUGS ($100 retail deductible, waived for mail order)			
Tier 1 (30-day supply / 90 day supply Mail Order)	$10 / $20 for mail order 90-day supply		
Tier 2 (30-day supply / 90 day supply Mail Order)	$35 / $70 mail order 90-day supply		
Tier 3 (30-day supply / 90 day supply Mail Order)	$70 / $140 mail order 90-day supply		
Tier 4 (30-day supply / 90 day supply Mail Order)	25% to $250 / N/A		
HOSPITAL SERVICES			
Emergency Room	10% after deductible	30% after deductible	50% after deductible
Urgent Care	$75 copay	$75 copay	$75 copay
Inpatient	10%	30%	50%

Dedicated Medcost toll free number for Carteret members:
1-800-740-3881

MEDICAL BENEFITS (Continued)

Administered by Medcost

	MEDICAL PLAN C OVERVIEW		
	Carteret Health	In-Network	Out-of-Network
Calendar Year Deductible	$2,000 single $4,000 family	$2,500 single $5,000 family	$4,000 single $8,000 family
Calendar Year Out-of-Pocket Maximum	$3,000 single $5,000 family	$4,500 single $6,500 family	$6,250 single $9,000 family
Coinsurance (You Pay)	10%	30%	50%
DOCTOR'S OFFICE			
Primary Care Office Visit	10% after deductible	30% after deductible	50% after deductible
Specialist Office Visit	10% after deductible	30% after deductible	50% after deductible
Preventive Services	Covered 100%	Covered 100%	50%
PRESCRIPTION DRUGS			
Tier 1 (30-day supply / 90 day supply Mail Order)		10% after deductible	
Tier 2 (30-day supply / 90 day supply Mail Order)		10% after deductible	
Tier 3 (30-day supply / 90 day supply Mail Order)		10% after deductible	
Tier 4 (30-day supply / 90 day supply Mail Order)		10% after deductible	
HOSPITAL SERVICES			
Emergency Room/Urgent Care	10% after deductible	30% after deductible	30% after deductible
Urgent Care	30% after deductible	30% after deductible	30% after deductible
Inpatient	10% after deductible	30% after deductible	50% after deductible

RELYMD

Carteret Health offers employees and their dependents enrolled in the Carteret Health plan the unique benefit of accessing a health care provider 24/7/365 via mobile app, web browser, or phone call. This service is provided to save you time, money, and to get you feeling better faster in an easy and convenient way. The average wait time to see a provider is fewer than 10 minutes.

24/7 Access to virtual care!

Your Co-Pay is just $15

When to use **RelyMD**

- If you're considering the ER or urgent care for a non-emergency medical issue.
- When leaving home to seek care just isn't possible.
- You or your family are traveling or in need of medical care.

Medical Conditions RelyMD commonly treats:

- Allergies
- Arthritic Pain
- Bronchitis
- Cold & Flu
- Constipation
- Eye Infections
- Fever
- Gout
- Headache
- Insect Bites
- Rashes
- Sinus Infectoin
- Sore throat
- UTI
- Nausea/vomiting

How to Access Your Account

It's important to remember, the primary benefits holder must first activate their account before dependents can use the service. Dependents under 18 can be added within the primary member's account. Dependents 18 and older must create their own account and then follow the in-app instructions to verify eligibility prior to starting a new consult.

1. Go to **patient.relymd.app** and click **"Sign Up" if you are new** or click **"Login" if you have an existing account.**
2. Complete the fields and enter your email address and password and click the **"Continue"** button
3. Once you login you will need to **add your benefit information**. To do this you must select **"Find benefit provider"** and start entering your **employer's name**, select it when it appears. The portal will let you know that it has been verified or additional steps that might be needed
4. Once complete, you can start a visit. If you face any issues, please contact **855-879-4332** to speak with a care coordinator

HOW YOUR PLAN WORKS

KNOW WHERE TO GO

If you need immediate medical attention, your first thought may be to go to the Emergency Room. However, if your condition is not serious or life threatening, you may have a less expensive choice. Use the chart below to identify where you should go for care!

Plan	Cost	When to Use
Primary Care	$	Routine, Primary, Preventive Care Regular Health Screenings Non-urgent treatment Chronic disease management
Virtual Visits	$	Cold, flu, fever, sore throat, diarrhea, rash, pink eye, sinus infections, cough, headache, stomach ache or ear ache
Convenience Care	$$	Common infections (ear, pink eye, strep, bronchitis), flu shots, vaccines, rashes, screenings
Urgent Care	$$$	Sprains, small cuts, strains, sore throats, minor infections, mild asthma, back pain or strain, vomiting, flu, fever, sports injuries *After hours care & no appointments necessary*
Emergency Room	$$$$	Heavy bleeding, large open wounds, chest pain, spinal injuries, difficulty breathing, major burns, severe head injuries, seizures, unconsciousness, poisoning *Life threatening emergency*

If you believe you are experiencing a medical emergency, go to your nearest emergency room or call 911, even if your symptoms are not as described here

Find a Provider:

www.medcost.com/members/care/find-doctor

VISION BENEFITS

Administered by Community Eye Care

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone. The chart below provides an overview of your available vision plan. Please refer to your plan document for specific details. Below outlines your plan options through Community Eye Care. Using an in-network provider will offer you the lowest service pricing.

VISION SERVICE	EYEWEAR ONLY	COMPREHENSIVE
Eye Exam — once every 12 months	N/A	Included Annually
LENSES — ONCE EVERY 12 MONTHS		
Single Vision Lenses	$150 Allowance	$150 Allowance
Lined Bifocal Lenses	$150 Allowance	$150 Allowance
Lined Trifocal Lenses	$150 Allowance	$150 Allowance
Lenticular Lenses	$150 Allowance	$150 Allowance
Frames — once every 24 months	$150 Allowance	$150 Allowance
Contact Lenses — once every 12 months if you elect contacts instead of lenses/frames	Included Annually	Included Annually

Find a Provider:

www.cecvision.com

DENTAL BENEFITS

Administered by Medcost

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Carteret Health Care dental benefit plan.

SERVICES	BASE PLAN	BUY-UP PLAN
	In-Network	In-Network
Calendar Year Deductible	$25	$25
Calendar Year Benefit Maximum	$1,200	$2,000
Preventive Dental Services (cleanings, exams, x-rays)	100%	100%
Basic Dental Services (fillings, root canal therapy, oral surgery)	80%	80%
Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	50%	50% - includes implants
Orthodontia Services (covered to age 19)	Not Covered	50%
Orthodontia Lifetime Maximum	N/A	$2,000

Find a Provider:

www.medcost.com/members/care/find-doctor

EMPLOYEE CONTRIBUTIONS

EMPLOYEE CONTRIBUTIONS FOR BENEFITS

BENEFIT PLAN	BI-WEEKLY
Medical/Rx Plan B* Wellness	
Employee	$55.49
Employee + Spouse	$198.36
Employee + Child(ren)	$151.41
Family	$253.68
Medical/Rx Plan C Wellness	
Employee	$41.95
Employee + Spouse	$168.44
Employee + Child(ren)	$119.07
Family	$224.56

BENEFIT PLAN	BI-WEEKLY
Medical/Rx Plan B* (Basic)	
Employee	$80.49
Employee + Spouse	$223.36
Employee + Child(ren)	$176.41
Family	$278.68
Medical/Rx Plan C (Basic)	
Employee	$66.95
Employee + Spouse	$193.44
Employee + Child(ren)	$144.07
Family	$249.56

*Part-time employees who enroll in the Medical/Rx Plan B pay an additional $50 per paycheck.

BENEFIT PLAN	BI-WEEKLY
Vision Eyewear Only	
Employee	$3.72
Employee + One	$7.30
Family	$10.96
Vision Comprehensive	
Employee	$5.62
Employee + One	$10.90
Family	$16.04

BENEFIT PLAN	BI-WEEKLY
Dental Base Plan	
Employee	$18.00
Employee + Spouse	$41.49
Employee + Child(ren)	$37.51
Family	$60.31
Dental Buy-Up Plan	
Employee	$20.17
Employee + Spouse	$46.49
Employee + Child(ren)	$42.03
Family	$67.56

LIFE INSURANCE BENEFITS

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Administered by Lincoln Financial Group

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by Carteret Health Care.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident.

Carteret Health Care provides full and part-time employees group life and accidental death and dismemberment (AD&D) insurance in the amount of 1x your annual base salary rounded to the next higher $1,000. Carteret Health Care pays the full cost of this benefit. **Don't forget to keep your beneficiaries up to date.**

VOLUNTARY LIFE AND AD&D INSURANCE

Administered by Lincoln Financial Group

Employees who want to supplement their group life and AD&D insurance benefits may purchase additional coverage. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through payroll deductions. You can purchase voluntary life and AD&D insurance in the increments listed below. Please note, applying for the first time or increasing coverage will require EOI (Evidence of Insurability) or medical underwriting.

Voluntary Life & AD&D Insurance	
Guaranteed Issue	Employee: $300,000 - less than 70 years old Spouse: $50,000
Employee Coverage	Elect $10,000 increments of coverage up to a maximum of $500,000 or 5x annual earnings
Spouse Coverage	Elect up to a $50,000 benefit
Child Coverage	Elect a $5,000 or $10,000 benefit

For More Information Visit:
www.lincolnfinancial.com

DISABILITY INSURANCE

DISABILITY INSURANCE

Carteret Health Care also provides disability insurance through Lincoln Financial Group. This benefit replaces a portion of your income if you become disabled and are unable to work. Full-time employees can elect short-term disability and receive employer paid long-term disability income benefits. In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income. You are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

SHORT-TERM DISABILITY

Options 1-3: President, Physician, VP, PA, FNP, Pharmacist, Therapist, CRNA, Director
Options 4-6: All other Benefited Employees

	STD Option 1	STD Option 2	STD Option 3	STD Option 4	STD Option 5	STD Option 6
Percentage of Income Replaced	60%	60%	60%	60%	60%	60%
Maximum Benefit Duration	13 weeks	11 weeks	9 weeks	26 weeks	24 weeks	22 weeks
Benefits Begin	8th day	15th day	31st day	8th day	15th day	31st day
Maximum Benefit	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500

LONG-TERM DISABILITY

	Long-Term Disability
Percentage of Income Replaced	60%
Benefits Payable	To Social Security Normal Retirement Age
Benefits Begin	After 6 months of disability
Maximum Benefit	Class 1 – CEO/President & Physician: $15,000 Class 2 – VP, Pharmacist, Director, CNRA: $9,000 Class 3 – All other employees: $7,500

SUPPLEMENTAL HEALTH BENEFITS

Administered by Aflac

The additional health benefit options below can be used to customize your coverage to complement your medical plan options. If you elect any other the voluntary options below, you will be responsible for the cost of the benefit. **Part-time employees are not eligible for these benefits.

VOLUNTARY ACCIDENT

Accident insurance can help protect you, your spouse, or your children from the unexpected expense of an accident. Some of the common reasons for claims under this plan include broken bones, burns, and sports related injuries – including kids organized sports.

This plan includes a $60 annual health screening benefit per covered member.

Aflac pays a cash benefit when qualified accidents result in:

- Admission to a hospital
- Dislocations or fractures
- Eye injuries
- Broken teeth
- Lacerations and burns
- Use of an ambulance
- Physical therapy
- Hospital confinement

Accident Insurance Bi-Weekly Premium			
Employee Only	Employee & Spouse	Employee & Children	Employee & Family
$7.48	$10.70	$14.26	$17.48

VOLUNTARY CRITICAL ILLNESS

Critical Illness insurance helps guard against financial hardship if you or a dependent is diagnosed with a covered condition. Some of the expenses this benefit can help pay include initial diagnosis, treatment, and follow-up care. You can choose between a $5,000 to $50,000 benefit for employees and up to a $25,000 benefit for spouses. Children under 26 are automatically covered at 25% of employee benefit.

Covered Illnesses Include:

- Invasive cancer
- Heart attack
- Stroke
- End-stage renal failure
- Major organ failure

See benefit summary for all covered conditions. This plan also features a **$100 annual health screening benefit per covered member.** Premium varies by age, tobacco status, and benefit amount, see rates in plan summary.

SUPPLEMENTAL HEALTH BENEFITS (continued)

Aflac.

VOLUNTARY HOSPITAL INDEMNITY

The Hospital Indemnity plan provides a benefit for hospital admission and confinement for an illness or injury. Benefit is paid directly to you and can be used however you need. **Part-time employees are not eligible for these benefits.

Event	Cash Benefit
Hospital Admission	Choice of $500 to $2,000
Hospital Stay	$100/day up to 15 days
Hospital ER	$100 up to 2x per year

Hospital Indemnity Insurance Bi-Weekly Premium				
	Employee Only	Employee & Spouse	Employee & Children	Employee & Family
Age 18-49	$12.72	$18.06	$16.14	$19.14
Age 50-59	$12.96	$19.08	$16.44	$19.38
Age 60-64	$13.38	$20.40	$16.68	$20.64

VOLUNTARY CANCER INSURANCE

A cancer diagnosis can take an emotional and financial toll on a household and this plan is designed to help alleviate some of the financial burden. Choose the coverage you want; 3 options are available:

	Low Plan	Medium Plan	High Plan
Cancer Screening	$25 once per year	$75 once per year	$100 once per year
Initial Diagnosis	$1,000	$4,000	$6,000
Radiation/Chemo	$600 per month	$1,200 per month	$1,500 per month
Portable	Yes		

For more information visit:

Aflac : Employee View (aflacenrollment.com)

or

scan the QR code to the right

SPENDING ACCOUNTS

OPTUM Bank®

Administered by Optum

FLEXIBLE SPENDING ACCOUNT (FSA)

You can save money on your healthcare and/or dependent day care expenses with an FSA. You set aside funds each pay period on a pretax basis and use them tax-free for qualified expenses. You pay no federal income or Social Security taxes on your contributions to an FSA. (That's where the savings comes in.) Your FSA contributions are deducted from your paycheck before taxes are withheld, so you save on income taxes and have more disposable income.

The **"use it or lose it" rule applies** to FSAs, therefore, any unused funds at the end of the plan year will be **forfeited**. You may submit claims until December 31st for expenses incurred during the plan year. This plan also includes a grace period. A grace period gives participants additional time to incur FSA eligible expenses 2.5 months beyond the year end date (December 15th).

A Healthcare FSA Allows employees who are not enrolled in an HDHP or contributing to an HSA to pay for certain IRS-approved medical care expenses with pre-tax dollars. For those enrolled on in a HDHP, employees can enroll in a limited purpose FSA to pay for eligible dental and vision expenses.

Healthcare Spending Account Maximum: $3,050

A dependent Care Spending Account allows employees to use pre-tax dollars toward qualified dependent care such as caring for children under age 13 or caring for elders

Dependent Care Spending Limit: $5,000 ($2,500 if married and filing separately)

HEALTH SAVINGS ACCOUNT (HSA)

A HSA is a tax-advantaged account that you and your employer can put money into to save for future medical expenses and is yours to keep. HSA funds can be used to pay for eligible medical, dental and vision expenses.

Any adult can contribute to an HSA if they are covered under a HSA-qualified "high deductible health plan" (HDHP), do not have any other first-dollar medical coverage, are not enrolled in Medicare and are not claimed as a dependent on someone else's tax return.

Your HSA is always yours, no matter what. Even if you leave the company, change health plans or retire. Unused money grows tax-free and can be invested with a minimum balance.

The 2023 maximums are:

- $3,850 for individual
- $7,750 for family
- $1,000 catch up contribution for those 55 and older

The 2024 maximums are:

- $4,150 for individual
- $8,300 for family
- $1,000 catch up contribution for those 55 and older

Qualified Medical Expenses:

The IRS maintains a list of all eligible expenses, common qualified expenses include acupuncture, ambulance services, dental treatment, contact lenses, doctor's fees and hearing aids.

View the complete list of qualified expenses at https://www.irs.gov/publications/p502/index.html.

Carteret Health Care will contribute $38.46 to employee only and $57.69 to employee + dependent(s) to your HSA account.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Administered by BHS

Provided by BHS, your Employee Assistance Program (EAP) provides you and your household members with **free, confidential, in-the-moment support** to help with personal or professional problems that may interfere with work or family responsibilities at no cost by Carteret Health Care.

SERVICES OFFERED

Services are available 24-hours a day, 7 days a week via the toll free number: 800-327-2251. BHS provides easy access through text, online request forms, live chat, and the mobile app.

WHAT HAPPENS NEXT?

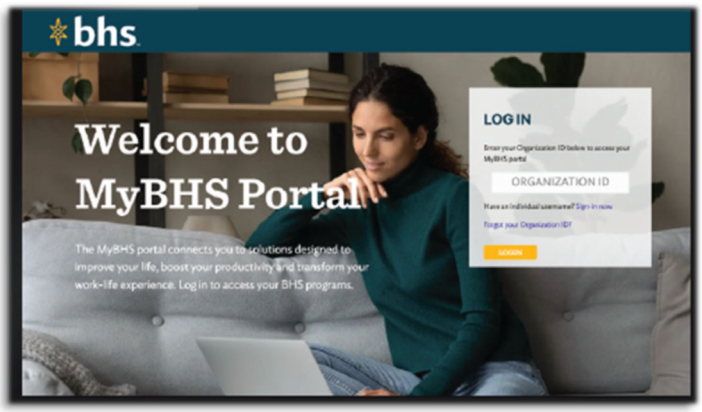
When you call the EAP, a Care Coordinator (master's level clinician) will confidentially assess the problem, assist with any emergencies and connect you to the appropriate resources. The Care Coordinator may resolve your need within the initial call; assess your need as a short-term issue, which can be resolved by an EAP counselor within the available sessions; assess your need as requiring long-term care and assist with connecting you to a community resource or treatment provider available through your health insurance plan.

COMMON REASONS TO CALL YOUR EAP

Relationships	Life Events	Risks	Challenges
Boss/ Co-worker	Birth/Death	Burnout/Anger	Daily responsibilities
Customers	Health/ Illness	Depression/ Anxiety	Financial/Legal
Friends	Marriage/Divorce	Suicidal thoughts	Parenting
Spouse/Kids	Promotion/ Retirement	Substance abuse	Stress/ Conflict

ACCESS THE MYBHS PORTAL

Access the MyBHS Portal online at www.mybhs.bhsonline.com or via the app.



ADDITIONAL BENEFITS

403(B) PLAN

Carteret Health Care's 403(b) retirement plan is designed to help you save for a financially secure future.

- You are automatically enrolled at 1% unless you opt out.
- Contributions are taken out pre-tax and/or post-tax (Roth)
- You may contribute 0% to 100% of your pre-tax salary

Carteret Health Care will match dollar for dollar up to 2% of your base pay (on pre-tax contribution).

You are automatically enrolled in the Contribution Accelerator where your contribution amount will increase by 1% annually, up to a maximum of 8% of your pay.

You are always 100% vested with your own contributions and there is a 3 year vesting schedule for Employer Match.

Loan provisions are available.

457(B) PLAN

You may participate in the 457(b) plan immediately if you belong to a select group of management or key highly compensated employees. Please contact HR to determine if you are in either category. Contributions will begin in the month after the month in which you complete enrollment.

Please note that 457(b) plan assets are owned by the employer until distribution. This means that in case of bankruptcy, all contributions and balances will be subject to your employer's general creditors before they may be distributed to you. The benefits provided by the plan are in the form of your employer's promise to pay you the value of the deferred compensation in the future.

Contribution limits - Your plan and the IRS limit how much may be contributed to your account each year. Contributions to the plan will be reported annually on your Form W-2, but are not included in the income subject to taxation. The current IRS annual limit is $18,500. You may elect to increase up to the max, decrease or stop your contributions at any time. Changes to your contributions will take effect in the month after the month you request them. Vesting refers to your "ownership" of your account the portion to which you are entitled even if you leave the plan. You are always 100% vested in your own contributions plus any earnings on them.

NC 529 COLLEGE SAVINGS PLAN

If paying for college for yourself, a child, grandchild, or someone else you care about is one of your top financial goals, this benefit will help you reach it.

Opening an account online is easy!

Visit www.CFNC.org/NC529 to download information, forms or complete enrollment online.

ADDITIONAL BENEFITS (continued)

MONEY PURCHASE PENSION PLAN

You are eligible for the Money Purchase Pension Plan after you've been employed for at least 1 plan year (October 1 to September 30) with 1,000 hours of service.

Carteret Health Care contributes **4%** of your annual base salary.

Employees are fully vested after **3 years** of credited service.

WELLNESS PROGRAM

Carteret Health Care is committed to being your partner in health. That's why all of our employees are eligible to participate in our wellness incentive program. Through our Well-Points program, you are encouraged to be proactive in managing your health – and you'll get rewarded for it!

- Employees eligible for CHC Medical insurance who complete the wellness program receive a $500 cash reward.
- Employees who are not benefit eligible receive a $100 cash reward.
- Employees qualify for up to $650 Wellness Discount on their insurance premiums by earning 500 Well-Points.

For more information, see your **Well-Points Program Brochure**.

WELLNESS BENEFIT INCLUDED WITH SUPPLEMENTAL HEALTH PLANS

If you enroll in one of the Supplemental Health Plans through Aflac, you may be eligible for an annual wellness benefit! Each plan member is eligible for this incentive one time per year.

You can earn your wellness benefit for getting a routine health screening – you're probably getting some of these tests already!

Common screenings include:

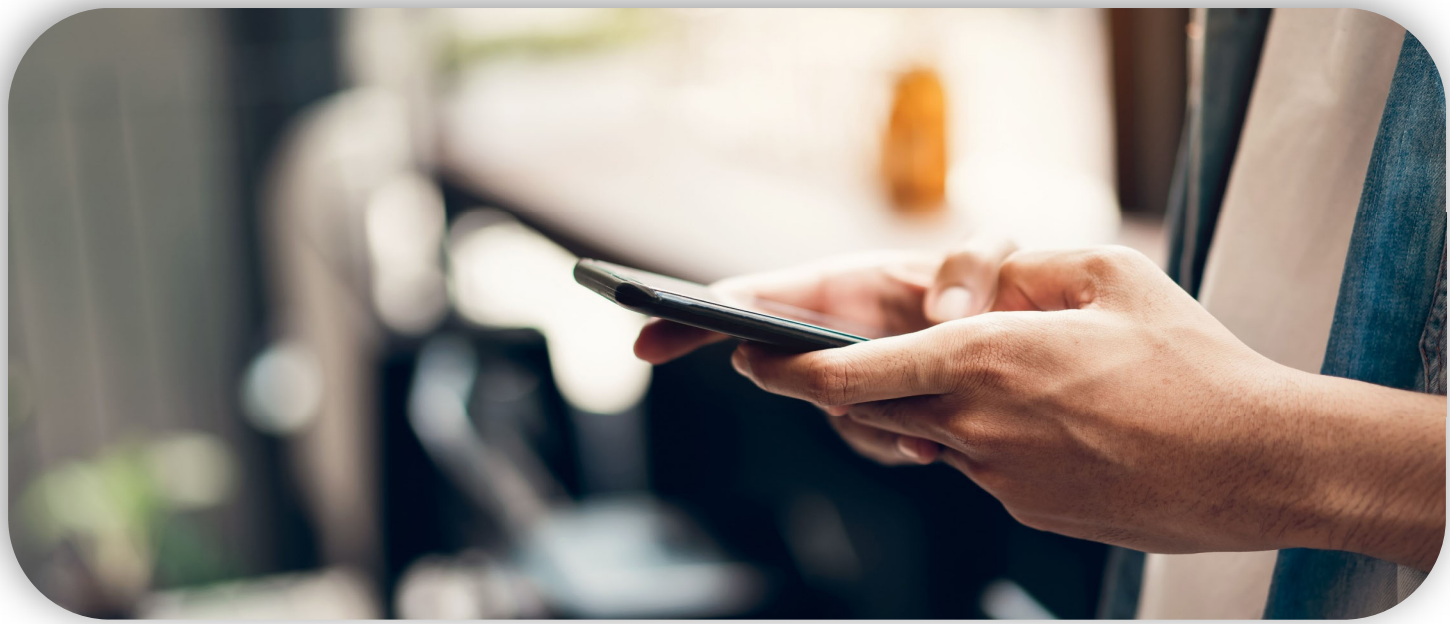
- Blood test
- Mammogram
- Chest x-ray
- Colonoscopy
- Pap smear
- Serum cholesterol test for HDL & LDL
- Stress test
- PSA test
- Fasting blood glucose test
- Skin cancer biopsy

Find more information about this benefit and how to file a claim at www.aflac.com.

CONTACT INFORMATION

If you have specific questions about a benefit plan, please contact the administrator below. For general information please contact Human Resources.

BENEFIT	ADMINISTRATOR	PHONE	WEBSITE/EMAIL
Medical	Medcost	800-740-3881	www.medcost.com
On-Demand Virtual Care	RelyMD	855-879-4332	www.relymd.com
Dental	Medcost	800-740-3881	www.medcost.com
Vision	Community Eye Care	888-254-4290	www.cecvision.com
Flexible Spending Account	Optum	800-243-5543	www.optumbank.com
Health Savings Account	Optum	800-243-5543	www.optumbank.com
Life and AD&D	Lincoln Financial Group	800-423-2765	www.lfg.com
Voluntary Life and AD&D	Lincoln Financial Group	800-423-2765	www.lfg.com
Short Term Disability	Lincoln Financial Group	800-423-2765	www.lfg.com
Long Term Disability	Lincoln Financial Group	800-423-2765	www.lfg.com
Accident	Aflac	800-992-3522	www.aflac.com
Cancer	Aflac	800-992-3522	www.aflac.com
Critical Illness	Aflac	800-992-3522	www.aflac.com
Hospital Indemnity	Aflac	800-992-3522	www.aflac.com
403(b) Savings Plan	Transamerica	800-755-5801	www.trsretire.com



LEGAL NOTICES

Notice of Creditable Coverage

Important Notice from Carteret Health Care

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 Carteret Health Care 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. **Carteret Health Care has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 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 while enrolled in your Employer's coverage as an active employee, please note that your Employer's coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in your Employer's coverage as a former employee.

You may also choose to drop your Employer's coverage. If you do decide to join a Medicare drug plan and drop your current your Employer's coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Carteret Health Care 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 Carteret Health Care changes. You also may request a copy of this notice at any time.

LEGAL NOTICES

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	**October 01, 2023**
Name of Entity/Sender:	**Carteret Health Care**
Contact—Position/Office:	**Justin du Mont - Plan Administrator**
Office Address:	**3500 Arendell St, PO BOX 1619** **Morehead City, North Carolina 28557-2901** **United States**
Phone Number:	**252-499-6033**

LEGAL NOTICES

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, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

LEGAL NOTICES

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

LEGAL NOTICES

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

LEGAL NOTICES

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

LEGAL NOTICES

HIPAA Special Enrollment Rights

Carteret Health Care Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Carteret Health Care Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Justin du Mont - Plan Administrator at 252-499-6033 or jhdumont@carterethealth.org.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Carteret Health Care is committed to the privacy of your health information. The administrators of the Carteret Health Care Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Justin du Mont - Plan Administrator at 252-499-6033 or jhdumont@carterethealth.org.

LEGAL NOTICES

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Medical Plan B Overview

In-Network Preferred (Individual: 90%/10% coinsurance and $1,000 deductible; Family: 90%/10% coinsurance and $3,000 deductible)

In-Network Non-Preferred (Individual: 70%/30% coinsurance and $2,000 deductible; Family: 70%/30% coinsurance and $6,000 deductible)

Plan 2: Medical Plan B Overview

In-Network Preferred (Individual: 90%/10% coinsurance and $1,000 deductible; Family: 90%/10% coinsurance and $3,000 deductible)

In-Network Non-Preferred (Individual: 70%/30% coinsurance and $2,000 deductible; Family: 70%/30% coinsurance and $6,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 252-499-6033 or jhdumont@carterethealth.org.

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

Wellness Program Disclosures

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

EEOC WELLNESS PROGRAM NOTICE

NOTICE REGARDING WELLNESS PROGRAM

Well-Points program will herein be referred to as "Wellness Program"

Your Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for You are not required to complete the HRA or to participate in the blood test or other medical examinations.

LEGAL NOTICES

However, employees who choose to participate in the wellness program will receive an Wellness incentive. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the Wellness Incentive.

Additional incentives may be available for employees who participate in certain health-related activities [or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting your Plan Administrator.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Patient Protections Disclosure

The Carteret Health Care Health Plan generally requires 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. Until you make this designation, Medcost designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Medcost at 800-795-1023 or www.medcost.com.

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

You do not need prior authorization from Medcost 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 the Medcost at 800-795-1023 or www.medcost.com.

COBRA General Notice

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

LEGAL NOTICES

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Justin du Mont.

LEGAL NOTICES

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov/**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

LEGAL NOTICES

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

Carteret Health Care
Justin du Mont - Plan Administrator
3500 Arendell St, PO BOX 1619
Morehead City, North Carolina 28557-2901
United States
252-499-6033

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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This benefit summary prepared by

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