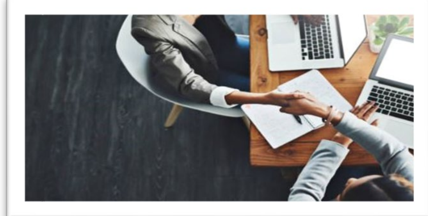
2024-2025

BENEFITS GUIDE

Provided to you by:

Welcome

We would like to welcome you to the 2024-2025 annual benefits summary package for ***Psychiatric Medical Care (PMC)***. This packet contains summaries of the benefits offered to you by ***Psychiatric Medical Care.*** We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.



This benefits guide provides an overview of benefit plans, including eligibility, election periods and costs. In addition, the guide offers descriptions and explanations of each coverage plan option. We urge you to carefully consider all aspects of these programs, including their premiums, accessibility to health care services, flexibility, and restrictions.

Info on the Go!

Scan with your Smartphone to access your 2024 Benefits Guide and enrollment materials online ANYTIME.

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Carrier Contacts

Your Carriers

Contact Name	Contact Information
Medical **Aetna**	Phone: **1 (800) 240-2386** Website: www.aetna.com
Health Savings Account (HSA) **Optum Financial**	Phone: **1 (866) 234-8913** Website: www.optum.com
Dental **Delta Dental**	Phone: **1 (800) 223-3104** Website: www.deltadentaltn.com
Vision **Delta Dental**	Phone: **1 (800) 877-7195** Website: www.deltadentaltn.com
Flexible Spending Accounts (FSAs) **Optum Financial**	Phone: **1 (866) 234-8913** Website: www.optum.com

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Life and AD&D **Guardian**	Phone: **1 (800) 525-4542** Website: www.guardianlife.com
Short-Term Disability **Long-Term Disability** **Guardian**	Phone: **1 (800) 268-2525** Phone: **1 (800) 538-4583** Website: www.guardianlife.com
Voluntary Benefits **Aetna**	Phone: **1 (888) 772-9682** Website: www.myaetnasupplemental.com
Employee Assistance Program (EAP) **Guardian**	Phone: **1 (800) 386-7055** Website: www.worklife.uprisehealth.com **Access code:** worklife
Added Value Programs **Guardian**	Phone: **1 (877) 433-6789** Website: www.willprep.uprisehealth.com Username: WillPrep Password: GLIC09

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Enrolling and Eligibility

Who is Eligible?

If you are a full-time employee, you are eligible to enroll in benefits described in this guide. You are eligible for benefits on the **first of the month following date of hire.**

You may enroll your eligible dependents in the same plans you choose for yourself, including medical, dental, vision and voluntary life insurance coverage. Eligible dependents may include the following:

- ✓ Your legal spouse
- ✓ Your Domestic Partner (same & opposite sex)
- ✓ Your children up to age 26
- ✓ Your unmarried dependent children over age 26 who are incapable of self-care because of a disability and who rely on you for support

When you enroll dependents, we have the right to ask that you submit copies of the following (if applicable):

- ✓ Marriage Certificate, an Affidavit of Domestic Partnership or Common Law Marriage
- ✓ Birth Certificate(s)
- ✓ Adoption Papers or papers to show legal adoption proceedings have started

If you do not provide this documentation within 30 days of hire, your dependents will not be enrolled in benefits.

Domestic Partner Coverage
You may cover your same-sex or opposite sex domestic partner for certain benefits. For Domestic Partner coverage, you must submit an Affidavit of Domestic Partnership verifying eligibility of your domestic partner. The Affidavit of Domestic Partnership is available within *Paylocity*. A Domestic Partner must be at least 18 years of age and you must have resided in the same household for at least 12 months. Please note, coverage for Domestic Partners is paid by the employee on a post-tax basis and imputed income will apply. Declaration Of Domestic Partnership (eforms.com)

Domestic Partner coverage is subject to imputed income. This means that the employee pays taxes on the value of the health benefits that their domestic partner receives. Domestic Partner imputed income is in addition to the monthly plan cost that the employee pays.

Enrolling for Coverage

Your enrollment period is a valuable time to review your benefits and choose the best options for you and your family. Review the 2024-2025 Employee Benefits Guide to understand the coverage available and changes to the ***PMC*** Benefits Program. **You can enroll in coverage within 30 days of your hire date or during the annual open enrollment period.**

Newly hired full-time employees enrolling for the first time, will make their benefit elections via (*Paylocity*), our online enrollment tool. You can make your benefit elections during the enrollment window, and coverage begins on the first of the month following date of hire. If you enroll after the 1st of the month, but still within your 30 day window, the benefits will be retroactive to the 1st of the month in which you were hired.

Please visit https://access.paylocity.com/ to access your account profile. Your personal benefit elections will be housed in *Paylocity*.

Everyone can access their benefits information via the *Paylocity* Portal to enroll and/or amend their benefits.

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Eligibility and Enrolling

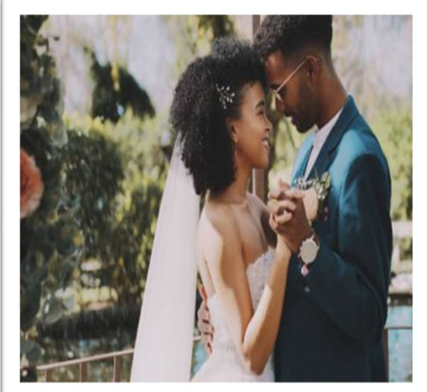
Passive Enrollment

This year's annual enrollment is a Passive Enrollment for medical, dental, vision and other voluntary benefits – these benefits will roll over if you do not make any changes.

ACTION REQUIRED: If you wish to re-enroll in the Health Savings Account (HSA) and/or the Flexible Spending Account (FSA), and/or the Dependent Care benefit, **you MUST re-enroll**. If you have questions, please contact Himan Resources.

Changing Your Coverage During the Year

Whether you are a newly hired employee or a current employee enrolling during the annual open enrollment, the elections you make at this time will remain in effect until ***PMC's*** next open enrollment period, unless you have a qualifying life event (as defined by the IRS) that allows a mid-year plan change.



These changes include (but are not limited to):

- ✓ Birth or adoption of a baby or child
- ✓ Loss of other healthcare coverage
- ✓ Eligibility for new healthcare coverage
- ✓ Marriage
- ✓ Divorce
- ✓ Change in child's dependent status

If you experience a qualifying life event, or if you have questions, please contact Human Resources (HR). You have 30 days after a qualifying event to notify HR and request a change to your benefit elections.

Note: The benefit changes you make must be consistent with the life event.

When Dependent Children Age Out

Dependent children can remain on the medical, dental and/or vision coverage(s) until the end of the calendar year in which they turn 26, at which time their coverage will be cancelled. Coverage under Voluntary Life and AD&D ends on their 26th birthday.

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Medical & Prescription Drug Benefits

Plan Year – June 1st through May 31st

PMC offers a comprehensive benefits program to help you and your family protect your health and financial security. Your benefits are a valuable part of your compensation; we encourage you to learn how your plans work so you can get the most from them. These plans encourage you to seek care from In-Network providers, which provide a higher level of benefit. You may choose to use Out-Of-Network providers, but if you do, your benefits will be reduced, and your out-of-pocket expense will increase. These plans do not require you to select a primary care provider, nor is it necessary to obtain a referral in order to see a specialist.

The following chart provides a summary of the key features of the **Medical** benefit options. Complete benefit summaries are available on the *Paylocity Portal*. The below refers to the member portion of the benefit.

	$2,000 PPO	$3,500 HDHP
	Network Name: Aetna CPOS II (Open Access)	
Medical Key Features	**In-Network**	**In-Network**
Annual Deductible *(Based on Calendar Year)*	*Embedded	*Embedded
Individual / Family	$2,000 / $6,000	$3,500 / $7,000
Out-of-Pocket Maximum Individual / Family	$4,000 / $12,000	$5,950 / $11,900
Coinsurance	20%	20%
Physician Services Office Visit Specialist Visit	$30 copay $60 copay	20% after deductible 20% after deductible
Preventative Care	100% covered	100% covered
Lab and X-Ray Services	20% after deductible	20% after deductible
Inpatient Hospital Services	20% after deductible	20% after deductible
Urgent Care	$75 Copay	20% after deductible
Emergency Room	$250 Copay	20% after deductible
Prescription Drugs		**Copays are after Medical Deductible has been met**
Retail *(30-day supply)*	$10/$35/$60	$10/$35/$60
Mail Order *(90-day supply)*	$20/$70/$120	$20/$70/$120
Mail Order Specialty	$40 or $60	$40 or $60
Semi-Monthly Employee Payroll Contributions *(24 Pay Periods)*		
Employee Only	**$36.00**	**$10.00**
****Employee + Spouse**	**$175.00**	**$60.00**
Employee + Child(ren)	**$110.00**	**$35.00**
****Family**	**$266.25**	**$85.00**

****Embedded** deductible and out-of-pocket (OOP), means that a "per member" deductible and OOP are embedded within the "per family" thresholds. Each covered family member is subject only to their "per member" deductible or OOP, and the family's exposure as a whole is limited by the family deductible and OOP limits.*

****Spousal Surcharge:** If your spouse is eligible for medical coverage through his or her employer and doesn't enroll in those benefits, but elects to enroll in **PMC's** medical benefits, a monthly spousal surcharge will be added to your premium. The monthly spousal surcharge is **$125**. If your spouse isn't eligible for benefits through his or her employer, is not employed, or is self-employed, you will not be charged a monthly surcharge if they enroll in **PMC's** benefits.

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Medical & Prescription Drug Benefits

Medical Key Reminders

- ✓ To limit your Out-of-Pocket expenses, please seek services from an *Aetna* provider. To find a provider, visit https://www.aetna.com/individuals-families/find-a-doctor.html.
- ✓ If services are provided by a non-*Aetna* provider, the member is responsible for any amounts exceeding the "allowable charges," in which case balance billing could occur.
- ✓ Dependent Child Age Limits: Covered to end of the year in which they turn age 26.

Choose Generics - The member pays the applicable copay (if applicable) only if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable copay plus the difference between. Be sure to discuss this with your physician when he or she writes your prescription.

Prescription Drug Coverage

We know prescription drug coverage is important to you and your family, so when you elect medical coverage, you are automatically covered under the prescription drug plan. You may fill your prescriptions at participating retail pharmacies. Under the prescription drug coverage, the mail order option allows you to buy qualified prescriptions in larger 90-day quantities for a slightly higher copay amount as a 31-day supply at the retail pharmacy. Mail order saves you time in trips to the pharmacy because prescriptions are delivered right to your door.

There are several categories of drugs under the plans. The differences between these categories are described below:

- ✓ Tier 1 – **Preferred Generic**: Frequently prescribed generic drugs.
- ✓ Tier 2 – **Non-Preferred Generic**: Generic drugs with higher costs than preferred generics.
- ✓ Tier 3 – **Preferred Brand**: Lowest cost brand name drugs.

Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to www.aetna.com or by calling *Aetna*.

CVS caremark®

☆ **Please Note:** After two refills of your maintenance medication, you will need to obtain a **90-day supply** from one of the below:

1. CVS Caremark Mail Service Pharmacy
2. CVS Pharmacy stores

Mail order provides you additional discounts to your refill. If you do not want to utilize mail order, you **MUST** call in advance and opt out of the program. If you don't opt out, you will **pay the full cost of your prescription on the third fill**. You can call **888-792-3862** for assistance opting out.

Note: MN does allow for some non-CVS pharmacies to participate in the Maintenance Choice program.

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Where To Seek Care

You think you may be sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new medication, but the pharmacy is closed. Instead of immediately choosing an expensive trip to the emergency room or relying on questionable information from the internet, take a look below at various care centers and resources and the types of care they provide.

Primary Care Center

When would I use this?

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

What type of care would they provide?

- Routine checkups
- Immunizations
- Preventive Services
- Manage your general health

What are the costs and time considerations?

- Often requires a copay and/or coinsurance.
- Normally requires an appointment.
- Usually little wait time with scheduled appointment.

Telehealth

When would I use this?

You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

What type of issues can they treat?*

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems

What are the costs and time considerations?

- Often requires a copay and/or coinsurance.
- Access to care is usually immediate.
- Certain states may not allow for prescriptions through telemedicine or virtual visits.

Do Your Homework

What may seem like an urgent care center could actually be a standalone ER. These newer facilities come with a higher price tag, so ask for clarification if the word emergency appears in the company name.

Urgent Care Center

When would I use this?

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

What type of care would they provide?*

- Strains, sprains
- Minor broken bones
- Minor infections
- Minor burns
- X-Rays

What are the costs and time considerations?**

- Often requires a copay and/or coinsurance that is generally higher than an office visit.
- Walk-in patients welcome but waiting periods may be longer as patients with more urgent needs will be treated first.

Emergency Room

When would I use this?

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

What type of issues can they treat?*

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

What are the costs and time considerations?**

- Often requires a much higher copay and/or coinsurance.
- Open 24/7 but waiting periods may be longer because patients with life-threatening emergencies will be treated first.

*This is sample of services and may not be all-inclusive.

**Cost and time information represent average only and are not tied to a specific condition or treatment.

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Health Savings Account (HSA)

Plan Year – June 1st through May 31st

PMC will offer an HSA to those who enroll in the $3,500 HDHP plan.

What is an HSA?

The HSA provides you with the ability to save and use pretax dollars to pay for eligible medical expenses (i.e., deductible). You can save approximately 25 percent of each dollar spent on medical expenses when you participate.

Contributions to your HSA are withdrawn from your paycheck on a pre-tax basis. This means you don't pay federal income tax, Social Security taxes, or local income taxes on the portion of your paycheck you contribute to the HSA. See "HSA Taxation" on page 10.

In addition to the company contribution, you may elect to make a personal contribution, which is 100% tax deductible from your gross income. The "combined" contributions made into your HSA account cannot exceed the following IRS limits set for calendar year 2024:

- $4,150 single
- $8,300 family (any level of coverage including one or more dependents)
- If you are 55 or over, you can add an additional contribution of $1,000

The ***PMC*** **Monthly** Employer HSA Contributions are as follows:

Employee Only	**$166.67** ($2,000/year)
Employee + Spouse	**$200.00** ($2,400/year)
Employee + Child(ren)	**$200.00** ($2,400/year)
Family	**$200.00** ($2,400/year)

What are the benefits of an HSA?

- ✓ Funds roll over – No "use it or lose it" provision.
- ✓ Earns interest – Monies accrue tax-free interest.
- ✓ Portable – Yours to keep. If you leave your employer, your HSA funds go with you.
- ✓ You can use the funds in your HSA for your spouse and child(ren), even if they are not enrolled in your medical plan.
- ✓ You can change the amount that you contribute or stop contributing altogether whenever you like. Changes are effective on the next payroll. Please contact the HR department to make a change.

You are eligible to enroll in an HSA if:

- ✓ You are enrolled in the $3,500 HDHP plan
- ✓ You have no other traditional medical coverage or prescription coverage
- ✓ You or your spouse are not enrolled in a General-Purpose Healthcare FSA
- ✓ You are not claimed as a dependent on another person's tax return
- ✓ You are not enrolled in Medicare, Medicaid nor have received care within the last three months through the Veteran's Administration for something that was not connected to a service disability

How to Open Your Health Savings Account

Employees enrolled in the $3,500 HDHP plan can open an HSA with Optum Financial. **Please note** that it is important that employees provide the required documentation to Optum Financial in a timely manner to assist with the opening of your HSA. If this documentation is not provided timely, it may result in delays of HSA contributions (both employee and employer contributions) being made to the account.

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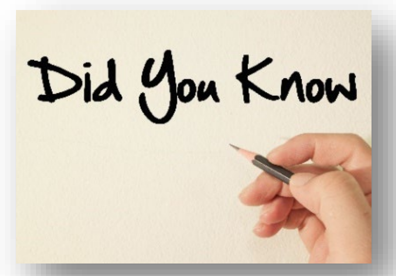
Understanding Health Savings Account (HSA)

IRS-Qualified Medical Expenses



You can use your HSA to pay for a wide range of IRS-qualified medical expenses for yourself, your spouse, or tax dependents. An IRS-qualified medical expense is defined as an expense that pays for healthcare services, equipment, or medications. Funds used to pay for IRS-qualified medical expenses are always tax-free. HSA funds can be used to reimburse yourself for past medical expenses if the expense was incurred after your HSA was established. While you do not need to submit any receipts to Optum Financial, you must save your bills and receipts for tax purposes.

Examples of IRS-Qualified Medical Expenses:

- ✓ Acupuncture
- ✓ Ambulance
- ✓ Annual Physical Examination
- ✓ Bandages
- ✓ Birth Control Pills, contraceptive devices
- ✓ Body Scan
- ✓ Breast Pumps and Supplies
- ✓ Breast Reconstruction Surgery
- ✓ Chiropractor
- ✓ Contact Lenses
- ✓ Crutches
- ✓ Dental Treatment
- ✓ Diagnostic Devices
- ✓ Disabled Dependent Care Expenses
- ✓ Eye Exam
- ✓ Eyeglasses
- ✓ Eye Surgery
- ✓ Hearing Aids
- ✓ Home Care
- ✓ Hospital Services
- ✓ Insurance Premiums
- ✓ Laboratory Fees
- ✓ Lactation Expenses
- ✓ Learning Disability
- ✓ Long-Term Care
- ✓ Medicines
- ✓ Nursing Home
- ✓ Nursing Services
- ✓ Optometrist
- ✓ Oxygen
- ✓ Physical Examination
- ✓ Pregnancy Test Kit
- ✓ Prothesis
- ✓ Psychiatric Care
- ✓ Special Education
- ✓ Sterilization
- ✓ Stop-Smoking Programs
- ✓ Surgery
- ✓ Transplants
- ✓ Vasectomy
- ✓ Vision Correction Surgery
- ✓ Weight-Loss Program
- ✓ Wheelchair
- ✓ Wig
- ✓ X-Ray Fees

Ineligible medical expenses may include:

- ✘ Baby Sitting, Childcare and Nursing Services for a Normal, Healthy Baby
- ✘ Controlled Substances
- ✘ Cosmetic Surgery
- ✘ Dancing Lessons
- ✘ Diaper Service
- ✘ Electrolysis or Hair Removal
- ✘ Flexible Spending Account
- ✘ Funeral Expenses
- ✘ Future Medical Care
- ✘ Hair Transplant
- ✘ Health Club Dues
- ✘ Health Coverage Tax Credit
- ✘ Health Savings Accounts
- ✘ Household Help
- ✘ Illegal Operations and Treatments
- ✘ Maternity Clothes
- ✘ Medicines and Drugs from other Countries
- ✘ Nonprescription Drugs and Medicines
- ✘ Nutritional Supplements
- ✘ Personal Use Items
- ✘ Swimming Lessons
- ✘ Teeth Whitening
- ✘ Veterinary Fees

This list is not all-inclusive; additional expenses may qualify, and the items listed below are subject to change in accordance with IRS regulations. For more information or clarification on individual list items, refer to Publication 502 or consult a tax professional.

HSA State Taxation: There are currently three states that, unlike the federal government, subject your HSA contributions (employee and employer) to state income taxes. The three states are New Jersey, California and Alabama. Similarly, these three states also subject earnings (interest and capital gains) on your HSA to state taxation. There are currently two other states, New Hampshire and Tennessee, that subject earnings on the account (but not the contributions) to state taxes. Tax laws are subject to change. Please contact your state tax authority or consult with a tax advisor to confirm the details for your state.

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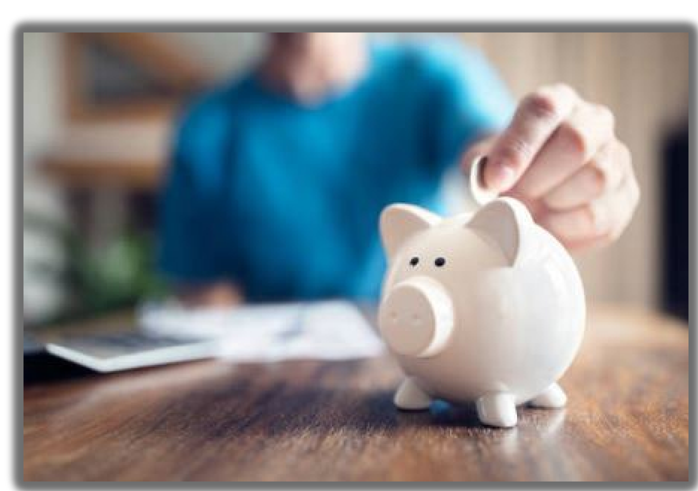
Flexible Spending Accounts (FSA)

Section 125 Plan

An FSA allows you to place money in a tax-sheltered, short-term account for use in paying for approved healthcare expenses. Enrollment occurs before the beginning of each plan year, or for new employees, during your initial enrollment period. **You must enroll each year** in order to participate in the Healthcare and Dependent Care Reimbursement Accounts. The amount you designate will be taken from your paycheck in equal amounts throughout the plan year. Keep your receipts and Explanation of Benefits (EOBs) in the event that *Optum Financial* or the IRS requests additional information on your transaction.



General Purpose HealthCare FSA

- ✓ Contribution Limit - **$3,200** (2024-2025)
- ✓ General Purpose Health Care FSA is for those **NOT** enrolled in the $3,500 HDHP Plan or have a regular PPO plan elsewhere. You are eligible to contribute to an FSA and use the funds for medical, dental and vision expenses not covered by the plan.
- ✓ The Health Care FSA contribution will be deducted from your paycheck over the course of the year. Since you pay no taxes on the money placed in the FSA, you effectively adjust your annual taxable salary.
- ✓ **Contributions available first day of new plan year.**

Limited Purpose HealthCare FSA

- ✓ Contribution Limit - **$3,200** (2024-2025)
- ✓ Limited Purpose Health Care FSA is for those enrolled in the $3,500 HDHP Plan. You are eligible to contribute to an FSA and use the funds for dental and vision expenses not covered by the plan.
- ✓ The FSA contribution will be deducted from your paycheck over the course of the year. Since you pay no taxes on the money placed in the FSA, you effectively adjust your annual taxable salary.
- ✓ **Contributions available first day of new plan year.**

Dependent Care FSA

- ✓ Contribution Limit (2024-2025):
  - **$5,000** if you are a single employee or married filing jointly
  - **$2,500** if you are married and filing separately
  - **Money only available as contributed via your payroll deductions**

IMPORTANT: Elections cannot be changed during the plan year unless you have a qualified change in family status like birth, death, marriage, or divorce. **Unused General Purpose and Limited Purpose FSA amounts in excess of $640 will be forfeited,** so plan carefully before making your elections.

General Purpose and Limited Health Care FSA Rollover Provision	**Up to $640** of 2024-2025 unused FSA dollars can be used to reimburse 2024-2025 eligible FSA expenses.
Claims must be incurred between June 1, 2024, and May 31, 2025. These claims may be submitted for reimbursement between June 1, 2024, and August 31, 2025.	

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Dental Benefits

Plan Year – June 1st through May 31st

Dental coverage is important to your overall health and wellness. You can enroll in dental benefits through *Delta Dental of Tennessee* for yourself and your family. The dental plans feature a network of dentists and specialists who have agreed to provide services at a discounted price.

If you choose to go to a dentist out of the network, you may be balanced billed for any charges over what is considered "reasonable and customary". The great thing about *Delta Dental of Tennessee* is that the reimbursement for what is considered reasonable, and customary is in the 90th percentile of fees charged in your area. This helps minimize any balancing billing but remember that the best way to maximize the benefit is by visiting an in-network dentist.

Please note, ID Cards are not required for you to receive services. Providers can confirm coverage with your Social Security Number.

Limit your Out-of-Pocket expenses by seeking services from a Delta Dental in-network dentist.

Network Name*: Delta Dental PPO and Delta Dental Premier*

The following chart shows the features of the **Dental** benefit option. A complete benefit summary is available on our *Paylocity* Portal.

Key Features	Delta Dental PPO Network	Delta Dental Premier Network	Out-of-Network
Network	Delta Dental PPO	Delta Dental Premier	
Calendar Year Deductible Individual / Family	$0/$0	$50 / $150	$50 / $150
Calendar Year Maximum Benefit	$1,500	$1,500	$1,500
Services			
Preventative & Diagnostic Services *(Deductible does not apply)*	Covered at 100%	Covered at 100%	Covered at 100%
Basic Services	Covered at 100%	Covered at 80%	Covered at 80%
Major Services	Covered at 60%	Covered at 50%	Covered at 50%
Orthodontia	Covered at 50%	Covered at 50%	Covered at 50%
Lifetime maximum	$1,250	$1,250	$1,250
Age Limitation	19	19	19
Reimbursement	*Negotiated Fee Schedule*		*90th percentile*
Semi-Monthly Employee Payroll Contributions *(24 Pay Periods)*			
Employee Only	**$4.21**		
Employee + Spouse	**$17.05**		
Employee + Child(ren)	**$19.09**		
Family	**$27.50**		

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Voluntary Vision Benefits

Plan Year – June 1st through May 31st

Your vision health is an important part of complete wellness. *Delta Dental of Tennessee* is pleased to present your vision benefits which are designed to give you and your covered family members the care, value, and service to help maintain good vision and overall health.

Please note, ID Cards are not required for services and vision providers can verify coverage by providing your Social Security Number (SSN).

Limit your Out-of-Pocket expenses by seeking services from a VSP in-network provider.

Network Name: *VSP Choice*

The following chart shows the features of the **Vision** benefit option. A complete benefit summary is available on our *Paylocity Portal*.

Vision		
Key Features	**In-Network Member Cost**	**Out-of-Network Reimbursement**
Annual Eye Exam *(Once every 12 months)*	$10 copay	Up to $45
Lenses *(Every 12 months in lieu of contact lenses)*		
Single	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal	$25 copay	Up to $65
Standard Frames *(Once every 12 months)*	$150 allowance Additional 20% off balance over allowance	Up to $70
Contact Lenses *(Every 12 months in lieu of frames and lenses)*		
Conventional	$150 allowance	Up to $105
Medically Necessary	$25 copay	Up to $210
Semi-Monthly Employee Payroll Contributions *(24 Pay Periods)*		
Employee Only	**$1.00**	
Employee + Spouse	**$3.25**	
Employee + Child(ren)	**$3.50**	
Family	**$5.50**	

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

Plan Year – June 1st through May 31st

Group Life and AD&D

Coverage is available through *Guardian*. Life and AD&D insurance is an important benefit as it provides your beneficiaries financial protection in the event of a tragic loss.

PMC provides full-time employees with group life and accidental death and dismemberment (AD&D) insurance and **pays for 100% of the coverage.**

The amount provided by ***PMC*** is **$50,000.**

Age Reduction: If you are age 65 or older, the amount of your Group Life Insurance will reduce to the following percentage of its original value:

Age of Employee	Reduction
65 but less than 70	35%
70 or older	50%
Terminate upon retirement	

Please make sure to add your beneficiary information upon enrollment.

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

Plan Year – June 1st through May 31st

Voluntary Life and AD&D

If you need additional Life insurance to meet your financial needs, you can purchase **Voluntary Life and AD&D** insurance through after-tax payroll deductions for yourself your spouse and your child(ren). Life insurance is about more than paying for memorial services—it is about making sure your family can maintain its standard of living if something happens to you. The amount of coverage your family needs depends on your personal situation (other income, monthly expenses, short and long-term debt such as credit card or mortgage expenses, etc.).

Employee Benefit Amount: Life/AD&D	✓ Increments of $10,000 to a maximum of $250,000. ✓ New Entrants: Guarantee Issue (GI) Amount $150,000
Spouse *(spouse age based on employee age)* Benefit Amount: Life/AD&D	✓ Increments of $5,000 to a maximum of $50,000. Not to exceed 100% of the employee election. ✓ New Entrants: GI Amount $25,000
Child(ren) Benefit Amount: Life/AD&D	✓ $5,000 or $10,000 ✓ New Entrants: GI Amount $10,000

Amounts over the GI are subject to Evidence of Insurability (EOI). Members utilizing the electronic EOI process (www.guardiananytime.com/eoi) will need to enter your Group Number 00561984.

Evidence of Insurability (EOI) Rules

- ✓ **New entrant:** If you elect coverage when you are initially eligible, EOI is required only for any amount over $150,000.
- ✓ **New entrant:** If you elect coverage for your spouse or domestic partner when you are initially eligible, EOI is required only for any amount over $25,000.
- ✓ Employees who previously declined coverage during their initial enrollment (as new entrant) can elect coverage for themselves and their spouse but must complete the required EOI form.
- ✓ Coverage for your over age dependent child(ren) ends at the end of the month in which they turn 26.
- ✓ **Annual Enrollment**: Employees who previously elected coverage for themselves can increase their coverage up to $50,000, up to GI amount without providing EOI. If you wish to increase your coverage by greater than $50,000, or above the GI amount you must complete the required EOI form.
- ✓ **Annual Enrollment**: Employees who previously elected coverage for their spouse and/or dependent child(ren), and request to increase coverage by any amount, you must complete the required EOI form.

Evidence of Insurability (EOI): is required if you did not apply for coverage when you were initially eligible (as a new entrant) or if you are requesting an amount of coverage that exceeds the maximum guaranteed issue amount in your plan. You will have 31 days to provide a complete EOI. Once your EOI is reviewed by Guardian, they will notify you in writing, approving, or denying your request for coverage. **If you do not complete EOI within 31 days or are denied the increase by the carrier, coverage will revert back to your original election(s).**

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Disability Income Benefits

Plan Year – June 1st through May 31st

If you become disabled and cannot work, no benefit becomes more important to your financial security than Disability Income protection. Disability coverage provides income protection in the event that you experience a non-occupational injury or illness that prevents you from working. You have access to Short-Term Disability (STD) and Long-Term Disability (LTD) insurance through *Guardian*.

Short-Term Disability Insurance (STD)

If an eligible employee is sick more than 7 consecutive days or disabled for more than 1 calendar day on an approved leave of absence per company policy, they must use PTO to satisfy the elimination period. Once that is exhausted an application can be made for short-term disability benefit, which will pay 60% of your weekly pay up to a maximum benefit of $1,000 per week, for a maximum of 13 weeks.

Elimination Period	7 days illness / 0 days injury
Income Replacement	60% of your pre-disability earning
Maximum Benefit	$1,000 weekly
Maximum Benefit Period	13 weeks

***PMC* pays 100% of this coverage.**

Long Term Disability Insurance (LTD)

If an employee is disabled for more than three consecutive months, application can be made for long-term disability benefits, which will pay 60% of your salary. ***PMC* pays 100% of this coverage.**

Elimination Period	90 days
Income Replacement	60% of your pre-disability earning
Maximum Benefit	$5,000 Monthly
Maximum Benefit Period	Social Security Normal Retirement Age (SSNRA)
Pre-existing Condition	3 months lookback; 12-month exclusion

Helpful Terms

Elimination Period – The period of time you have to wait before benefits begin, starting the day you become ill or injured.

Maximum Monthly Benefit – The highest dollar amount a disabled employee can receive on a monthly basis under the LTD plan.

Pre-Disability Earnings – The amount of a policyholder's wages or salary in effect on the day before the disability began.

Maximum Benefit Period – The maximum length of time during which benefits will be paid.

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Voluntary Benefits

Plan Year – June 1st through May 31st

PMC offers a suite of voluntary benefits to you and your family. *Aetna* offers the following voluntary benefits:

Accident Insurance

Accidents are usually followed by a series of bills. Even if you have good insurance, you may still have to cover out-of-pocket costs such as doctor bills, ambulance fees, and hospital expenses. Accident insurance from Aetna can help protect you, your spouse, and your dependent children from the unexpected expenses of an accident.

Dislocations	Open (Surgery)	Closed (No Surgery)
Hip	$6,000	$3,000
Knee/Kneecap	$3,000	$1500
Ankle, or Bones of the Foot	$1,500	$750
Elbow, Wrist, or Lower Jaw	$1,200	$600
Shoulder	$1,200	$600
Collarbone	$300 or $1,200	$150 or $600
Finger or Toe	$300	$150
Hospital Stay		
Non-ICU Admission (Initial Day)	$1,000	
ICU Admission (Initial Day)	$2,000	
Non-ICU (Daily)	$200	
ICU (Daily)	$400	
Semi-Monthly Payroll Deductions (24 Pay Periods)	Employee Only	$4.70
	Employee + Spouse	$8.08
	Employee + Child(ren)	$9.02
	Employee + Family	$12.13

Critical Illness Insurance

Critical illness coverage offers specialized benefits to supplement other health insurance when you and your family may be most vulnerable, during the working years. Includes coverage for heart/stroke, cancer, and other critical illnesses. Please see the benefit summary for detailed coverage information, including conditions that pay a percentage of the elected benefit, and specific conditions covered under the plan.

Coverage Information	
Employee Volume Amount	$10,000 or $20,000
Spouse Volume Amount	50% of employee's benefit
Child Volume Amount	50% of employee's benefit
Health Screening Benefit	$50 benefit payable to any covered person on your plan one time each year, once you provide proof of an eligible health screening

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Voluntary Benefits

Plan Year – June 1st through May 31st

Hospital Indemnity Insurance

Hospital indemnity insurance works to complement your medical insurance by providing a cash payout for hospital visits. This plan will pay out a lump sum of monies for specific claims associated with a hospital admission, or a daily benefit for a covered hospital stay, such as having inpatient surgery, being in the ICU, etc. This can also be used in conjunction with the accident and/or critical illness insurance.

Hospital Indemnity		
Hospital Admission (Initial Day) 1/plan year & must be 24+ hour inpatient stay	$1,000	
Hospital Daily (Begins on day 2 of stay)	$100	
Hospital Daily in ICU (Begins on day 2 of stay)	$200	
Newborn Routine Care/stay	$100	
Observation Unit (Initial Day) 1/plan year	$100	
Substance Abuse Daily	$100	
Behavioral Health Daily	$100	
Rehabilitation Unit Daily (Related to an illness or accident)	$50	
Semi-Monthly Payroll Deductions (24 Pay Periods)	Employee Only	$7.07
	Employee + Spouse	$15.75
	Employee + Child(ren)	$12.11
	Employee+ Family	$20.01

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Added Value Programs

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) provides a network of experienced professionals who can offer counseling for you and your dependents facing difficult legal, emotional, or financial issues. Counselors and qualified professionals are available 24 hours a day, 365 days a year, and all calls are completely confidential – nothing is reported back to your employer. Services include online resources, 3 in-person counseling sessions, and unlimited telephonic counseling. The EAP is available to all benefit eligible employees.

Topics Include:

- ✓ Family
- ✓ Parenting
- ✓ Addictions
- ✓ Emotional
- ✓ Legal
- ✓ Financial
- ✓ Relationships
- ✓ Stress

For more support or information please visit worklife.uprisehealth.com (Access **Code:** worklife) or talk with a specialist at 1-800-386-7055.

Will Preparation and Estate Guidance

No matter how well you plan your life, you can be sure unforeseen challenges will arise. If you are enrolled in Voluntary Life and AD&D insurance, you have access to *uprisehealth* through Guardian to help manage these challenges. The uprisehealth program provides access to a wide array of services to help you and your loved ones through life's difficulties.

Services include:

Online Will Preparation – Having a will is important because it allows you to designate who will receive your property and assets when you die. Without one, your state determines how your estate is distributed.

Estate Guidance – Find step-by-step instructions to name an executor to manage your estate, choose a guardian for your children, specify wishes for your property and provide funeral and burial instructions.

Guidance Resources – Access to articles, tutorials, videos, and "Ask the Expert" advice on a wide range of topics — including legal, financial, family, and career. It is a way to stay "in the know" on important matters that impact both your personal and professional life.

It is east to access *uprisehealth* services, just call **1-877-433-6789** or visit willprep.uprisehealth.com
Username: WillPrep   Password: GLIC09

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Your PMC Contacts

Your Human Resources Team

Contact Name	Title	Phone	Email
Devin McIntosh	HR Specialist	(615) 647-0750 ext. 151	dmcintosh@psychmc.com
Tanya Blake	Director of Benefits & Total Rewards	(615) 647-0750	Tanya.blake@psychmc.com

Your Hauser Team

Contact Name	Contact Information	Description
Julie Price, Client Executive	Phone: (513) 410-2797 Email: jprice@thehausergroup.com	Julie & Dineka are responsible for benefit plan presentations to members and assisting in developing Wellness initiatives. Also, day-to-day point of contacts for plan questions, eligibility, and assistance in resolving escalated claims.
Dineka Johnson, Client Executive	Phone: (513) 885-0917 Email: djohnson@thehausergroup.com	
Matt Otto, Senior Consultant	Phone: (513) 984-7014 Email: motto@thehausergroup.com	Matt ensures that your health plan runs smoothly and efficiently. He will oversee any question or issue that you wish to elevate to a management level.

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Important Notices

Notice of Patient Protections & Prior Authorization Procedures

Your **Aetna** plans allow you to visit any doctor or hospital you choose. However, Prior Authorization is required for certain services. Make sure Your Provider obtains Prior Authorization before any planned hospital stays (except maternity admissions), skilled nursing and rehabilitative facility admissions, certain outpatient procedures, Advanced Radiological Imaging services, certain Specialty Drugs, and Durable Medical Equipment costing $500 or more. Contact **Aetna** Customer Service using the number on the back of your medical ID card or online at **www.aetna.com** to find out which services require Prior Authorization. You can also call the customer service department to find out if your admission or other service has received Prior Authorization. For more information, please refer to your Evidence of Coverage document located online at **www.aetna.com**.

Women's Health and Cancer Rights Act of 1998

Patients who undergo a mastectomy, and who elect breast reconstruction in connection with the mastectomy, are entitled to coverage for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including Lymphedemas, in a manner determined in consultation with the attending physician and the patient.

The coverage may be subject to Coinsurance and Deductibles consistent with those established for other benefits. For more information, please refer to your Evidence of Coverage document located online at **www.aetna.com**.

Newborns and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your Out-of-Pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Human Resources.

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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 January 31, 2024. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

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IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

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OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

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

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

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

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Notice of Privacy Practices

Aetna is required to maintain the privacy of all medical information as required by applicable laws and regulations; provide a notice of privacy practices to all Members; inform Members of the Plan's legal obligations; and advise Members of additional rights concerning their medical information. For more information, please refer to your Evidence of Coverage document located online at [www.aetna.com.](www.aetna.com)

All Members will be notified of any changes by receiving a new notice of the Plan's privacy practices. You may request a copy of this notice of privacy practices at any time by contacting **Aetna.**

Uniformed Services Employment and Reemployment Rights Act of 1994

A Subscriber may continue his or her Coverage and Coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was covered under the Plan prior to the leave.

Important Notice from *Psychiatric Medical Care (PMC)* About Your Prescription Drug Coverage and Medicare for plans:

- **$2,000 PPO Plan**
- **$3,000 HDHP Plan**

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

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under your **Aetna** is creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current **Aetna** coverage will not be affected. You can keep this coverage if you elect part D, and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current ***PMC*** coverage, be aware that you and your dependents will not be able to get this coverage back until next Annual Open Enrollment or a mid-year qualifying event. **For More Information About Your Options Under Medicare Prescription Drug Coverage…**

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 06/01/2024
Name of Entity/Sender: ***Psychiatric Medical Care, LLC***
Office Contact/Position: Maggie Music / Chief Human Resource Officer
Phone: (615) 335-0781
Address: 8 Cadillac Drive, Suite 230, Brentwood, TN 37027

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New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved OMB No. 1210-0149 (expires 6-30-2024)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that does not meet certain standards. The savings on your premium that you are eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact **YOUR HUMAN RESOURCE DEPARTMENT**.

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Psychiatric Medical Care, LLC			4. Employer Identification Number (EIN) 20-0247392
5. Employer address 8 Cadillac Drive, Suite 230			6. Employer phone number (615) 647-0750
7. City Brentwood		8. State TN	9. ZIP code 37027
10. Who can we contact about employee health coverage at this job? Maggie Music			
11. Phone number (if different from above)	12. Email address mmusic@psychmc.com		

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

- As your employer, we offer a health plan to:
  - [X] All employees. Eligible employees are:
    Full-time Employees working 30+ hours per week
  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [X] We do offer coverage. Eligible dependents are:
    1. Legal Spouses
    2. Domestic Partners (same & opposite sex)
    3. Dependents up to age 26
  - [ ] We do not offer coverage.

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

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

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

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

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

[X] **Yes** (Continue)

[ ] 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?______________________(mm/dd/yyyy) (Continue)

14. Does the employer offer a health plan that meets the minimum value standard*?
[X] Yes (Go to question 15) [ ] No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (do not include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $ 20.00
b. How often? [ ] Weekly [ ] Every 2 weeks [ ] Twice a month [X] Monthly [ ] Quarterly [ ] Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

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16. What change will the employer make for the new plan year?_____________
[ ] Employer won't offer health coverage
[ ] Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $______________
b. How often? [ ] Weekly [ ] Every 2 weeks [ ] Twice a month [ ] Monthly [ ] Quarterly [ ] Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of1986)

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NOTES:

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ADDRES: 8 Cadillac Dr. Suite 230
Brentwood, TN 37027
PHONE: (615) 647-0750

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