ENSIGN SERVICES

2023 Ensign Compliance Notices Booklet

Each year, there are legally required notices and disclosures that Ensign Services, Inc. (or our insurance carriers) are required to make to participants in the benefit plans. These notices and disclosures are for your information.

Notice or Disclosure **Page**

September 2022

Medicare Part D Notice of Creditable Coverage

Important Notice about Your Prescription Drug Coverage and Medicare.

The key purpose of this notice is to advise you that the prescription drug coverage you have under your Ensign Services, Inc. Comprehensive Health and Welfare Benefit Plan's medical option is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2023 (This is known as "creditable coverage.") The reason this is important is that if you or a covered dependent are or become eligible for Medicare and you decide to enroll in a Medicare prescription drug plan during a subsequent annual enrollment period, you will not be subject to a late enrollment penalty as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

Notice of Creditable Coverage

Please read this notice carefully. This notice has information about your current prescription drug coverage under the Ensign Services, Inc. Comprehensive Health and Welfare Benefit Plan and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage is available to everyone with Medicare.
2. Ensign has determined that the prescription drug coverage offered by the Ensign Services, Inc. Comprehensive Health and Welfare Benefit Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay in 2023.
3. Read this notice carefully – it explains the options you have under Medicare's prescription drug coverage, and can help you decide whether or not you want to enroll. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

If you are covered under one of the Ensign Services, Inc. Comprehensive Health and Welfare Benefit Plan's prescription drug plans, your existing coverage is, on average, at least as good as standard Medicare. Therefore, if you are or become eligible for Medicare, you can keep this coverage and not pay extra if you later decide to enroll in a Medicare prescription drug plan.

Medicare participants can enroll in a Medicare prescription drug plan from October 15 through December 7. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to keep that coverage and join a Medicare prescription drug plan later. Each year after that, you will have the opportunity to enroll in a Medicare prescription drug plan from October 15 through December 7.

If you decide to enroll in a Medicare prescription drug plan, you may also continue your employer coverage. The employer plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. You may also drop your employer coverage, in which case Medicare will be your only payer. You can reenroll in the employer plan at annual enrollment or if you have a special enrollment event.

The prescription drug plan offerings for 2023 for Medicare eligible individuals include:

- Choice HSA PPO Plan
- Value Copay Plan
- Premier EPO Plan
- Kaiser HMO 2000 with HSA (CA Only)
- SIMNSA Baja CA Premier Access HMO (San Diego, CA County Only)

You should know that if you drop or lose your coverage under the Ensign Services, Inc. Comprehensive Health and Welfare Benefit Plan and don't promptly enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until next November to enroll. However, if you involuntarily lose credible prescription drug coverage, you will be eligible for a two month Special Enrollment Period (SEP) to enroll in a Part D plan.

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

More detailed information about Medicare plans that offer prescription drug coverage will be available in the "Medicare & You" handbook. Medicare participants will get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can get more information about Medicare prescription drug plans:

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

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

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare, which offer prescription drug coverage, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Special Health Care Enrollment Notice

If you decline enrollment for medical benefits for yourself or your eligible dependents because of other health insurance or group health coverage, you may be able to enroll yourself and your eligible dependents in the medical benefits provided under the Ensign Services, Inc. Comprehensive Health and Welfare Benefit Plan if you or your eligible dependents lose eligibility under that other coverage (or if the other employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your eligible dependents' other coverage ends (or after the other employer stops contribution toward the other coverage).

In addition, if you have a new dependent as the result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself, your spouse and your new eligible children. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

If you request a change due to a special enrollment even within the 30-day timeframe, coverage will become effective on the date of the birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment.

Effective April 1, 2009 the plan must allow a HIPAA special enrollment for employees and dependents who are eligible but not enrolled if they lose Medicaid or CHIP coverage because they are no longer eligible, or they become eligible for a state's premium assistance program. Employees have 60 days from the date of the Medicaid/CHIP event to request enrollment under a medical plan. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

COBRA Rights

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) and the Omnibus Budget Reconciliation Act of 1989 (OBRA) require employers to offer their employees, and their eligible family members, who would otherwise lose group coverage under specified circumstances, called "qualifying events", the opportunity for a temporary extension of medical, dental and vision coverage at 102% of the full group rates. This brief summary is not intended as the official notice of your rights required by federal and state law. We have included this summary to inform you that you have these rights. You will receive a separate, detailed explanation of your right to continue health insurance coverage shortly after your employment begins and at any time you become eligible for the benefit.

Paperwork Reduction Act

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.

Notice Regarding Primary Care Providers and Access to Obstetrical and Gynecological Care

The Kaiser HMO plan options generally permit the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Kaiser network and who is available to accept you or your family members. You may designate a pediatrician as the primary care provider for a child. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser Permanente at www.kp.org or 800-464-4000.

You do not need prior authorization from Kaiser 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 the Kaiser network who 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 Kaiser Permanente at www.kp.org or 800-464-4000.

Women's Health and Cancer Rights Act Notice

All Ensign Services, Inc. Comprehensive Health and Welfare Benefit Plan medical options, as required by the Women's Health and Cancer Rights Act of 1998, provide benefits for mastectomy-related services. This includes reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications related to all stages of the mastectomy (including lymphedemas). These mastectomy-related benefits are subject to the same annual deductibles and coinsurance rules that apply to other medical and surgical benefits. For more information, call the medical plan carrier for which you are enrolled at the telephone number on your medical plan ID card.

Newborns' and Mothers' Health Protection Act Notice

This notice is required by the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA). Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending physician, after consulting with the mother, from discharging the mother and her newborn earlier than the 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay that does not exceed 48 hours (or 96 hours).

Health Insurance Marketplace Coverage: Options and Your Health Coverage

General Information

The Health Insurance Marketplace is a way to buy health insurance as part of the health care law that went into effect in 2014. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new marketplace and employment-based health coverage offered by Ensign Services.

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 for 2023 through the Marketplace begins on November 1, 2022 and ends December 15, 2022.

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 Ensign Services 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 Ensign Services that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in the Ensign Services plans. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if Ensign Services does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from Ensign Services that would cover you (and not any other members of your family) is more than 9.66% of your household income for the year, or if the coverage Ensign Services 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 benefit 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 Ensign Services, then you may lose Ensign Services' contribution 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 the coverage offered by Ensign Services, please check your summary plan description or contact the Ensign Benefits Center at 877-352-8104.

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.

Information About Health Coverage Offered by Your Employer

This section contains information about the health coverage offered by Ensign Services. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information.

Employer name:
Ensign Services, Inc.

Employer Identification Number (EIN):
11-3645368

Employer address:
27101 Puerta Real
Suite 450
Mission Viejo, CA 92691

Employer phone number:
877-352-8104

Who can we contact about employee health coverage?

Ensign Benefits Center
877-352-8104

Here is some basic information about health coverage offered by Ensign Services:

- At Ensign Services, we offer a health plan to some employees. Eligible employees are employees of an Ensign-affiliated company regularly scheduled to work at least 30 hours per week who have completed the benefits eligibililty waiting period. Eligible employees do not include leased employees, independent contractors, casual employees, interns, on-call employees, seasonal employees, temporary employees, zerohour employees or individuals covered by a collective bargaining agreement that does not provide for participation in the plan.

- We do offer coverage to dependents. Eligible dependents include legal spouse and children under age 26, or disabled dependent children of any age who is unable to support himself/herself due to a physical or mental disability who became disabled before age 26.

- 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 though Ensign Services 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.

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

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

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

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

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

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

State	Website	Telephone
Alabama – Medicaid	https://myalhipp.com/	1-855-692-5447
Alaska – Medicaid	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	1-855-MyARHIPP (855-692-7447)
Arkansas – Medicaid	http://myarhipp.com/	1-855-692-7447
California – Medicaid	Health Insurance Premium Payment (HIPP) Program: http://dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	Phone: 916-445-8322 Fax: 916-440-5676
Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	Health First Colorado Website: https://www.healthfirstcolorado.com/ CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus HIBI: https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program	HFC: 1-800-221-3943 / State Relay 711 CHP+: 1-800-359-1991 / State Relay 711 HIBI: 1-855-692-6442
Florida – Medicaid	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecove ry.com/hipp/index.html	1-877-357-3268
Georgia – Medicaid	GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162 press 2
Indiana – Medicaid	Healthy Indiana Plan for low-income adults 19-64: http://www.in.gov/fssa/hip/ All other Medicaid: https://www.in.gov/medicaid/	1-877-438-4479 1-800-457-4584
Iowa – Medicaid & CHIP (Hawki)	Medicaid Website: https://dhs.iowa.gov/ime/members Hawki Website: http://dhs.iowa.gov/Hawki HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	Medicaid: 1-800-338-8366 Hawki: 1-800-257-8563 HIPP: 1-888-346-9562
Kansas – Medicaid	https://www.kancare.ks.gov/	1-800-792-4884
Kentucky – Medicaid	KI-HIPP Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Kentucky Medicaid Website: https://chfs.ky.gov	1-855-459-6328 1-877-524-4718
Louisiana – Medicaid	www.medicaid.la.gov or www.ldh.la.gov/lahipp	Medicaid hotline 1-888-342-6207 LaHIPP 1-855-618-5488

State	Website	Telephone
Maine – Medicaid	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms	1-800-442-6003 TTY: Maine relay 711 1-800-977-6740 TTY: Maine relay 711
Massachusetts – Medicaid & CHIP	https://www.mass.gov/masshealth/pa	1-800-862-4840 TTY: (617) 886-8102
Minnesota – Medicaid	https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp	1-800-657-3739
Missouri – Medicaid	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana – Medicaid	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	1-800-694-3084 Email: HHSHIPPProgram@mt.gov
Nebraska – Medicaid	http://www.ACCESSNebraska.ne.gov	Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada – Medicaid	http://dhcfp.nv.gov	1-800-992-0900
New Hampshire – Medicaid	https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program	603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
New Jersey – Medicaid & CHIP	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP: http://www.njfamilycare.org/index.html	Medicaid: 609-631-2392 CHIP: 1-800-701-0710
New York – Medicaid	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina – Medicaid	https://medicaid.ncdhhs.gov/	919-855-4100
North Dakota – Medicaid	http://www.nd.gov/dhs/services/medicalserv/medicaid/	1-844-854-4825
Oklahoma – Medicaid & CHIP	http://www.insureoklahoma.org	1-888-365-3742
Oregon – Medicaid	http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html	1-800-699-9075
Pennsylvania – Medicaid	https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx	1-800-692-7462
Rhode Island – Medicaid & CHIP	http://www.eohhs.ri.gov/	1-855-697-4347, or Direct RIte Share Line 401-462-0311
South Carolina – Medicaid	https://www.scdhhs.gov	1-888-549-0820
South Dakota – Medicaid	http://dss.sd.gov	1-888-828-0059
Texas – Medicaid	http://gethipptexas.com/	1-800-440-0493
Utah – Medicaid & CHIP	Medicaid: https://medicaid.utah.gov/ CHIP: http://health.utah.gov/chip	1-877-543-7669
Vermont – Medicaid	http://www.greenmountaincare.org/	1-800-250-8427
Virginia – Medicaid & CHIP	https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp	Medicaid: 1-800-432-5924 CHIP: 1-800-432-5924
Washington – Medicaid	https://www.hca.wa.gov/	1-800-562-3022
West Virginia – Medicaid	https://dhhr.wv.gov/bms/ https://mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 1-855-699-8447
Wisconsin – Medicaid & CHIP	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
Wyoming – Medicaid	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	1-800-251-1269

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
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

Ensign Services, Inc. Important Notice

Comprehensive Notice Of Privacy Policy And Procedures

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice is provided to you on behalf of:

Ensign Services, Inc. Comprehensive Health and Welfare Benefit Plan

This notice pertains only to healthcare coverage provided under the Plan.

The Plan's Duty to Safeguard Your Protected Health Information.

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask the Ensign Human Resources Department at (949) 487-9500, or contact the Plan's Privacy Official, described below), and will be posted on the Ensign benefits website at www.ensignbenefits.com under Resources > Legal Notices.

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information.

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
  - **Treatment**: Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
  - **Payment**: Of course, the Plan's most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan detailed information about the care they

provided, so that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse's plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

- **Health care operations**: The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

- **Other Uses and Disclosures of Your PHI Not Requiring Authorization**. The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

  - **To the Plan Sponsor**: The Plan may disclose PHI to the Ensign-affiliated employers who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; accounting department for purposes of reconciling appropriate payments of premiums to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan's provision of benefits.
  - **Required by law**: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
  - **For public health activities**: The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
  - **For health oversight activities**: The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
  - **Relating to decedents**: The Plan may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
  - **For research purposes**: In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
  - **To avert threat to health or safety**: In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
  - **For specific government functions**: The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

- **Uses and Disclosures Requiring Authorization**: For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

- **Uses and Disclosures Requiring You to have an Opportunity to Object**: The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information.

You have the following rights relating to your protected health information:

- **To request restrictions on uses and disclosures**: You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.

  — Effective February 17, 2010, you can restrict disclosure of PHI for payment or health care operations if you pay the health care provider the full out-of-pocket cost.

- **To choose how the Plan contacts you**: You have the right to ask that the Plan send you information at an alternative address or by an alternative means. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.

- **To inspect and copy your PHI**: Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.

- **To request amendment of your PHI**: If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

How to Complain about the Plan's Privacy Practices.

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach.

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach. The notice will be provided to you if the breach poses a significant risk of financial, reputational or other harm to you.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint.

If you have questions about this Notice please contact the Plan's Privacy Official (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, or breach notification process, please contact the Privacy Official.

Privacy Official.

The Plan's Privacy Official, the person responsible for ensuring compliance with this Notice, is:

Debbie Miller
Chief Compliance Officer
(949) 487-9500

Effective Date.

The effective date of this Notice is: January 2020.

Affordable Care Act (ACA) Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.12% for 2023 (9.61% in 2022) of your modified adjusted household income.

Notice of Non-discrimination

Affiliates of The Ensign Group are committed to providing a surprising level of attention and service which includes delivery of care without discrimination based on race, color, national origin, sex, age or disability.

We take reasonable steps to provide meaningful access to each individual with limited English proficiency and/or disabilities. These steps include the provision of language assistance services such as oral language assistance or written translation through a qualified interpreter and to provide appropriate auxiliary aids and services for persons with disabilities.

For access to these free services, please contact the staff at the location where you are receiving care.

If you believe we have discriminated against you or failed to provide these free services in a timely manner you may report your concern to Ensign Compliance Hotline at (866) 256-0955, online at http://ensigngroup.silentwhistle.com or by mail to address below.

Ensign Services, Inc.
Attn: Compliance Department
29222 Rancho Viejo Rd., Suite 127
San Juan Capistrano, CA 92675

You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail, email or phone:

Centralized Case Management Operations
U.S. Department of Health and Human Services/Office for Civil Rights
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201

Phone: 800-868-1019
TTD: 800-537-7697
Email: OCRcomplaint@hhs.gov

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.

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 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 of benefits.
  - — Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, the federal telephone number for information and complaints is 1-800-985-3059.

Visit cms.gov/nosurprises/consumers for more information about your rights under federal law.