# Simply for you

benefits for real life

# 2023 Benefits Guide

Go to the Benefit Solutions Center at **benefitsolutions.ehr.com** for details and to enroll by your deadline.

# What's Inside

Your health and well-being are important to us, so we provide benefit options to make your life and your family's lives better. Together, let's invest in you. Read over this guide for details on your 2023 benefits from A to Z. If you have questions, the Benefit Solutions Center is here to help.

## ACTION REQUIRED!

If you do not provide proof of eligibility for each enrolled dependent, they **will not have coverage** starting January 1, 2023 (or your effective date, as a new hire), even if you enroll them.

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## Know Your Options

We want to help you learn more about all the benefits you have available to you. This guide is designed to provide you with an overview of the variety of benefits available to support your health, lifestyle, finances, and family. Benefits to help you plan for your future. Benefits for peace of mind. And benefits to help you make a change for the better.

### Annual Enrollment Benefits

Benefits you can enroll in only during Annual Enrollment, if eligible, as a new hire or newly eligible employee, or if you have a qualified life event

- Medical
- Dental
- Vision
- Tax savings accounts
- Supplemental life insurance and accidental death and dismemberment (AD&D)
- Disability
- Accident, critical illness, and hospital indemnity insurance
- Legal services
- Child and elder care program
- Identity protection

### Anytime Benefits

Benefits you can enroll in or change any time during the year, if eligible

- 401(k) Retirement Savings Plan
- Auto and home insurance
- Pet insurance
- Employee Stock Purchase Plan (enrollment is on a quarterly basis)

### Automatic Benefits

Benefits you get automatically as a full-time employee or part-time employee, if eligible

- Basic life insurance and AD&D
- Employee Assistance Program (EAP)
- Employee discount program

## Benefits Enrollment

### Annual Enrollment

You have the Annual Enrollment period to review your coverage for the benefits listed on the previous page and make any changes for the following calendar year. If you miss the deadline, you may not have coverage under these plans, unless you have a qualified life event and make allowed changes within 31 calendar days.

### New Hire/Newly Eligible

You have 31 calendar days following the date you're hired or become eligible for benefits. If you miss your deadline, you won't be able to enroll in most benefits, including medical, dental, and vision coverage, until the next Annual Enrollment, unless you have a qualified life event.

### Qualified Life Events

Qualified life events determined by the IRS could allow you to enroll in health coverage or change your elections outside of Annual Enrollment. If you have a qualified life event, you have 31 calendar days from the date of the event to enroll or make changes to your benefits. Examples of qualified life events include:

- Marriage or divorce
- Birth, adoption, or entry of an order requiring you to provide medical insurance for child(ren)
- A change in employment status (e.g., full-time to part-time or part-time to full-time)
- The death of your spouse or one of your dependents
- A leave of absence
- You or your spouse becoming Medicare-eligible
- A gain or loss of coverage (e.g., your spouse begins to cover your child(ren) on their plan)
- Turning 26 and losing coverage through a parent's plan

Keep in mind, your change in coverage must be consistent with your change in status, and you must provide acceptable documentation to support the event, as well as dependent verification documents if you are adding a dependent.

Questions regarding specific qualifying life events and your ability to request changes should be directed to the Benefit Solutions Center. Don't miss out on a chance to update your benefits!

## Eligibility Requirements

Your eligibility for benefits depends on your employment type and the number of hours you work each week.

If you are covered by a Collective Bargaining Agreement, contact your Human Resources Department and/or union representative, as your plan provisions may be different.

### Who is Eligible

If you are classified as a full-time employee or as a benefits-eligible part-time employee and have completed the eligibility period, you are eligible to participate in the medical, dental, vision, life, and disability plans as well as additional voluntary benefits. Visit the **Benefit Solutions Center** for a complete list of benefits and eligibility requirements, including rules on dependent eligibility.

### Dependent Eligibility Verification

The company requires dependent verification to ensure we're complying with legal and regulatory requirements. Covering ineligible participants on our health plans affects all participants. We value you as an employee and want to continue to provide a comprehensive and affordable health plan for you and your eligible family members.

Employees enrolling any dependents to a company health plan for 2023 will be required to provide written proof of eligibility (e.g., state-issued marriage certificates, federal tax returns, state-issued birth certificates, adoption paperwork, etc.) for each enrolled dependent. Dependent verification documents can be mailed or uploaded directly to the **Benefit Solutions Center** website.

To see who are considered eligible dependents, go to "Benefits Eligibility" in the **Benefit Solutions Center**.

### ACTION REQUIRED!

If you do not provide proof of eligibility for each enrolled dependent, they **will not have coverage** starting January 1 (or your effective date, as a new hire), even if you enroll them.

## How to Enroll

To make your elections, visit the **Benefit Solutions Center** at **benefitsolutions.ehr.com**.

- Log in using your credentials.
- If you're new to the **Benefit Solutions Center**, click the "First time user? Create an account" link to create your account.
- Then, type "enrollment" into the search bar to access the Benefits Enrollment Center.

**The Enrollment Center makes enrollment easy:**

**Learn.** Watch a short video to learn more about the Benefits Enrollment Center.

**Decide.** Take a look around the **Benefits Enrollment Center** to learn about your coverage options. Visit the **Resource Library** to learn more or enter specific questions in the chat. Think about who you need to cover.

**Choose.** When you're ready, click the "Enroll Now" button to start enrollment. Use the "Help Me Choose" tool for personalized suggestions and guidance as you consider the benefits available.

**Access the Benefit Solutions Center from any device, anytime, anywhere.**

If you prefer to speak to a representative, call **1-844-877-8591** Monday through Friday, 7 AM to 7 PM CT.

# HEALTH

## Medical Benefits

Your health matters to you, and it matters to us, too. Our medical plans offer comprehensive coverage so you can get the healthcare you need. No matter which plan you choose, you'll get:

### Comprehensive Coverage

All of our medical plans cover services like office visits, virtual visits, inpatient and outpatient care, and mental health treatment. Services are available in- and out-of-network, but the plans cover more — meaning you'll spend less — when you stay in the network.

### Free Preventive Care

Annual physical exams, wellness visits, and standard immunizations are free with your medical plan when you use in-network providers. Other covered services include screenings for blood pressure, cancer, cholesterol, depression, obesity, anemia, diabetes, and more.

Note: If your doctor finds a new condition or potential risk during your covered screening, the services may be billed as diagnostic with out-of-pocket costs.

### Selecting a Medical Plan

There's no right or wrong answer when it comes to selecting a medical plan. When choosing, consider your healthcare needs and personal preferences.

It's also a good idea to think about expected healthcare expenses as you weigh your options. When you're ready to enroll, the "Help Me Choose" tool on the **Benefit Solutions Center** will provide personalized suggestions.

Compare medical plans and choose the right fit for you on the **Benefit Solutions Center**.

### Tobacco User?

You may pay more for medical coverage. When you enroll, you'll be asked about your tobacco use. If you and/or your covered dependents have used tobacco products (cigarettes, e-cigarettes, cigars, pipes, smokeless tobacco) within the past 12 weeks, you may pay a surcharge every pay period for medical coverage.

If you're ready to make today your quit day, the Employee Assistance Program (EAP) can help. Learn more about the EAP on page 11. Your medical plan may also offer tobacco cessation support.

### How to Find a Provider

To find network providers, select the "Get Medical Care" tile on the Benefit Solutions Center at **benefitsolutions.ehr.com**.

## Where to Go for Care

You have choices when you need medical care. It's important that you understand what they are and how they work. This overview can help you choose the right option to get high-quality care when you need it.*

| Nurse Line | Telemedicine | Doctor's Office | Urgent Care | Emergency Room |
|---|---|---|---|---|
| Get quick answers for non-urgent health questions via phone | Get care anytime, anywhere via video chat | Exams, screenings, non-urgent care, specialist referrals | Urgent, but not serious or life-threatening | Serious or life- or limb-threatening emergency |

Affordability ◄······► Urgency

### Nurse Line

If you need a quick answer for a non-immediate health issue, call the nurse line. A nurse can offer help with questions related to:

- Symptoms
- When to seek care
- Medications and side effects
- Self-care for home treatment

Nurse lines are typically available 24/7. This service is usually free with your medical insurance, but availability varies by carrier.

### Telemedicine

If you have a minor illness or ailment, and would prefer not to leave your home, telemedicine or virtual care can help. Get support from board-certified, U.S.-based doctors for common health issues, such as:

- Cold and flu symptoms
- Urinary tract problems
- Allergies
- Bronchitis
- Sinus issues
- Depression

Telemedicine virtual visits can be immediate or require an appointment. Copays and coinsurance may apply.

### Doctor's Office

Your primary doctor knows you and your health history and can access your medical records, provide routine care, and manage your medications. Visit your primary care physician when you need:

- Routine checkups
- Immunizations
- Preventive services
- General health management
- Referrals to specialists for direct care

Visits with your primary care physician require an appointment and are best for non-urgent care. If you are getting preventive care, your visit may be free with your medical plan. Other services may require a copay or coinsurance.

### Urgent Care Center

Urgent care centers treat critical but non-life-threatening injuries or illnesses, such as:

- Strains or sprains
- Minor broken bones
- Minor infections and burns
- X-rays

Urgent care centers are usually open nights and weekends, but your waiting period depends on the health emergency level of the other patients. Your visit may require a copay or coinsurance.

### Emergency Room

Go to the emergency room when you need immediate treatment for a serious or life-threatening condition, such as:

- Heavy bleeding
- Chest pain or trouble breathing
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

These are not the only reasons to go to the emergency room. If you're having a serious or life-threatening emergency not on the list, go to the emergency room. Depending on the severity of your condition, you may want to call 911 for help. The costs for your care will depend on your medical plan.

## Do Your Homework

Always use providers and facilities that are in your carrier's network for cost savings. If unsure, utilize your medical carrier's provider search tool. See **page 20** for a complete list of contacts. (If you live in an area that includes Tenet network facilities or providers, they provide an additional benefit.) If you need urgent care, make sure you don't mistakenly choose a standalone emergency room with higher costs.

*This is a sample list of services. Contact your insurance carrier for costs and coverage details.

## Prescription Drug Benefits

Need a prescription? When you enroll in a medical plan, you're covered. All of our medical plan options include generic, brand-name, and specialty prescription drug coverage through OptumRx.*

### Where to Fill Prescriptions

How you can fill your prescription depends on the type of drug you need.

#### Short-Term Medications

You can fill short-term prescriptions, like antibiotics, at any in-network retail pharmacy.

#### Maintenance Medications

For prescriptions you take on an ongoing basis, you must get 90-day fills from a Walgreens retail pharmacy or through the convenient OptumRx home delivery service. The home delivery service sends medications right to your door, and you can sign up for automatic refills.

#### Specialty Medications

Specialty medications are drugs that are very expensive or require complicated treatment regimens or complex requirements. You must fill specialty prescriptions through the Optum Specialty Pharmacy.

*If you enroll in a Green Shield medical plan, you automatically receive prescription drug coverage through Green Shield.

### Save Money on Prescriptions

Before you fill a prescription, check with your doctor to see if a generic alternative is available. Generics are as safe and effective as their brand-name equivalents, and usually save you money.

If a generic isn't available, you can check the OptumRx formulary to see a list of brand-name drugs that are preferred based on safety, cost, and effectiveness.

If you're prescribed a brand-name medication that isn't on the formulary, you may receive a letter asking you to work with your doctor to submit a prior authorization request.

## Terms to Know

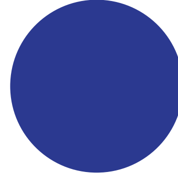
Navigating the healthcare landscape can be challenging, and it's helpful to become familiar with certain terms to understand the available plans and their design. Here are a few key terms to know:

### Copay

The fixed amount you pay for healthcare services at the time you receive them.

### Deductible

The amount you must pay for covered services before your insurance starts paying its portion.

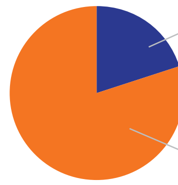


**You pay 100% up to the deductible**

### Coinsurance

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20%, your payment would be:

- $100 if you haven't met your deductible
- $20 (20% of $100 charge) if you have met your deductible, but not your out-of-pocket maximum

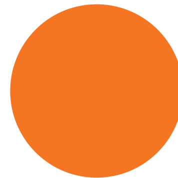


**% You pay**

**% Plan pays**

### Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.



**Plan pays 100% through end of year**

## How to Pick a Plan

Which plan is right for you? When deciding, consider any medical needs you foresee for the upcoming plan year, your overall health, and any medications you currently take. Please note that not all plan types are available in all areas.

### How does an HDHP (high deductible health plan) work?

- You'll pay less in premiums (think less money from your paycheck), but typically more at the time of service.
- You'll pay for the full cost of non-preventive medical services and prescriptions until you reach your deductible.
- You can also use a Health Savings Account in conjunction, which provides a tax-advantaged safety net for planned or unexpected medical costs.
- If you expect to mostly use preventive care (which is fully covered in-network), this plan could be for you.

### How does a PPO (Preferred Provider Organization) work?

- You'll pay more in premiums out of your paycheck, but typically less at the time of service.
- You're able to choose from a network of providers who offer a fixed copay for certain services.
- If you expect to need more medical care this year or have a chronic illness, the PPO could be the right choice for you.
- This plan includes access to the Healthcare Flexible Spending Account.

### How does an EPO (Exclusive Provider Organization) work?

- You'll pay less at time of service, typically but higher premiums out of your paycheck.
- In-network services are paid with copays or coinsurance.
- Members may seek care from an in-network provider only.
- Services provided by an out-of-network provider will not be covered.

### How does a Tenet Network EPO work?

- Members may seek care from an in-network provider only, which is a smaller network designed around Tenet's providers and partners.
- You'll typically pay less at the time of service and less in premiums out of your paycheck (using Tenet facilities and providers gives us more control over the costs).
- In-network services are paid with copays or coinsurance.
- Services provided by an out-of-network provider will not be covered.

### How does an HMO (Health Maintenance Organization) work?

- In-network services are paid with copays or coinsurance.
- Members may seek care from an in-network provider only. Services provided by an out-of-network provider will not be covered.
- In-network providers are contracted with the Presbyterian HMO plan to provide services to members at a discounted fee.
- You do not need a referral to see a specialist.

To learn more about the plans available to you and to compare and choose the right medical plan for your needs, visit the **Benefit Solutions Center**.

## Dental Benefits

Taking care of your dental and oral health is an important part of your overall health and well-being. Regular visits to the dentist are a key part of maintaining healthy teeth and gums. The company offers a choice of dental plans through Delta Dental that cover a full range of services, including preventive care, major care, and orthodontia.

In-network preventive care is covered at no cost. You generally pay a percentage of the total cost for other covered services, like fillings and orthodontia.

Learn more about dental coverage on the **Benefit Solutions Center**.

### Network Dentists

If you use a dentist who doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit Delta Dental at **www.deltadentalins.com**.

## Vision Benefits

As with annual physicals or dental exams, it's important to get regular eye exams, even if you don't wear corrective lenses. Regular eye exams can help you stay on top of your overall health. The company offers comprehensive vision coverage through VSP, which covers eye exams, lenses and frames, and discounts on laser eye surgery.

Our vision plan offers in- and out-of-network coverage, but going in-network for preventive care services, like routine eye exams, will save you money. And staying in-network means you won't have to file claims.

Find in-network providers at **www.vsp.com**.

Our vision plans have had an upgrade this year! The plan will pay a higher amount for certain services as well as lenses and frames, and you can receive them more often. Learn more about vision coverage on the **Benefit Solutions Center**.

## Employee Assistance Program

Being your best sometimes requires a little support. If you're looking for assistance with issues big or small, our Employee Assistance Program (EAP) is a great place to start. And it comes at no cost to you — whether you're enrolled in a company-sponsored medical plan or not.

Through this program, you and your family have access to mental health assistance and legal and financial help from a number of professionals. You have 24-hour access to helpful resources by phone, and the EAP benefit includes **five free phone or face-to-face visits per issue with a licensed professional**.

The EAP can help with a variety of issues, including:

- Emotional health and well-being
- Marital or family conflicts
- Child care concerns
- Alcohol or drug dependency
- Relationship problems
- Job pressures
- Stress or anxiety
- Depression
- Grief and loss
- Financial or legal advice
- Senior care

All services provided are confidential and will not be shared with the company. You may access information, benefits, educational materials, and more either by phone at **1-866-335-2340** or online at **tenet.mybeaconwellbeing.com**.

# FINANCIAL

## Tax-Savings Accounts

If you're looking for ways to save money on your medical, dental, and vision expenses, you might consider a Health Savings Account or a Flexible Spending Account. These accounts put more money in your pocket each year by reducing your taxable income.

### Health Savings Account

If you select a high deductible health plan, you are eligible to open a Health Savings Account (HSA) through Fidelity Investments. An HSA is a great way to save for healthcare expenses (medical, prescription, vision, and dental expenses) — all while lowering your taxable income. With an HSA, you can set aside before-tax* money to pay for eligible healthcare expenses now or let it build up for the future. The money in this account (including interest and investment earnings) grows tax-free. When the funds are used for qualified medical expenses, they are spent tax-free.

### HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2023, contributions (which include any employer contributions) are limited to the following:

| 2023 Annual HSA Funding Limits | |
|---|---|
| Individual coverage | $3,850 |
| Family coverage | $7,750 |
| Catch-up contributions (age 55+) | $1,000 |

With an HSA, your balance rolls over from year to year — you never lose it, even if you leave the company or retire.

*HSAs offer pre-tax savings under federal laws and most state income tax laws. California and New Jersey tax HSA contributions.

### How to Use the HSA

When you enroll in a medical plan with an HSA option, Fidelity Investments will send you instructions to open your account. You must go through the enrollment steps from Fidelity Investments to open your account. **It will not automatically open**. Once your HSA is open, you make contributions through before-tax payroll deductions. Your contributions can't exceed the 2023 IRS HSA contribution limit. When you need to use your account, you can:

- Pay with your Fidelity HSA debit card or write a check from your Fidelity HSA checkbook. The funds will come directly out of your HSA.
- Pay for an eligible expense with your own money, and then contact Fidelity to request reimbursement.
- Schedule and submit payments online using Fidelity's BillPay program.

If you already own a Health Savings Account with Fidelity because you have enrolled prior to joining the company (e.g., through another employer), once you enroll and your eligibility data is sent to Fidelity, you can access and review your HSA by signing in to www.NetBenefits.com or calling Fidelity. There is no "use-it-or-lose-it" rule with an HSA, so you may set up your account at Fidelity to receive new contributions.

### Flexible Spending Accounts

Similar to an HSA, a Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses. You build up your balance through automatic payroll deductions. These accounts lower your taxable income, saving you money.

Tenet offers two FSAs:

- A Healthcare FSA for eligible healthcare expenses
- A Dependent Care FSA for eligible day care expenses for your dependents

### Healthcare Flexible Spending Account

If you enroll in a PPO, HMO, or EPO plan, or if you waive medical coverage, you're eligible for a Healthcare FSA. You can contribute up to $2,850 annually for qualified medical, dental, and vision expenses (deductibles, copays, and coinsurance) with pre-tax dollars, reducing your taxable income and increasing your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive the service, without waiting for reimbursement. With a Healthcare FSA, your total annual election amount is available to you on the first day of the plan year, which can help you budget for larger health-related expenses.

### How to Use the Healthcare FSA

If you enroll in the Healthcare FSA, you will receive an FSA debit card from Benefits Accounts. The FSA debit card allows you to pay for eligible healthcare expenses at the point of service and deducts funds directly from the total amount you elected for the year for your Healthcare FSA. This allows you to avoid waiting for reimbursement.

You may use your FSA debit card at locations such as doctor and dentist offices, pharmacies, and vision service providers. The card cannot be used at locations that do not offer services under the Plan unless the provider has also complied with IRS regulations. Should you attempt to use the card at an ineligible location, the swipe transaction will be denied.

### Dependent Care Flexible Spending Account

Do you pay for child care or elder care? If so, consider participating in the Dependent Care FSA. It's another great way to lower the amount you pay in taxes and budget for expected costs. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time.

- With the Dependent Care FSA, you can set aside up to $5,000 ($2,000 for highly compensated employees) to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- Expenses are reimbursable if the provider is not your dependent.
- To be reimbursed, you must provide the tax identification number or Social Security number of the party providing care.

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time. Examples of eligible dependent care expenses include:

- In-home baby-sitting services (not provided by a tax dependent)
- Care of a preschool child by a licensed nursery or day care provider
- Before- and after-school care
- Day camp
- In-house dependent day care

### How to Use the Dependent Care FSA

Debit cards are not issued for a Dependent Care FSA. When you incur a dependent care expense, you will need to file a claim for reimbursement with Benefits Accounts. You can file a claim online and will need to submit receipts along with the claim. You will be reimbursed once you have the funds available in your account to cover the amount of the claim.

### General Rules and Restrictions

The IRS has the following rules and restrictions for Healthcare and Dependent Care FSAs:

- Expenses must be incurred during the 2023 plan year.
- Dollars cannot be transferred between FSAs.
- You cannot participate in a Dependent Care FSA and claim a dependent care tax deduction at the same time.
- You must "use it or lose it" — any unused funds will be forfeited.
- You cannot change your FSA election in the middle of the plan year unless you experience a qualifying life event.

### Use It or Lose It

**All Healthcare FSA and Dependent Care FSA funds must be used by December 31 of the current plan year. Claims must be submitted by March 31 of the following year. Unused funds are forfeited at the end of each year, so estimate your expenses carefully.**

## Comparing an HSA to a Healthcare FSA

| | Health Savings Account (HSA) | Healthcare Flexible Spending Account (FSA) | Limited-Purpose Healthcare Flexible Spending Account |
|---|---|---|---|
| **Which medical plan can I have with this account?** | A high deductible health plan (HDHP) | A PPO, EPO, HMO, or waived coverage | If you contribute to an HSA, you can also contribute to the Limited-Purpose FSA for dental and vision expenses only. |
| **What happens at the end of the year?** | HSAs work like a bank account that you own and manage. Unused money stays in your account from year to year, and you can even take it with you if you leave your job or retire. | Your account balance must be used for expenses incurred in the calendar year. "Use it or lose it," but you can submit eligible claims through March 31 of the following year. | |
| **Does the money in the account earn interest?** | Yes, it grows tax-free with interest or investment earnings. | No | |
| **How much can I contribute in 2023?** | You can contribute up to the IRS maximum of $3,850 for individuals and $7,750 for family coverage. (Note, this maximum includes any company contribution.) | You can contribute up to $2,850 on a pre-tax basis. | In addition to your HSA contribution, you can contribute up to $2,850 on a pre-tax basis to your LPFSA. |
| **What happens to money left in my account if I leave Tenet or retire?** | The money is yours to take with you, with no limit in the amount you can accumulate. | Your account balance must be used for expenses incurred up to your date of termination, but you can submit eligible claims through March of the following year. | |

### Consider this...

You can only pair a Healthcare FSA with a medical plan that does **NOT** come with an HSA. Per IRS regulations, you cannot contribute to a Healthcare FSA and an HSA in the same year.

## Other

### Health Reimbursement Account

If you are covered by a medical plan with a Health Reimbursement Account (HRA) option, an HRA will be opened on your behalf. An HRA is a company-funded account you can use to pay qualified healthcare expenses (medical, prescription, dental, and vision) for you, your spouse, and your dependents. The HRA is opened automatically for you and is available on the first day your benefits begin. You cannot make personal contributions to an HRA.

### Using Your HRA

You'll receive a debit card that can be used at doctors' offices, healthcare facilities, and pharmacies. If you don't pay for qualified expenses with your debit card, you may pay with your own money and file a claim for reimbursement.

### Looking to save a little more for healthcare expenses each year?

Consider opening a Healthcare FSA (see page 13). If you have both an FSA and HRA, you'll have one debit card for both accounts, and your FSA dollars will be used first.

> **Note**
>
> If you're covered by a Collective Bargaining Agreement, contact your HR Department or Union Representative as plan provisions may be different.

## Savings and Retirement

### 401(k) Retirement Savings Plan

The company helps you build financial security in retirement by offering a valuable 401(k) Retirement Savings Plan. Enrollment in a 401(k) account is not part of Annual Enrollment. You can enroll, change, or stop your contributions anytime.

### What is a 401(k)?

This employer-sponsored retirement account can help build and create choices for your future self by saving money — tax free — from your paycheck. Due to the value of compounding interest, the sooner you participate in a 401(k), the better. Eligible employees can invest for retirement while receiving certain tax advantages. Administrative and record-keeping services for this plan are provided by Fidelity Investments. You are eligible if you are full-time, part-time, or a PRN employee.

### Key Features

- **Tax advantages.** Currently, you can contribute up to $22,500, or $30,000 if you're age 50 or older, in pre-tax dollars. These contributions reduce your taxable income.
- **Employer match.** Before-tax contributions you make to the plan may be eligible for a discretionary employer match.
- **You pick.** You get a mix of investment options to choose from to best fit your goals.

### Managing Your Account

You can enroll in the 401(k) Retirement Savings Plan or change your contribution amount after you have 30 days of service. To enroll, call the My Financial Benefits Line at **1-800-372-4015** or log on to **www.netbenefits.com**.

### Employee Stock Purchase Plan

Eligible employees may purchase Tenet Healthcare common stock at a 5% discount through the Employee Stock Purchase Plan (ESPP). You can elect 1–10% of your post-tax salary, up to an annual maximum of $25,000, to purchase shares.

You can have payments directly deducted from your paycheck. You must hold your shares for at least one year before you sell them.

You have an opportunity to enroll in the ESPP each quarter.

To verify eligibility, log in to Fidelity Investments at **www.netbenefits.com** or call a representative at **1-800-544-9354**.

## Protection Benefits

### Life and AD&D

It's difficult to think about what would happen if something ever happened to you, but it's important to have a plan in place to make sure your family is provided for. Securing survivor benefits now provides you peace of mind that your loved ones will be financially protected in the event of an absence or unexpected event. Life insurance provides your beneficiaries with a payment if you die. Accidental death & dismemberment (AD&D) insurance pays a benefit if you have a covered loss or death caused by an accident. Both plans are administered through Unum.

### Basic Life and AD&D

You automatically receive this coverage, paid for by the company.

### Supplemental Life and AD&D

The basic benefits provided to you may not be enough to cover expenses in a time of need. Therefore, extra coverage is available to protect you and your family. Eligible employees may purchase additional Life and AD&D insurance when you enroll in benefits. If you purchase supplemental coverage for yourself, you can also purchase supplemental insurance for your spouse or domestic partner and your children. You may be asked to complete an Evidence of Insurability (EOI) form.

**For more information and rates, visit the Benefit Solutions Center.**

Designate a beneficiary to receive your life and AD&D benefits if you die. You can update your beneficiary at any time on the Benefit Solutions Center website.

### Disability

Disability coverage helps you prepare for the unexpected. Our disability plans pay you when you're sick or injured and it's going to be more than a few days before you can get back to work. Additional coverage is available on a voluntary basis. For more information, including coverage options, visit the **Benefit Solutions Center**.

### Short-Term Disability

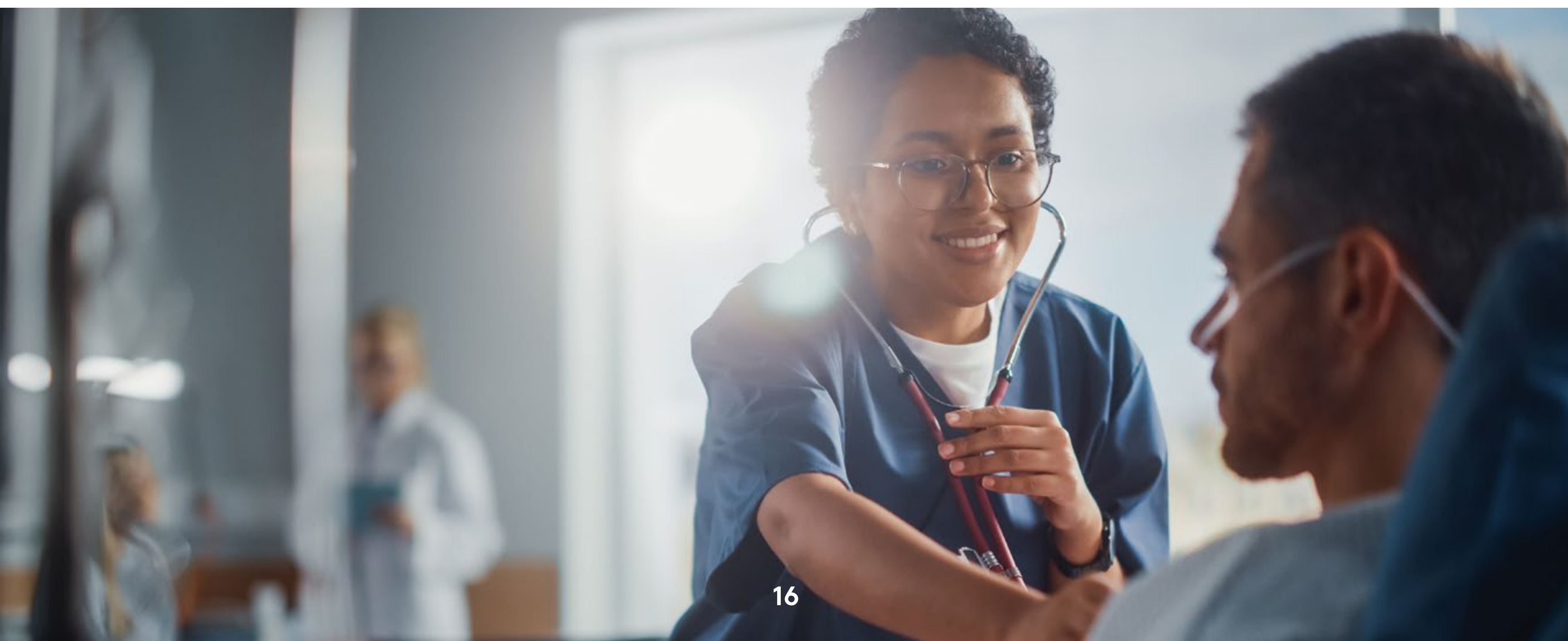
This pays you a percentage of your gross weekly salary if you cannot work because of a covered illness, injury, or other disability, including maternity leave. The plan doesn't cover work-related injuries.

### Long-Term Disability

If you're still disabled after your short-term disability benefits end, long-term disability allows you to continue receiving a percentage of your gross weekly salary.

Before enrolling in disability, consider what percentage of your salary you'd need for living expenses if you couldn't work.

When you enroll in short-term disability, you'll also choose the length of time you need to wait before you can start receiving benefits (called an elimination period).



## Supplemental Health Benefits

Take your financial protection a step further. We offer several ways for you to supplement your medical plan coverage. These voluntary insurance plans can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for you and your dependents and is offered at discounted group rates.

### Accident Insurance

Accidents happen when you least expect them and are traumatic enough without worrying about finances. An accident plan can help you be more prepared for when they do. If you have a covered accident, Accident Insurance can help you pay for costs not covered by your medical plan. Covered accidents include burns, broken bones, emergency dental work, ear, or eye injuries, and more. An Accident plan pays you cash directly to use however you need it most, including for expenses such as:

- Your deductible, copays, or coinsurance
- Hospital treatment, ambulance, X-rays, and exams
- Supportive care, such as follow-up treatment or physical therapy
- Other daily living expenses, such as rent, gas, child care, and groceries

### Critical Illness

If faced with a major illness, your out-of-pocket expenses could be substantial, even with medical and disability coverage. Critical illness insurance pays you a lump cash benefit if you're diagnosed with a serious illness, like a heart attack, cancer, or stroke. You could also receive benefits if a diagnosis happens a second time, or if you have a different diagnosis. A critical illness plan doesn't replace your medical coverage; instead, it complements it. You can use the benefits to pay out-of-pocket medical costs or personal expenses, including:

- Your deductible, copays, or coinsurance
- Over-the-counter medication and prescription costs
- Out-of-network doctor visits and medical services
- Household bills, like your mortgage, car payments, and utilities
- Daily living expenses, like extended child care

### New for 2023! Hospital Indemnity Insurance

A new Hospital Indemnity plan is available that can help cover expenses if you are admitted to the hospital. Whether you're planning a hospital stay, or one comes up unexpectedly, the costs can really add up fast. The Hospital Indemnity plan pays a cash benefit when you have a hospitalization due to an illness, injury, surgery, or even delivering a baby. The plan pays a lump-sum benefit for admission and a daily benefit for a covered hospital stay. You can also use the benefits to help pay out-of-pocket medical costs or personal expenses.

For a complete list of covered illnesses and injuries, and to find rates and enroll in voluntary supplemental health benefits, visit the **Benefit Solutions Center**.

## Long-Term Care Insurance*

If you are no longer able to care for yourself, you might need help from an in-home care service or nursing facility. These services are expensive. Long-term care insurance, offered through Unum, allows you to get quality care and protect your finances if you become chronically ill or mentally or physically disabled and need assistance with daily activities. You can use the benefit for in-home care, a residential care facility, a skilled nursing facility (like a nursing home), or hospice.

If you choose to elect coverage for your spouse or domestic partner, your parents, and/or your grandparents, you'll enroll them directly with Unum. Your family members must be under age 85 when you initially elect coverage for them.

**You can enroll in coverage for yourself on the Benefit Solutions Center.**

*This benefit is not available to USPI employees.

### ACTION REQUIRED!

In 2023, Accident, Critical Illness, and Hospital Indemnity Insurance will be offered through Aetna. Accident and Critical Illness insurance plans are being enhanced, with higher payouts and additional covered events, as well as lower premiums. And, a new Hospital Indemnity plan has been added.

If you are enrolled in supplemental health benefits in 2022, your elections will not carry over. **Be sure to re-enroll** if you want to continue coverage in 2023.

## Voluntary Benefits

### Legal Insurance

Get access to a network of attorneys — available in person or by email and online tools — who can help you with common legal matters through the MetLife Legal Plan. There is no limit on the number of times you may use the plan, and the monthly premium is deducted from your paycheck.

Benefits include assistance with:

- Will preparation
- Real estate matters
- Traffic violations
- Family law, including adoptions
- Tax audits
- Personal bankruptcy
- Debt collection or identity theft

**New for 2023!**

We've upgraded the plan to include:

- Caregiving services (Family First)
- Divorce, dissolution, and annulment
- Probate proceedings
- Habeas corpus
- Insurance claims
- Misdemeanor defense
- Up to four hours of network attorney time and services for non-covered matters (total per family)

**For a full list of covered services, visit the Work/Life > Voluntary Benefits section of the Benefit Solutions Center.**

### Identity Protection

Everyday things like online shopping, banking, and even browsing can expose personal information and make you vulnerable to cybercriminals and identity theft. To help protect you, Allstate Identity Protection delivers comprehensive identity and financial monitoring, including:

- Ongoing identity and credit monitoring
- An annual credit report
- Monthly credit score tracking
- Financial transaction monitoring
- Social media monitoring
- Data breach notifications
- Family coverage

Once enrolled, you will receive a monthly Identity Health level score. If suspicious activity is detected, a privacy expert is available 24/7 to help you resolve the issue.

**To get started, visit the Work/Life > Voluntary Benefits section of the Benefit Solutions Center.**

### Important!

You'll receive a welcome email within 48 hours after your effective date with your Member ID and login button.

To activate your account, click the login button, enter your Member ID, Social Security number, and date of birth. Confirm your mailing address and create a username and password. You can then see your plan benefits and get started using them.

### Travel Assistance*

As part of your Basic Life plan, Unum includes their Travel Assistance program. This benefit is provided at no additional cost to you and includes a wealth of services when traveling 100 miles or more from home for either business or vacation. Day or night, you and your family can get support for medical, legal, and other important services. Before traveling, make sure you download the Assist America mobile app available on the Apple App Store or Google Play.

Your activation code is 01-AA-UN-762490. If you need travel assistance, you can call **1-800-872-1414** (within the U.S.) or **+1-609-986-1234** (outside the U.S.).

*This benefit is not available to Tenet or Conifer employees.

## WORK/LIFE

## Other Voluntary Benefits

Access these benefits year-round on BenefitHub.

### Auto and Home Insurance

Get coverage for your possessions. BenefitHub gives you access to competitive rates on home and auto coverage and allows you to comparison shop your coverage among top national insurance carriers.

You can purchase coverage for your:

- Vehicle
- Home or condo (some state exclusions apply)
- Apartment or rental property
- Boat

You can also purchase personal excess liability coverage.

The cost for coverage is deducted from your paycheck after taxes. The amount you pay varies based on things like the policy you choose, what you cover, and where you live.

### Pet Insurance

Caring for your pet can be expensive. Pet insurance coverage through Nationwide can help you focus more on your pet's health and less on the cost. Pet insurance covers veterinarian treatment if your dog or cat has a covered injury or illness.

The cost of coverage depends on the age, species, and size of your pet, where you live, and the plan you choose.

### Employee Discount Program

Who doesn't love a discount? BenefitHub offers rewards and discounts on commonly purchased things like:

- Health and wellness resources
- Food, flowers, and gifts
- Activities and events
- Pet supplies
- Cell phones
- Electronics
- Apparel

You can also search for local deals in your area.

### Child and Elder Care Referrals

This program gives you personal assistance with research and referrals for child care, elder care, and education — plus discounts on day care, elder care, and tutors.

For more details on these benefits, visit the Benefit Solutions Center > Work/Life > Voluntary Benefits Program.

# CONTACTS

| | Provider | Website | Phone Number |
|---|---|---|---|
| **Benefit Questions** | Benefit Solutions Center | **www.benefitsolutions.ehr.com** | 1-844-877-8591 |
| **COBRA Questions** | Benefit Connect COBRA | **www.cobra.ehr.com** | 1-877-29-COBRA (1-877-292-6272) |
| **Medical** | Aetna | **www.aetna.com** | 1-800-824-2705 |
| | BCBS of Alabama | **www.bcbsal.com** | 1-844-258-3227 |
| | BCBS of Texas | **www.bcbstx.com** | 1-888-762-2191 |
| | Green Shield | **www.greenshield.ca** | 1-888-711-1119 |
| | Presbyterian HMO | **www.phs.org** | 1-800-356-2219 |
| | UMR | **www.umr.com** | 1-800-826-9781 |
| **Prescription Drug** | OptumRx | **www.optumrx.com** | 1-844-568-4146 |
| **Dental** | Delta Dental | **www.deltadentalins.com** | 1-800-336-8264 |
| **Vision** | VSP | **www.vsp.com** | 1-800-877-7195 |
| **Telemedicine** | Aetna (Teladoc) | **www.teladoc.com/aetna** | 1-800-835-2362 |
| | BCBS Alabama (Teladoc) | **www.teladoc.com/alabama** | 1-855-477-4549 |
| | BCBS Texas (MDLIVE) | **www.mdlive.com/bcbstx** | 1-888-680-8646 |
| | UMR (Teladoc) | **www.teladoc.com** | 1-800-835-2362 |
| **Health Savings Account (HSA)** | Fidelity | **www.netbenefits.com** | 1-800-372-4015 |
| **Health Reimbursement Account (HRA)** | Benefit Solutions Center | **www.benefitsolutions.ehr.com** | 1-844-877-8591 |
| **Flexible Spending Accounts (FSAs)** | Benefits Accounts | **www.benefitsolutions.ehr.com** | 1-844-877-8591 |
| **Life and AD&D Insurance** | Unum | **www.unum.com** | 1-800-445-0402 |
| **Disability** | Unum | **www.unum.com** | 1-888-673-9940 |
| **401(k) Retirement Savings Plan** | Fidelity Retirement Savings | **www.401k.com** or **www.netbenefits.com** | 1-800-372-4015 |
| **Employee Stock Purchase Plan (ESPP)** | Fidelity Investments | **www.netbenefits.com** | 1-800-544-9354 |
| **Critical Illness, Accident, and Hospital Indemnity Insurance** | Aetna | Tenet: **https://aet.na/tenet-shp** Conifer/USPI: **https://aet.na/tenet-ntpf** | 1-800-607-3366 |
| **Legal Insurance** | MetLife Legal | **www.metlife.com/info/tenet/** | 1-800-821-6400 |
| **Identity Protection** | Allstate | **www.myaip.com/tenethealthcare** | 1-800-789-2720 |
| **Long-Term Care** | Unum | **www.unum.com** | 1-888-852-2232 |
| **Travel Assistance** | Unum | **www.unum.com** | 1-800-872-1414 (within the U.S.) +1-609-986-1234 (outside of the U.S.) |
| **Employee Assistance Program (EAP)** | Beacon Health | **www.tenet.mybeaconwellbeing.com** | 1-866-335-2340 |
| **Voluntary Benefits Program** | Benefit Solutions Center | **www.benefitsolutions.ehr.com** | 1-844-877-8591 |
| **Employee Discount Program** | BenefitHub | Tenet/USPI: **www.tenet.benefithub.com** Conifer: **www.conifer.benefithub.com** | 1-866-664-4621 |

## Important Notice from Tenet about Creditable Prescription Drug Coverage and Medicare

**This notice has information about your current prescription drug coverage under the Tenet Employee Benefit Plan (the "Plan") and about your options under Medicare's prescription drug coverage. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage.**

**The purpose of this notice is to advise you that the prescription drug coverage listed below under the Plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2023. This is known as "creditable coverage." Why this is important: if you or your covered dependent(s) are enrolled in any prescription drug coverage during 2023 listed in this notice and are currently or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty — as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment.**

**You should keep this notice with your important records. If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.**

### Notice of Creditable Coverage

Please read this notice carefully. It has information about prescription drug coverage under the Plan and about your options under Medicare's prescription drug coverage. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

You may have heard about Medicare's prescription drug coverage (called Part D) and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals losing employer/union coverage through no fault of their own may be eligible for a two-month Medicare Special Enrollment Period.

If you are covered by one of the Tenet prescription drug coverage options under the Plan, you'll be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2023. This is called creditable coverage. Coverage under one of these prescription drug coverage options will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you also may continue your employer coverage under the Plan. In this case, the Plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Tenet coverage, Medicare will be your only payer. If you are an active employee, you can re-enroll in the Plan at Annual Enrollment or if you have a special enrollment event or Life Event for the Tenet Plan. If you are a retiree who has elected COBRA and you waive or drop Tenet coverage, you may not re-enroll in the Plan.

You should know that if you waive or lose coverage under the Tenet Plan and you 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 days or longer without creditable prescription drug

coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium may go up by at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium may consistently be at least 19% higher than what most other people pay. You may have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future — such as before the next period you can enroll in Medicare prescription drug coverage, if this Tenet coverage changes, or upon your request.

**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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You also may be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. For information, contact the Social Security Administration (SSA) online at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.**

For more information about this notice or your prescription drug coverage, call the **Benefit Solutions Center** at **1-844-877-8591**.

Dated: October 1, 2022

## Notice of Privacy Practices

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

The Tenet Employee Benefit plan (the "Plan"), Tenet Healthcare Corporation, and United Surgical Partners, INTL, provides health benefits to eligible employees of Tenet and participating entities (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by employer medical plans. This information, known as Protected Health Information (PHI), includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the following medical benefit coverage options provided under the Plan: medical, dental, vision, Employee Assistance Plan, and Healthcare Flexible Spending Account. The medical benefit coverage options may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the "Plan" in this notice, unless specified otherwise.

**The Plan's duties with respect to health information about you**

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. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to Tenet to protect your privacy, so different policies may apply to other Tenet programs or to data unrelated to the Plan.

### How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- Payment includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" Plan functions such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another medical plan in order to coordinate payment of benefits.
- Health care operations include activities by this Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. For example, the Plan may use information about your claims to review the effectiveness of wellness programs. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

The amount of health information used or disclosed will be limited to the minimum necessary for these purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes. The Plan may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

### How the Plan may share your health information with Tenet

The Plan, or its health insurer, may disclose your health information without your written authorization to Tenet for Plan administration purposes. Tenet may need your health information to administer benefits under the Plan. Tenet agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. The following groups at Tenet may have access to PHI in certain circumstances for Plan administration functions:

| Group | Reason for Receiving PHI |
|---|---|
| Plan Administrator and Benefits Appeal Committee | Reviewing employee benefit appeals |
| Corporate Benefit Administrators | Discussing health or claims issues with employees |
| Payroll Department | Entering and viewing payroll deductions for health care premiums |
| Information Technology Department | Unforeseen computer hardware issues |

Here's how additional information may be shared between the Plan and Tenet, as allowed under the HIPAA rules:

- The Plan, or its insurer, may disclose "summary health information" to Tenet, if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer, may disclose to Tenet information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option offered by the Plan.

In addition, you should know that Tenet cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Tenet from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation, is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

#### Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative. The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

| | |
|---|---|
| Workers' Compensation | Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws. |
| Business Associates | We may contract with individuals or entities known as Business Associates to perform various functions or provide specific services with respect to the Plan. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us. |
| Treatment Alternatives or Health-Related Benefits and Services | We may use or disclose your protected health information to send you information about treatment alternatives or other health related benefits and services that might be of interest to you. |
| Necessary to Prevent Serious Threat to Health or Safety | Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody. |
| Public Health Activities | Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects. |
| Victims of Abuse, Neglect, or Domestic Violence | Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk). |
| Judicial and Administrative Proceedings | Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information). |
| Law Enforcement Purposes | Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises. |

| | |
|---|---|
| Decedents | Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties. |
| Organ, Eye, or Tissue Donation | Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death. |
| Research Purposes | Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project. |
| Health Oversight Activities | Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws. |
| Specialized Government Functions | Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates. |
| HHS Investigations | Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule. |

Other uses or disclosures of your health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from the Plan at any time.

**Your individual rights**

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right.  If you wish to exercise any of the rights listed below, contact the **Benefit Solutions Center** at **1-844-877-8591**.

**Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse**

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to persons you identify as being involved in your care or payment for your care, such as family members, close friends, or others. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

**Right to receive confidential communications of your health information**

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement that disclosure of all or part of the information could endanger you. The Plan will consider reasonable requests carefully; however, the Plan is not required to agree to all requests.

### Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- the access or copies you requested;
- a written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request. You may request an electronic copy of your health information if it is maintained in an electronic format. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies, if any, must be reasonable and based on the Plan's cost.

### Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- make the amendment as requested;
- provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

### Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made:

- for treatment, payment, or health care operations (except with respect to electronic health records for treatment, payment, or health care operations, where you may receive information on disclosures of your health information for up to three years before the date of your request);
- to you about your own health information;
- incidental to other permitted or required disclosures;
- where authorization was provided;
- to family members or friends involved in your care (where disclosure is permitted without authorization);
- for national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- as part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing

this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

#### Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

#### Notification of a breach

The Plan is required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

#### Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice took effect in 2018. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice via email, or through regular mail if you do not have a Tenet email address.

#### Complaints

If you believe your privacy rights have been violated, you may complain to the Plan or to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint, contact the **Benefit Solutions Center** at **1-844-877-8591**.

#### Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact the **Benefit Solutions Center** at **1-844-877-8591**.

#### Health Providers and Your Health Information

Health providers (such as doctors, medical clinics, health maintenance organizations, insurers, hospitals, etc.) may also use and disclose your health information. You also have rights regarding the health information which they obtain and have about you. You should consult the notices of privacy practices which you receive from health care providers for information regarding how and under what circumstances they may use and release your health information and what rights you have with respect to their practices regarding your health information.

## Special Enrollment Rights

#### HIPAA Special Enrollment Rules

HIPAA requires we notify you about your right to later enroll yourself and eligible dependents for coverage under the medical benefit coverage options under the Tenet Employee Benefit Plan (the Plan") under "special enrollment provisions" briefly described below.

- **Loss of Other Coverage.** If you decline enrollment for yourself or for an eligible dependent (including your spouse) because you have other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents for medical benefit coverage under the Plan if you or your dependents lose eligibility for that other coverage, or if the other employer stops contributing toward your or your dependents' other coverage. You must request enrollment within 31 days after your or your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage.
- **New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.** If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents for medical benefit coverage under the Plan. You must complete enrollment and provide proof within 31 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse, if your spouse was not previously covered.
- **Enrollment Due to Medicaid/CHIP Events.** If you or your eligible dependents are not already enrolled in medical benefit coverage under the Plan, you may be able to enroll yourself and your eligible dependents if: (i) you or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. The CHIP Model Notice containing additional information about this right as well as contact information for state assistance is included below. You may also request a copy from the Plan Administrator.

Please contact the **Benefit Solutions Center** at **1-844-877-8591** to request special enrollment or for additional details, including the effective dates of coverage applicable to each of these special enrollment provisions. Additional information regarding your rights to enroll in medical benefit coverage under the Plan is found in the applicable summary plan description(s) or insurance contract(s).

## Women's Health and Cancer Rights Act Notices (WHCRA)

Did you know that the medical benefit coverage options under the Tenet Employee Benefit Plan (the "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, prostheses, and complications resulting from a mastectomy (including lymphedema)? If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the medical benefit coverage option under the Plan in which you're enrolled.

If you would like more information on WHCRA benefits, contact the **Benefit Solutions Center** at **1-844-877-8591**.

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

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

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

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

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

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your state for more information on eligibility.**

**ALABAMA — Medicaid**
Website: **http://www.myalhipp.com**
Phone: (855) 692-5447

**ALASKA — Medicaid**
The AK Health Insurance Premium Payment Program
Website: **http://myakhipp.com/**
Phone: (866) 251-4861
Email: **customerservice@myakhipp.com**
Medicaid Eligibility: **http://dhss.alaska.gov/dpa/pages/medicaid/default.aspx**

**ARKANSAS — Medicaid**
Website: **http://myarhipp.com/**
Phone: 1-855-MyARHIPP (855) 692-7447

**CALIFORNIA — Medicaid**
Health Insurance Premium Payment (HIPP) Program
Website: **http://dhcs.ca.gov/hipp**
Phone: (916) 445-8322
Email: **hipp@dhcs.ca.gov**

**COLORADO — Medicaid and Child Health Plan Plus (CHP+)**
Health First Colorado Website: **https://www.healthfirstcolorado.com/**
Health First Colorado Member Contact Center:
(800) 221-3943 (TTY: Colorado relay 711)
CHP+ Website: **https://www.colorado.gov/pacific/hcpf/child-health-plan-plus**
CHP+ Phone: (800) 359-1991 (TTY: Colorado relay 711)
Health Insurance Buy-In Program (HIBI): **https://hcpf.colorado.gov/health-insurance-buy-program**
HIBI Customer Service: 1-855-692-6442

**FLORIDA — Medicaid**
Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**
Phone: (877) 357-3268

**GEORGIA — Medicaid**
GA HIPP Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: (678) 564-1162, Press 1
GA CHIPRA Website: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**
Phone: (678) 564-1162, Press 2

**INDIANA — Medicaid**
Healthy Indiana Plan for low-income adults 19-64:
Website: **http://www.in.gov/fssa/hip/**
Phone: (877) 438-4479
All other Medicaid:
Website: **https://www.in.gov/medicaid/**
Phone: 1-800-457-4584

**IOWA — Medicaid and CHIP (Hawki)**
Medicaid Website: **https://dhs.iowa.gov/ime/members**
Medicaid Phone: 1-800-338-8366
Hawki Website: **http://dhs.iowa.gov/hawki**
Hawki Phone: (800) 257-8563
HIPP Website: **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**
HIPP Phone: 1-888-346-9562

**KANSAS — Medicaid**
Website: **https://www.kancare.ks.gov/**
Phone: 1-800-792-4884

**KENTUCKY — Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx**
Phone: 1-855-459-6328
Email: **KIHIPP.PROGRAM@ky.gov**
KCHIP Website: **https://kidshealth.ky.gov/Pages/index.aspx**
Phone: 1-877-524-4718
Kentucky Medicaid Website: **https://chfs.ky.gov**

**LOUISIANA — Medicaid**
Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp**
Phone: (888)-342-6207 (Medicaid hotline) or (855)-618-5488 (LaHIPP)

**MAINE — Medicaid**
Enrollment Website: **https://www.maine.gov/dhhs/ofi/applications-forms**
Phone: (800) 442-6003 (TTY: Maine relay 711)
Private Health Insurance Premium Webpage: **https://www.maine.gov/dhhs/ofi/applications-forms**
Phone: (800) 977-6740 (TTY: Maine relay 711)

**MASSACHUSETTS — Medicaid and CHIP**
Website: **https://www.mass.gov/masshealth/pa**
Phone: (800) 862-4840
TTY: (617) 886-8102

**MINNESOTA — Medicaid**
Website: **https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp**
Phone: (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: (800) 694-3084
Email: **HHSHIPPProgram@mt.gov**

**NEBRASKA — Medicaid**
Website: **http://www.accessnebraska.ne.gov**
Phone: (855) 632-7633
Lincoln Phone: (402) 473-7000
Omaha Phone: (402) 595-1178

**NEVADA — Medicaid**
Website: **http://dhcfp.nv.gov**
Phone: (800) 992-0900

**NEW HAMPSHIRE — Medicaid**
Website: **https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**
Phone: (603) 271-5218 (Toll free: (800) 852-3345, ext 5218)

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

**NEW YORK — Medicaid**
Website: **https://www.health.ny.gov/health_care/medicaid/**
Phone: (800) 541-2831

**NORTH CAROLINA — Medicaid**
Website: **https://medicaid.ncdhhs.gov/**
Phone: (919) 855-4100

**NORTH DAKOTA — Medicaid**
Website: **http://www.nd.gov/dhs/services/medicalserv/medicaid/**
Phone: (844) 854-4825

**OKLAHOMA — Medicaid and CHIP**
Website: **http://www.insureoklahoma.org**
Phone: (888) 365-3742

**OREGON — Medicaid**
Website: **http://healthcare.oregon.gov/pages/index.aspx** or **http://www.oregonhealthcare.gov/index-es.html**
Phone: (800) 699-9075

**PENNSYLVANIA — Medicaid**
Website: **https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx**
Phone: (800) 692-7462

**RHODE ISLAND — Medicaid and CHIP**
Website: **http://www.eohhs.ri.gov/**
Phone: (855) 697-4347
Direct Rite Share Line: (401) 462-0311

**SOUTH CAROLINA — Medicaid**
Website: **https://www.scdhhs.gov**
Phone: (888) 549-0820

**SOUTH DAKOTA — Medicaid**
Website: **http://dss.sd.gov**
Phone: (888) 828-0059

**TEXAS — Medicaid**
Website: **http://gethipptexas.com/**
Phone: (800) 440-0493

**UTAH — Medicaid and CHIP**
Medicaid Website: **https://medicaid.utah.gov/**
CHIP Website: **http://health.utah.gov/chip**
Phone: (877) 543-7669

**VERMONT — Medicaid**
Website: **http://www.greenmountaincare.org/**
Phone: (800) 250-8427

**VIRGINIA — Medicaid and CHIP**
Website: **https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp**
Medicaid Phone: (800) 432-5924
CHIP Phone: (800) 432-5924

**WASHINGTON — Medicaid**
Website: **http://www.hca.wa.gov/**
Phone: (800) 562-3022

**WEST VIRGINIA — Medicaid**
Website: **https://dhhr.wv.gov/bms/**
or **http://mywvhipp.com/**
Medicaid Phone: (304) 558-1700
CHIP Toll-Free Phone: (855) MyWVHIPP
(855-699-8447)

**WISCONSIN — Medicaid and CHIP**
Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**
Phone: (800) 362-3002

**WYOMING — Medicaid**
Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/**
Phone: (307) 777-7531

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

**U.S. Department of Health and Human Services**
Centers for Medicare & Medicaid Services
**www.cms.hhs.gov**
(877) 267-2323, option 4, ext. 61565

## Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 7/31/2023)

## Newborns' Act Disclosure

Group health plans, such as the medical benefit coverage options under the Tenet Employee Benefit Plan, generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## Model General Notice Of COBRA Continuation Coverage Rights

### Introduction

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

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

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower

costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

### What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a "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 or domestic partner of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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 domestic partnership ends; 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 (divorce or legal separation of the employee and spouse, termination of a domestic partnership 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: the Benefit Solutions Center at 1-844-877-8591.**

### 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 or domestic partners, 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, domestic partner 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, domestic partner 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 the domestic partnership ends; 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, domestic partner or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

### Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

### 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 **Benefit Solutions Center** 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 Benefits Solution Center.

### Plan contact information

The **Benefit Solutions Center** at **1-844-877-8591**.

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This booklet describes benefit plans applicable for eligible employees of Tenet Healthcare Corporation and its affiliates, subject to the terms of the formal Plan Documents. This document modifies information contained in your Summary Plan Description and constitutes a Summary of Material Modifications ("**SMM**"). This SMM should be kept with your Summary Plan Description.

The information presented here does not replace the official plan documents. If there is a conflict between this document and the plan document for any of the benefits described in this document, the plan document will control. Tenet reserves the right to amend the plan and benefits described herein from time to time or to terminate them entirely.

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