IMPORTANT NOTICES

2024 Privacy Reminder Notice

We are required by law to keep your health information private. The Parkland Employee Health Plan Notice of Privacy Practices explains how we use health information about you. It also lets you know when we can share that information with others. It tells you about your rights to your health information and how you can use those rights. If you would like a copy of the Parkland Employee Health Plan Notice of Privacy Practices, please call 469-419-3000 (ext. 7-3000). You can also write us at:

Parkland Employee Health Plan
Office of Talent Management, Benefits Department
Moody Outpatient Center
5151 Maple Ave., 5th Floor
Dallas, TX 75235

These and other notices can be viewed and printed from ParklandBenefits.org > Resources > Legal Notices.

NOTIFICACIÓN DEL AVISO DE PRÁCTICAS DE PROVACIDAD

Por ley, estamos obligados a mantener su información médica de manera condencial. La notificación Prácticas de Privacidad del Plan de Salud para Empleados de Parkland explica cómo utilizamos su información de salud. También le informa cuándo podemos compartir esa información a otras personas. Le habla sobre los derechos que usted tiene a su información médica y cómo puede usar esos derechos.

Si desea una copia de la notificación de Prácticas de Privacidad del Plan de Salud para Empleados de Parkland, por favor llame al 469-419-3000 (ext. 7-3000). También puede escribirnos a:

Parkland Employee Health Plan
Office of Talent Management, Benefits Department
Moody Outpatient Center
5151 Maple Ave., 5th Floor
Dallas, TX 75235

Women's Health and Cancer Rights Act of 1998

As a result of the Women's Health and Cancer Rights Act of 1998, if you have breast reconstruction in connection with a mastectomy, coverage will be available as follows:

- Reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses (e.g., breast implant) and
- Treatment for physical complications of the mastectomy, including lymphedema.

Benefit payment is subject to the deductible and benefits under the plan.

Newborns' and Mothers' Health Protection Act

Federal law prevents group health plans from restricting benefits for hospital stays in connection with childbirth to less than 48 hours following a normal delivery or 96 hours following a cesarean section. However, the mother's or newborn's attending provider, after consulting with the mother, can discharge the mother or her newborn earlier than 48 or 96 hours, as applicable.

Pregnant Workers Fairness Act (PWFA)

The Pregnant Workers Fairness Act (PWFA) is a federal law that, starting June 27, 2023, requires covered employers to provide "reasonable accommodations" to a qualified worker's known limitations related to pregnancy, childbirth or related medical conditions, unless the accommodation will cause the employer an "undue hardship." An undue hardship is defined as causing significant difficulty or expense.

"Reasonable accommodations" are changes to the work environment or the way things are usually done at work.

WHAT ARE SOME POSSIBLE ACCOMMODATIONS FOR PREGNANT WORKERS?

- Being able to sit or drink water
- Receiving closer parking
- Having flexible hours
- Receiving appropriately sized uniforms and safety apparel
- Receiving additional break time to use the bathroom, eat and rest
- Taking leave or time off to recover from childbirth
- Being excused from strenuous activities and/or exposure to chemicals not safe for pregnancy

WHAT OTHER FEDERAL EMPLOYMENT LAWS MAY APPLY TO PREGNANT WORKERS?

Other laws that apply to workers affected by pregnancy, childbirth or related medical conditions include:

- **Title VII** that prohibits employment discrimination based on sex, pregnancy or other protected categories (enforced by the U.S. Equal Employment Opportunity Commission (EEOC))
- **The ADA** that prohibits employment discrimination based on disability (enforced by the EEOC)
- **The Family and Medical Leave Act** that provides unpaid leave for certain workers for pregnancy and to bond with a new child (enforced by the U.S Department of Labor)
- **The PUMP Act** that provides nursing mothers a time and private place to pump at work (enforced by the U.S. Department of Labor)

Learn more at **www.EEOC.gov/Pregnancy-Discrimination**.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not 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 **healthcare.gov.**

For Texas residents, go to texas.gov/services/financial/health-insurance-premium-payment-hipp-program or call 1-800-440-0493 to see if you are eligible for assistance from Medicaid in paying your employee health plan premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below or on the following page, 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 (543-7669**) or go to **insurekidsnow.gov** to find out how to apply. If you qualify, ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or **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, 2023. Contact your state for further information on eligibility.

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

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

CALIFORNIA — Medicaid
Health Insurance Premium Payment (HIPP) Program
Website: dhcs.ca.gov/hipp
Phone:1-916-445-8322
Fax: 1-916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO — Medicaid and CHIP
Health First Colorado Medicaid Website: https://www.healthfirstcolorado.com/
Phone: 1-800-221-3943/ State Relay 711
CHP+ Website: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Phone: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com
HIBI Customer Service: 1-855-692-6442

FLORIDA — Medicaid
Website: flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

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

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

IOWA — Medicaid and CHIP (Hawki)
Medicaid Website: dhs.iowa.gov/ime/members
Phone: 1-800-338-8366
Hawki Website: dhs.iowa.gov/Hawki
Phone: 1-800-257-8563
Health Insurance Premium Payment (HIPP) Program:
dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
1-888-346-9562

KANSAS — Medicaid
Website: kancare.ks.gov
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

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

LOUISIANA — Medicaid
Website: medicaid.la.gov or ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE — Medicaid
Enrollment Website: mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
Private Health Insurance Premium
Website: maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine Relay 711

MASSACHUSETTS — Medicaid and CHIP
Website: mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY:1-617-886-8102
Email: masspremassistance@accenture.com

MINNESOTA — 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

MISSOURI — Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

MONTANA — Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA — Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178

NEVADA — Medicaid
Website: https://dhcfp.nv.gov
Phone: 1-800-992-0900

NEW HAMPSHIRE — Medicaid
Website: dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 1-603-271-5218
Toll-free: 1-800-852-3345, ext 5218

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

NEW YORK — Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA — Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 1-919-855-4100

NORTH DAKOTA — Medicaid
Website: hhs.nd.gov/healthcare
Phone: 1-844-854-4825

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

OREGON — Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA — Medicaid and CHIP
Medicaid Website: dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
Phone: 1-800-986-KIDS (5437)

RHODE ISLAND — Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)

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

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

TEXAS — Medicaid
Website: texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

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

VERMONT — Medicaid
Website: dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA — Medicaid and CHIP
Medicaid Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
CHIP Website: coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON — Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA — Medicaid and CHIP
Medicaid Website: dhhr.wv.gov/bms/
Medicaid Phone: 1-304-558-1700
CHIP Website: http://mywvhipp.com/
CHIP Phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN — Medicaid and CHIP
Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING — Medicaid
Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any more states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, you can contact either:

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

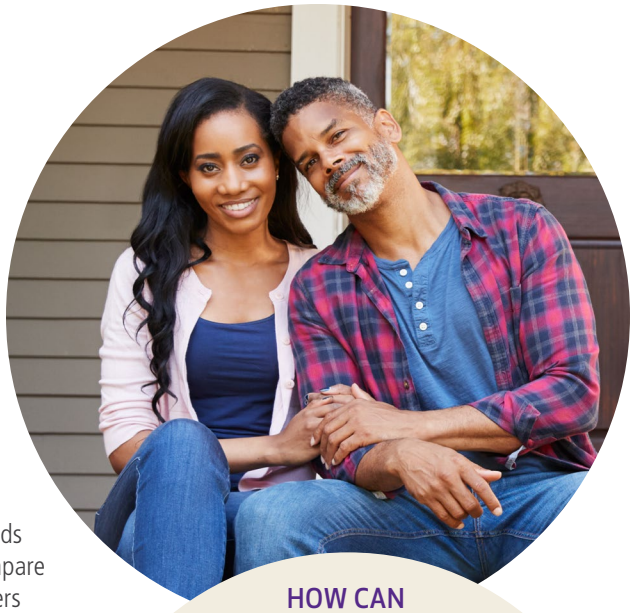
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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 (expires 1/31/2026).

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, Americans gained 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 Nov. 1, 2023, and ends Dec. 15, 2023, for coverage starting as early as Jan. 1, 2024. Outside of this open enrollment period, you can only enroll in or change Marketplace coverage if you qualify for a Special Enrollment Period as a result of certain life events.

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) in 2024 is more than 8.39% 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, 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.

[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% of such costs.

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your Summary Plan Description or contact the Parkland Benefits department at 469-419-3000 (ext. 7-3000).

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.

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. This information is effective as of Nov. 1, 2023, and is subject to change.

3. Employer name Dallas County Hospital District	4. Employer Identification Number (EIN)	
5. Employer address 5200 Harry Hines Boulevard	6. Employer phone number 469-419-3000 (ext. 7-3000)	
7. City Dallas	8. State TX	9. ZIP code 75235
10. Who can we contact about employee health coverage at this job? Parkland Benefits Department		
11. Phone number (if different from above) Same as above	12. Email address Felicia.Miller@phhs.org	

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

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☑ Some employees. Eligible employees are:
    - – Full time employees
    - – Part-time-with-benefits employees

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:
    - – Your lawful spouse as recognized by Texas Law
    - – Any child of yours who is: 1) less than 26 yrs old, 2) legally adopted, 3) children for whom you are the legal guardian, and 4) grandchildren for whom you have legal custody
  - ☐ 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.

** 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's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

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?

☐ **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)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ **Yes** (Go to question 15)

☐ **No** (STOP)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't 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 didn't receive any other discounts based on wellness programs.

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

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.

16. What change will the employer make for the new plan year effective Jan. 1, 2024?

☐ 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% of such costs

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 by federal law from surprise billing or balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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" means providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be allowed to bill you for the difference between what your health plan pays, 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 towards your plan's deductible or 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. Surprise bills could cost thousands of dollars depending on the procedure or service.

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 deductibles, 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.

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 never 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.

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 any additional costs to out-of-network providers and facilities directly in accordance with your health plan coverage.
- 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 of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, contact Cigna at 1-800-247-4433.

For more information about your surprise billing rights visit **the Center for Medicare and Medicaid Services' End Surprise Billing website at cms.gov/nosurprises**. You may also visit the Department of Labor's surprise billing website (**dol.gov/ebsa**) or call the Employee Benefits Security Administration (EBSA) Toll-Free Hotline at **866–444–EBSA** (3272).

Medicare Notice

CREDITABLE COVERAGE NOTICE FROM THE PARKLAND EMPLOYEE HEALTH PLAN ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Parkland Employee Health Plan (PEHP), including the Preferred Provider Organization (PPO) and the High Deductible Health Plan (HDHP), and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

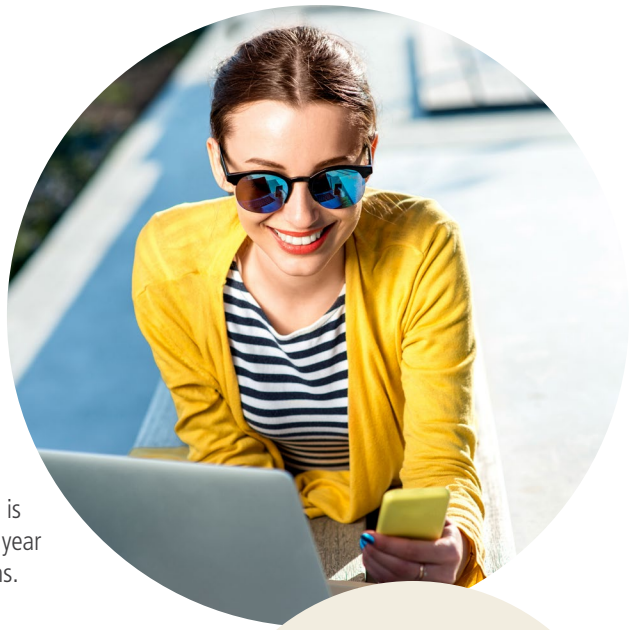
There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

2. Parkland Health has determined that the prescription drug coverage offered by the Parkland Employee Health Plan is, on average for all plan participants, expected to pay out as much as the 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 Oct. 15 through Dec. 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.
What happens to your current coverage if you decide to join a Medicare drug plan?	If you decide to join a Medicare drug plan, your current Parkland Employee Health Plan coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Parkland Employee Health Plan coverage, be aware that you and your dependents may not be able to get this coverage back.
When will you pay a higher premium (penalty) to join a Medicare drug plan?	You should also know that if you drop or lose your current coverage with the Parkland Employee Health Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Medicare Notice (continued)



FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

For more information, contact Felicia Miller, Executive Vice President & Chief Talent Officer, at 469-419-3000 (ext. 7-3000).

Note: You will receive this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Parkland Employee Health Plan changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, contact the Social Security Administration (SSA) at **ssa.gov** or 800-772-1213 (TTY 800-325-0778).

Date	Sept. 30, 2023
Name of Entity/Sender	Parkland Benefits Department/ Parkland Employee Health Plan
Contact/Position/Office	Felicia Miller, Executive Vice President & Chief Talent Officer
Address	5200 Harry Hines Boulevard Office of Talent Management, Benefits Department Dallas, TX 75235
Phone Number	469-419-3000 (ext. 7-3000)
Email Address	Felicia.Miller@phhs.org

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 you have maintained creditable coverage and whether you are required to pay a higher premium (a penalty).

[1] According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. CMS Form 10182-CC Updated April 1, 2011