El Camino Hospital
2026 Plan Year Annual Legal Notices

October 7, 2025

To All Eligible Employees:

No action is needed, these notices are part of our administrative obligations. The attached notices are provided to all employees of El Camino Hospital to advise you of your certain rights and responsibilities concerning your benefits. Please read these notices as they contain important information about your benefits and rights associated with our benefit program.

- Health Insurance Marketplace Coverage Options And Your Health Coverage
- HIPAA Notice of Availability of Notice Of Privacy Practices
- HIPAA Special Enrollment Rights
- Notice of Declining Enrollment
- Women's Health and Cancer Rights Act of 1998
- Newborns' and Mothers' Health Protection Act of 1996
- California Maternity Coverage
- Patient Protection Disclosure – Non-Grandfathered Plans
- Rebates for Failure to meet Medical Loss Ratio Requirements
- Wellness Program: Alternative Standard and Disclosure Policy
- No Surprises Act (NSA) Notice
- Medicare Part D Annual Notice - Creditable
- Premium Assistance Under Medicaid and The Children's Health Insurance Program (CHIP)
- El Camino Hospital Health & Welfare Plan
- El Camino Hospital Summary Annual Report (SAR)

If you have any questions about any of these notices, please consult with the El Camino Hospital Human Resources Department.

If you (and/or your dependents) have Medicare, or will become eligible for Medicare within the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please read the notice on Pages 10-12 for more details.

It is recommended that you retain a copy of this document for your records.

2026 Legal Notices

Health Insurance Marketplace Coverage Options And Your Health Coverage
PART A: General Information

When key parts of the health care law took effect in 2014, there was 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 some basic information about the 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 tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November 2025 for coverage starting as early as January 1, 2026.

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 doesn't meet certain standards. The savings on your premium that you're 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 9.96% (this percentage applies to the 2026 health plans, the affordable percentage amount is adjusted by the IRS each year) 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. An employer- sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefits costs covered by the plan is no less than 60% of such costs.

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; contact the Member Services Department of your health care provider as shown on your benefit ID card, or contact the Human Resources Department at (650) 940-7222 or benefits@elcaminohealth.org.

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

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: El Camino Hospital **4.** EIN: 94-3167314

5. Employer Street Address: 2500 Grant Road **6.** Phone: 650-940-7222

7. City: Mountain View **8.** State: CA **9.** Zip: 94040

10. Who can we contact about employee health coverage at this job? Human Resources Department

11. Phone No. (if different from above): 650-940-7222 **12.** Email: benefits@elcaminohealth.org

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

- As your employer, we offer a health plan to:
  - ☐ All Employees. Eligible employees are:
  - ☒ Some Employees. Eligible employees are: Regular full-time and part-time employees who are scheduled to work 20 hours or more per week. Also, employees who are not regularly scheduled to work full-time but during the Look-Back Measurement method worked an average of 30 hours per week.

    With respect to dependents:
    ☒ We do offer coverage. Eligible dependents are: Your children up to the age of 26, regardless of their student status, residency, marital status or financial dependence and Spouse/State Registered Domestic Partner, if eligible.
  - ☐ We do not offer coverage.

☒ 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.

* 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% of such costs (Section 36B(c)(2)C)(ii) of the Internal Revenue Code of 1986).

** 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, www.healthcare.gov/, or if you reside in California, www.CoveredCA.com, will guide you through the process.

HIPAA Notice of Availability of Notice Of Privacy Practices

This Plan is required by law to provide notice of the Plan's duties and privacy practices with respect to covered individuals' protected health information by providing a Notice of Privacy Practices (NOPP) to participants. The Plan's NOPP is available upon request. To obtain a copy of the NOPP, or for more information regarding the Plan's privacy policies or your rights under HIPAA, contact the Human Resources Department at (650) 940-7222 or benefits@elcaminohealth.org.

HIPAA Special Enrollment Rights

HIPAA requires we notify you about your right to later enroll yourself and eligible dependents for coverage in El Camino Hospital's health plan under "special enrollment provisions" briefly described below.

- **Loss of Other Coverage**. If you decline enrollment for yourself or for an eligible dependent because you have other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents under El Camino Hospital's health 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 30 days after you 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 under El Camino Hospital's health plan. You must request enrollment within 30 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 El Camino Hospital's health 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 Human Resources Department at (650) 940-7222 or benefits@elcaminohealth.org for details, including the effective dates of coverage applicable to each of these special enrollment provisions. Additional information regarding your rights to enroll in group health coverage is found in the applicable group health plan summary plan description(s) or insurance contract(s).

Notice of Declining Enrollment (As Provided by HIPAA)

When you decline enrollment for yourself and/or your dependents (including your spouse) and state that you and/or your dependents have other coverage under another group health plan or health insurance coverage as the reason for declining to enroll, then special rules may apply to you and/or your spouse and/or your child/ren in the event you and/or your dependents have lost this other coverage due to the loss of eligibility.

Loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

If you decline enrollment for yourself and/or dependents because you have COBRA continuation coverage under another plan, you will not be eligible for a Special Enrollment until COBRA continuation coverage has been exhausted or terminated as a result of loss of eligibility.

Loss of Eligibility includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing.

Under these rules, a group health plan is required to provide a special enrollment period for yourself and/or your dependents should they request enrollment within 30 days after the loss of other coverage has occurred.

Women's Health & Cancer Rights Act Of 1998

In the case of an employee or dependent who receives benefits under the plan in connection with a mastectomy and who elects breast reconstruction (in a manner determined in consultation with the attending physician and the patient), coverage will be provided for:

- Reconstruction of the breast on which mastectomy has been performed, including nipple and areola reconstruction and re-pigmentation to restore the physical appearance of the breast;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary". Benefits will be provided on the same basis as for any other illness or injury under the Plan.

If you would like more information on WHCRA benefits, contact the Human Resources Department at (650) 940-7222 or benefits@elcaminohealth.org.

Newborns' And Mothers' Health Protection Act Of 1996

Under federal law (Newborns' Act), 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 child birth 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 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 pre-certification.

A number of states adopted requirements for benefits covering maternity stays prior to the enactment of the Newborns' Act. The federal law does not preempt state law if the state law meets certain criteria. For information on pre- certification, contact the Human Resources Department at (650) 940-7222 or benefits@elcaminohealth.org.

California Maternity Coverage

Group health plans and health insurance issuers with policies or contracts issued in the State of California generally may not, under California law, restrict benefits for inpatient hospital care to a time period less than 48 hours following a normal vaginal delivery and less than 96 hours following a delivery by caesarean section. However, coverage for inpatient hospital care may be for a time period less than 48 or 96 hours if both of the following conditions are met: (a) the decision to discharge the mother and newborn before the 48 or 96 hour time period is made by the treating physicians in consultation with the mother; (b) the contract or policy covers a post discharge follow-up visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating physician. Furthermore, the Plan may not:

- Reduce or limit the reimbursement of the attending provider for providing care to an individual enrollee/insured in accordance with the coverage requirements.
- Provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual enrollee/insured in a manner inconsistent with the coverage requirements.
- Deny a mother or her newborn eligibility, or continued eligibility, to enroll or to renew coverage solely to avoid the coveragerequirements.
- Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum coverage requirements.
- Restrict inpatient benefits for the second day of hospital care in a manner that is less than favorable to the mother or her newborn than those provided during the preceding portion of the hospital stay.
- Require the treating physician to obtain authorization from the health care service plan or insurer prior to prescribing any services.

Patient Protection Disclosure – Non-Grandfathered Plans

Aetna's HMO plans generally requires a designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you and/or your family members. Until you make this designation, Aetna will designate one for you. For information on how to select a primary care provider, and for a list of participating primary care providers, contact Aetna at (833) 576-2491.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network or specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Aetna at (833) 576-2491.

Rebates For Failure To Meet Medical Loss Ratio Requirements

In the event that El Camino Hospital qualifies and receives a return of premium (Rebate) as a result of an insurance issuer's failure to meet the Medical Loss Ratio requirements under the Affordable Care Act, El Camino Hospital at its option, shall either:

- Reimburse Plan participants through a payroll adjustment in the amount determined under the Affordable Care Act regulations;
- Reduce employee contributions by an amount determined under Affordable Care Act regulations to reflect the employee's share of the Rebate; or
- Use the Rebate to enhance benefits under the Plan by an amount determined under Affordable Care Act regulations.

Wellness Program: Alternative Standard And Disclosure Policy

The El Camino Hospital's wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors. You are not required to complete the HRA in order to participate in the program. The HRA is used to personalize your experience on the Virgin Pulse platform and provide you with the information to help you understand your current health and potential risk. It is administrated by a third party and is completely anonymous and confidential. You are also encouraged to share any results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and El Camino Hospital may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the

event a data breach occurs, involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Employee Wellness & Health Services at (650) 940-7021.

No Surprises Act (NSA) Notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost- sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post- stabilization services. (See a summary of your rights and how to file a complaint below).

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in- network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

California law protects consumers from surprise medical bills and prohibits balance billing when you receive emergency services provided by an out-of-network doctor or hospital. California law also protects consumers from surprise medical bills when they receive non-emergency services at an in-network facility but are treated there by a professional who is out-of-network.

A summary of your rights can be found at the following website:
https://www.dmhc.ca.gov/Portals/0/Docs/DO/BalanceBillingFactSheet.pdf

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation ofbenefits.
    - Count any amount you pay for emergency services or out-of-network servicestoward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:
Department of Managed Health Care's Help Center at 1-888-466-2219, or file a complaint at https://www.dmhc.ca.gov/file-a-complaint/contact-your-health-plan.aspx.

Medicare Part D Creditable Coverage Notice

Important Notice About Your Prescription Drug Coverage and Medicare: Creditable Coverage

If you (and/or your dependents) have Medicare, or will become eligible for Medicare within the next 12 months, federal law gives you more choices about your prescription drug coverage. Please read the following notice for more details.

Please read this notice carefully. It has information about your prescription drug coverage under the ***El Camino Hospital's*** *health plan (Employer Plan) and the coverage options available to Medicare Part-D eligible individuals. This Notice also provides information on additional resources that may help you decide which prescription drug coverage to choose.*

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

The purpose of this notice is to advise you that the Employer Plan prescription drug coverage listed below is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay. This is known as "creditable coverage."

- OptumRx Prescription plan
- Aetna HSA HDHP PPO Rx plan

Why this is important: Coverage under one of these plans may help you avoid a Medicare Part D late enrollment penalty. If you or your covered dependent(s) are enrolled in the Employer Plan 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.

Late Enrollment Penalty (Higher Premium Charge)

You should know that if you waive or drop coverage under the Employer Plan and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Medicare Part D premium may go up by at least 1% per month for every month that you do 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 Medicare Part D.

Medicare Prescription Drug Coverage

You may have heard about Medicare's prescription drug coverage (called Medicare Part D), and wondered how it would affect you. Medicare offers prescription drug coverage to everyone with Medicare. 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 Part D eligible, and each year thereafter during Medicare open enrollment (October 15 through December 7). Individuals who decide to drop their creditable employer/union coverage may be eligible for a two month Medicare Special Enrollment Period.

Interaction Between Coverages

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or a family member of an active employee, your current Employer Plan through El Camino Hospital will be affected. For those Individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at https://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

In addition, if you waive or drop your current Employer Plan coverage to enroll in a Medicare Part D plan, you and your dependents will be able to re-enroll in the Employer Plan coverage at open enrollment or when you have a special enrollment event.

Additional Information

Contact the person listed at the end of this Notice for further information about your current prescription drug coverage.

NOTE: 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 the Employer Plan coverage changes, or upon your request.

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

Here's how to get more information about Medicare prescription drug plans:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see a copy of the *Medicare & You* handbook for the telephone number) for personalized help.
- 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 about this extra help, 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, you may be required to provide a copy of this notice when you join a Part D plan to show that you have maintained creditable coverage and, therefore, may not be required to pay a higher Part D premium.

For more information about this notice or your employer-sponsored prescription drug coverage, contact your plan administrator.

For purposes of this notice, the plan administrator is:
El Camino Hospital
Phone number: (650) 940-7222

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, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/chp 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/programs/third-party-liability/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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://hhs.iowa.gov/medicaid Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services (https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki) Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://www.chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	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: https://dhhs.ne.gov/Pages/Medicaid-Eligibility.aspx 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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: https://www.nj.gov/humanservices/dmahs/clients/medicaid Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp Phone: 1-800-692-7462 CHIP Website: https://www.pa.gov/agencies/dhs/resources/chip 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: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
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/medicaid/index.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, 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)

El Camino Hospital Health & Welfare Plan

Listed below are names, addresses and telephone numbers, as well as other information, which will help you gain information about the plan.

Plan Sponsor:
El Camino Hospital
2500 Grant Road
Mountain View, CA 94040
650-940-7000

Plan Administrator:
El Camino Hospital
2500 Grant Road
Mountain View, CA 94040
650-940-7000

Employer Identification Number of Plan Sponsor: 94-3167314

Member Contacts:
Deanna W. Dudley, JD, MBA
Chief Human Resources Officer

Name of Plan:
El Camino Hospital Health & Welfare Plan

Services of Legal Process
Legal process should be served on the Plan Administrator at the address listed above.

Statement of ERISA Rights
As a participant in the El Camino Group Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA).
ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's Office, all plan documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as annual reports and plan descriptions.

2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating right for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate you plans, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you, any other plan participants, and beneficiaries. No one, including the Hospital, the union, or any other person, may fire you or otherwise discriminate against you in any way, to prevent you from obtaining benefits or exercising your rights under ERISA. If your claim for benefits is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request material from the plan and so not receive them within 30 days, you may file suit in a federal court. In such a case, the court my require the plan administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in the state or federal court. If it should happen that plan fiduciaries misused the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you lose, the court may order you to pay these costs and fees. If you have any questions about this statement or about your rights under ERISA, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the U.S. Department of Labor Management Services Administration, Department of Labor. The flexible benefit plan is operated according to the terms of legal documents including insurance contracts and plan documents. In the event of a conflict between this enrollment booklet and the legal documents, the legal document will be followed.

SUMMARY ANNUAL REPORT FOR EL CAMINO HOSPITAL HEALTH & WELFARE PLAN

This is a summary of the annual report of the El Camino Hospital Health & Welfare Plan (Employer Identification Number 94-3167314, Plan Number 502) for the plan year 01/01/2024 through 12/31/2024. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

El Camino Hospital has committed itself to pay certain Prescription Drug Plan, Dental, Vision and Health Care Flexible Spending Account claims incurred under the terms of the plan.

Insurance Information

The plan has insurance contracts with Aetna Health, Inc., Concern EAP, Delta Dental of California, Hartford Life and Accident, Aetna Life Insurance Co., University Health Alliance, Sierra Health and Life Insurance Company, Inc., Metropolitan Life Insurance Company, MetLife Legal Plans and Metropolitan General Insurance Company to pay certain Health, HMO Contract, Prescription Drug, Dental, Vision, Employee Assistance Program, Life Insurance, Accidental Death & Dismemberment, Long-term Disability, Critical Illness, Accident, Hospital Indemnity, and Legal claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2024 were $78,172,101.

Your Rights to Additional Information

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

1. Insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the plan administrator, at 2500 Grant Road, Mountain View, CA 94040-4302 and phone number, 650-940-7000. The charge to cover copying costs will be $3.00 for the full annual report, or $0.25 per page for any part thereof.

You also have the legally protected right to examine the annual report at the main office of the plan: 2500 Grant Road, Mountain View, CA 94040-4302, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The annual report is also available online at the Department of Labor website www.efast.dol.gov.