Employee Benefits 2022

Important Contacts

Coverage	Provider	Contact	Group Number	Website
Medical	OSMA Health	(866) 304-5628	TBD	www.osmahealth.com
Dental **Vision** **Basic Life & AD&D** **Vol Life & AD&D** **Short Term Disability** **Long Term Disability**	Mutual of Omaha	(800) 228-7104	TBD	www.mutualofomaha.com
HSA	Bend HSA	(877) 201-3235	N/A	www.bendhsa.com
Benefits Assistance	Higginbotham Employee Response Center	(866) 419-3518	N/A	helpline@higginbotham.net
Higginbotham	Chas Dummit	(817) 347-70214	N/A	cdummit@higginbotham.net
Higginbotham	Maggie Parker	(713) 693-6112	N/A	mlparker@higginbotham.net

Welcome

Our Employees are our Most Valuable Asset

We are pleased to offer you a comprehensive benefits package intended to protect your well-being and financial health. This guide is your opportunity to learn more about the benefits available to you and your eligible dependents beginning January 1, 2022.

To get the best value from your health care plan, please take the time to evaluate your coverage options and determine which plans best meet your health care and financial needs. By being a wise consumer, you can support your health and maximize your health care dollars.

Each year during Open Enrollment, you have the opportunity to make changes to your benefit plans. The enrollment decisions you make this year will remain in effect through December 31, 2022. You may make changes to your benefit elections only when you have a Qualifying Life Event. After such an event, you can make changes to your health care coverage within 30 or 60 days; otherwise, you cannot make changes to your benefits coverage until the next Open Enrollment period.

Availability of Summary Health Information

To help you make an informed choice and compare your options, a Summary of Benefits and Coverage (SBC) is available, which summarizes important information about your health coverage option in a standard format. The SBCs are available on the web at www.abadmin.com or by calling 888-244-5096.

Table of Contents

NOTE: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 26 for more details.

Eligibility

Eligible Employees	Eligible Dependents
• Work an average of 30 hours per week • Benefits are effective first of the month following 60 days	• Legal Spouse • Children under the age of 26 • Unmarried mentally or physically disabled children, regardless of age

NOTE: When covering dependents, you must select the same plans for your dependents as you select for yourself.

Qualifying Life Events

Once you elect your benefit options, they will remain in effect for the entire plan year until the following Open Enrollment. You may only change coverage during the plan year if you have a Qualifying Life Event, and you must do so within 30 or 60 days of the event.

30 –Day Notification Timeframe	60-Day Notification Timeframe
• Marriage, legal separation or annulment • Birth, adoption or placement for adoption of an eligible child • Change in your spouse's employment that affects benefits eligibility • Change in residence that affects your eligibility for coverage • Significant change in coverage or cost in your, your spouse's or child's benefit plans • FMLA Leave, COBRA event, Court Judgment or Decree • Receiving a Qualified Medical Child Support Order	• Death of a spouse or child • Divorce • Change in your child's eligibility for benefits (reaching the 26 age limit) • Becoming eligible for Medicare or Medicaid/CHIP

If you have a Qualifying Life Event and want to request a mid-year change, you must notify Human Resources and complete your election changes within 30 or 60 days following the event. Be prepared to provide documentation to support the Qualifying Life Event.

How to Enroll

Online Enrollment Instructions

1. Go to **www.benefitsinhand.com.** (First time users: Follow steps 2-5. Returning users: Log in and start at step 6.)

2. If this is your first time to log in, click on the **New User Registration** link. Once you register, you will just use your username and password to log in.

3. Enter your personal information and Company Identifier of **FCH&C** and click **Next.**

4. Create a username (work email address recommended) and password, then check the I **agree to terms and conditions** box before you click Finish.

5. If you used an email address as your username, you will receive a validation email to that address. You may now log in to the system.

6. Click the **Start Enrollment** button to begin the enrollment process.

7. Confirm or update your personal information and click **Save & Continue.**

8. Edit dependents or add dependents that need to be covered on your benefits. Once all dependents are listed, click Save & Continue.

9. Follow the steps on the screen for each benefit to make your selection. Please notice there is an option to Decline Coverage. If you wish to decline, click the **Don't want this benefit?** button and select the reason for declining.

10. Once you have elected or declined all benefits, you will see a summary of your selections. Click the Click to Sign button. Your enrollment will not be complete until you click the **Click to Sign** button.

EMPLOYEE RESPONSE CENTER

QUESTIONS

CALL or EMAIL

ANSWERS

THE EMPLOYEE RESPONSE CENTER
CAN ASSIST YOU WITH:

- Enrollment
- Benefit information
- Claims or billing questions
- Eligibility issues

(866) 419-3518

helpline@higginbotham.net

Bilingual

8:00 am – 5:00 pm CST
Monday – Friday

If you reach voicemail, your call will be returned within 24 hours or next business day.

Call us toll-free or send us an email... *We can help!*

Higginbotham™

Medical Coverage

FALLS COMMUNITY HOSPITAL & CLINIC offers one medical plan using the **UHC Choice Plus Network**. The HDHP option offers the freedom to see any provider when you need care. When you use providers from within the Choice Plus network, you receive benefits at the discounted network cost. If you use non-PPO providers, you will pay more for services.

High Deductible Health Plan (HDHP)

The HSA plan allows you the freedom to see any provider when you need care, although you will pay less if you use in-network providers. You must satisfy a higher deductible that applies to almost all healthcare expenses, including those for prescription drugs. Once your deductible is met, the plan pays 100%.

Health Coverage Reminder

The Patient Protection and Affordable Care Act (PPACA) requires most individuals to have minimum essential health coverage. You may obtain coverage through your employer or through the Marketplace.

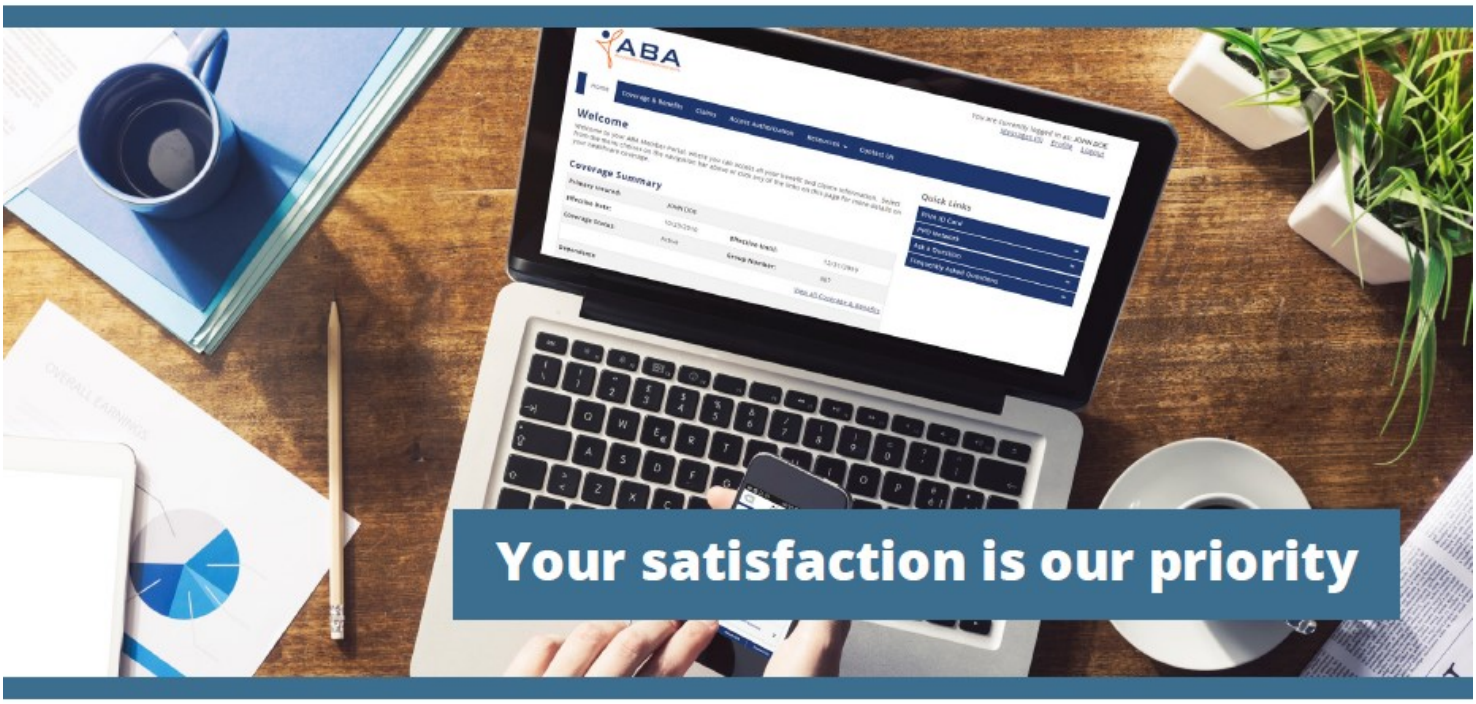
- Depending on your income and the coverage offered by your employer, you may be able to obtain lower cost private insurance in the Marketplace.
- If you buy insurance through the Marketplace, you may lose any employer contribution to your health benefits.
- Visit **www.HealthCare.gov** for Marketplace information.

REMINDER: You may only purchase insurance through the Marketplace if you experience a qualifying event OR during Open Enrollment. The Federal Marketplace Open Enrollment dates are November 1 through December 15.

Medical Coverage

	ABA OSMA HDHP Choice	
	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible		
Individual	$5,000	$5,000
Family	$10,000	$10,000
Calendar Year Out-of-Pocket Maximum (Includes Deductible)		
Individual	$5,950	$10,000
Family	$11,900	$20,000
Lifetime Maximum	Unlimited	Unlimited
Coinsurance / Copays		
Preventive Care	Covered 100%	Not Covered
Primary Care Physician	Deductible + 10%	Deductible + 50%
Specialist	Deductible + 10%	Deductible + 50%
Diagnostics: Lab & X-Ray	Deductible + 10%	Deductible + 50%
Advanced Radiology Imaging (Outpatient)	Deductible + 10%	Deductible + 50%
Urgent Care	Deductible + 10%	Deductible + 50%
Emergency Room	Deductible + 10%	Deductible + 10%
Inpatient Hospital Care	Deductible + 10%	Deductible + 10%
Outpatient Surgery	Deductible + 10%	Deductible + 10%
Pharmacy		
Retail RX (up to 31 day supply)		
Tier 1—Preferred Generic (Preferred/ Non-Preferred Pharmacy)	Deductible + 10%	Not Covered
Tier 2—Preferred Brand (Preferred/ Non-Preferred Pharmacy)	Deductible + 10%	Not Covered
Tier 3—Non-Preferred Brand (Preferred/ Non-Preferred Pharmacy)	Deductible + 10%	Not Covered

ABA MEMBER PORTAL



Access the information you need as soon as you need it.

Developed with convenience in mind, our single source member portal provides quick and easy access to view claims, deductibles and maximums, access ID cards, download important documents, update member information and more.

To create a user account, please complete the following steps:

1. Visit **www.abadmin.com**. Click on **Member Login** in the top right-hand corner.
2. Click on **Proceed to our sign up process**.
3. Read the License Agreement and click **Agree**.
4. Complete all applicable forms. Please enter your first and last name, date of birth, and either Social Security number or member ID (exactly as it appears on your ID card).

The Member Portal may also be accessed via the **MyABA mobile application**, which is available for download on the Google Play™ store or the Apple® App Store®.

If you have any questions or need assistance, our customer service representatives are available **Monday through Friday** from **8 a.m. to 6 p.m.** by calling **1.800.247.7114**.

Since 1985, ABA has been offering innovative, cost-efficient health benefits to self-funded plan sponsors as a strategic asset and not just an added cost. With our concierge-style service, members receive the right care, at the right place, at the right time.

ABA
Assured Benefits Administrators

Where to Go for Healthcare

When you need medical attention, you should go to your primary care doctor whenever you can. Your doctor knows you best and has quick access to your medical records. However, there are times when you might need to go to a facility other than your doctor's office. This list shows examples of various care providers and the services they generally provide. The cost of medical care can vary widely. Your cost depends on where and how you receive care. Knowing the facts can help you manage your health and your health care dollars.

TELEMEDICINE/ MDLIVE

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- Available 24/7/365
- Talk with a doctor via your computer or mobile phone
- Use for non-emergency conditions
- Medication may be prescribed
- Takes 10-15 minutes

FOR HELP WITH

- Allergies
- Cough/cold/flu
- Infections
- Diarrhea
- Rash
- Sore throat
- Fever
- Stomachache

DOCTOR'S OFFICE

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- Office hours vary
- Generally best place for routine, preventive or non-emergency care
- Established relationship and able to treat based on knowledge of medical history

FOR HELP WITH

- Routine exam
- Vaccinations
- Preventive services
- General health management
- Common infections
- Minor skin conditions
- Minor injuries
- Earache
- Sprains and strains

RETAIL HEALTH CLINIC

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- Based on retail store hours
- Usually lower out-of-pocket costs than urgent care
- Often located in stores and pharmacies to provide low-cost treatment for minor medical problems

FOR HELP WITH

- Common infections
- Minor skin conditions
- Vaccinations
- Pregnancy tests
- Minor injuries
- Earache

URGENT CARE CENTER

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- Hours vary and usually open evenings, weekends and holidays
- Use when doctor's office is closed and not a true emergency
- Average wait time is 11-20 minutes
- Online and/ or telephone check-in

FOR HELP WITH

- Sprains and strains
- Minor infections
- Small cuts that may require stitches
- Minor burns

HOSPITAL EMERGENCY ROOM

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- Open 24/7/365
- Place to go for true emergency or trauma
- Average wait time is over 4 hours
- Multiple bills for services such as doctor and facility

FOR HELP WITH

- Any life- threatening or disabling condition
- Sudden loss of consciousness
- Major injuries
- Chest pain; numbness in face, arm or leg; difficulty speaking
- Severe shortness of breath
- High fever
- Coughing or vomiting blood
- Cut or wound that will not stop bleeding
- Broken bones

FREESTANDING EMERGENCY ROOM

$$$$$$$

- Open 24/7/365
- Does not include trauma care or cardiac services requiring catheterization
- May be out-of-network, which means you will pay more for care and possibly balance billed
- Charged fees for facility, laboratory and each doctor you see
- May provide imaging and lab services
- Does not always accept ambulances

FOR HELP WITH

- Most major injuries except trauma
- Severe pain

Health Savings Account

By enrolling in FALLS COMMUNITY HOSPITAL & CLINIC's qualified High Deductible Health Plan (HDHP), you have the option of opening a Health Savings Account (HSA) through **Bend HSA**. Any individual who is not currently covered by another medical plan that is not an IRS qualified HDHP, not enrolled in Medicare, or claimed as a dependent on someone else's tax return can open an HSA.

What Is An HSA?

An HSA is like a 401(k) for health care. It is a tax-advantaged personal savings account that you can use to pay for qualified health care expenses—now or in the future.

Triple Tax Savings

Contributions	Investment Earnings	Distributions
		
All contributions can be made pre-tax, decreasing your overall taxable income.	Earn money tax-free through investments or interest payments.	Pay for qualified health care expenses tax-free from the money in your account.

Other Advantages of an HSA

- Portability (you keep your HSA, even if you change employers or medical insurance plans)
- Unused contributions or investment earnings rollover each year

HSA Annual Contributions 2021/2022	
Coverage Level	Maximum Contribution
Employee Only	$3,600 / $3,650
Employee + Dependents	$7,200 / $7,300
Employee 55+	An additional $1,000/year

Opening the HSA

Once you enroll in the HDHP medical plan, you are eligible to enroll in the HSA administered by Bend HSA. Once you are enrolled, you will receive a debit card from Bend HSA for managing your HSA account reimbursements. Funds available for reimbursement are limited to the balance in your HSA. To view your account information, go to www.bendhsa.com.

You, NOT your employer, are responsible for maintaining ALL records and receipts for HSA reimbursements in the event of an IRS audit.

Refer to IRS Publication 502 Medical and Dental Expenses at www.irs.gov for a complete description of eligible medical and dental expenses.

Dental Coverage

Our dental plan helps you maintain good dental health through affordable options for preventive care, including regular checkups and other dental work. Premium contributions for dental will be deducted from your paycheck on a pre-tax basis. Dental coverage is provided through **Mutual of Omaha.**

DPPO Plan

Two levels of benefits are available with the DPPO dental plans depending on whether or not your dentist is in or out of the PPO network. You have the flexibility to select the provider of your choice, but your level of coverage may vary based on the provider you see for services. Staying in-network and going to a contracted DPPO provider will provide you with the highest level of benefits and the deepest discounts your plan has to offer. Your out-of-network reimbursement is 80th percentile—UCR.

How to Find a Dentist

To find an in-network dentist, visit www.dentistsforme.com/mutualofomaha or call 888-338-3875 to speak with Member Services.

	DPPO PLAN
Calendar Year Deductible	
Individual	$50
Family	$150
Calendar Year Maximum Benefit	
Per Individual	$1,500
Services	
Preventive Procedures **Exams, Cleanings, X-rays, Sealants, Fluoride Treatments (children under age 16 only), Space Maintainers**	Covered 100%
Basic Procedures **Fillings, Oral Surgery (simple extractions), Surgical Extraction of Impacted Teeth, Endodontics, Periodontics**	20% Coinsurance
Major Procedures **Crowns, Dentures, Bridges, Repairs**	50% Coinsurance
Orthodontia	50% Coinsurance
Orthodontia Lifetime Max	$1,500

Vision Coverage

The vision plan, offered to you by FALLS COMMUNITY HOSPITAL & CLINIC through **Mutual of Omaha** using the **EyeMed** network, is designed to provide your basic eyewear needs and preserve your health and eyesight. In addition to detecting eye problems, vision exams can help identify certain medical conditions such as diabetes or high cholesterol. You may seek care from any licensed optometrist, ophthalmologist or optician, but plan benefits are higher if you use a **EyeMed** provider. www.eyedoclocator.eyemedvisioncare.com/mutual/en

	Vision Plan
	PARTICIPATING PROVIDER
	You pay
Cost	
Exam	$10 Copay
Lenses	
Single Lenses	$25 Copay
Bifocals	$25 Copay
Trifocals	$25 Copay
Frames	$130 Allowance + 20% off remaining balance
Contacts in lieu of Frames/Lenses	
Conventional	$130 Allowance + 15% off remaining balance
Medically Necessary	$0
Benefit Frequency	
Exams	Once every 12 months
Lenses	Once every 12 months
Frames	Once every 24 months

Life and AD&D Insurance

Life and Accidental Death & Dismemberment (AD&D) insurance provides you with the peace of mind knowing you can help meet your family's financial needs even if you are not there to provide for them.

Basic Life and AD&D Insurance

FALLS COMMUNITY HOSPITAL & CLINIC pays the full cost of Basic Life and AD&D coverage for all eligible full-time employees. Coverage is provided through **Mutual of Omaha.**

Benefit	Coverage
Basic Employee Life	$10,000
Basic Employee AD&D	$10,000
Benefits reduce 35% at age 65 and 50% at age 70	

Voluntary Life and AD&D Coverage

You may purchase additional Life and AD&D insurance for you and your eligible dependents.

If you decline Voluntary Life insurance when first eligible or if you elect coverage and wish to increase your benefit amount at a later date, Evidence of Insurability (proof of good health) may be required before coverage is approved. Once annually, you will be able to increase your insurance amount by up to $10,000 without Evidence of Insurability. You must elect Voluntary coverage for yourself in order to elect coverage for your spouse or children. Coverage is provided through **Mutual of Omaha.**

Voluntary Employee Life

- Minimum Benefit—$10,000
- Maximum Benefit—$500,000 ($10,000 increments)
- Guarantee Issue— $150,000

Voluntary Spouse Life

- Minimum Benefit—$5,000
- Maximum Benefit—$50,000 not to exceed 50% of employee coverage
- Guarantee Issue— $50,000

Voluntary Child(ren) Life

- Minimum Benefit—$10,000
- Maximum Benefit—$10,000

- Employee must be enrolled in order to elect coverage for dependents. The Guarantee Issue amount for newly eligible employees is $150,000 and spouse is $50,000. If you are a currently employee and you previously waived coverage, an Evidence of Insurability (EOI) will be required if electing coverage this year. This form will be reviewed by Guardian before a benefit is approved/denied.
- Benefits reduce 35% at age 65 and 50% at age 70.

Voluntary Life and AD&D Rates

Age *(Spouse's premium is calculated based on employee's age)*	Employee / Spouse Rate per $1,000
< 25	$0.064
25-29	$0.064
30-34	$0.082
35-39	$0.118
40-44	$0.170
45-49	$0.280
50-54	$0.460
55-59	$0.720
60-64	$0.960
65-69	$1.560
Child(ren) Rate	$0.221

Conversion, Portability, and Waiver of Premium

Upon termination of employment, you have the option to continue your company paid and/or voluntary life and AD&D insurance and pay premiums directly to **Mutual of Omaha**. Your company paid life insurance and voluntary life may be converted to an individual policy. Portability is available for your voluntary life and AD&D coverage. If you are disabled at the time your employment is terminated, you may be eligible for a Waiver of Premium while you are disabled. Contact your Human Resources Department for a Conversion, Portability, and/or Waiver of Premium application.

Designating a Beneficiary

A beneficiary is the person or entity you designate to receive the death benefits of your life insurance policy. You can name more than one beneficiary and you can change beneficiaries at any time. If you name more than one beneficiary, identify the share for each.

Voluntary Disability Insurance

If you suddenly become ill or are involved in an accident and are unable to work, it is easy to fall behind on your rent or mortgage, car payment, and other expenses. That is why a salary replacement plan is an important benefit for you and your family. Rates will auto calculate in Benefits in Hand.

Short Term Disability Insurance

STD insurance pays a percentage of your weekly salary for a covered disability or injury that prevents you from working for more than 7 days. Benefits begin at the end of an elimination period and continue while you are disabled up to 26 weeks. Coverage is provided through **Mutual of Omaha.**

Benefit	Coverage
Weekly Benefit	66.67% up to $1,500
Benefit Waiting Period	7 days
Benefit Duration	26 Weeks
Pre-existing Conditions	3 months prior/6 months insured

Long Term Disability Insurance

LTD insurance pays a percentage of your monthly salary for a covered disability or injury that prevents you from working for more than 180 days. Benefits begin at the end of an elimination period and continue while you are disabled up to the Social Security Normal Retirement Age (SSNRA). Coverage is provided through **Mutual of Omaha.**

Benefit	Coverage
Monthly Benefit	60% up to $6,000
Benefit Waiting Period	180 days
Benefit Duration	Social Security Normal Retirement Age
Pre-existing Conditions	3 months prior/12 months insured
Definition of Disability	24 month own occupation limit

Rates

This worksheet helps you calculate your **per pay check** costs and is not an enrollment form.

All rates will auto calculate in Benefits In Hand.

Medical Coverage		**Medical**
	ADA OSMA HDHP Choice	$
Employee Only	$52.50	
Employee + Spouse	$325.50	
Employee + Child(ren)	$234.50	
Employee + Family	$507.00	
Dental Coverage		**Dental**
Employee Only	$15.73	
Employee + Spouse	$31.35	$
Employee + Child(ren)	$42.34	
Employee + Family	$64.29	
Vision Coverage		**Vision**
Employee Only	$3.62	
Employee + Spouse	$6.80	$
Employee + Child(ren)	$7.14	
Employee + Family	$10.46	
Basic Life/AD&D		**Life/AD&D**
Employee Only	Paid by FALLS COMMUNITY HOSPITAL & CLINIC	$ 0.00
Voluntary Life & AD&D		**Vol Life & AD&D**
Employee Only	Rates and calculations will automatically be calculated in Benefits in Hand	$
Family		$
Short-Term Disability		**STD**
Employee Only	Rates and calculations will automatically be calculated in Benefits in Hand	$
Long-Term Disability		**LTD**
Employee Only	Rates and calculations will automatically be calculated in Benefits in Hand	$
Health Savings Account (HSA)		**HSA**
	Rates and calculations will automatically be calculated in Benefits in Hand	$
Total	→	**$**

Required Notices

Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Special Enrollment Rights

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

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later 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 enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for such assistance.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact:

FALLS COMMUNITY HOSPITAL & CLINIC

322 Coleman St

Marlin, TX 76661

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 FALLS COMMUNITY HOSPITAL & CLINIC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription 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. FALLS COMMUNITY HOSPITAL & CLINIC has determined that the prescription drug coverage offered by the FALLS COMMUNITY HOSPITAL & CLINIC medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare prescription drug plan, as long as you later enroll within specific time periods.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription drug plan, you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7 but as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting FALLS COMMUNITY HOSPITAL & CLINIC at the phone number or address listed at the end of this section.

If you choose to enroll in a Medicare prescription drug plan and cancel your current FALLS COMMUNITY HOSPITAL & CLINIC prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

For more information about this notice or your current prescription drug coverage:

Contact the Human Resources Department at 713-895-8668.

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You may also request a copy.

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 will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription 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 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at 800-772-1213. TTY users should call 800-325-0778.

Remember: Keep this Creditable Coverage notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, 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 whether or not you are required to pay a higher premium (a penalty).

Date: 4/1/2021

Name of Entity/Sender: FALLS COMMUNITY HOSPITAL & CLINIC

Contact Office: Human Resources

Address: 322 Coleman St, Marlin, TX 76661

Notice of HIPAA Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information known as protected health information (PHI), includes virtually all individually identifiable health information held by a health plan - whether received in writing, in an electronic medium or as oral communication. This notice describes the privacy practices of the Employee Benefits Plan (referred to in this notice as the Plan), sponsored by FALLS COMMUNITY HOSPITAL & CLINIC, hereinafter referred to as the plan sponsor.

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. It is important to note that these rules apply to the Plan, not the plan sponsor as an employer.

You have the right to inspect and copy protected health information which is maintained by and for the Plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask the Human Resources Department to amend the information. For a full copy of the Notice of Privacy Practices describing how protected health information about you may be used and disclosed and how you can get access to the information, contact the Human Resources Department.

Complaints: If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint, please contact the Privacy Officer.

FALLS COMMUNITY HOSPITAL & CLINIC

Human Resources

322 Coleman St

Marlin, TX 76661

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 are 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 and CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 20XX. Contact your State for further information on eligibility.

ALABAMA – Medicaid
Website: http://www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890

Phone (Anchorage): 907-269-6529

COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf
Medicaid Customer Contact Center: 1-800-221-3943

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 1-404-656-4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.hip.in.gov
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone: 1-800-403-0964

IOWA – Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http:/dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://www.mn.gov/dhs/ma/
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/
AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 1-855-632-7633

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: www.eohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: http://health.utah.gov/medicaid
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website:
http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website:
www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid
Website: http://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 20XX, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

OMB Control Number 1210-0137 (expires 10/31/2016)

Continuation of Coverage Rights Under COBRA

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.

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 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,PartB, 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 [or enter longer period permitted under the terms of the Plan] after the qualifying event occurs.

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, Medicaid, 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**.

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

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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:

Company Name: FALLS COMMUNITY HOSPITAL & CLINIC

322 Coleman St

Marlin, TX 76661

Notes

Higginbotham™

This brochure highlights the main features of FALLS COMMUNITY HOSPITAL & CLINIC Benefits Program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. FALLS COMMUNITY HOSPITAL & CLINIC reserves the right to change or discontinue its benefit plans at any time.