If you (and/or your dependents) have Medicare or you 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 30 for more details.

The information in this brochure is a general outline of the benefits offered under Prime Healthcare Services (Prime) benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.
Dear Valued Employee:

Prime Healthcare Services (Prime) understands the importance of offering a comprehensive benefit program that meets the needs of our diverse workforce. We are pleased to continue to provide a suite of quality benefit plans to all benefit eligible employees.

2016 Core Health Plan Offerings

- Saint Mary’s General Hospital Employee Medical Plan
- Saint Mary’s General Hospital Comprehensive PPO Medical Plan
- Saint Mary’s General Hospital Enhanced PPO Medical Plan
- Value Plan
- Healthy Lifestyles Wellness Program
- Delta Dental of New Jersey PPO℠ Plan
- Delta Dental of New Jersey Premier® / Advantage POS Program
- Delta Dental of New Jersey Flagship DMO Plan
- Davis Vision Plan
- Employee Assistance Program (EAP)
- Sun Life Financial Basic Life and Accidental Death & Dismemberment (AD&D) Insurance
- HR Simplified Flexible Spending Accounts (FSA)

In addition to the core health plans, you can purchase any of the following Voluntary Products

- Sun Life Financial Optional Life Insurance
- Sun Life Financial Long Term and Short Term Disability Insurance
- Trustmark Voluntary Insurance – Universal Life with Long Term Care, Universal LifeEvents®, Critical Illness, Accident Plan (available during Open Enrollment only)
- MetLaw Prepaid Legal Plan
- MetLife Home and Auto Insurance
- VPI Pet Insurance
**PLAN HIGHLIGHTS**

**Medical Plans**

Saint Mary’s General Hospital Employee Medical Plan
(Full-Time and Part-Time Employees)

The Saint Mary’s General Hospital Employee Medical Plan offers comprehensive coverage and a broad network of physicians and hospitals.

Saint Mary’s General Hospital Comprehensive and Enhanced PPO Plans (Full-Time and Part-Time Employees)

These PPO plans offer a three tier benefit structure which allow for maximum flexibility and choice. These plans provide excellent coverage for routine and preventative care, as well as for the most serious and complex health issues.

Value Plan (Full-Time and Part-Time Employees)

The Value Plan offers essential health benefits as specified under the Affordable Care Act.

**Dental Plans**

Dental Plans

Delta Dental of New Jersey offers three different dental plans for your consideration; Delta Dental PPO, Delta Dental Advantage/Premier POS and DeltaCare Flagship DMO. These three plans offer unique calendar year maximums and provide varying levels of benefits.

**Vision Plan**

Davis Vision

The Vision plan offered through Davis Vision covers vision exams, frames and lenses.

**Employee Assistance Program (EAP)**

ComPsych

Your physical and emotional health is important to us. ComPsych service connects you with the best mental health and counseling services to fit your individual needs.

**Flexible Spending Accounts (FSA)**

HR Simplified

Flexible Spending Accounts let you pay for eligible health care and dependent care expenses on a pre-tax basis.

**Life and Accidental Death & Dismemberment (AD&D) Insurance**

Sun Life Financial

Life insurance provides protection for your beneficiary in the event of your death. Prime will provide a benefit amount equal to your annual salary up to a maximum limit. This benefit is provided to benefit eligible employees at no cost to you.

Full-time and part-time benefit eligible employees may apply for Optional Life Insurance at affordable group rates. Life insurance coverage is also available for eligible dependent family members. Premiums are determined by your age.

Evidence of Insurability may be requested.

**Voluntary Disability (Short and Long Term) Income Protection**

Sun Life Financial

When illness or injury makes it impossible for you to work for an extended period of time, employee’s income may be continued under the Voluntary Disability plans. Eligible employees may apply for disability coverage at low group rates.

Evidence of Insurability may be requested.
ELIGIBILITY

Benefit Eligible Employees

Full-time and qualified part-time employees who are regularly scheduled to work 37.5 hours of service per pay period are eligible for benefits the first of the month following 60 days of employment.

Directors and Administration staff are eligible the first day of the month following the date of hire.

Contact Human Resources for additional information.

Dependents

Dependents eligible for coverage include your legally married spouse, a civil union partner, and children up to age 26. Coverage for your dependent children will continue through the end of the month in which they turn age 26. Physically or mentally disabled children of any age who are unmarried and financially dependent on an employee may be eligible. For vision coverage, dependent children are covered to age 31.

Opt-Out Credit

Employees selecting the Opt-Out credit must waive the medical benefit through the online enrollment portal and provide the insurance carrier name and policy number.

If you have a dependent spouse or child who works for Prime Healthcare Services, he/she will not be eligible to be added to your plan as a dependent or participate in the Opt-Out program. Benefits must be renewed annually in order to receive the Opt-Out credit.

If your legally married spouse or a civil union partner has other medical coverage and decides not to enroll (Opt-Out) in the Prime Medical Plan, you will be entitled to receive an Opt-Out credit in the amount of $40 per pay period. In order to receive the Opt-Out credit, you must waive the medical benefit through the online enrollment portal and provide the insurance carrier name and policy number.
ELIGIBILITY (continued)

Qualifying Events

You will not be allowed to change your plan selections or add dependents until the next benefit year (starting January 1) unless you have a qualified change in status. Qualified changes in status typically follow a life event such as marriage, divorce, birth or adoption. Changes must be submitted to Human Resources within 31 days of a life event.

The following are considered qualified changes in status:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, and death of a spouse
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child
- Change in employment status, including the start or termination of employment by you, your spouse, or your dependent child
- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits
- Change in a child’s dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- Change in your health coverage or your spouse’s coverage attributable to your spouse’s employment
- Change in an individual’s eligibility for Medicare or Medicaid
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child or dependent foster child
- A special event under HIPAA (the Health Insurance Portability and Accountability Act), including acquisition of a new dependent or spouse or loss of coverage under another health insurance policy or plan if the coverage is terminated because of:
  - Voluntary or involuntary termination of employment or reduction in hours of employment or death, divorce, or legal separation
  - Termination of employer contributions toward the other coverage, OR
  - If the other coverage was COBRA Continuation Coverage, exhaustion of the coverage
Full-time and qualified part-time employees who are regularly scheduled to work 37.5 hours of service per pay period will be eligible to elect the Saint Mary's General Hospital Employee Medical Plan.

<table>
<thead>
<tr>
<th>Plan Benefits</th>
<th>Saint Mary's General Hospital Employee Medical Plan</th>
<th>Anthem Blue Cross BlueCard Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible (Individual / Family)</td>
<td></td>
<td>$1,000 / $2,000</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum (Individual / Family)</td>
<td></td>
<td>$4,850 / $9,700</td>
</tr>
<tr>
<td>Hospital Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient / Outpatient (including Maternity)</td>
<td>No charge at Saint Mary's General Hospital or at a Prime Healthcare Facility, otherwise 20%</td>
<td></td>
</tr>
<tr>
<td>• Emergency Room (copay waived if admitted)</td>
<td>$25 copay at a Prime Healthcare Facility; otherwise $250 copay</td>
<td></td>
</tr>
<tr>
<td>• Urgent Care</td>
<td>$30 copay</td>
<td></td>
</tr>
<tr>
<td>• Ambulance</td>
<td>$250 copay/trip</td>
<td></td>
</tr>
<tr>
<td>Physician Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician Office Visits</td>
<td>$30 copay</td>
<td></td>
</tr>
<tr>
<td>• Specialist Visits</td>
<td>$45 copay</td>
<td></td>
</tr>
<tr>
<td>• Routine Annual Physical</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td>• Maternity Care*</td>
<td>$30 copay</td>
<td></td>
</tr>
<tr>
<td>• Post-Natal</td>
<td>$30 copay</td>
<td></td>
</tr>
<tr>
<td>• Well-Baby and Well-Child Care</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td>• X-ray and Lab Procedures (CT-MRI / Complex Imaging)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Rehabilitation Therapies (Physical, Occupational, Speech)</td>
<td>$30 copay (30 visits/cal year combined max)</td>
<td></td>
</tr>
<tr>
<td>• Chronic Renal Dialysis</td>
<td>No charge at a Prime Healthcare Facility, otherwise 20% (Chronic renal dialysis treatments are limited to 39 visits)</td>
<td></td>
</tr>
<tr>
<td>• Home Health Care</td>
<td>20% (100 visits/cal year)</td>
<td></td>
</tr>
<tr>
<td>• Durable Medical Equipment</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>• Chiropractic</td>
<td>$30 copay (20 visits max/calendar year)</td>
<td></td>
</tr>
<tr>
<td>Mental Health / Substance Use Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Mental Health / Substance Use Disorder</td>
<td>No charge at Saint Mary's General Hospital or at a Prime Healthcare Facility, otherwise 20%</td>
<td></td>
</tr>
<tr>
<td>• Outpatient Mental Health / Substance Use Disorder</td>
<td>$30 copay</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Retail (up to a 30-day Supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Generic / Formulary Brand</td>
<td>$10 copay / $30 copay</td>
<td></td>
</tr>
<tr>
<td>• Maintenance Rx Filled at Retail Pharmacy (after 2nd fill: up to a 31-day Supply)</td>
<td>$20 copay / $60 copay</td>
<td></td>
</tr>
<tr>
<td>– Generic / Formulary Brand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mail Order (up to a 90-day Supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Generic / Formulary Brand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Rx Copay Maximum (Individual / Family)</td>
<td></td>
<td>$1,000 / $2,000</td>
</tr>
</tbody>
</table>

* For all plans, tiered into Physician PCP office visit benefit, afterwards all services are included in Global Charges.

This is a brief summary of the benefits available under the Prime plans. In the event of a discrepancy between this summary and the Plan Document, the Plan Document will prevail. Prime retains the right to modify or eliminate these or any other benefits at any time and for any reason.
MEDICAL (continued)

Full-time and qualified part-time employees who are regularly scheduled to work 37.5 hours of service per pay period will be eligible to elect the Saint Mary’s General Hospital Comprehensive PPO Plan.

<table>
<thead>
<tr>
<th>Plan Benefits</th>
<th>Saint Mary’s General Hospital Comprehensive PPO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tier 1 (Domestic) PPO Network</td>
</tr>
<tr>
<td>Annual Deductible (Individual / Family)</td>
<td>$0 / $0</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum (Individual / Family) (includes Deductible)</td>
<td>$2,500 / $5,000</td>
</tr>
<tr>
<td>Hospital Care</td>
<td></td>
</tr>
<tr>
<td>• Inpatient / Outpatient</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency Room (copay waived if admitted)</td>
<td>$25 copay</td>
</tr>
<tr>
<td>• Urgent Care</td>
<td>$15 copay</td>
</tr>
<tr>
<td>• Ambulance</td>
<td>N/A</td>
</tr>
<tr>
<td>Physician Care</td>
<td></td>
</tr>
<tr>
<td>• Physician Office Visits</td>
<td>$15 copay</td>
</tr>
<tr>
<td>• Specialist Visits</td>
<td>$25 copay</td>
</tr>
<tr>
<td>• Routine Annual Physical</td>
<td>No charge</td>
</tr>
<tr>
<td>• Maternity Care*</td>
<td>$15 copay</td>
</tr>
<tr>
<td>• Post-Natal</td>
<td>$15 copay</td>
</tr>
<tr>
<td>• Well-Baby and Well-Child Care</td>
<td>No charge</td>
</tr>
<tr>
<td>• X-ray and Lab Procedures (CT-MRI / Complex Imaging)</td>
<td>No charge</td>
</tr>
<tr>
<td>• Rehabilitation Therapies (Physical, Occupational Speech)</td>
<td>$15 copay</td>
</tr>
<tr>
<td>*</td>
<td>(limited to 40 visits/therapy/calendar year)</td>
</tr>
<tr>
<td>• Chronic Renal Dialysis</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Dialysis Center: 10% after deductible</td>
</tr>
<tr>
<td>• Home Health Care</td>
<td>N/A</td>
</tr>
<tr>
<td>*</td>
<td>(limited to 100 visits/cal year)</td>
</tr>
</tbody>
</table>

* For all plans, tiered into Physician PCP office visit benefit, afterwards all services are included in Global Charges.

This is a brief summary of the benefits available under the Prime plans. In the event of a discrepancy between this summary and the Plan Document, the Plan Document will prevail. Prime retains the right to modify or eliminate these or any other benefits at any time and for any reason.
### Medical Plan Benefits

<table>
<thead>
<tr>
<th>Plan Benefits</th>
<th>Saint Mary’s General Hospital Comprehensive PPO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tier 1 (Domestic) PPO Network</td>
</tr>
<tr>
<td><strong>Physician Care (continued)</strong></td>
<td></td>
</tr>
<tr>
<td>• Durable Medical Equipment</td>
<td>N/A</td>
</tr>
<tr>
<td>• Chiropractic</td>
<td>$25 copay</td>
</tr>
<tr>
<td><strong>Mental Health / Substance Use Disorder</strong></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Mental Health / Substance Use Disorder</td>
<td>No charge</td>
</tr>
<tr>
<td>• Outpatient Mental Health / Substance Use Disorder</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
</tr>
<tr>
<td>• Retail (up to a 30-day Supply)</td>
<td></td>
</tr>
<tr>
<td>– Generic</td>
<td></td>
</tr>
<tr>
<td>– Formulary Brand</td>
<td></td>
</tr>
<tr>
<td>– Non-Formulary Brand</td>
<td></td>
</tr>
<tr>
<td>• Mail Order (up to a 90-day Supply)</td>
<td></td>
</tr>
<tr>
<td>– Generic</td>
<td></td>
</tr>
<tr>
<td>– Formulary Brand</td>
<td></td>
</tr>
<tr>
<td>– Non-Formulary Brand</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Rx Copay Maximum</strong></td>
<td></td>
</tr>
</tbody>
</table>

This is a brief summary of the benefits available under the Prime plans. In the event of a discrepancy between this summary and the Plan Document, the Plan Document will prevail. Prime retains the right to modify or eliminate these or any other benefits at any time and for any reason.
### MEDICAL (continued)

Full-time and qualified part-time employees who are regularly scheduled to work 37.5 hours of service per pay period will be eligible to elect the Saint Mary’s General Hospital Enhanced PPO Plan.

<table>
<thead>
<tr>
<th>Plan Benefits</th>
<th>Saint Mary’s General Hospital Enhanced PPO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tier 1 (Domestic) PPO Network</td>
</tr>
<tr>
<td>Annual Deductible (Individual / Family)</td>
<td>$0 / $0</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum (Individual / Family) (Includes Deductible)</td>
<td>$1,400 / $2,800</td>
</tr>
</tbody>
</table>

**Hospital Care**

- **Inpatient / Outpatient**
  - No charge
  - Inpatient: $300 copay/admission, then 100%
  - Outpatient: No charge
  - 30% after deductible

- **Emergency Room (copay waived if admitted)**
  - $25 copay
  - $100 copay, no deductible
  - $100 copay, no deductible

- **Urgent Care**
  - $10 copay
  - $20 copay
  - 30% after deductible

- **Ambulance**
  - N/A
  - 10% after deductible
  - 30% after deductible

**Physician Care**

- **Physician Office Visits**
  - $10 copay
  - $20 copay
  - 30% after deductible

- **Specialist Visits**
  - $20 copay
  - $40 copay
  - 30% after deductible

- **Routine Annual Physical**
  - No charge
  - No charge
  - 30% after deductible

- **Maternity Care**
  - $10 copay
  - $40 copay
  - 30% after deductible

- **Post-Natal**
  - $10 copay
  - $20 copay
  - 30% after deductible

- **Well-Baby and Well-Child Care**
  - No charge
  - No charge
  - 30% after deductible

- **X-ray and Lab Procedures (CT-MRI / Complex Imaging)**
  - No charge
  - 10% after deductible
  - 30% after deductible

- **Rehabilitation Therapies (Physical, Occupational Speech)**
  - $10 copay
  - $40 copay
  - 30% after deductible
  - (limited to 40 visits/therapy/calendar year)

- **Chronic Renal Dialysis**
  - No charge
  - Treatment: 100% after deductible
  - Dialysis Center: 10% after deductible
  - (No maximum)
  - 30% after deductible

- **Home Health Care**
  - N/A
  - 10% after deductible
  - 30% after deductible

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*For all plans, tiered into Physician PCP office visit benefit; afterwards all services are included in Global Charges.*
### Saint Mary’s General Hospital Enhanced PPO Plan

<table>
<thead>
<tr>
<th>Plan Benefits</th>
<th>Tier 1 (Domestic) PPO Network</th>
<th>Tier 2 PPO Network</th>
<th>Tier 3 (OON) PPO Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Care (continued)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Durable Medical Equipment</td>
<td>N/A</td>
<td>10% after deductible</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>• Chiropractic (25 visits max/calendar year)</td>
<td>$20 copay</td>
<td>$40 copay</td>
<td>30% after deductible</td>
</tr>
<tr>
<td><strong>Mental Health / Substance Use Disorder</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Mental Health / Substance Use Disorder</td>
<td>No charge</td>
<td>$300 copay/admission, then 100%</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>• Outpatient Mental Health / Substance Use Disorder</td>
<td>No charge</td>
<td>$20 copay</td>
<td>30% after deductible</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Retail (up to a 30-day Supply)**
  - Generic: $15 copay
  - Formulary Brand: $40 copay
  - Non-Formulary Brand: $60 copay

- **Mail Order (up to a 90-day Supply)**
  - Generic: $30 copay
  - Formulary Brand: $80 copay
  - Non-Formulary Brand: $120 copay

**Annual Rx Copay Maximum**: Combined with Medical Out-of-Pocket Max

This is a brief summary of the benefits available under the Prime plans. In the event of a discrepancy between this summary and the Plan Document, the Plan Document will prevail. Prime retains the right to modify or eliminate these or any other benefits at any time and for any reason.
The Value Plan is available to all employees. This plan has a $5,000 annual deductible and utilizes the Anthem Blue Cross BlueCard network.

<table>
<thead>
<tr>
<th>Plan Benefits</th>
<th>Value Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible (Individual / Family)</td>
<td>$5,000 / $10,000</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum (Individual / Family)</td>
<td>$6,250 / $12,500</td>
</tr>
</tbody>
</table>

### Hospital Care

- **Inpatient / Outpatient (including Maternity)**
  - Inpatient: 30% after deductible + $500 inpatient copay
  - Outpatient: 30% after deductible ($500 copay for Ambulatory Surgical Center)
- **Emergency Room (copay waived if admitted)**
  - $300 copay, then 30% after deductible
- **Urgent Care**
  - $120 copay (three visits/year), then 30% after deductible
- **Ambulance**
  - $300 copay, then 30% after deductible

### Physician Care

- **Physician Office Visits**
  - $60 copay (three visits/year), then 30% after deductible
- **Specialist Visits**
  - $70 copay after deductible
- **Routine Annual Physical**
  - No charge
- **Post-Natal**
  - $60 copay (three visits/year), then 30% after deductible
- **Well-Baby and Well-Child Care**
  - No charge
- **X-ray and Lab Procedures**
  - 30% after deductible
- **Rehabilitation Therapies** *(Physical, Occupational, Speech)*
  - 30% after deductible (24 visits/calendar year max)
- **Chronic Renal Dialysis**
  - 30% after deductible (Chronic renal dialysis treatments are limited to 39 visits)
- **Home Health Care**
  - 30% after deductible (24 visits/calendar year max)
- **Durable Medical Equipment**
  - 30% after deductible
- **Chiropractic**
  - 30% after deductible (20 visits max/calendar year)

### Mental Health / Substance Use Disorder

- **Inpatient Mental Health / Substance Use Disorder**
  - Facility based: 30% after deductible; Physician Services: 0% after deductible
- **Outpatient Mental Health / Substance Use Disorder**
  - $60 copay (three visits/year), then 30% after deductible

### Prescription Drugs

- **Retail (up to a 30-day Supply)**
  - Generic: $25 copay
  - Formulary Brand: $50 copay
- **Mail Order (up to a 90-day Supply)**
  - Generic: $50 copay
  - Formulary Brand: $100 copay

### Annual Rx Copay Maximum (Individual / Family)

- $600 / $1,200

This is a brief summary of the benefits available under the Prime plans. In the event of a discrepancy between this summary and the Plan Document, the Plan Document will prevail. Prime retains the right to modify or eliminate these or any other benefits at any time and for any reason.
Go Green Initiative – How to Obtain Your Explanation of Benefits (EOB)

Obtaining your EOBs for your medical plan is easy! Although they will be mailed to you on a monthly basis, you can obtain them online through MESA, Keenan’s Online Resource for Benefit, Eligibility & Claims Status.

Register now at keenan-mesa.javelinaweb.com to access the following at any time:

- Claims Status
- Plan Documents
- Coverage Summary
- Eligibility Status

Registration is easy and will give you instantaneous access to your information. Additionally, you may opt-out of receiving paper copies in the mail, or request an email notification when a new EOB is available to view on MESA.
HEALTHY LIFESTYLES WELLNESS PROGRAM

Prime Healthcare Services supports you in your journey to achieve optimal health and fitness. We are pleased to provide the Healthy Lifestyles Wellness Program to you and your adult dependents. **You must be enrolled in the medical plan in order to be eligible for the Healthy Lifestyles Wellness Program.**

Healthy Lifestyles starts with a private Well-Being Assessment designed to help you identify current lifestyle habits and learn how these habits affect your overall well-being. By utilizing online tools and resources, you will be able to compare your score with others your age and develop a personalized plan to improve your overall health. You will receive a personalized well-being plan to help you reach your healthy best. The program includes resources to assist with exercise and fitness, healthy eating, weight management, smoking cessation assistance, and more. Health coaching from a team of experts is available to help you set realistic goals and stay motivated and focused. Custom trackers make it easy to record activities every day and see progress for weight, exercise, medication, healthy eating and more!

**Here's How to Get Started!**

1. Go to MyHealthyLifestyles.com and select sign up.
2. Enter your name, date of birth, postal / zip code, select your gender and click Next.
3. Enter your email address, phone number and create a username and password.
4. Select and answer your challenge questions (used to retrieve a forgotten password), agree to the Terms and Conditions and click Next.
5. Select Well-Being Assessment to get a complete picture of your current health and what it will take to improve it.
6. Select Start and answer the questions on the screens.
7. When you answer the last question and click Finish, your answers will be processed.
8. Click View Full Report or download a PDF of your results. You may now select Create Your Well-Being Plan.
9. Healthy Lifestyles will show you the areas that the program can help you address. Use the radio buttons to indicate your interest in working on each area and click Next.
10. Based on the information you’ve provided, Healthy Lifestyles will recommend a primary focus area and two connected focus areas. Use the recommended focus areas or swap them out with others. Click Next to continue.
11. You can choose to add the trackers that support your focus areas here, or you can add them at a later time. After you have chosen your trackers, click Finish to complete your well-being plan set-up.
12. Congratulations! You are now ready to start using your well-being plan, trackers and all of the online resources and tools that Healthy Lifestyles has to offer.
### DENTAL

Delta Dental of New Jersey is your dental carrier offering three dental plans for your consideration. Members may visit any provider of their choice but will maximize benefits when using an In-Network provider.

<table>
<thead>
<tr>
<th>Plan Benefits</th>
<th>Delta Dental PPO Plan</th>
<th>Delta Dental Premier® / Advantage POS Plan</th>
<th>DeltaCare Flagship DMO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Calendar Year Maximum</strong></td>
<td>$1,500</td>
<td>$1,200</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td>$25 (major services only)</td>
<td>$25 (major services only)</td>
<td>None</td>
</tr>
<tr>
<td>• Waived for Diagnostic and Preventive Services</td>
<td>Yes</td>
<td>Yes</td>
<td>None</td>
</tr>
<tr>
<td><strong>Diagnostic and Preventive</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Oral Exams</td>
<td>No charge</td>
<td>100% of Delta’s Allowable Charge</td>
<td>80%</td>
</tr>
<tr>
<td>• Teeth Cleaning</td>
<td>No charge</td>
<td>100% of Delta’s Allowable Charge</td>
<td>80%</td>
</tr>
<tr>
<td>• Full Mouth X-rays</td>
<td>No charge</td>
<td>100% of Delta’s Allowable Charge</td>
<td>80%</td>
</tr>
<tr>
<td>• Fluoride Treatment</td>
<td>No charge</td>
<td>100% of Delta’s Allowable Charge</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Basic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fillings</td>
<td>80%</td>
<td>80% of Delta’s Allowable Charge</td>
<td>80%</td>
</tr>
<tr>
<td>• Sealants</td>
<td>80%</td>
<td>80% of Delta’s Allowable Charge</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Root Canals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Gingivectomy per Quadrant</td>
<td>80%</td>
<td>80% of Delta’s Allowable Charge</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Periodontics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inlays / Onlays / Crowns</td>
<td>50%</td>
<td>50% of Delta’s Allowable Charge</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Crowns</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Complete Denture</td>
<td>50%</td>
<td>50% of Delta’s Allowable Charge</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Orthodontics</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Child</td>
<td>Not covered</td>
<td>Not covered</td>
<td>$2,400 copay (estimate only; based on 24-month treatment plan)</td>
</tr>
<tr>
<td>• Adult</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>• Ortho Lifetime Maximum</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This is a brief summary of the benefits available under the Prime plans. In the event of a discrepancy between this summary and the Plan Document, the Plan Document will prevail. Prime retains the right to modify or eliminate these or any other benefits at any time and for any reason.
Davis Vision features a broad provider network with substantial access across the U.S. in a variety of settings.

<table>
<thead>
<tr>
<th>Plan Benefits</th>
<th>Davis Vision</th>
<th></th>
<th></th>
<th>Davis Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td></td>
<td></td>
<td>Out-of-Network</td>
</tr>
<tr>
<td></td>
<td>Visionworks</td>
<td>Collection Providers</td>
<td>Non-Collection Providers</td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>Up to $30</td>
</tr>
<tr>
<td>Contact Lens Evaluations (fitting and follow-up in lieu of lenses and frames)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Standard Collection</td>
<td>$20 copay</td>
<td>Not available</td>
<td>Not available</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Standard Non-Collection</td>
<td>$20 copay</td>
<td>$20 copay</td>
<td>$20 copay</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Specialty Non-Collection</td>
<td>$60 allowance</td>
<td>$60 allowance</td>
<td>$60 allowance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Materials (spectacle lenses/pair)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Single</td>
<td>$20 copay</td>
<td>$20 copay</td>
<td>$20 copay</td>
<td>Up to $25</td>
</tr>
<tr>
<td>• Bifocal</td>
<td>$20 copay</td>
<td>$20 copay</td>
<td>$20 copay</td>
<td>Up to $35</td>
</tr>
<tr>
<td>• Trifocal</td>
<td>$20 copay</td>
<td>$20 copay</td>
<td>$20 copay</td>
<td>Up to $45</td>
</tr>
<tr>
<td>• Lenticular</td>
<td>$20 copay</td>
<td>$20 copay</td>
<td>$20 copay</td>
<td>Up to $60</td>
</tr>
<tr>
<td>Frames</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Collection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Fashion</td>
<td>Not available</td>
<td>Included</td>
<td>Not available</td>
<td>Not covered</td>
</tr>
<tr>
<td>– Designer</td>
<td>Not available</td>
<td>Included</td>
<td>Not available</td>
<td>Not covered</td>
</tr>
<tr>
<td>– Premier</td>
<td>Not available</td>
<td>$25 copay</td>
<td>Not available</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Non-Collection</td>
<td>$130 allowance</td>
<td>$130 allowance</td>
<td>$130 allowance</td>
<td>Up to $30</td>
</tr>
<tr>
<td>Contact Lenses (only one option available in lieu of lenses and frames)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Collection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Fashion</td>
<td>Not available</td>
<td>Two lenses</td>
<td>Not available</td>
<td>Not covered</td>
</tr>
<tr>
<td>– Designer</td>
<td>Not available</td>
<td>Two boxes</td>
<td>Not available</td>
<td>Not covered</td>
</tr>
<tr>
<td>– Premier</td>
<td>Not available</td>
<td>Eight boxes</td>
<td>Not available</td>
<td>Not covered</td>
</tr>
<tr>
<td>• Non-Collection</td>
<td>$130 allowance</td>
<td>$130 allowance</td>
<td>$130 allowance</td>
<td>Up to $75</td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Eye Exam</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Frames or Contact Lenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This is a brief summary of the benefits available under the Prime plans. In the event of a discrepancy between this summary and the Plan Document, the Plan Document will prevail. Prime retains the right to modify or eliminate these or any other benefits at any time and for any reason.
ComPsych provides you with an Employee Assistance Program (EAP) that is designed to help you manage life’s challenges. Everyone needs a helping hand once in a while, and your EAP can provide confidential access 24/7. It can refer you to professional counselors and services that can help you resolve emotional health, family and work issues. This benefit is provided at no cost to you, and is available to all household members.

EAP services include:

- **Employee Assistance Program (EAP):** Complete referral assistance to in-person emotional counseling support, helping you and your family members address an array of personal difficulties, including stress, anxiety, depression, family / marital relationships, substance use disorder, difficulties at work, etc.

- **FamilySource®:** Can help you sort out issues like being a new parent, locating a quality caregiver for an elder, sending your child to college, choosing a contractor, finding pet care, and more. FamilySource will provide expert information and identify specific resources and referrals to help you make your decision.

- **LegalConnect®:** Provides telephone access to licensed attorneys for information about any legal concern you may be facing, whether it is regarding a home purchase, estate issues, or any legal issue. If your legal matter requires in-person assistance, you are eligible to receive a free half-hour consultation with the ComPsych selected, in-network attorney, in your area. After the consultation, you are eligible to receive a 25% discount on his or her customary legal fees thereafter.

- **FinancialConnect®:** Allows you to consult directly with a financial professional by telephone. Call anytime for tools and information regarding your specific financial questions on: budgeting, tax issues, credit cards and loans, investment resources and other money matters.

- **EstateGuidance®:** Now with EstateGuidance, you have the opportunity to create a Will at no cost. This benefit offers you the ease and simplicity of online Will preparation right on your PC! By creating an online Will you can name a guardian for your children, name an executor(s) to settle your estate, and specify funeral and burial wishes.
Basic Life and AD&D

Eligible Employees

Basic Life and Accidental Death & Dismemberment (AD&D) Insurance, through Sun Life Financial, is an important part of your comprehensive benefits package. For peace of mind and the financial protection for you and your family in the event of death or a serious accident, all full-time and part-time employees are automatically enrolled in the Basic Life and AD&D Insurance program. Employees who are covered by a collectively bargained agreement should refer to their contract for specific benefit amounts.

- **Basic Life / AD&D**: For most employees, 1x base annual earnings subject to a maximum of $750,000

Optional Life

Eligible employees may enroll in Optional Life Insurance at affordable group rates. Premiums are determined by your age and will be withheld from your paycheck. You may elect a benefit amount in increments of $20,000, up to a maximum of $300,000. If you elect Optional Life for yourself, you may also elect coverage for your dependents. You may elect spouse life coverage in increments of $10,000, up to $100,000. You have the option to elect dependent life coverage for your eligible dependent children in flat amounts of $5,000, $10,000 or $25,000. Child coverage cannot exceed 50% of the employee’s coverage. **Evidence of Insurability may be required.**

For any amount elected after your initial eligibility period or above the guarantee issue amount, you must complete a Medical History Statement (Evidence of Insurability) and be approved for the amount elected. The initial guarantee issue amounts are as follows:

- **Employee**:
  - $125,000 (if under age 60)
  - $65,000 if age 60 or older

- **Spouse**:
  - $30,000; coverage ends on the plan anniversary date on or after your spouse turns 70

- **Child(ren)**:
  - $100 (14 days but less than six months of age)
Voluntary Short Term Disability (STD)

Sun Life Financial also provides Voluntary Short Term Disability (STD) benefits for full-time and part-time eligible employees. Short Term Disability is fully coordinated with State Disability Insurance (SDI). Evidence of Insurability may be requested.

Eligible employees can elect 60% of pre-disability weekly earnings, to a maximum of $2,500.

Voluntary Long Term Disability (LTD)

If you remain disabled beyond the duration of STD, your disability claim will transition to the Long Term Disability (LTD) benefit. Approved claim payments will begin following 180 days of the disability.

Eligible employees who want to purchase LTD can elect 60% of pre-disability monthly earnings, not to exceed a maximum benefit of $5,000.
A great way to save money over the course of a year is to participate in the Flexible Spending Accounts (FSA). These accounts allow you to redirect a portion of your salary on a pre-tax basis into reimbursement accounts. Money from these accounts can be used to pay eligible out-of-pocket expenses such as health care deductibles, copays, Rx, and dependent care expenses.

Pre-tax means the dollars you use for eligible expenses are not subject to Social Security tax, federal income tax and, in most cases, state and local taxes. Money you would have paid in taxes can be used to pay qualified expenses.

There are two accounts: Health Care Spending Account and Dependent Care Spending Account. You may use either account, or both. When you enroll, you decide how much money to contribute to your personal accounts for the coming year. These contributions will be gradually deducted from your paycheck in equal amounts through the year and deposited into your account.

Benefits must be elected annually at each open enrollment in order to participate in these plans. Prior amounts do not automatically roll-over into the new plan year.

**Health Care Spending Account**

This account will reimburse you with pre-tax dollars for health care expenses not reimbursed under your family’s health care plans. The minimum amount you may contribute to a Health Care Spending Account for the plan year is $120; the maximum is $2,550.

Please note: You must save your itemized receipts for all debit card purchases in case you are asked to provide them to HR Simplified, the third party administrator, for substantiation, per IRS guidelines.

**Dependent Day Care Spending Account**

This account will reimburse you with pre-tax dollars for day care expenses for your child(ren) and other qualifying dependents. The minimum amount you may contribute to a Dependent Day Care Spending Account for the plan year is $120; the maximum is $5,000, or $2,500 if you are married and file separate tax returns. Eligible dependents include:

- Children under the age of 13 who qualify as dependents on your federal tax return; and
- Children or other dependents of any age who are physically or mentally unable to care for themselves and who qualify as dependents on your federal tax return. You may use the federal childcare tax credit and the Dependent Day Care Spending Account. However, your federal credit will be offset by any amount deferred into the dependent day care plan.
FLEXIBLE SPENDING ACCOUNTS (continued)

How Your FSA Accounts Work

Each year during the Open Enrollment period, you decide how much you want to contribute to your health care and dependent care spending account(s) for the next calendar year.

At the start of the plan year, money is deducted from your paycheck in equal increments before taxes. These funds are contributed to your health care and/or dependent care spending account(s), thus saving you tax dollars.

As a participant of the FSA plan, you will be provided an FSA debit card. This card is linked to your FSA account. When purchasing qualified health care services or products, simply use your FSA debit card and the transaction is complete. You must save your itemized receipts for all debit card purchases in case you are asked to provide them to HR Simplified for substantiation as per IRS guidelines.

When you have an eligible expense and need to submit a claim form for reimbursement, the form can be found and/or submitted at mypretax.com. You can also contact HR Simplified or Human Resources for assistance.

Non-debit card claims can be mailed to:

HR Simplified, 5320 W. 23rd Street, Suite 350, Minneapolis, MN 55416,
or faxed to 877.723.0146

Upon review and approval of the eligible expenses submitted to FSA, you will be reimbursed for the expense(s).

Be Cautious!

Only qualifying health care and dependent care expenses incurred during the plan year, or grace period, will be eligible for reimbursement. This plan year begins on January 1st and ends on December 31st.

Use it or lose it. Money in the accounts must be claimed within 90 calendar days after the end of the plan year or it will be forfeited.

Annual Grace Period

If at the end of your plan year you have a balance in your health care or dependent care account, you will have the opportunity to utilize those funds for qualified expenses during the grace period that ends on March 15th. After March 15, any funds that are left in your rollover account will be forfeited.

Once you enroll, you can only change your elected payroll deduction if there is a change in family status, such as marriage, divorce, death, birth, adoption, change in employment status, or provider cost change for dependent day care.

If you are no longer working for Prime, you can continue to submit reimbursement requests for expenses incurred up to your date of separation. Please note, all requests for reimbursement must be received by HR Simplified within 90 calendar days of your last day of employment.
In addition to your regular benefits, Voluntary benefits are available through Trustmark. These benefits are optional and do not replace any of your other benefit coverages. For costs and complete coverage details, talk to your Benefit Counselor during the Open Enrollment period.

**Universal Life with Long Term Care Insurance Plan**

Trustmark’s Universal Life insurance can supplement existing life insurance coverage you may already have. Group term life insurance costs increase with age and reduce or disappear at retirement. Universal Life is permanent insurance with premiums that do not increase as you get older. Universal Life insurance not only offers benefits if you die, it also builds cash value you can use while you are alive. Another important feature is that you can continue the policy if you change jobs or retire. This plan provides permanent coverage designed to last to age 100 at a level premium and level benefit.

Your Universal Life insurance policy is flexible:

- You can apply for coverage for yourself, your spouse, children and grandchildren, even if you choose not to participate.

- You can select the coverage amount that makes sense for you and you can adjust your coverage as your needs change.

This Plan provides many other advantages such as:

- Accrues tax-deferred interest on the accumulated cash value at competitive rates guaranteed not to fall below 3%.

- Pays a living benefit of up to 75% upon diagnosis of a terminal illness.

- A Home Health and Long Term Care Rider, which pays up to two times the face amount in monthly benefits for medically necessary long term, home health care and adult day care expenses.

- All family premiums are waived if you (the Plan’s insured) are totally disabled.

To protect against inflation, this policy also gives you the option to purchase automatic increases in coverage amounts at certain policy anniversaries.

**Life Insurance – Universal LifeEvents®**

This is permanent life insurance designed to take care of needs throughout the lifetime, paying a higher death benefit during working years. The death benefit reduces to one-third at age 70; however the full benefit amount can be utilized to help with the cost of long term care services.

Benefits include coverage for:

- Benefits up to $300,000
- Long Term Care pays 4% per month for Long Term Care, Home Health Care, Adult Day Care or Assisted Living – 25 months
- Restoration of LTC Benefits
- Extension of LTC Benefits – 25 months
- Waiver of Premium (optional)

Key Components:

- Guaranteed Benefit Increases with $1 increases in weekly premium (optional)
- Family coverage including grandchildren
- Guaranteed Renewable to age 100

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**Saint Mary’s General Hospital**
Critical Illness Insurance

This coverage provides a substantial cash benefit upon the first diagnosis of a covered condition. It helps pay for expenses not covered by medical insurance. Benefits can be used however the employee chooses, from daily expenses to time off of work for family members.

Covered Conditions include:

- Invasive Cancer
- Stroke
- Organ Transplant
- Occupational HIV Infection
- Coronary Artery By-Pass (25% benefit)
- Heart Attack
- Renal Failure
- Paralysis
- Blindness
- ALS

Key Components:

- Benefits up to $100,000
- Double Benefit, pays up to twice the face amount for two separate covered conditions
- Guaranteed Benefit Increases with $1 increases in weekly premium (optional)
- Annual Health Screening Benefit – $100
- Family coverage
- No coordination with other insurance
- Benefit is paid to the employee
- Guaranteed Renewable to age 100

Accident Insurance

This benefit helps pay for the unexpected expenses that result from accidents above and beyond what health insurance pays. Benefits can be used however the employee chooses, from medical insurance deductibles to the cost of driving to a doctor appointment or child care expenses.

Benefits include coverage for:

- Initial care benefits: physician visit, ambulance, emergency room treatment, hospital benefits, lodging, blood, surgery, emergency dental
- Injury benefits: burn; concussion; dislocation; eye injury; fracture; herniated disc; laceration; loss of finger, toe, hand, foot, or sight; tendon ligament; rotator cuff injury; torn knee cartilage

Please refer to schedule of benefits for benefit amounts.

Key Components:

- Annual $100 health screening benefit
- Benefits up to $100,000 for Catastrophic Accident
- 24 hour coverage
- Organized sports are covered (except if being paid)
- Family coverage
- No coordination with other insurance
- Benefit is paid to the employee
- Guaranteed Renewable to age 100

Most insurance policies contain exclusions, limitations and terms for keeping them in force. Your representative will be glad to provide you with costs and complete details.
VPI® Pet Insurance

You want the best for your pet. While it’s hard to anticipate accidents and illnesses, VPI / NCC pet insurance makes it a little easier to be prepared for them. From wellness care to significant medical incidents, veterinary pet insurance is the smart way to protect your pet’s health, and your pocketbook.

Veterinary pet insurance provides benefits for veterinary treatments related to accidents and illnesses, including cancer. A VPI / NCC policy covers diagnostic tests, x-rays, prescriptions, hospitalization, and more.

With veterinary pet insurance you can enroll for coverage at anytime. For more information or to enroll, call 800.GET.MET 8 (800.438.6388) or visit metlife.com/mybenefits.

Auto and Home Insurance

MetLife Auto & Home offers a voluntary group auto and home program that provides you with access to insurance coverage for your personal insurance needs. With MetLife Auto & Home you can take advantage of valuable features and benefits:

- You can receive up to a 15% employee group discount
- Save more with our multi-policy discounts when you insure both your home and auto
- Choose from a variety of insurance policies to meet your coverage needs including: boat, condo, motor home, and recreational vehicle, and renter’s insurance

Since everyone’s insurance policies renew at different times during the year, you may apply for auto and home insurance through this group program at any time by calling 800.GET.MET 8 (800.438.6388) or metlife.com/mybenefits.

MetLaw®

With MetLaw, the group legal plan made available by Hyatt Legal Plans, Inc., a MetLife® company, you’ll have access to legal services and representation on a wide range of matters including Wills and estate planning, financial matters, real estate, traffic offenses (no DUI) and more. Once enrolled, you will be required to remain in the plan for the full benefit plan year. You may apply for MetLaw during your Open Enrollment period.
TRAVEL ASSISTANCE AND IDENTITY THEFT

Sun Life Financial provides two personal services – Emergency Travel Assistance and Identity Theft programs.

Emergency Travel Assistance

If you have a medical emergency while you are more than 100 miles away from home, you don’t have to face it alone. With one simple phone call, you can be connected to Assist America’s staff of medically trained, multilingual professionals who can advise you in a medical emergency, 24/7. You have immediate access to:

• pre-qualified, multilingual doctors, hospitals, pharmacies, and dentists anywhere in the world
• medical consultation, evaluation, and referral
• hospital admission guarantee
• emergency medical evacuation
• lost prescription assistance
• legal and interpreter services and more

You or your family (whether traveling together or separately) can activate Assist America’s emergency services with one call to the number on your Assist America ID card, whether you are on vacation or on a business trip (spouse business travel excluded).

Identity Theft Protection

Identity theft is a serious crime. Each year, millions of Americans have their personal financial information stolen and must spend a significant amount of time and money to restore their records. If you ever become a victim of identity theft, you don’t have to face it alone.

You have the support of a powerful Identity Theft Protection program through Assist America’s SecurAssist® Identity Protection program. It provides:

• 24/7 telephone support and step-by-step guidance by anti-fraud experts,
• an expert case worker who is assigned to you and will help you notify your credit bureaus and file paperwork to correct your credit reports,
• help canceling stolen cards and reissuing new cards, and
• help notifying police, financial institutions, and government agencies.

You can also help stop identity theft before it happens:

• You can securely register up to 10 credit or debit cards for 24/7 surveillance.
• Registered cards are monitored using sophisticated webcrawling technology that watches underground chat rooms where thieves are selling and trading stolen personal information.
• You receive early warning of potential threats and are notified if your identity has been misused.
Check your Personal Choices Web site. Personal Choices can be accessed 24/7 from work or home PCs and offers immediate answers to benefit questions. You can view and compare your benefit choices, link to carrier websites, download forms and analyze your benefit needs. This web-based forum contains helpful information and a multitude of decision support tools. A link to Personal Choices will be available on your online enrollment Web site.

The following is a summary of the information and resources available on the Web site:

- **Benefits**: This section lists benefit plans offered to Prime employees as well as a detailed description of each plan. This section can be used to compare and contrast different plans. It also contains your Summary Plan Descriptions and Evidence of Insurability forms.

- **Resources**: Contains news on a variety of health topics, as well as news articles and important benefits documents.

- **Understanding Benefits**: Presents the employee with situational questions, such as “Who am I?” The employee is able to choose an answer, such as “young single employee”, and receive information specific to that employee-type.

- **State and Federal Programs**: Provides information and links to a variety of governmental programs including COBRA, FMLA, and HIPAA. Contact Human Resources for more specific information.

- **Life Events**: Provides employees with information for specific life events such as Having a Baby or Getting Married. This section also covers a variety of topics such as Family and Relationships, Health Education, Finances and Insurance, and Purchases. The Life Events page also contains a Health and Wellness section, which provides links to health and wellness websites such as WebMD and wellness.com.

- **Calculators**: This section provides a variety of calculators including budget, credit lines, home financing, and retirement.
For Saint Mary’s General Hospital Dental Plan

This is a summary of the annual report of the Saint Mary’s Hospital Dental Plan, EIN 22-1494446, Plan No. 506, for the period January 1, 2014 through December 31, 2014. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan had a contract with Flagship Health Systems to pay dental claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2014 was $53,076.

Self-Funded Information

The plan also had an Administrative Service Agreement with Delta Dental Plans of NJ to pay certain dental claims incurred under the terms of the plan. Total costs for the plan year ending December 31, 2014 were $432,017. These costs included $27,276 in administration and related expenses and $404,741 in benefits paid to participants and beneficiaries.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. Financial information and information on payments to service providers;
2. Insurance information, including sales commissions paid by insurance carriers

To obtain a copy of the full annual report, or any part thereof, write or call the office of Saint Mary’s General Hospital, 350 Boulevard, Passaic, NJ 07055, 973.365.4659. There is no charge for copying costs.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report.

You also have the legally protected right to examine the annual report at the main office of the plan (Saint Mary’s General Hospital, 350 Boulevard, Passaic, NJ 07055) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.
2014 SUMMARY ANNUAL REPORT (continued)

For Saint Mary’s General Hospital Health Insurance, Prescription, Vision and Life Plan

This is a summary of the annual report of the Saint Mary’s General Hospital Health Insurance, Prescription, Vision and Life Plan, EIN 22-1494446, Plan No. 507, for the period January 1, 2014 through December 31, 2014. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan had contracts with Symetra Life Insurance Company, Reliastar Life Insurance Company and Davis Vision to pay Health, Life and Vision Insurance claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2014 were $538,410.

Self-Funded Information

The plan also had an Administrative Service Agreement with Horizon Blue Cross Blue Shield of New Jersey to pay certain medical claims incurred under the terms of the plan. Total costs for the plan year ending December 31, 2014 were $7,141,500. These costs included $414,319 in administration and related expenses and $6,727,181 in benefits paid to participants and beneficiaries.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. Financial information and information on payments to service providers;
2. Insurance information, including sales commissions paid by insurance carriers

To obtain a copy of the full annual report, or any part thereof, write or call the office of Saint Mary’s General Hospital, 350 Boulevard, Passaic, NJ 07055, 973.365.4659. There is no charge for copying costs.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report.

You also have the legally protected right to examine the annual report at the main office of the plan (Saint Mary’s General Hospital, 350 Boulevard, Passaic, NJ 07055) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.
IMPORTANT NOTICES

Newborns and Mothers
Health Protection Act (NMHPA)

A health plan which provides benefits for pregnancy delivery generally may not restrict benefits for a covered pregnancy Hospital stay (for delivery) for a mother and her newborn to less than 48 hours following a vaginal delivery or 96 hours following a Cesarean section. Also, any utilization review requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women’s Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prosthetics, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator for more information.

COBRA Continuation Coverage

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 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 cover must pay for COBRA continuation coverage.

If you’re an Employee, you’ll become a Qualified Beneficiary if you lose 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;
IMPORTANT NOTICES (continued)

- 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; or
- The Employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other Qualifying Events (e.g., 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 Prime Healthcare Services, Human Resources.

Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if part of the Employer’s Plan) are not eligible for continuation under COBRA.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a Covered Employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be furnished by U.S. mail, registered or certified, postage prepaid and properly addressed to the Plan Administrator.

Each notice must include all of the following items: the Covered Employee’s full name, address, phone number and Social Security number; the full name, address, phone number and Social Security number of each affected Dependent, as well as the Dependent’s relationship to the Covered Employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred on; a copy of the Social Security Administration’s written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

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 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.

DISABILITY EXTENSION OF THE 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...
IMPORTANT NOTICES (continued)

may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This 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 COBRA CONTINUATION COVERAGE

If your family experiences another Qualifying Event during the 18 months of COBRA continuation of coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation of 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 receiving COBRA continuation of coverage if the Employee or former Employee dies; becomes entitled to Medicare (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 the Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

OTHER OPTION BESIDES COBRA CONTINUATION COVERAGE

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 HealthCare.gov.

IF YOU HAVE QUESTIONS

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 dol.gov/ebsa. (Address and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit 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.

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan’s full cost of coverage during the same period for similarly situated non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. The “full cost” includes any part of the cost which is paid by the Employer for non-COBRA Beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an Employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period later than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary in writing, of any termination of COBRA coverage based on the criteria stated in this subsection that occurs prior to the end of the Qualified Beneficiary’s applicable maximum coverage period. Notice will be given within 30 days of the Plan’s decision to terminate.
IMPORTANT NOTICES (continued)

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description for more information.

Special Enrollment Rights Notice

Changes to Your Health Plan Elections

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this plan if there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or CHIP is in effect, you may be able to enroll yourself and/or your Dependents in this plan if you or your Dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your Dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and/or your Dependents into this plan. However, you must request enrollment no later than 60 days after the determination for eligibility for such assistance.

If you have a change in family status such as a new Dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death or Qualified Medical Child Support Order, you may be able to enroll yourself and/or your Dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption or placement for adoption or divorce (including legal separation and annulment).

Medicare Part D – Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Prime Healthcare Services (Prime) 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. Prime has determined that the prescription drug coverage offered by Prime 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, your current Prime coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Prime 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 Prime 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 Prime Healthcare Services for further information. NOTE: You will 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 Prime changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

- Visit medicare.gov.
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

REMEMBER

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

Date: November 2015
Name of Entity / Sender: Prime Healthcare Services
Contact: Human Resources

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Prime Healthcare Services in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855.653.3626 or at KeenanDirect.com, or contact the Health Insurance Marketplace directly at HealthCare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2015 and ends on January 31, 2016.
CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, or offers medical coverage that is not “Affordable” or does not provide “Minimum Value.” If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s medical plan.

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

PART B: EXCHANGE APPLICATION INFORMATION

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855.653.3626 or at KeenanDirect.com.

<table>
<thead>
<tr>
<th>3. Employer name</th>
<th>4. Employer Identification Number (EIN)</th>
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<tbody>
<tr>
<td>Prime Healthcare Services</td>
<td>33-0943449</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Employer address</th>
<th>6. Employer phone number</th>
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</thead>
<tbody>
<tr>
<td>3300 E. Guasti Road</td>
<td>909.638.0101</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. City</th>
<th>8. State</th>
<th>9. ZIP code</th>
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<tbody>
<tr>
<td>Ontario</td>
<td>CA</td>
<td>91761</td>
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</table>

<table>
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<tr>
<th>10. Who can we contact about employee health coverage at this job?</th>
<th>11. Phone number (if different from above)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kimberly Mendez</td>
<td><a href="mailto:kmendez1@primehealthcare.com">kmendez1@primehealthcare.com</a></td>
</tr>
</tbody>
</table>

Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

Prime Healthcare Services Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan’s Notice of Privacy Practices, please contact your Human Resources Department.

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

Please see the Summary Plan Description for more information.
Below is a listing of the telephone numbers you can call with questions about the plans available to you. You can also use the web site (if available) to access information from providers for the various plans.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Plan Number</th>
<th>Phone Number</th>
<th>Web Site</th>
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<tbody>
<tr>
<td><strong>Medical</strong></td>
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<tr>
<td>• Saint Mary’s General Hospital Employee Medical and Value Plans</td>
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<tr>
<td>– Keenan Customer Service</td>
<td>N/A</td>
<td>888.773.7218</td>
<td>keenan.com/benefits/phs</td>
</tr>
<tr>
<td>– Anthem Blue Cross BlueCard Provider Finder</td>
<td>N/A</td>
<td></td>
<td>anthem.com/ca</td>
</tr>
<tr>
<td>– Express Scripts Prescription Drugs</td>
<td>JYEA</td>
<td>866.718.7955</td>
<td>express-scripts.com</td>
</tr>
<tr>
<td>• Healthy Lifestyles</td>
<td>N/A</td>
<td></td>
<td>myhealthylifestyles.com</td>
</tr>
<tr>
<td><strong>Dental</strong></td>
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<tr>
<td>• Delta Dental of New Jersey</td>
<td>09396</td>
<td>800.452.9310</td>
<td>deltadentalins.com</td>
</tr>
<tr>
<td><strong>Vision</strong></td>
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<tr>
<td>• Davis Vision</td>
<td>503884-A</td>
<td>800.999.5431</td>
<td>davisvision.com</td>
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<tr>
<td><strong>Employee Assistance Program (EAP)</strong></td>
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<tr>
<td>• ComPsych</td>
<td>N/A</td>
<td>877.595.5284</td>
<td>guidanceresources.com Web ID: EAPComplete</td>
</tr>
<tr>
<td><strong>Basic Life / AD&amp;D, Optional Life and LTD</strong></td>
<td></td>
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<tr>
<td>• Sun Life Financial</td>
<td>93678</td>
<td>800.247.6875</td>
<td>sunlife-usa.com</td>
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<tr>
<td><strong>Flexible Spending Accounts (FSA) and COBRA</strong></td>
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<tr>
<td>• HR Simplified – FSA</td>
<td>N/A</td>
<td>888.318.7472</td>
<td>mypretax.com</td>
</tr>
<tr>
<td>• HR Simplified – COBRA</td>
<td>N/A</td>
<td>888.318.7472</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Other Voluntary Insurance Products</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Trustmark</td>
<td>N/A</td>
<td>800.918.8877</td>
<td>trustmarkinsurance.com</td>
</tr>
<tr>
<td>• MetLaw, MetLife Auto / Home, VPI Insurance</td>
<td>800.438.6388</td>
<td></td>
<td>metlife.com/mybenefits</td>
</tr>
<tr>
<td><strong>Emergency Travel Assistance</strong></td>
<td>N/A</td>
<td>800.872.1414</td>
<td>assistamerica.com</td>
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<tr>
<td>• Within U.S.</td>
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<tr>
<td>• Outside U.S.</td>
<td></td>
<td>609.986.1234</td>
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<tr>
<td><strong>Identity Theft</strong></td>
<td>N/A</td>
<td>877.409.9597</td>
<td>securassist.com/sunlife</td>
</tr>
<tr>
<td><strong>Personal Choices</strong></td>
<td>N/A</td>
<td>N/A</td>
<td>keenan.com/personalchoices User ID: SMGH Password: Benefits</td>
</tr>
</tbody>
</table>