Memorial

A GUIDE TO YOUR

2022

TOTAL REWARDS
EMPLOYEE BENEFITS

Welcome to Memorial!

As a Memorial employee, you help to shape the quality of life for people throughout the Gulf Coast and around world.

Every staff member plays an important role in Memorial's mission in Building a Healthier Community; we work together to make Memorial a success, and our teamwork extends to your benefits.

As one of the most comprehensive healthcare systems in the state, Memorial's high-quality benefits are among the rewards you receive in return. These benefits are an important part of your total compensation.

Your health and well-being are important to us and we know that making benefits choices can be a bit overwhelming. So, we have tools and information to help you make the right choices for you and your family.

This guide offers a comprehensive overview of your health and welfare benefits options, including details about eligibility, enrollment, and the plans available to you.

If you have questions, your Benefits Team is here to help. You can call, email or stop by our benefits office. You'll find our contact information on the back cover of this guide.


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BEST
Memorial
Information

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Eligibility & Enrollment

Memorial Hospital offers a variety of benefits to support you and your family's needs. Choose options that cover what's important to your unique lifestyle.

Eligibility

If you are in a benefits-eligible status, you are eligible to participate in the medical, dental, vision, life and disability plans and additional benefits.

If you are enrolled in medical, dental and/or vision coverage with Memorial Hospital and experience a change in employment status you will be offered Consolidated Omnibus Reconciliation Act of 1985 (COBRA) continuation coverage.

Specific information will be mailed to you following your change in employment status.

When Does Coverage Begin?

Your elections are effective on the first of the month following 30 days of benefits-eligible employment. You won't be able to change your benefits until the next enrollment period unless you experience a qualifying life event. There is a 30-day time limit from the date of a qualifying event to allow changes with appropriate documentation required.

Eligible Dependents

Dependents eligible for coverage in the Memorial Hospital benefits plans include:

- **Your legal spouse.**
- **Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children and children for whom legal guardianship has been awarded to you or your spouse).**
- **Dependent children 26 or more years old, unmarried and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).**

Verification of dependent eligibility is required upon enrollment. Some plans have differing age restrictions. Please check with the Benefits Office if you have any questions.

The following documentation must be submitted prior to enrollment.

Legal Spouse

- **A copy of government-issued Marriage Certificate and Social Security card**

OR

- **A copy of Federal Tax Return issued within the last two (2) years and Social Security card**

Biological Child / Adopted Child

- **A copy of government-issued Birth Certificate**
  Social Security card

Stepchild

- **A copy of government-issued Birth Certificate and government-issued Marriage Certificate (for the child's parent and employee) and Social Security card.**

Coordination of Benefits

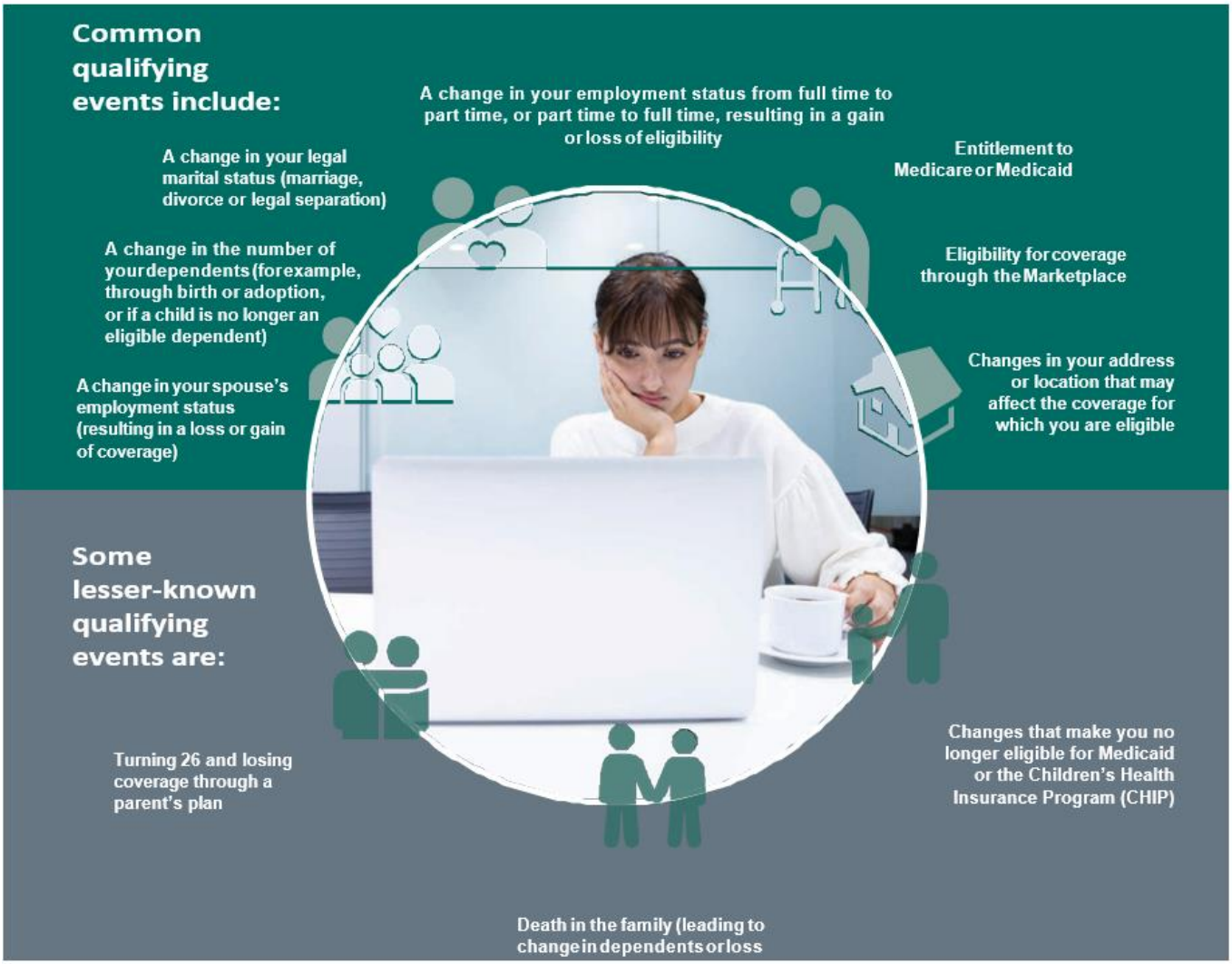
If you are enrolling yourself or dependents in the Medical or Dental Plan, Select Administrative Services (SAS) requires you to complete a Coordination of Benefits (COB) form. The COB form may be found on the SAS website at https://sas.vbagateway.com.

Eligibility & Enrollment – Qualifying Events

What are Qualifying Life Events?

Most people know you can change your benefits when you start a new job or during Open Enrollment. But did you know that changes in your life may permit you to update your coverage at other points in the year? Qualifying Life Events (QLEs) determined by the IRS could allow you to enroll in health insurance or change your elections outside of the annual time.

When a Qualifying Life Event occurs, you have 30 days to request changes to your coverage. Keep in mind your change in coverage must be consistent with your change in status.



Questions regarding specific life events and your ability to request changes should be directed to the Benefits Department at 228-865-3306. Don't miss out on a chance to update your benefits!

Preparing for Enrollment

As a committed partner in your health, Memorial absorbs a significant amount of your benefit costs. Your contributions for medical, dental and vision benefits are deducted on a pre-tax basis, lessening your tax liability. Please note that employee contributions vary depending on level of coverage. Typically, the more coverage you have, the higher your portion.

Enrollment To-Do

Update your personal information.

If you've experienced a qualifying life event in the last year, you may need to change your elections or update your personal information.

Double-check covered and restricted medications.

If you make any changes to your plan, consider how it affects your prescription coverage.

Enrolling a Spouse?

If you're enrolling your Spouse please provide a copy of your marriage license along with their Social Security card.

Enrolling a Child?

If you're enrolling your Child please provide a copy of their birth certificate along with their Social Security card.

Review available copay schedules.

Take a look at your options – if you foresee a lot of medical needs this year, you might want to know what those copays might be.

Check to see if your provider is in-network.

Going in-network often saves you money. Check for any plan changes to make sure your provider is still covered in-network.

Plan Changes - 2022

What's Changing in 2022

- We are now offering a second health plan option called the **High Deductible Health Plan (HDHP)** with an optional **Health Savings Account (HSA)** for more plan possibilities to meet your individual needs. **See page 10** for more details.
- All medical premiums (Access or HDHP) will now include a **15% monthly surcharge for tobacco users**. **See page 10** for more details.
- The new Tobacco-Usage Surcharge Program will provide **employees and their dependents** with options for taking steps toward cessation with the ability to customize their cessation approach at no cost to the employee.
- Changes to Carry-Over Rule for FSAs. **See page 27**
- Healthcare Flexible Spending Account (FSA) limit is increasing to $2,750.
- Dependent Care Flexible Spending Account now offers a direct deposit reimbursement option.
- Transamerica Cancer Insurance. **See page 37**
- Auto Enrollment and Auto Escalation. **See page 41**

NEW YEAR. NEW PLANS. NEW CHOICES.

(NEW) Tobacco Use Surcharge

Tobacco-Use Surcharge

Memorial is committed to the health and wellness of our employees and patients. Our commitment to a tobacco-free workplace aligns with our initiatives of a safe and healthful community and a culture of wellness for our staff.

Beginning Plan Year 2022, staff enrolled in the hospital's medical plans (Access or HDHP Plan) who declare themselves tobacco users will incur a 15% monthly surcharge. This surcharge is intended to encourage employees who use tobacco to consider quitting tobacco while also offsetting the higher costs associated with covering tobacco users.

How do I attest?

Employees enrolled in medical coverage must acknowledge online via the Tobacco-Use Surcharge Affidavit included in the Open Enrollment/New Hire Enrollment sessions whether tobacco has been used within the last 90 days.

Who does the employee need to attest for?

You need to acknowledge whether or not you are a tobacco user if you are one of the following medical plan subscribers:

- Employee
- Spouse
- Covered Dependent (age 21+)

How much is the surcharge?

The surcharge is in addition to the medical plan premium and is 15% per pay period for biweekly employees. The surcharge will be applied effective January 2, 2022.

What happens if I do not attest to my tobacco use?

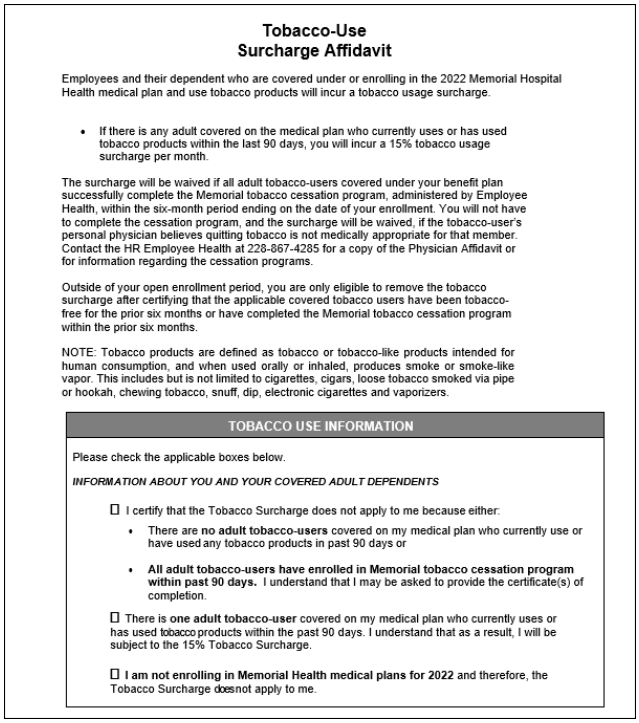
You will be charged the surcharge rate.

What if I stop smoking during the plan year?

A reasonable alternative is made available during the certification process for individuals who would like to become non-tobacco users. This allows up to 1 year to complete a tobacco cessation program. Tobacco cessation programs are available at no cost to you and your dependents. Please contact the Employee Health Department for tobacco cessation program information.

If you become a non-tobacco user or complete the tobacco cessation program under the reasonable alternative option, you can change your status during the Mid-Year 2022 Open Enrollment, Open Enrollment Plan Year 2023, or by contacting Benefits.

If your tobacco use status changes at any time during the plan year while you are enrolled in a Memorial healthcare plan, and you are tobacco free for three months without completion of a cessation program, you will contact Employee Health for cessation sign-off and contact Benefits to change your status within 30 days. For more information contact Benefits@mhg.com or go to the Employee Benefits Site.



Tobacco-Use Surcharge Affidavit

Employees and their dependent who are covered under or enrolling in the 2022 Memorial Hospital Health medical plan and use tobacco products will incur a tobacco usage surcharge.

- If there is any adult covered on the medical plan who currently uses or has used tobacco products within the last 90 days, you will incur a 15% tobacco usage surcharge per month.

The surcharge will be waived if all adult tobacco-users covered under your benefit plan successfully complete the Memorial tobacco cessation program, administered by Employee Health, within the six-month period ending on the date of your enrollment. You will not have to complete the cessation program, and the surcharge will be waived, if the tobacco-user's personal physician believes quitting tobacco is not medically appropriate for that member. Contact the HR Employee Health at 228-867-4285 for a copy of the Physician Affidavit or for information regarding the cessation programs.

Outside of your open enrollment period, you are only eligible to remove the tobacco surcharge after certifying that the applicable covered tobacco users have been tobacco-free for the prior six months or have completed the Memorial tobacco cessation program within the prior six months.

NOTE: Tobacco products are defined as tobacco or tobacco-like products intended for human consumption, and when used orally or inhaled, produces smoke or smoke-like vapor. This includes but is not limited to cigarettes, cigars, loose tobacco smoked via pipe or hookah, chewing tobacco, snuff, dip, electronic cigarettes and vaporizers.

TOBACCO USE INFORMATION

Please check the applicable boxes below.

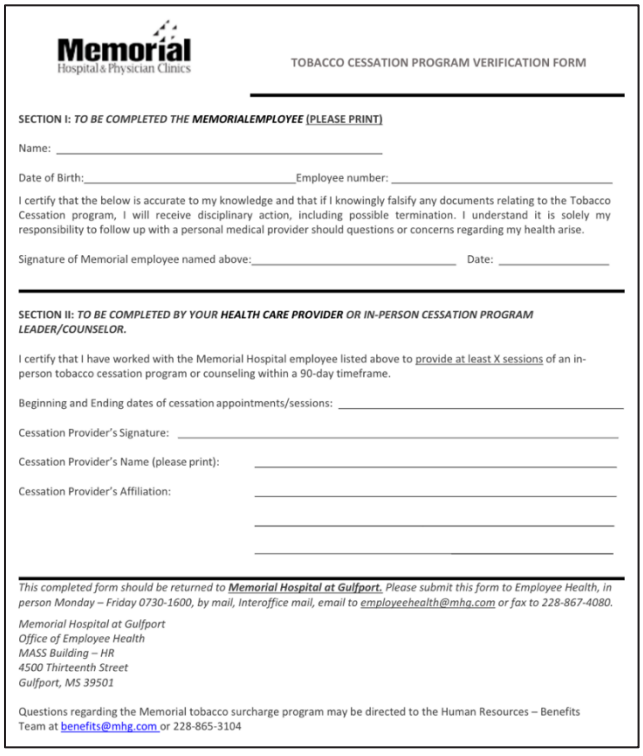
INFORMATION ABOUT YOU AND YOUR COVERED ADULT DEPENDENTS

☐ I certify that the Tobacco Surcharge does not apply to me because either:

- There are **no adult tobacco-users** covered on my medical plan who currently use or have used any tobacco products in past 90 days or
- **All adult tobacco-users have enrolled in Memorial tobacco cessation program within past 90 days.** I understand that I may be asked to provide the certificate(s) of completion.

☐ There is **one adult tobacco-user** covered on my medical plan who currently uses or has used tobacco products within the past 90 days. I understand that as a result, I will be subject to the 15% Tobacco Surcharge.

☐ **I am not enrolling in Memorial Health medical plans for 2022** and therefore, the Tobacco Surcharge doesnot apply to me.



Memorial Hospital & Physician Clinics

TOBACCO CESSATION PROGRAM VERIFICATION FORM

SECTION I: ***TO BE COMPLETED THE MEMORIALEMPLOYEE*** **(PLEASE PRINT)**

Name: _____

Date of Birth:_____Employee number: _____

I certify that the below is accurate to my knowledge and that if I knowingly falsify any documents relating to the Tobacco Cessation program, I will receive disciplinary action, including possible termination. I understand it is solely my responsibility to follow up with a personal medical provider should questions or concerns regarding my health arise.

Signature of Memorial employee named above:_____ Date: _____

SECTION II: ***TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER OR IN-PERSON CESSATION PROGRAM LEADER/COUNSELOR.***

I certify that I have worked with the Memorial Hospital employee listed above to provide at least X sessions of an in-person tobacco cessation program or counseling within a 90-day timeframe.

Beginning and Ending dates of cessation appointments/sessions: _____

Cessation Provider's Signature: _____

Cessation Provider's Name (please print): _____

Cessation Provider's Affiliation: _____

_____

_____

This completed form should be returned to ***Memorial Hospital at Gulfport.*** *Please submit this form to Employee Health, in person Monday – Friday 0730-1600, by mail, Interoffice mail, email to employeehealth@mhg.com or fax to 228-867-4080.*

Memorial Hospital at Gulfport
Office of Employee Health
MASS Building – HR
4500 Thirteenth Street
Gulfport, MS 39501

Questions regarding the Memorial tobacco surcharge program may be directed to the Human Resources – Benefits Team at benefits@mhg.com or 228-865-3104

Medical Plan

Medical benefits are provided through Select Administrative Services (SAS). Consider the physician networks, premiums and out-of-pocket costs for each plan. Keep in mind your choice is effective for the entire plan year, unless you have a qualifying life event.

Medical Premiums

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your per 24 pay periods contributions.

PER 24 PAY PERIODS CONTRIBUTIONS

CONTRIBUTIONS FOR NON-SMOKER AND NON-TABACCO USER

	ACCESS PLAN		HDHP PLAN	
	You Pay	MHG Pays	You Pay	MHG Pays
EMPLOYEE	$49.50	$408.00	$15.50	$442.00
EMPLOYEE + SPOUSE	$247.50	$695.00	$177.50	$765.00
EMPLOYEE + CHILD(REN)	$137.50	$581.50	$84.00	$635.00
FAMILY	$325.00	$942.00	$231.00	$1,036.00

CONTRIBUTIONS FOR SMOKER AND TOBACCO USER

	ACCESS PLAN		HDHP PLAN	
	You Pay	MHG Pays	You Pay	MHG Pays
EMPLOYEE	$56.93	$400.58	$17.83	$439.68
EMPLOYEE + SPOUSE	$284.63	$657.88	$204.13	$738.38
EMPLOYEE + CHILD(REN)	$158.13	$560.88	$96.60	$622.40
FAMILY	$373.75	$893.25	$265.65	$1,001.35

How to Find a Provider

Visit https://sas.vbagateway.com or call Customer Care at 228-865-0514 or 800-847-6621 for a current list of Select Administrative Services (SAS) network providers.

Medical Plan – Summary

This chart summarizes the medical coverage provided by Select Administrative Services (SAS). All covered services are subject to medical necessity as determined by the plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations. Please see MHG Access and HDHP Plan Summary of Benefits for a full benefit schedule.

	MHG ACCESS PLAN		MHG HDHP PLAN	
	TIER 1 (IN-NETWORK)	TIER 2 (OUT-OF- NETWORK)	TIER 1 (IN-NETWORK)	TIER 2 (OUT-OF- NETWORK)
DEDUCTIBLE				
INDIVIDUAL	$0/person	$3,000/person	$2,000/person	$5,000/person
FAMILY	$0/family	$3,000/family	$4,000/family	$10,000/family
CALENDAR YEAR OUT-OF-POCKET MAXIMUM				
INDIVIDUAL	$7,350/person	Unlimited	$4,500/person	Unlimited
FAMILY	$14,700/family	Unlimited	$9,000/family	Unlimited
PHYSICIAN AND ALLIED HEALTH PROVIDER SERVICES				
PREVENTIVE CARE	No Copay	50% Coinsurance	0% Coinsurance	50% Coinsurance
PRIMARY CARE	$20 Copay	50% Coinsurance	20% Coinsurance*	50% Coinsurance
SPECIALIST SERVICES	$50 Copay	50% Coinsurance	20% Coinsurance	50% Coinsurance
MEMORIAL WALK-IN CLINIC	$20 Copay	50% Coinsurance	20% Coinsurance	50% Coinsurance
URGENT CARE	N/A	$75 Copay	20% Coinsurance	50% Coinsurance
MRI, CT, PET & ULTRASOUND	$150 Copay (not per test)	50% Coinsurance	20% Coinsurance	50% Coinsurance
SURGICAL PROCEDURES IN THE OFFICE	30% Coinsurance	50% Coinsurance	20% Coinsurance	50% Coinsurance
LAB & X-RAY SERVICES				
LAB, X-RAY, AND MAMMOGRAMS	No Copay	50% Coinsurance	20% Coinsurance	50% Coinsurance
FACILITY SERVICES				
INPATIENT FACILITY SERVICES	$700 Copay	50% Coinsurance	20% Coinsurance	50% Coinsurance
PHYSICIAN SERVICES FOR OBSTETRICAL CARE (Includes most prenatal, delivery, and postpartum)	$350 Copay			
AMBULATORY/OP SURGERY	$350 Copay			
EMERGENCY SERVICES				
EMERGENCY DEPARTMENT VISIT	$200 Copay	50% Coinsurance	20% Coinsurance	50% Coinsurance
EMERGENCY MINOR CARE VISIT	$100 Copay			
AMBULANCE, LAND OR AIR	$200 Copay			
BEHAVIORAL HEALTH SERVICES/CHEMICAL DEPENDENCY				
INPATIENT FACILITY SERVICES	$700 Copay	50% Coinsurance	20% Coinsurance	50% Coinsurance
OUTPATIENT FACILITY VISITS	$20 Copay			
REHABILITATION SERVICES				
PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY	$20 Copay	50% Coinsurance	20% Coinsurance	50% Coinsurance
CARDIAC REHABILITATION SERVICES (Max 36 sessions within 12 consecutive months)	$20 Copay			

*After Deductible

Generally, you must pay all the costs from out-of-network providers up to the deductible amount before this plan begins to pay if you elect to choose out-of-network providers. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

Our Plans Are Self-Funded

Our medical, dental and pharmacy plans are self-funded, which means that Memorial bears the financial risk of the plan. Rather than paying insurance premiums to an insurance carrier as with fully insured plans, Memorial pays fixed costs for using the insurance carrier's network of physicians and variable costs for the members' claims. Self-insured plans allow for more control and freedom in plan design. Together, Memorial and employees share the cost for healthcare.

Medical Plan – (NEW) High Deductible Health Plan (HDHP)

Getting to Know the HDHP

If you have never used a High Deductible Health Plan (HDHP) before, it may appear out of your comfort zone. Unfortunately, people often see a higher deductible than an Access Medical Plan and stick with what's familiar instead of exploring a new option.

When you elect the HDHP, you also have the option to sign up for the Health Savings Account (HSA) that boasts many benefits. Now that it's time to make your elections for 2022 benefits, take a moment to understand why the HDHP could keep more money in your pocket while providing the same amount of coverage as you could receive in a different type of medical plan.

Back to Basics

An HDHP is designed primarily for people who are relatively healthy and don't make many trips to the doctor's office besides basic preventive check-ups. Despite its main function, the plan can help others benefit from it as well. Those who choose this type of plan will pay less out of every paycheck than for the Access Medical Plan.

Because of these lower premiums (the amount you pay out of every paycheck) the deductible (the amount you need to pay until the insurance begins to kick in) is higher than a plan you may have had in the past. However, with the help of a Health Savings Account (HSA), you can use the contributions that you make to pay for the higher out-of-pocket costs along the way.

HSA

Here is how the HSA plan works. You have the option of contributing to your HSA with payroll deductions. This allows you to contribute before taxes are deducted - which decreases your taxable income. When a medical expense pops up and you haven't hit your deductible yet, you will need to pay for those costs out-of-pocket, or you can use the money in your HSA to help pay for them.

At the end of the year, if you haven't used all the money in your HSA, no problem! The amount carries over year to year so there is no pressure to use it. If you are healthy and do not tap into your HSA funds, you can use your HSA to cover the full costs of your future deductibles or invest the money once you hit a certain balance. You can even take your account with you if you leave Memorial.

"What if I get sick and end up with a lot of medical bills?"

The HDHP protects you if you end up having more medical bills than you expected. Once you meet the plan's annual deductible, you and the plan will begin sharing the costs through what's called "coinsurance." This means the plan pays most of the cost and you pay the remainder. Plus, there's a built-in annual out-of-pocket maximum, which is the most money you'd be responsible for paying each year. If you hit the annual out-of-pocket maximum amount, the plan will cover all costs for the remainder of that year for eligible expenses.

And now we're back to the looming question: Is this plan my best option? Every individual and family is different, but if you would characterize yourself (and/or your covered family members) as relatively healthy and you only go to the doctor for your yearly check-up, the HDHP with an HSA could help cater to you. Read on for more details.

Why the HDHP?

A High Deductible Health Plan takes you out of the passenger's seat and into the driver's seat when it comes to your health care spending. Instead of paying a higher monthly premium, a smaller amount will be taken out of every paycheck so you will mainly pay for the services you need. Although you must meet the higher deductible before the plan starts paying, with the help of the Health Savings Account (HSA), you will be able to use pre-tax dollars in the case of an emergency or to pay a deductible.

Cut Costs with the HDHP

Now that you're in the driver's seat, here's how to make all the right turns to save.

1. **Protect yourself with preventive care.** Fend off serious medical conditions—before they require expensive treatment—with preventive care. Preventive care is covered at 100% when you see an in-network provider. This means that services such as annual physical exams, immunizations, and screenings are provided at no cost (no copay, no coinsura**nce, no need to meet the plan deductible).**
2. **Make sure your doctor is in-network.** Before you get care, verify that your health care provider is in-network. You pay less when you go to an in-network provider because you pay negotiated rates.
3. **Ask your doctor about generics.** If you take a brand-name drug, you know how expensive it can be. Ask your doctor about switching to a generic. Generic drugs meet the same FDA standards for quality, strength, and purity as their brand-name counterparts, at a fraction of the cost.

Medical Plan – (NEW) High Deductible Health Plan (HDHP)

Highlights of an HDHP

- You can use any doctor or hospital, but you'll pay less when you use in-network providers.
- In-network preventive care is covered at 100% (you don't have to pay anything).
- Once you reach the out-of-pocket maximum, the plan pays 80% of eligible expenses for the rest of the year.
- The plan comes with a Health Savings Account (HSA) to help pay for eligible expenses and your annual deductible if you choose to use it.

Paying for Care

What to expect when you visit your health care provider:

1	2	3	4	5
See an in-network doctor.	Ask your healthcare provider to file a claim with your medical plan.	Your medical plan tracks your deductible **OR** pays a percentage if you've met the annual deductible.	Your health care provider bills you for services not covered by your medical plan.	You can pay the bill out-of-pocket or use your HSA balance.

If your visit is for preventive care, remind your health care provider to code the visit correctly so that you're not charged for care.

What to expect when you pay for prescriptions:

You can fill your prescriptions at a pharmacy or by mail-order. Here's what you can expect when you fill a prescription at a pharmacy:

1	2	3
Present your ID card to the pharmacist.	If you haven't met the annual deductible, you pay full price for prescription drugs. If you've met the annual deductible, you'll pay a copay or coinsurance.	You can pay for your prescription drug out-of-pocket or use your HSA balance.

Let's Recap

Three main parts to the HDHP:

1. Annual Deductible: Amount you pay before the medical plan pays a share of your medical and prescription expenses.
2. HSA: An account to which you contribute pre-tax earnings to help you pay for eligible expenses to meet your deductible (if you wish to use it).
3. Annual out-of-pocket maximum: Your annual safety net. If an unexpected expense arises, or you just end up spending more, out-of-pocket maximum is the most that you will have to pay before the plan pays for 100% of all eligible expenses for the remainder of the year.

Medical Plan – NEW High Deductible Health Plan (HDHP) – Health Saving Account (HSA)

Health Savings Account

If you enroll in the High Deductible Plan (HDHP), you will also be eligible for the Health Savings Account (HSA). You can think of your HSA as a personal savings account for your health care expenses, with some impressive tax advantages.

Start Here

Your Tax-Free Contribution
You can contribute funds from your paycheck before taxes are taken out up to the yearly maximum contribution amount.

Savings for the Future
You can also save your funds for the future and allow them to earn interest.

Pay Expenses
You can use your HSA to pay for eligible expenses on a tax-free basis.

For example:
- Copays Deductibles
- Prescriptions
- Dental and Vision expenses

HOW MUCH CAN YOU CONTRIBUTE?	2022 IRS CONTRIBUTION LIMIT	YOUR MAXIMUM CONTRIBUTION AMOUNT
Employee Only	$3,650	$3,360
Family Coverage	$7,300	$7,300

Let's break it down

- ☑ You can add funds into the HSA that are not subject to federal income taxes up to the IRS limits.
- ☑ The HSA allows you to pay for qualified medical expenses with these tax-free funds.
- ☑ The account can earn interest on a tax-free basis, and you can roll funds over year after year.
- ☑ If you leave Memorial, you can take your HSA with you.

Medical Plan – Pharmacy Benefits

Prescription Drug Coverage for Medical Plan

Our Prescription Drug Program is coordinated through Memorial Outpatient Pharmacy & Express Scripts. That means you will only have one ID card for both medical care and prescriptions. Information on your benefits coverage and a list of network pharmacies is available online at https://sas.vbagateway.com or by calling the Customer Care number on your ID Card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Preferred, Non-Preferred or Specialty Drugs.

	MEMORIAL OUTPATIENT PHARMACY	MHG ACCESS PLAN EXPRESS SCRIPTS	MEMORIAL HDHP OUTPATIENT PHARMACY	MHG HDHP PLAN EXPRESS SCRIPTS
RETAIL PRESCRIPTION (30-DAY SUPPLY)				
GENERIC	$5 Copay	$50 Copay	$5 Copay	$50 Copay*
PREFERRED	$20 Copay	$75 Copay	$20 Copay	$75 Copay*
NON-PREFERRED	$50 Copay	$125 Copay	$50 Copay	$125 Copay*
SPECIALTY DRUGS	$75 Copay	20% Coinsurance up to a maximum of $350 at Accredo Specialty Pharmacy if not available at Memorial outpatient Pharmacy	$75 Copay	20% Coinsurance up to a maximum of $350*
RETAIL PRESCRIPTION (60-DAY SUPPLY)				
GENERIC	$10 Copay	N/A	$10 Copay	N/A
PREFERRED	$40 Copay	N/A	$40 Copay	N/A
NON-PREFERRED	$100 Copay	N/A	$100 Copay	N/A
SPECIALTY DRUGS	N/A	N/A	N/A	N/A
RETAIL PRESCRIPTION (90-DAY SUPPLY)				
GENERIC	$10 Copay	$100 Copay	$10 Copay	$100 Copay*
PREFERRED	$60 Copay	$150 Copay	$60 Copay	$150 Copay*
NON-PREFERRED	$150 Copay	$250 Copay	$150 Copay	$250 Copay*
SPECIALTY DRUGS	N/A	N/A	N/A	N/A

*After deductible

Specialty Drugs must be filled at Memorial Outpatient Pharmacy. If a specialty drug is not available as determined by Memorial Outpatient Pharmacy and must be filled at Accredo Specialty Pharmacy, a copay of 20% up to $350 will apply.

Generic Drugs

Looking to save money on medication costs? You've most likely heard that generic prescription drugs are a more affordable option, so here's the skinny: Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety and strength. Because they are the same medicine, generic drugs are just as effective as brand-name drugs and undergo the same rigid FDA standards. But on average, **a generic version costs 80% to 85% less than the brand-name equivalent.** To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

Medical Plan – Helpful Information

Rising Costs of Healthcare

The cost of healthcare in the U.S. has been steadily growing each year. Why? Some of the factors include an aging population, increased demand for care (resulting in higher prices for premiums and prescription drugs) and an increase in chronic illnesses. **Memorial wants to help keep you healthy, so we do what we can to keep your healthcare costs reasonable.** Make sure you're informed about your options so you can make the best healthcare choices for you and your family. Placing an importance on preventive care, making healthy choices, and managing costs will help keep your health — and wallet — in control in the long run.

Out-of-Network Services

If you and/or your eligible dependents receive services by out- of-network providers, you may be responsible for additional costs. SAS reimburses out-of-network providers at the SAS Fee Schedule, which may be less than the amount charged by the out-of-network provider. Any amounts over the SAS Fee Schedule are the responsibility of the member and DO NOT count toward the CY Out-of-Pocket Maximums. SAS will reimburse the provider up to the SAS Fee Schedule and this amount will be used to calculate deductible and coinsurance amounts. The member must pay their deductible, coinsurance and any balance over the SAS reimbursement. If you have any questions concerning this policy, please contact SAS prior to receiving your services.

Fee-Schedule Pricing

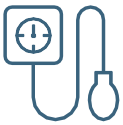
With all the different providers out there, pricing for medical services can vary greatly. Your cost can depend on your deductible, copay and coinsurance. With fee-schedule pricing, services are covered up to a fee-schedule cost. Under the Memorial Hospital medical plan, all MRI/CT/PET Scans will be subject to the copay amount if you use an in-network provider. All out-of-network services will be subject to the deductible and coinsurance amounts as determined by Select Administrative Services (SAS). This means you may be responsible for your portion of the copay and/or coinsurance along with any amounts over the fee-schedule cost. To confirm that you do not have any additional out-of-pocket costs, call 228-865-0514 or 800-847-6621 or research provider pricing online at https://sas.vbagateway.com.

Medical Plan – Preventive Care

Most health plans are required to cover a set of preventive services—at no cost to you!

Screening tests and routine checkups are considered preventive, which means they're often paid at 100%. Keep up to date with your primary care physician to save time and money and keep yourself healthier in the long run. Under the U.S. Patient Protection and Affordable Care Act (PPACA), some common covered services include:

Wellness visits, physicals and standard immunizations



Screenings for blood pressure, cancer, cholesterol, depression, obesity and diabetes

Pediatric screenings for hearing, vision, obesity and developmental disorders

Anemia screenings, breastfeeding support and pumps for pregnant and nursing women

Iron supplements (for children ages 6 to 12 months at risk for anemia)

Take advantage of these covered services. However, remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. This means if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

Medical Plan – Vigilant Health Center (Onsite Clinic)

Memorial Vigilant Health Center

We are pleased to introduce the Memorial Vigilant Health Center for Memorial Medical Plan (SAS) employee members! Any employee, spouse or dependent children are eligible to attain care for the clinic if enrolled in the SAS Access Medical Plan. The Center is an enhanced service that will work in conjunction with Employee Health Services and your physician to help you navigate and best utilize the healthcare system. Its programs are designed to eliminate barriers to care, identify medical needs and chronic conditions, and improve access to care. As a result, it will help you better achieve your health and wellness goals, while lowering our healthcare costs.

Communication between employees and providers is completely confidential and will not be shared with your employer. The Center is staffed by a Nurse Practitioner Navigator, Nurse Practitioner, LPN, Care Manager, Health Coach, and Employee Health Services.

Some of the services The Center offer include:

CHRONIC CONDITION MANAGEMENT
» Management and personalized care of diseases, such as diabetes, high cholesterol, hypertension, and others **» Individualized exercise, medication, and lifestyle education and management programs** **» Collaboration with providers and specialists on plans of care and care monitoring**
ACUTE CARE
» Treatment for conditions, such as sprains and strains; rashes and skin infections; allergies and asthma; colds, flu and sore throat; and digestive illness **» A Nurse Practitioner Navigator to answer your questions about your coverage, diagnosed conditions, or physician or ancillary service referrals**
WELLNESS/PREVENTION
» Health Risk Assessments **» Health education programs** **» Personalized health coach consults** **» Patient portal to manage health and wellness metrics that meet "Healthy You" program goals** **» Body Mass Index, Ale, and fingerstick glucose screening** **» Yearly physicals**
SMOKING CESSATION PROGRAM
» Our Memorial Vigilant Health Center qualified treatment specialist(s) utilize the ACT Center Tobacco Treatment Program for all who voluntarily enroll. This program is used to help people quit using tobacco and stay tobacco free using a proven, evidenced-base approach.

There are three ways to schedule an appointment:

Online: **https://gulfportmemorial.as.me**
Email: **gpmem.clinic@vigilant-health.com**
Phone: **228-575-1900**
Hours of operation: **Monday through Friday from 7:30 a.m. to 4:00 p.m.**

Vigilant Health Center - Tobacco Cessation

The purpose of the Smoking Cessation Program is to provide Memorial employees and family members with the tools necessary to be permanently tobacco/nicotine free.

Our goals are:

1. To have the organization 90% tobacco free by **2025**
2. To empower employees and family members to become healthier
3. To decrease the number of tobacco related illnesses organization wide
4. To decrease the number of tobacco related insurance claims
5. To decrease the amount of lost work time due to tobacco related illness

Our Memorial Vigilant Health Center Qualified treatment specialist(s) will utilize the ACT Center Tobacco Treatment Program for all who voluntarily enroll.

The ACT Center Tobacco Treatment (ACTT) Program is used to help people quit using tobacco and stay tobacco free using a proven, evidence-based approach. The treatment program utilizes a multi-faceted approach to guide tobacco cessation practices, including the Centers for Disease Control and Prevention's (CDC) Best Practices for ***Comprehensive Tobacco Control Programs***, and the Public Health Service (PHS) Guideline, ***Treating Tobacco Use and Dependence***. The program specialist(s) will have consistency in content but will individualize the method of delivery and program duration based upon the enrolled member's need.

Treatment involves:

1 Initial Session, to gather key information about the smoker, determine if this is the best program for them, and give them the opportunity to ask questions

6 Treatment Sessions, to provide counseling to assist in the development of skills to overcome obstacles to nicotine cessation, and to provide medications, when appropriate, to assist the employee to permanently abstain from the use of all nicotine products

Follow-up Sessions, to increase chances of staying nicotine free permanently

Medical Plan – WHERE TO GO FOR CARE

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

PRIMARY CARE PROVIDER

When would I use this?

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

What type of care would they provide?*

- Routine checkups
- Immunizations
- Preventative services
- Manage your general health

What are the costs and time considerations? **

- Requires copay
- Normally requires an appointment
- Usually little wait time with scheduled appointments

MEMORIAL VIGILANT HEALTH CENTER

Who can use this?

Employees, spouses and children ages 14 and over who are enrolled in the SAS Medical Plan are eligible to use the Memorial Vigilant Health Center

When would I use this?

You need routine or immediate care and are unable to see your primary care doctor

What type of care would they provide?*

Answers to questions regarding:

- Sprains/Strains
- Rashes/Allergies/Asthma
- Colds/Flu/Sore Throat
- Health Risk
- Assessments/Personalized
- Health Coach Consultant

What are the costs and time considerations? **

- Clinic is available 7:30 AM – 4:00 PM M-F
- This service is at no cost to you, your spouse, or dependent child(ren) as a part of your medical insurance

MEMORIAL WALK-IN CLINICS

When would I use this?

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

What are the costs and time considerations? **

- Requires copay
- Walk-in patients are welcome but waiting periods may be longer as patients with more urgent needs will be treated first.

What type of care would they provide?*

- Sprains/Strains
- Minor broken bones (e.g. finger)
- Minor burns
- X-rays

EMERGENCY ROOM

When would I use this?

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

What type of care would they provide?*

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

What are the cost and time considerations? **

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

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

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

Dental Plans

Brushing your teeth and flossing are great, but don't forget to visit the dentist too! Memorial Hospital offers affordable plan options for routine care and beyond. Coverage is available from Select Administrative Services.

Preferred Provider Dentists

If you use a dentist who is not a preferred provider, your out- of-pocket costs are subject to change beyond the fee schedule. To find a dentist on the Preferred Provider list, visit Select Administrative Services at https://sas.vbagateway.com.

Dental Premiums

Premium contributions for dental are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your per 24 pay periods premium.

Dental Plan Summary

This chart summarizes the dental coverage provided by Select Administrative Services.

	PLAN 1 DENTAL $500	PLAN 2 DENTAL $1,000	PLAN 3 DENTAL $2,000	PLAN 2 ADD'L $1,000 PRE-TAX**	PLAN 3 ADD'L $1,000 PRE-TAX**
PER 24 PAY PERIODS CONTRIBUTIONS					
EMPLOYEE ONLY	$4.60	$8.85	$11.60	$50.50	$53.25
EMPLOYEE + SPOUSE	$9.45	$18.10	$23.75	$59.75	$65.40
EMPLOYEE + CHILD(REN)	$9.85	$18.90	$24.75	$60.55	$66.40
EMPLOYEE + FAMILY	$15.95	$30.55	$40.05	$72.20	$81.70
DEDUCTIBLE					
INDIVIDUAL	$50/person	$50/person	$50/person	$50/person	$50/person
FAMILY	$150/family	$150/family	$150/family	$150/family	$150/family
MAXIMUM					
PER PERSON	$500	$1,000	$2,000	$1,000	$2,000
COVERED SERVICES					
PREVENTIVE SERVICES Oral Exams, Routine Cleanings, Bitewing X-rays, Fluoride Applications, Sealants, Space Maintainers, Panoramic X-rays	$0	$0	$0	$0	$0
BASIC SERVICES Full Mouth X-rays, Fillings, Oral Surgery, Simple Extractions	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*	20% Coinsurance*
MAJOR SERVICES Oral Surgery, Complex Extractions, Denture Adjustments and Repairs, Root Canal Therapy, Periodontics, Crowns, Dentures, Bridges	Not Covered	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*
ORTHODONTICS Dependent Child(ren) Only	Not Covered	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*	50% Coinsurance*
ORTHODONTIC LIFETIME MAXIMUM	Not Available	$1,000/person per lifetime	$2,000/person per lifetime	$1,000/per person per lifetime**	$2,000/per person per lifetime**

*After Deductible

**NOTE: The additional $1,000 Family Orthodontic plan is a pretax premium benefit AND should ONLY be elected if there is a covered member who has or will soon exhaust the individual Orthodontic Lifetime benefit under the Dental $1,000 or $2,000 plan. The additional $1,000 is completely PAID BY YOU as a premium for the pre-tax advantage and is non-refundable if not used within the plan year for which the premium is paid.

Vision Plans

Don't wear glasses? Even you shouldn't skip an annual eye exam! Memorial Hospital provides you and your family access to quality vision care with a comprehensive vision benefit through AlwaysCare.

Vision Premiums

Premium contributions for vision are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your per 24 pay periods premium.

PER 24 PAY PERIODS CONTRIBUTIONS	
EMPLOYEE ONLY	$3.07
EMPLOYEE + SPOUSE	$6.04
EMPLOYEE + CHILD(REN)	$6.13
EMPLOYEE + FAMILY	$9.36

Vision Plan Summary

This chart summarizes the vision coverage provided by AlwaysCare.

	ALL PARTICIPATING PROVIDERS	OUT-OF-NETWORK ALLOWANCE	FREQUENCY
EXAMS			
COPAY	$10 Copay	Up to $50	Once every 12 months
MATERIALS			
COPAY	$10 Copay		Once every 12 months
LENSES			
SINGLE VISION	Covered by Copay	Up to $50	Once every 12 months
BIFOCAL	Covered by Copay	Up to $70	
TRIFOCAL	Covered by Copay	Up to $85	
LENTICULAR	Covered by Copay	Up to $125	
PROGRESSIVE	$70 Allowance		
FRAMES			
ALLOWANCE	$130 allowance ($94 at Walmart, Sam's Club and Costco*)	Up to $63	Once every 12 months
CONTACTS (IN LIEU OF LENSES AND FRAMES - INCLUDES FIT, FOLLOW-UP, AND MATERIALS)**			
COPAY	$10 Copay		Once every 12 months
ELECTIVE	Up to $150 allowance	Up to $150	
MEDICALLY NECESSARY	Covered in full	Up to $210	

Special payment and reimbursement terms apply for material purchases at Costco.
****Some providers, such as Walmart, may charge for a contact lens fit and evaluation separately from your contact lens allowance, leaving the entire allowance for materials.**

Thoughts & Tips:

More than 150 million Americans use corrective eyewear to compensate for refractive errors.

Flexible Spending Account (FSA) **Healthcare**

Healthcare Flexible Spending Accounts

Healthcare Flexible Spending Accounts offer employees the opportunity to use pre-tax dollars to reimburse employees for medical and dental care not reimbursed or reimbursable by any other plan. These expenses must be for "medical care" as described in Code 213 (d)(1). (Ref: www.irs.gov)

Once you have elected to participate, it stays in effect for 12 months (Plan Year) or from the time of your effective date to year end and cannot be changed except under certain events allowed by the IRS. Employee Contributions are deducted by 26 pay checks per year.

For medical expenses to be reimburse the following must be met:

» The expense must be for medical care incurred by the employee, spouse or dependent. The expense must have been incurred in the Plan Year.

» The employee cannot be reimbursed for expenses for which he or she claims a tax deduction.

» The full amount of your election is available any time during the Plan Year.

» Your election will have loaded on the Benny Prepaid Benefit Card. You can use the Benny Card to pay for qualified medical expenses not covered by your health insurance. The Benny Card automatically deducts the cost of your eligible expenses from your FSA.

» A manual claim may still be submitted with the properly signed claim form with receipts from a provider showing the date of service and the description of service. (e.g. EOBs, hospital or doctor bills, pharmacy receipts. Canceled checks are not permitted.)

» You have 90 days after the end of the Plan Year to request reimbursement of manual claims. Health FSA participants are subject to the use-it-or-lose-it rule. Contributions made to the Plan Year that are not used during the one plan year cannot be carried over to the next plan year and cannot be returned.

» IRS Publication No 502 can be used as a guide as to what expenses can be reimbursed. This must be used with caution, as to some statements do not apply to Health FSA. (e.g. insurance premiums are not reimbursable under a Health FSA.)

Warning:

1. FSA (BENNY CARD) funds can no longer be used to purchase OTC medicine and drugs unless a medicine or drug is prescribed. A "prescription" means a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in the at state.

The OTC items affected include items in the following categories:

» Acid controllers
» Allergy & sinus anti-fungal/ itch
» Antibiotic product
» Anti-diarrhea
» Anti-gas
» Baby rash ointments/ creams
» Cold sore remedies
» Cough, cold & flu
» Digestive aids
» Feminine
» Motion sickness
» Pain relief
» Respiratory treatments
» Sleep aids & sedatives
» Stomach remedies

2. If you have a prescription for an OTC medicine or drug, you must pay out of pocket at point of sale and then submit a manual claim requesting reimbursement. You cannot use your Benny™ Prepaid Benefits Card for this purchase.
3. You can continue to use your FSA funds to purchase OTC items that are not considered a medicine or drug (e.g. bandages, splints, contact lens solution, etc.) Please note that insulin remains an eligible expense with or without

   a prescription. So, your Benny Prepaid Benefits Card can continue to be used for these purchases.
4. Remember to consider these new OTC rules when estimating the dollar amount to put in your FSA account for the next plan year.

If you have questions or need more information, please contact Select Administrative Services at (228) 865-0514, ext 563.

Flexible Spending Account (FSA) **Dependent Care**

Dependent Care Flexible Spending Accounts

Dependent Care Flexible Spending Accounts offer employees the opportunity to use pretax dollars to be reimbursed for day care expenses of their children (under the age 13 years) or dependent adults while the employee and spouse are "gainfully employed." Employee Contributions are deducted by 26 pay checks per year.

Once you have elected to participate it stays in effect for 12 months (Plan Year) and cannot be changed except under certain events allowed by the IRS.

» Dependent care flexible spending account will affect the calculations of your Dependent Care Tax Credit.

» A claim must be submitted with the properly signed claim form with receipts from the provider showing name, address, tax id number and dates of service. The expenses must have been incurred in the Plan Year.

» You have 90 days after the end of the Plan Year to request reimbursement. Dependent Care FSA participants are subject to the use-it-or-lose-it rule. Contributions made to the Plan Year that are not used during the one plan year cannot be carried over and cannot be reimbursed.

(NEW) Changes to Carry-Over Rule for FSAs

Changes made to the Flexible Spending Account (FSA) rules at the end of December now allow for the carry-over of funds from one calendar year to the next.

Any unused funds from CY 2020 will be carried over to CY 2021. This will apply to both Medical FSAs and Dependent Care FSAs. These dollars can be used in two ways;

1. To pay for expenses incurred in 2020, but submitted for reimbursement in 2021

2. To pay for expenses incurred in CY 2021

SAS, our partner in administering the FSA program, will process claims utilizing any 2020 plan funds first. The debit card is setup to function in the same manner, utilizing any 2020 plan funds first.

At the end of the year, any unused funds contributed in 2021 will then be carried over into 2022.

If you have any questions, you can call SAS directly at 1-800-847-6621.

Health Savings Account (HSA)

Need funds to help cover out-of-pocket healthcare expenses? Consider a Health Savings Account (HSA). **An HSA is a personal healthcare bank account used to pay for qualified medical expenses and funded by you, and in some cases your employer too.** HSA contributions and withdrawals for qualified healthcare expenses are tax free. You must be enrolled in a HDHP to participate.

Your HSA can be used for qualified expenses for you, your spouse and/or tax dependent(s), even if they are not covered by your plan. If you are not currently enrolled in an HDHP but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

HSA Bank will issue you a debit card, giving you direct access to your account balance. Use your debit card to pay for qualified medical expenses, with no need to submit receipts for reimbursement. You must have a balance in your HSA account to use the card.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, over-the-counter medications and more. Check out IRS Publication 502 on www.irs.gov for a complete list of eligible expenses.

Eligibility

You are eligible to contribute to an HSA if:

» You are enrolled in an HSA-eligible High Deductible Health Plan.
» You are not covered by your Spouse's non-HDHP health plan.
» Your Spouse does not have a healthcare Flexible Spending Account or Health Reimbursement Account.
» You are not eligible to be claimed as a dependent on someone else's tax return.
» You are not enrolled in Medicare or TRICARE.
» You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

How to Enroll

To enroll in the company-sponsored HSA, you must elect the HDHP with Memorial. Complete all HSA enrollment materials and designate the amount to contribute on a pre-tax basis. Memorial will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

Thoughts & Tips:
It's up to you how much to contribute to your HSA. Buying a new car, new house or sending a kid to college? You can contribute less this year. Paid off your student loans or got a new job? Stash the annual max in your account.

Your Money. Your Account.

Your HSA is a personal bank account that you own and administer. It's up to you how much you contribute, when to use the money for medical services, and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year-over-year to use in retirement. HSA funds are also portable if you change jobs. There are no vesting requirements or forfeiture provisions.

Plan. Spend. Save.

Contributions to an HSA can be made through payroll deduction on a pre-tax basis when you open an account with HSA Bank. **The money in this account (including interest and investment earnings) grows tax free.** When the funds are used for qualified medical expenses, they are spent tax free.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2022, contributions are limited to the following:

HSA FUNDING LIMITS	
EMPLOYEE	$ 3,650.00
FAMILY	$ 7,300.00
CATCH-UP CONTRIBUTION (AGES 55+)	$ 1,000.00

HSA contributions in excess of the IRS annual contribution limits ($3,650 for individual coverage and $7,300 for family coverage for 2022) are not tax deductible and are generally subject to a 6% excise tax.

The Memorial HSA is established with HSA Bank. You may be able to roll over funds from another HSA. For more enrollment information, contact Human Resources or visit www.hsabank.com.

FSA vs. HSA

Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs) are both ways to save pre-tax money to pay for your eligible healthcare costs. Which one is right for you?

	FSA	HSA
OWNERSHIP	Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.	You own your HSA. It is a savings account in your name and you always have access to the funds, even if you change jobs.
ELIGIBILITY & ENROLLMENT	You're eligible for an FSA if it's offered by your employer. You can elect a Healthcare FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You cannot be enrolled in both a Healthcare FSA and an HSA.	1. You must be enrolled in a Qualified High Deductible Health Plan to be eligible to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or eligible for a spouse's FSA or enrolled in Medicare or TRICARE. 2. You can change your contribution at any time during the Plan Year.
TAXATION	Contributions are tax free via payroll deduction. However, the funds spent are not tax free.	For Federal tax purposes, the money in the account is "triple tax free," meaning: 1. Contributions are tax free. 2. The account grows tax free. 3. Funds are spent tax free (if used for qualified expenses).
CONTRIBUTIONS	Both you and your employer can contribute to the account according to IRS limits. The contribution limit for the Healthcare FSA for 2022 is $2,750.	Both you and your employer can contribute to the account according to IRS limits. The contribution limit for 2022 is $3,650 for individuals and $7,300 for families. This amount includes the employer contribution. If you are 55 or older, you may make a "catch-up" contribution of $1,000 per year.
PAYMENT	Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit your receipts for reimbursement.	Many HSAs include a debit card, ATM withdrawal or checkbook to pay for qualified expenses directly. You can also use online bill payment services from the HSA financial bank. You decide when to use the money in your HSA to pay for qualified expenses, or if you want to use another account to pay for services and save the money in your HSA for future expenses or retirement.
ROLL OVER OR GRACE PERIOD	You must use the money in the account by end of the Plan Year; however, a Healthcare FSA may allow up to $500 to roll over to the next year. A Healthcare FSA or Dependent Care FSA may include a 2.5-month grace period after the end of the Plan Year for any extra expenses to be incurred and reimbursed. A plan can have either a rollover or a grace period, but not both. Any unclaimed funds at the end of the run out are lost and returned to your employer.	The money in the account rolls over from year to year. Funds are always yours and may be used for future qualified expenses — even in retirement years.
QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, dental care and vision care. A full listing of eligible expenses is available at www.irs.gov.	Physician services, hospital services, prescriptions, dental care, vision care, Medicare Part D plans, COBRA premiums and long-term care premiums. A full listing of eligible expenses is available at www.irs.gov.
OTHER TYPES	Dependent Care FSA: Allows you to set aside pre-tax dollars for elder or child dependent care and covers expenses such as day care and before- and after-school care.	There is only one type of HSA.

Please refer to your Summary Plan Description or plan certificate for your plan's specific FSA or HSA benefits.

Life Insurance Plans - Term Life

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

Your Basic Life and AD&D insurance benefit is $10,000. **If you are a benefits-eligible status employee, you automatically receive Life and AD&D insurance even if you elect to waive other coverage (Physicians not eligible).**

Voluntary Life and AD&D Insurance

Eligible employees may purchase additional Voluntary Life and AD&D insurance. Premiums are paid through payroll deductions. Note: If you are not a New Hire and at Open Enrollment you want to buy up your Voluntary Life insurance, you will need to go through Evidence of Insurability. Managers and Physicians, please refer to your schedule of benefits.

VOLUNTARY EMPLOYEE LIFE + AD&D	
COVERAGE AMOUNT	$10,000 increments
WHO PAYS	Employee
MAXIMUM BENEFIT	$750,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	3x your annual salary ($300,000 max)
VOLUNTARY SPOUSE LIFE	
COVERAGE AMOUNT	Choice of $5,000, $10,000, $20,000, and $50,000
WHO PAYS	Employee
MAXIMUM BENEFIT	$50,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Choice of $5,000, $10,000, and $20,000
VOLUNTARY CHILD LIFE	
COVERAGE AMOUNT	$10,000 or $20,000
WHO PAYS	Employee
MAXIMUM BENEFIT	$20,000

EMPLOYEE VOLUNTARY LIFE INSURANCE	
PREMIUM RATES/$1,000 (PER 24 PAY PERIODS)	
AGE (AS OF JANUARY 1, 2022)	RATE PER $1,000 OF COVERAGE
0-24	$0.0225
24-29	$0.027
30-34	$0.036
35-39	$0.0405
40-44	$0.045
45-49	$0.585
50-54	$0.086
55-59	$0.153
60-64	$0.2295
65-69	$0.4365
70-74	$0.6975
75-99	$0.6975

VOLUNTARY AD&D INSURANCE
Included in Life

VOLUNTARY SPOUSE LIFE INSURANCE	
PREMIUM RATES – 24 PAY PERIODS	
$5,000	$0.39
$10,000	$0.79
$20,000	$1.56
$50,000	$3.91

VOLUNTARY CHILD LIFE INSURANCE	
PREMIUM RATES – 24 PAY PERIOD PREMIUM	
$10,000	$0.63
$20,000	$1.25

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:					
$	÷ 1,000 =	$	x Age Based Rate =	$	
Benefit Elected				Monthly Premium	

Life Insurance Plans – Universal Life

Transamerica Life Insurance Company

Life Insurance and "Living Benefit" in One Policy

» Can cover spouse and children
  - Employee – can apply for $10,000 – $500,000
  - Spouse – can apply for $10,000 – $100,000
  - Children – can apply for $20,000

» Can only enroll during annual open enrollment – new hires can enroll when first eligible

» All employees benefit eligible can enroll

» Guaranteed Issue – Cannot be turned down as long as you are actively at work and not disabled

» Can have this policy in addition to group term or other life insurance coverage

» Portable – can keep at same cost if you retire or change jobs

» Builds cash value – cash value earns current interest rate on tax sheltered basis

» Can raise or lower amount of insurance as your needs change – within certain guidelines

» Can borrow or make withdrawals from cash value

Loans, withdrawals and death benefit accelerations will reduce the policy value and the death benefit and may increase lapse risk. Policy loans are tax free provided the policy remains in force. If the policy is surrendered or lapses, the amount of the policy loan will be considered a distribution from the policy and will be taxable to the extent that such loan plus other distributions at that time exceed the policy basis.

This is a brief summary of TransElite® Universal Life Insurance underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa. Policy Form Series CPGUL300 and CCGUL300. Forms and form numbers may vary. This insurance may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.

Employee – can buy 5x annual earnings up to $150,000 on a Guaranteed Issue basis. Amounts above $150,000 require medical questions. Maximum amount is $500,000. Maximum age to buy is 80. Can keep policy to age 100.

Spouse – can get $15,000 on a Guaranteed Issue basis. Amounts above $15,000 require medical questions. Disabled spouses are not eligible. Maximum amount is $100,000. Maximum age for spouse to buy is 65. Can keep policy to age 100.

Children – Employee can elect to add up to a $20,000 child term rider to their policy on each child in the family through age 25 for $2.50 per pay period per $10,000 benefit. This includes ALL children, including stepchildren and adopted children for a cost of $2.50 or $5.00 (depending on benefit level elected). At age 25, this rider may be converted into a $50,000 permanent life policy for the child to keep as long as the premiums continue to be paid.

Living Benefit – If a covered person has a chronic illness that causes memory or reasoning problems or if you are unable to perform at least two activities of daily living for yourself, such as dressing, bathing, eating, toileting, etc. this benefit will pay 4% of your death benefit each month for up to 50 months.

Example: $100,000 face amount x 4% = $4000 per month for 50 months which equals a total payout of $200,000. Premiums are waived while on this benefit. Also, once this benefit has been used up, the insured will have a paid-up policy equal to 25% of the original death benefit. In this example, this would be $25,000. This rider is not available to employees already age 75+. This benefit is not based on your charge for care. It pays full 4% regardless of what your care costs. It also does not matter where you receive care, nursing home, assisted living facility, in your own home or in a relative's home. It would also pay benefits for an accident that would cause you to require care due to the above conditions.

Waiver of Monthly Deductions for Layoff or Strike
Waives the monthly deductions for up to six months per year if the employee is involuntarily laid off. Benefits are limited to three layoffs per year and are based on the employee's layoff only. Layoff of an insured spouse or child does not qualify for this waiver. Premium payments must have begun prior to the insured employee's layoff. Rider is available through age 55 and terminates on the employee's 60th birthday or when the insurance is assigned to another party, whichever is earlier.

Terminal Illness Benefit – Pays 75% of death benefit, one time, up to $100,000 if you are diagnosed with a terminal illness with 12 months or less to live. Balance paid at death. Not available to issue ages 76+.

Waiver of Monthly Deductions for Total Disability Waives the monthly deductions while an employee is totally disabled.

Once the six-month waiting period is satisfied, monthly deductions will be waived retroactively to the commencement of total disability and continue as long as the employee remains totally disabled, subject to certain conditions. The disability must begin prior to age 60.

Term vs Universal Life Insurance – An Overview

Although life insurance comes in various forms, two common types are term life and universal life insurance. The main differences between these are the duration of the term, cash value accumulation, and cost.

Key Takeaways

» Term life insurance provides coverage for a specific period of time, for a fixed premium, and with no cash value accumulation.
» Universal life is a form of permanent life insurance with a cash value account, whereby premiums received above the cost of insurance are invested.
» The premiums for term life are relatively low compared to universal life.

Term Life Insurance

Term life insurance is the most basic insurance policy. It is a life insurance policy that provides coverage for a specific period of time and usually for a fixed premium. Some policies provide coverage for dismemberment and additional coverage for accidental death. If you or your beneficiaries do not make any claims during the term the policy, it will expire. At expiration, some insurers allow for the continuation of the policy at a higher rate or the conversion of the term policy into a permanent policy. Generally, term life insurance is cheaper to buy during the earlier years of life, when the risk of death is relatively low. Prices rise in accordance with increasing risks and
advancing age.

Universal Life Insurance

Universal life insurance falls under a broader category of policies sometimes referred to as cash-value or permanent insurance. These types of insurance policies combine death benefits with a savings component or cash value that is reinvested and tax-deferred. The savings portion is accumulated throughout the life of the policy and can often be cashed in at some future point. Because these policies are permanent, early termination of the contract by the policyholder typically results in penalties. During the earlier stages of your life, a large portion of the premium paid to this policy is routed to the savings component. During the later
stages of life, when the cost of insurance is higher, less of the premium is devoted to the cash portion and more to the purchase of insurance.

For example, if a 20-year-old purchases term insurance, his or her premium might be $20 per month. With a universal policy, the same 20-year-old might pay a premium of $100 per month, with $20 going toward death insurance and the remaining $80 going toward savings. When the person reaches age 45, term insurance might cost $50 per month, while universal life would still cost $100 per month, although a lower portion of that amount would go into savings.

Life Insurance Plans - Comparison

Life Insurance: term vs. Universal Life

TERM LIFE	UNIVERSAL LIFE
WHAT IS IT?	
• Provides protection during your working years • Affordable coverage to help survivors weather an unexpected loss	• Provides benefits for a lifetime • More than just a death benefit — value you can use during times of need
WHY DO YOU NEED IT?	
Income replacement Kind of like renting a house: employees use the protection for a set period of time • Can help pay the costs families face during the working years if the breadwinner dies prematurely; Housing, Education, Saving for Retirement • Can be used to pay for the expenses associated with terminal illness	Final expenses plus cash accumulation Kind of like owning a house: you keep the benefit for a lifetime • Can help pay final expenses • Can also be used to pay for the expenses associated with terminal illness — including long-term care • Accumulates cash value at a guaranteed interest rate; employees can borrow against this value
HOW DOES IT WORK?	
Flexible, normally ends at retirement • You may increase coverage as your needs evolve • The benefit typically decreases after age 65, and can end at • retirement, when income replacement may no longer be necessary • Guaranteed issue means you can get coverage with no health questions or exams	Guaranteed premium, level benefit — for life • Your premium is locked-in for the amount of coverage you desire — the younger you are, the lower the premium. Rates this affordable with guaranteed issue are usually only available in the workplace • The level death benefit does not decrease with age • The coverage continues for life as long as the premiums are paid • Guaranteed issue — generally available only in the workplace — means you can get coverage with no health questions or exams
HOW LONG DO THEY WORK TOGETHER?	
Protection for now, helpful benefits for later. With valuable protection for your working years and benefits that carry into retirement, a combination of Term Life and Permanent Life provide comprehensive protection for your loved ones.	

What's a beneficiary? Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life offered by Memorial. You receive the benefit payment for a dependent's death under the Lincoln Financial Group insurance.

Name a primary and contingent beneficiary to make your intentions clear. Make sure to indicate their full name, address, Social Security number, relationship, date of birth and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches majority age at 21. If you need assistance, contact Human Resources or your own legal counsel.

Life Insurance Plans – Value Adds

These Value Adds are offered to you at no cost through Lincoln Financial Group.

LifeKeysSM

Create your will online — easily and economically. Follow a step-by-step guide through the entire process, and then use online instructions to execute your will.

GuidanceResourcesR Online

GuidanceResources® Online is the place to go for articles, tutorials, streaming videos and "Ask the Expert" personal responses on topics such as:

- Law and regulations
- Health and wellness
- Money and investments
- Work and education
- Family and relationships
- Leisure and home

Identity Theft

Identity theft is one of the fastest-growing crimes in the U.S. Be sure you have the information you need to recognize and prevent it. Our online resource helps you:

- Spot the warning signs
- Take steps to protect your cell phone, computer and tax records from fraud
- Lessen the damage and repair your credit if identity Theft occurs
- Link to essential resources such as credit reporting bureaus, the FBI Internet Crime Complaint Center, ID Theft Resource Center, and more

For Your Beneficiaries

Services are available for up to one year after a loss, and include:

- A combination totaling six in-person sessions for grief counseling, or legal or financial information, and
- Unlimited phone counseling

To access LifeKeysSM services: Call 855-891-3684 or visit www.Lincoln4Benefits.com (Web ID = LifeKeys)

LifeKeysSM services are provided by ComPsych® Corporation, Chicago, IL.

TravelConnect

TravelConnectSM services provide travel assistance to you and your family at no additional cost

- Travel more than 100 miles from home
- Business and leisure travel
- Staff and resources provide 24/7 support

How TravelConnectSM Services Help

- **Destination information.** Provide up-to-date
- information about weather, currency, local culture and more
- **Emergency arrangements.** Coordinate new travel plans if traveler is ill or injured including medical emergency evacuation and transportation, dependent child transportation and travel monitoring
- **Money transfers**. Arrange transfer of funds
- **Lost or stolen travel documents.** Arrange replacement passports, tickets and other travel documentation
- **Legal referrals.** Find an attorney and assist with bail bonds
- **Translation services.** Provide translation services or refer to a local translator
- **Emergency messages.** Send emergency messages for traveler
- **Emergency pet services.** Arrange for a pet's boarding or return home during a traveler's medical emergency

A program description is available at www.Lincoln4Benefits.com. To use **TravelConnect** S M services, call FrontierMEDEX at 800-527-0218 and provide them with ID number 322541.

TravelConnect S M travel assistance services are provided by FrontierMEDEX, Baltimore, MD.

Accident Plan

Accident Coverage

Accidents happen. You can't always prevent them, but you can take steps to reduce the financial impact. AccidentAdvance, available through Transamerica Life
Insurance Company, provides benefits for you and your
covered family members if you have expenses related to
an accidental injury. Health insurance helps with medical expenses, but this Insurance is an additional layer of protection that can help you pay deductibles, copays and even typical day-to-day expenses such as a mortgage or car payment. Benefits under this plan are payable to you to use as you wish.

The Accident insurance policy pays cash benefits to help with costs associated with out-of-pocket expenses and bills in the event of a covered accident:

- Emergency Treatment – $150
- Hospital Admission – $1,050
- Intensive Care Unit – $600/day
- Ambulance Transportation – $210

This is a brief summary of AccidentAdvance® accident-only insurance underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa. Policy Form Series CPACC100 and CCACC200-0118. Policy forms and numbers may vary and may not be available in all jurisdictions. Limitations and exclusions apply. Please refer to the policy, certificate and riders for complete details.

ACCIDENT ACCOUNT RATES	MONTHLY	24 PAY PERIODS
EMPLOYEE ONLY	$ 12.92	$ 6.46
EMPLOYEE + SPOUSE	$ 20.10	$ 10.05
EMPLOYEE + CHILD(REN)	$ 16.20	$ 8.10
FAMILY	$ 24.12	$ 12.06

SUMMARY OF BENEFITS*	
FRACTURES	$420 - $6,000
DISLOCATIONS	$180 - $4,800
EMERGENCY CARE-PHYSICIANS TREATMENT & X-RAYS	$150
ACCIDENT FOLLOW-UP TREATMENT	$50
HOSPITAL CONFINEMENT	$200/day (up to 365 days)
ICU CONFINEMENT	$600/day (up to 15 days)
MAJOR DIAGNOSTIC EXAM BENEFIT (MRI, CT, SCAN, EEG)	$240
PHYSICIAN FOLLOW-UP VISIT	$50
THERAPY SERVICES	$50
MAJOR SURGERY-OPEN ABDOMINAL, CRANIAL OR THORACIC (EXCLUDES LAPAROSCOPIC)	$1,500
PROSTHETIC DEVICES	$750-$1,500
BURNS (2ND & 3RD DEGREE)	$600 - $12,000
CONCUSSION	$200
EYE INJURIES	$70 - $400
DISMEMBERMENT	$2,500 - $50,000
PARALYSIS	$7,500 - $15,000
LACERATION	$80 - $600
AMBULANCE	$210 - $1,050
MEDICAL APPLIANCE	$200
EMERGENCY DENTAL WORK	$80 - $300
FAMILY LODGING BENEFIT -PAYS FOR LODGING FOR PATIENT COMPANION	$150 per night (up to 30 days)
ANNUAL WELLNESS BENEFIT	$50 (1x per calendar year)

*This list is a summary. Refer to plan documents for a comprehensive list of overed benefits.

Critical Illness Plan

Critical Illness Coverage

CriticalEvents illness insurance through Transamerica Life Insurance Company pays a lump-sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like; for example: to help pay for expenses not covered by your medical plan, lost wages, childcare, travel, home healthcare costs or any of your regular household expenses.

Covered Benefits

(Paid at 100% of your elected benefit amount unless otherwise noted):

- Heart Attack
- Stroke
- Miscellaneous Diseases
- Invasive Cancer
- Carcinoma in Situ (25%)
- Prostate Cancer (25%)
- Bone Marrow Failure
- End Stage Renal Failure
- Major Organ Transplant
- Alzheimer's Disease (30%)
- Occupational HIV

Plan Highlights

- Guaranteed Issue Coverage (no medical questions)
  – Employee: $30,000
  – Spouse: 100% of the employee's Initial Benefit
  – Child(ren): 100% of the employee's Initial Benefit
- Pre-Existing Conditions: This plan does NOT have a pre-existing condition exclusion; however, your date of diagnosis must be on or after the effective date of your policy for benefits to be paid.
- Wellness Benefit: A $50 wellness benefit is payable for each covered member for completing certain wellness screenings such as a pap test, cholesterol test, mammogram, colonoscopy or stress test.
- Rates are based on your age and benefit amount and will be calculated for you when you go online for enrollment. Rates for this plan are grouped in five-year increments and are subject to increase each time you enter a new age-band. Refer to TransAmerica for additional information.
- This is a brief summary of CriticalEvents® critical illness indemnity insurance underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa. Policy Form Series TMCI1000-0118 and TCCI1000-0118. Forms and numbers may vary. Insurance may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.

(NEW) Cancer Insurance

CancerSelect Plus Cancer Insurance

Everyone knows the heartbreak of being diagnosed with cancer from an emotional standpoint and the financial repercussions. Memorial is pleased to announce our new Cancer Insurance – CancerSelect Plus offered through Transamerica. All benefits-eligible employees are eligible for Cancer Insurance. This plan is designed to help offset the direct and indirect expenses associated with cancer.

PER 24 PAY PERIODS CONTRIBUTIONS	
EMPLOYEE ONLY	$17.20
EMPLOYEE + SPOUSE	$30.49
EMPLOYEE + CHILD(REN)	$19.44
EMPLOYEE + FAMILY	$30.49

SUMMARY OF BENEFITS*	
Hospital Confinement	$400
Extended Benefits	$800
Attending Physician	$80
Impatient Drugs and Medicinee	$60
Private Duty Nurse	$400
Ambulance	$400
Extended Care Facility	$400
Hospice Care	$400
Inpatient Surgery	$5,000
Outpatient Surgery	$7,500
Anesthesia	25%
Prosthesis	$2,500
Reconstructive Surgery - Breast Cancer: simple or total mastectomy	$600
Reconstructive Surgery - Breast Cancer: radical mastectomy	$850
Second Surgical Opinion	$500
Associated Blood & Plasma Expenses	$500
New or Experimental Treatment	$10,000
Initial Diagnosis Benefit	$5,000

***This list is a summary. Refer to plan documents for a comprehensive list of covered benefits.**

Disability Plans

Short-Term Disability (STD) Insurance

Short-Term Disability (STD) benefits are available for purchase on a voluntary basis. STD insurance replaces 60% of your income if you become partially or totally disabled for a short time. Certain exclusions, along with pre-existing condition limitations, may apply. Please refer to plan documents for further details.

WEEKLY MAXIMUM BENEFIT	**$1,500**
ELIMINATION PERIOD	**14 days**
MAXIMUM BENEFIT PERIOD	**91 days**

Long-Term Disability (LTD) Insurance – 40%

Long-Term Disability (LTD) benefits are paid for by Memorial and are available to you at no cost. LTD insurance replaces 40% of your income if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. Please refer to plan documents for further details.

MONTHLY MAXIMUM BENEFIT	**$4,000**
ELIMINATION PERIOD	**90 days**
MAXIMUM BENEFIT PERIOD	**Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.**

(LTD) Insurance** – 60%

Voluntary Long-Term Disability (LTD) benefits are available for purchase on a voluntary basis. LTD insurance replaces 60% of your income if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. Please refer to plan documents for further details.

ALL BENEFITS ELIGIBLE BENEFITS-ELIGIBLE STATUS AND PART-TIME EMPLOYEES	
MONTHLY MAXIMUM BENEFIT	**$6,000**
ELIMINATION PERIOD	**90 days**
MAXIMUM BENEFIT PERIOD	**Payments will last for as long as your are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner**

VOLUNTARY LONG-TERM DISABILITY RATES	
FOR ALL BENEFIT-ELIGIBLE FULL-TIME AND PART-TIME EMPLOYEES	**$0.408 per 100 of covered payroll**

**NOTE: If you are not a New Hire and Open Enrollment you want to buy up your LTD insurance you will need to go through Evidence of Insurability.

Voluntary Long-Term Disability

Please use the calculation below to get an estimate of what your premiums may look like.

TO CALCULATE HOW MUCH YOUR LTD COVERAGE WILL COST:						
	÷12=		xRate		÷$100	
Annual Salary		Monthly Covered Payroll		Amount		Bi-weekly Premium

TO CALCULATE HOW MUCH YOUR STD COVERAGE WILL COST:						
	÷12=		xRate		÷$100	
Annual Salary		Monthly Covered Payroll		Amount		Bi-weekly Premium

Note: Managers and Physicians, please refer to your schedule of benefits for additional benefit options.

Retirement Plans

Whether you're just starting out in your career or you've been in the workforce for years, it's always a good time to plan for retirement.

VOYA FINANCIAL

Contributing to a 403(b) account now can help keep you financially secure later in life. The Memorial 403(b) plan provides you with the tools and flexibility you need to prepare. This 403(b) plan is provided through Voya. **What is a 403(b)?** This employer-sponsored retirement account can help build and create choices for your future self by saving money — tax free — from your paycheck. Due to the value of compounding interest, the sooner you participate in a 403(b), the better.

Eligible employees can invest for retirement while receiving certain tax advantages. Administrative and record-keeping services for this plan are provided by Voya. You may start making pre-tax contributions into the plan the month after you were hired.

Contributing to the Plan

The deferred contribution limit set annually by the IRS is $19,500 for 2022. If you are age 50 or older this calendar year and you already contribute the maximum allowed to your 403(b) account, you may also make a "catch-up contribution." This additional deposit accelerates your progress toward your retirement goals. The maximum catch-up contribution is $6,500 for 2022 — for a combined total contribution allowance of $26,000. See your plan administrator for details. Employee contributions are deducted by 26 pay checks per year.

How Much Should I Be Saving?

Industry standards suggest saving, at a minimum, 12% to 15% of your income, inclusive of Memorial's matched contribution of 50% of your contributions up to 4% of your salary as well as a Service Based contribution based on years of service as outlined on the chart below. **Benefits-eligible employees are eligible for employer match and service-based contributions. Please refer to the chart on the following page for more details and eligibility.** If you cannot afford to save that much right now, at least make sure to be saving up to the matching amount so you are not leaving free money behind.

SERVICE BASED CONTRIBUTION PROVIDED BY MEMORIAL	
YEARS OF SERVICE	PERCENTAGE CONTRIBUTION
<3	0%
3-9	1%
10-14	2%
15-19	3%
20-25	4%
25+	5%

Changing or Stopping Your Contributions

You may change the amount of your contributions anytime. All changes are effective as soon as administratively feasible and remain in effect until you modify them. You may also discontinue your contributions and start them again at any time by logging on to your Voya account at voyaretirementplans.com.

Consolidating Your Retirement Savings

If you have an existing qualified retirement plan (pre-tax) with a previous employer, you may transfer that account into the plan any time. Contact our Voya representative at 228-867-5181 for details. Regardless of which retirement account you choose or how much you contribute, it's important to think of it as a long-term strategy. Dipping into the account early will jeopardize the quality of your retirement and rack up penalties from the IRS.

Investing in the Plan

It's up to you how to invest the assets in your account. The Memorial Hospital 403(b) plan offers a selection of investment options for you to choose from. You may change your investment choices any time. Contact the Voya adviser for details/investment choices or call 228-867-5181. You may also change your investment elections and transfer between investment options by accessing your account at voyaretirementplans.com.

Vesting

The term ""vested" refers to employer paid contributions you are eligible to take with you should you leave Memorial Hospital. When you are fully vested at 5 years of service, you will own 100% of any company match and/or service-based contributions. You always own and are fully vested in your own personal contributions.

VESTING SCHEDULE	
YEARS OF SERVICE	PERCENTAGE VESTED
5 yrs. of eligible service	100%

Retirement Plans - Summary

RETIREMENT PLANS:	CARRIER	WHO IS ELIGIBLE	WHO CONTRIBUTES	ELIGIBILITY	BENEFIT TO EMPLOYEES
RETIREMENT SAVINGS PLAN 403(B) TRADITIONAL PLAN	Voya	All Employees employees contribution	Employee	First of the month following hire date	Pre-Tax Contributions/ Dedicated Voya financial advisor onsite
		Memorial match for benefits-eligible employees hired after 1/1/12	Memorial Hospital	Employees must be participating and have worked 1,000 hours in a calendar year and be employed on the last day of the year to be eligible for the match.	50% match up to 4% of eligible salary for employees in a benefits-eligible status. 100% vested in match after 5 years of eligible service
		Physicians	Memorial Hospital	Physicians in a benefit-eligible status	50% match up to 3% of eligible salary for physicians in a benefits-eligible status. 100% vested in match after 5 years of service
RETIREMENT SAVINGS PLAN 403(B) ROTH PLAN	Voya	All Employees employees contribution	Employee	First of the month following hire date	Post-Tax Contributions/ Dedicated Voya financial advisor onsite
		Memorial match for benefits-eligible employees hired after 1/1/12	Memorial Hospital	Employees must be participating and have worked 1,000 hours in a calendar year and be employed on the last day of the year to be eligible for the match.	50% match up to 4% of eligible salary for employees in a benefits-eligible status. 100% vested in match after 5 years of eligible service
		Physicians	Memorial Hospital	Physicians in a benefit-eligible status	50% match up to 3% of eligible salary for physicians in a benefits-eligible status. 100% vested in match after 5 years of service
RETIREMENT SAVINGS PLAN 457 PLAN DEFERRED COMPENSATION PLAN	Voya	All Employees and Physicians	Employee/physician	First of the month following hire date	Pre-Tax Contributions/ Dedicated Voya financial advisor onsite

Thoughts & Tips: When you retire, you'll need at least 70% of your pre-retirement maintain your standard of living. Social Security retirement benefits typically replace only about 40%, so start building that nest egg now.

Retirement Plans - (NEW) Automatic Enrollment / Automatic Escalation

Automatic Enrollment

The Memorial Retirement Savings Plan ("Plan") makes saving for retirement even easier by offering an automatic enrollment feature for all newly-hired employees.

As a new hire, you are automatically enrolled in the Plan starting with your first paycheck, at which time Voya, the Plan's record keeper, will create an account for you. This means that 4% will be taken from your eligible compensation each pay period and contributed to the Plan as a salary reduction contribution.

Going forward, you can choose to contribute more, less, or even nothing at any time by signing into your Plan account at voyaretirementplans.com and electing a different contribution percentage (including a 0% contribution).

Automatic Escalation

The Plan also has an automatic escalation feature. All Plan participants who are not making salary reduction contributions of at least 10% on January 1st of each year, will automatically have their salary reduction contribution increased by 1% at that time. Thereafter, each January 1st your salary reduction percentage will increase by an additional 1% until your contribution percentage reaches 10%.

This automatic escalation feature will not change your salary reduction contribution level if you already participate at a 10% (or greater percentage) level. You can change your contribution level at any time at voyaretirementplans.com. Any employer-matching contributions will be based on your new contribution level.

Retirement Plans - (NEW) Automatic Enrollment / Automatic Escalation FAQs

1. Does the Plan's automatic enrollment feature apply to me?

The Plan's automatic enrollment feature applies to all newly hired eligible employees. This means 4% of your eligible compensation for each pay period will be contributed to the Plan as a salary reduction contribution, starting with your first paycheck and continuing through the end of June. Every January 1, your contribution level will increase by 1% (see question 2 below for more information on the automatic escalation feature), until your salary reduction contribution reaches 10% of your eligible compensation. To learn more about the Plan's definition of eligible compensation, you can review the Plan's summary plan description. Your salary reduction contributions to the Plan are taken out of your compensation on a pre-tax basis (unless you select a Roth, or After-tax deduction) and are not subject to federal income tax at that time. Instead, they are contributed to your Plan account and will change over time based on any market gains or losses. Your account will be subject to federal income tax only when withdrawn. This helpful tax rule is a reason to save for retirement through Plan contributions. You are in charge of the amount that you contribute. You may decide to do nothing and contribute 4%, or you may choose to contribute an amount that better meets your needs. You must notify Voya Retirement if you want to opt out of the Plan's automatic enrollment feature and receive a refund of any salary reduction contributions made within the first 90 days of your employment (see question 6 for more information on opting out and receiving a refund). You can change your contribution level at any time on the Voya Retirement website. Be aware that there are limits on the maximum amount you may contribute to your account. You may want to contact Voya Retirement or your tax advisor to find out how these limits affect you. The limits are described in the Plan's summary plan description.

2. Does the Plan's automatic escalation feature apply to me?

If you are not contributing at a 10% level on January 1st your salary reduction contributions will automatically increase by 1% at that time. Every January 1 thereafter, your contribution level will increase another 1% (unless you choose a different level or notify Voya Retirement each year that you want to opt out of the Plan's Automatic escalation feature), until your salary reduction contributions reach 10% of your eligible compensation. You can elect to make a different percentage contribution to the Plan or to not contribute on Voya Retirement's website. Each year, Voya Retirement will send a communication reminding you of the upcoming automatic escalation. If you do not want your salary reduction contributions increased for the year, you must follow the instructions from Voya Retirement on how to opt out of the automatic escalation feature.

3. In addition to the contributions taken out of my compensation, what amounts will my employer contribute to my Plan account?

Memorial will match, 50% of your contribution up to 4% of eligible compensation you contribute each pay period as well as a Service Based contribution based on your years of service (see retirement plan for more details and eligibility). If you have questions about whether you are eligible for employer contributions, please contact the Benefits Team.

4. When will my Plan account be vested and available to me?

You are always fully vested after 5 years of service with Memorial in all contributions to the Plan (both employer and employee contributions). Even though you are vested in your entire Plan account, there are limits on when you may withdraw your funds. These limits may be important to you in deciding how much, if any, to contribute to the Plan. Generally, you may only withdraw money after you leave your job, reach age 59½, or become disabled. Also, there is generally an extra 10% tax on distributions before age 59½. Any amount remaining in your Plan account upon your death will be paid to your designated beneficiary. You also can borrow certain amounts from your Plan account and may be able to withdraw your salary reduction contributions if you have a hardship. Hardship distributions are limited to the dollar amount of your salary reduction contributions and may not be taken from earnings, matching or basic contributions. Hardship distributions must be for a specified reason – for qualifying medical expenses, costs of purchasing your principal residence (or preventing eviction from or foreclosure on your principal residence, or repairing qualifying damages to your principal residence), qualifying post-secondary education expenses, or qualifying burial or funeral expenses. Before you can take a hardship distribution, you must have taken other permitted withdrawals and loans from qualifying employer plans, unless doing so would be counter-productive. If you take a hardship distribution, you may not contribute to the Plan or other qualifying employer plans for 6 months. You can learn more about the Plan's hardship withdrawal and loan rules in the Plan's summary plan description. You can also learn more about the extra 10% early distribution tax in IRS Publication 575, Pension and Annuity Income.

5. How will my Plan account be invested?

The Plan lets you invest your account in a number of different investment funds. Unless you choose a different investment fund or funds, your Plan account will be invested in the target date default fund based on your assumed retirement age. You can change how your Plan account is invested among the Plan's offered investment funds on the Voya Retirement website. Information about the Plan's investment funds and procedures for changing how your Plan account is invested can be found on the Voya Retirement website.

6. Can I change the amount of my contributions?

Yes. You can always change the amount you contribute to the Plan at any time on the Voya Retirement website. If you know that you do not want to contribute to the Plan, you must notify Voya Retirement that you wish to opt out of the Plan's automatic enrollment and escalation features. You must notify Voya Retirement each year that you want to opt out of the Plan's automatic escalation feature. If you are a new hire and do not wish to have automatic enrollment contributions taken from your compensation, you must decrease your contributions to zero on the Voya Retirement website. During the 90 days after automatic contributions are first taken from your pay, you can also withdraw the prior automatic contributions by contacting Voya Retirement. (Note: this withdrawal right is not available for the annual 1% automatic escalation amounts.) If you withdraw your automatic contributions, you lose any employer matching contributions associated with the automatic contributions. Also, your withdrawal will be subject to federal income tax (but not the extra 10% tax that normally applies to early distributions) and reported on a Form 1099-R at the end of the year. If you decrease salary reduction contributions to zero, no further contributions will be taken from your compensation until the next annual automatic escalation period occurs. You can always choose to continue or restart your contributions on the Voya Retirement website. If you would like a copy of the Plan's summary plan description or other Plan documents, please visit the Benefits Retirement website at https://memorialretirementplans.com. If you wish to start, stop or change your contributions to the Plan, or want information on the Plan's investment fund options, please sign into your Plan account on Voya Retirement's website: www.Voya.com .

If you have questions about how the Plan works or your rights and obligations under the Plan, please contact Tim Roling, Memorial's Voya Investment Advisor Representative, at 228-867-5181 or email retirement@mhg.com . You are also welcome to contact Voya Retirement at (800) 584

VOYA FINANCIAL

Paid Leave

Memorial offers Paid Leave for its benefits-eligible employees, Leave accrued on 26 pay checks per year.

LENGTH OF CONTINUOUS SERVICE	PTO LEAVE EMPLOYED BEFORE 12/31/14	PTO LEAVE EMPLOYED AFTER 1/1/15	SICK LEAVE ACCRUAL HOURS
0-4 Years	7.39 Hours per Pay Period	6.46 Hours per Pay Period	1.85 Hours per Pay Period
Annual Accrual	192 Hours	168 Hours	48 Hours
Maximum Accrual	264 Hours	228 Hours	480 Hours
5-9 Years	8.31 Hours per Pay Period	7.39 Hours per Pay Period	
Annual Accrual	216 Hours	192 Hours	48 Hours
Maximum Accrual	300 Hours	264 Hours	480 Hours
10-14 Years (& Dept. Heads w/ >5 Years Service)	9.23 Hours per Pay Period	8.31 Hours per Pay Period	1.85 Hours Per Pay Period
Annual Accrual	240 Hours	216 Hours	48 Hours
Maximum Accrual	336 Hours	300 Hours	480 Hours
15 Plus Years (& Dept. Heads w/ <5 Years Service)	10.15 Hours per Pay Period	9.23 Hours per Pay Period	1.85 Hours Per Pay Period
Annual Accrual	264 Hours	240 Hours	48 Hours
Maximum Accrual	372 Hours	336 Hours	480 Hours

PTO

- To be eligible to accrue PTO hours, the employee must be in a benefits eligible category and eligible to earn leave accruals.
- Part-time Plus 20 leave accruals are based on the hours worked up to the full-time accrual.
- Up to 48 hours may be cashed out or converted to Sick Leave on the employee's benefit service date.
- Up to 12 hours of PTO may be used in the first three months of employment.

SICK ABSENCE

Sick Absence hours are paid from the first day if hospitalized or for outpatient surgery or stay in the observation unit, paid if ill at home more than 24 consecutive work hours (Doctor's excuse and approval of Department Director necessary), paid for FMLA entitlement according to schedule; cumulative to maximum of 480 hours; special provisions for employees who have reached the maximum accrual.

	OTHER PAID LEAVES
BEREAVEMENT LEAVE FOR EMPLOYEES IN A BENEFITS-ELIGIBLE STATUS	Up to 24 hours of paid time away from work in the event of death of an immediate family member. Employees in a part-time + 20 status receive 1/2 of this benefit.
JURY DUTY PAY FOR EMPLOYEES IN A BENEFITS-ELIGIBLE STATUS	Paid time away from work for employees who are required to serve on Jury Duty
MILITARY LEAVE FOR EMPLOYEES IN A BENEFITS-ELIGIBLE STATUS	Paid military leave up to 15 shifts per year for employee's service in the Armed Forces

Note: Physicians are eligible for Paid Time Away from Work (PTAW). Refer to employment contract for details.

Pet Insurance

Nationwide® Pet Insurance – Employee Preferred Pricing on Exclusive Plans

You work hard to provide your family with everything they need. So, whether your family includes kids with two feet or kids with four paws, you know what responsibility looks like.

My Pet Protection® from Nationwide® helps you provide your pets with the best care possible. Plans cover accidents, illnesses and hereditary conditions.

» 24/7 vethelpline® is available to all pet insurance members ($150 value)

» Freedom to use any vet

» Custom made plans for employees only

» Rates not based on age and no age limitations

» 70% or 50% reimbursement of vet's invoice

» Low $250 annual deductible

Note: Rates vary by State of residency and type of pet. Please contact Nationwide for more info at 888-899-4874 or www.petinsurance.com/gulfportmemorial.

Choose from two levels of coverage

50% reimbursement

70% reimbursement

	My Pet Protection
Accidents, including poisonings and allergic reactions	●
Injuries including cuts, sprains, and broken bones	●
Common illnesses, including ear infections, vomiting and diarrhea	●
Serious/chronic illnesses, including cancer and diabetes	●
Hereditary and congenital conditions	●
Surgeries and hospitalizations	●
X-rays, MRIs and CT scans	●
Prescription medications and therapeutic diets	●

Identity Theft/Legal Protection

Identity Theft Protection

Identity theft protection is available on a voluntary basis. In today's online world, there is a new identity fraud victim every two seconds. Protect yourself with ID Shield. ID Shield monitors millions of transactions every second, alerting you to suspicious activity by text, phone or email. This protection is different than free credit
monitoring and offers a full set of features to help protect you and your covered family members against identity theft.

ID Shield membership features:

- ID Shield Identity Alert System
- Lost wallet protection
- Address change verification
- ID Shield Privacy Monitor
- Live member service support
- Identity restoration support
- Data breach notifications

This plan is available via payroll deduction and is yours to keep if you retire or leave Memorial.

ID SHIELD RATES (PER PAY PERIOD)	
EMPLOYEE (1 BUREAU MONITORING)	$4.23
FAMILY (1 BUREAU MONITORING)	$7.98
EMPLOYEE (3 BUREAU MONITORING)	$6.48
FAMILY (3 BUREAU MONITORING)	$12.98

Legal Protection

LegalShield is available on a voluntary basis. The service
provides legal protection at a tap of a button. LegalShield membership features:

- Advice & Consultation
- Family Assistance
- Documentation Preparation
- Representation
- Auto Services
- IRS Services

LEGAL SHIELD RATES (PER PAY PERIOD)	
FAMILY	$10.48

COMBO RATES (PER PAY PERIOD)	
LEGALSHIELD AND 1 BUREAU IDSHIELD - EMPLOYEE ONLY	$14.70
LEGALSHIELD AND 1 BUREAU IDSHIELD - EMPLOYEE + FAMILY	$16.95
LEGALSHIELD AND 3 BUREAU IDSHIELD - EMPLOYEE ONLY	$14.70
LEGALSHIELD AND 3 BUREAU IDSHIELD - EMPLOYEE + FAMILY	$20.95

Tuition Reimbursement / Student Loan Relief

Tuition Reimbursement

Whether you're looking to move into a management position or make a career move, going back to school is the best way to make that happen. The only thing that may be stopping you is the expense of pursuing that advanced degree. Memorial's tuition reimbursement program is designed to encourage employees to maximize their potential and to give them an opportunity to advance within the system.

Any benefits-eligible employee is eligible to apply for participation in the plan except for employees that are signed up for Pay-in-Lieu-of-Benefits. Employees are eligible after 90 days of employment and must complete the application approval process PRIOR to the start of classes.

Employees have up to a $10,000 benefit available for tuition expenses for approved classes based on years of service. Part-time employees (20+ hours) will receive 50% of eligible tuition expenses at the time of reimbursement up to the maximum amount.

Tuition Reimbursement Checklist:

- Submit Application Before Classes Start
- Receive Approval From HR
- Submit Grades and Receipt After Class Ends
- Receive Reimbursement

For more detailed information about the program, please see Tuition Reimbursement Policy 11_19.

Student Loan Relief

Student Loan Relief / Forgiveness Program is available to you on a voluntary basis through Fiducius. We encourage you to take a step to improve your financial wellness and learn if Fiducius can help you better manage your student loans. Questions, or trouble logging in? Call 513-645-5400, email or visit their website for more information and success stories.

It's Easy to Get Started with Loan Relief™ Benefit

Let the student loan experts at Fiducius get to work for you:

1. Access – learn about your personal financial situation and goals
2. Advise – identify the best option to solve your student loan issue
3. Relieve – provide a customized Student Loan Financial Wellness Plan

Fiducius will fully educate you about all available options and provide a personalized Student Loan Financial Wellness Plan at no cost before you decide whether or not to use their services. As with other voluntary benefits, like life insurance, you only pay Fiducius when you choose to use their services. We encourage you to take a step to improve your financial wellness and learn if Fiducius can help you better manage your student loans.

The CUSTOM PLAN is yours at no cost. For more information, call 513-645-5400 or visit their website at www.getfiducius.com

Employee Assistance

Memorial cares about you and wants you to succeed in all aspects of life, so we offer a variety of additional benefits to help make your day-to-day easier.

Employee Assistance Program

We know life is complicated, and sometimes we all just need a little help. Our Employee Assistance Program (EAP) helps manage your and your family's total health, including mental, emotional and physical. And it comes at no cost to you — whether you're enrolled in a company-sponsored medical plan or not. This program is offered through American Behavioral at no cost to you.

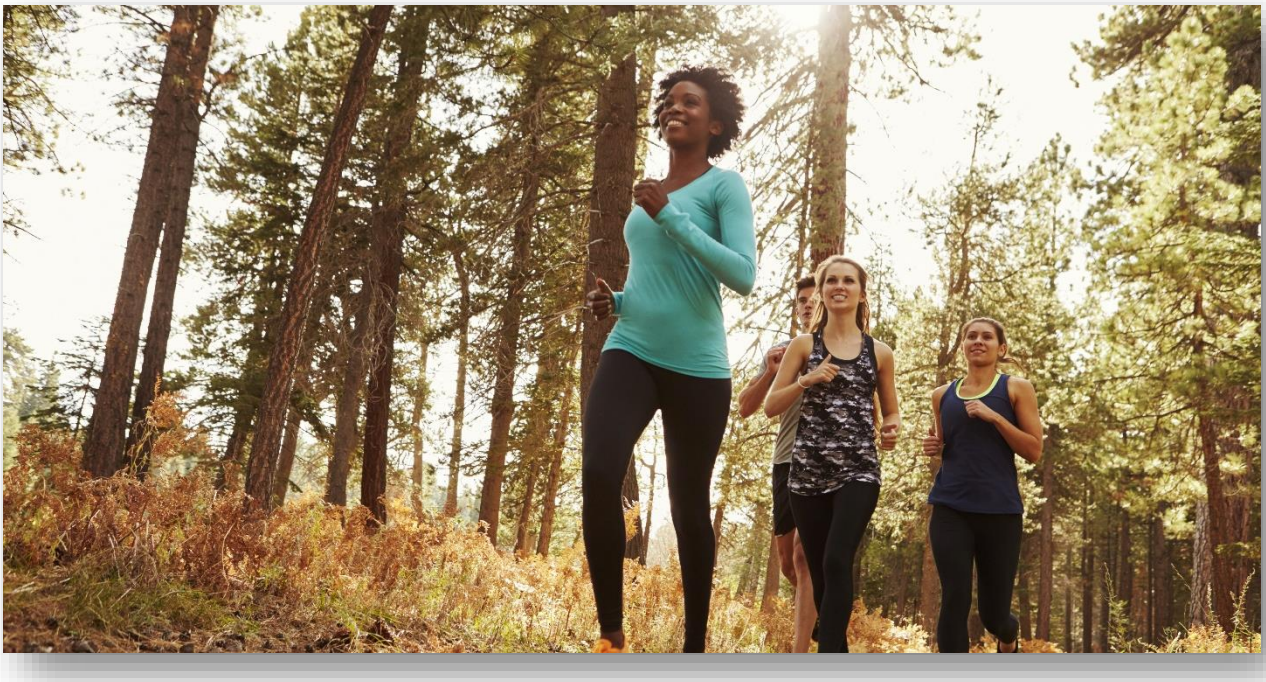
Through this program, you have access to mental health assistance and legal and financial help from a number of professionals. You have 24-hour access to helpful resources by phone, and the EAP benefit includes three face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with Memorial. You may access information, benefits, educational materials and more either by phone at 800-925-5327 or online at www.americanbehavioral.com.

The Program provides referrals to help with:

- Family life (elder and childcare locator, adoption, building a family, parenting, aging, education)
- Financial (estate/retirement planning, investing, education, budgeting, tax planning)
- Health (diet/nutrition, allergies, health assessments, fitness/exercise)
- Legal (debt/bankruptcy, real estate, setting up your business, caring for children)
- Emotional problems (non-clinical depression, mental health issues, divorce/separation, personal issues)
- Personal growth (leadership, effective communication, writing a presentation)
- Stress-related issues (diet, financial, fitness, stress on the job, family stress)
- 24/7 phone access on a toll-free number to consultants who are qualified to help in a variety of areas
- Translation services for non-English speaking individuals
- 24/7 access through the American Behavioral website to extensive resource materials and web-based training programs on a wide array of issues, whether they result from work or personal life
- In-person counseling sessions (up to 3 free visits per year)
- Unlimited scheduled telephonic coaching sessions for work/life issues

Additional Benefits

ADDITIONAL BENEFITS OFFERED TO MEMORIAL HOSPITAL EMPLOYEES	
Health Assessments	**Employee Health provides a variety of healthcare services such as Flu Shots, TB test, over the counter medications.**
Memorial Federal Credit Union	**Convenient Payroll Deductions. Christmas Club and Auto Loans Available**
Fitness Center	**On-Site Fitness Center at the Main Campus with low monthly fees and payroll deductions.**
Direct Deposit	**Employees are required to enroll in direct deposit to have 100% of the payroll checks sent the financial institution of their choice.**
ADDITIONAL PERKS OFFERED TO MEMORIAL EMPLOYEES	
Gift Shop	**Gift Shop at the Main Campus**
ATM	**On-Site ATM at the Main Campus located outside the Cafeteria. There is a $0.50 fee charge.**
Cafeteria and Village Food Court Discount	**Employee Discount with Memorial ID Badge**
Cellular Service Discounts	**Discounts for cell service - AT&T, Verizon and C-Spire**



Pay-In-Lieu-Benefits (PILB)

The Pay-In-Lieu-of-Benefits option allows you to have the choice to receive an additional 20% added to your base pay in lieu of certain benefits.

By electing PILB, you will receive a 20% differential to your base hourly rate of pay while you are in a "Pay-in-Lieu of Benefits" status. In exchange for the additional 20% in pay, you will not be eligible for the following three benefits options:

- You will not accrue, nor be able to use Paid Time Off or Sick leave
- You will not be eligible for the Tuition Reimbursement program
- You will not be eligible to enroll in any insurance plans, including Flexible Spending Accounts

Important to know

If you change from PILB to Benefits in the future, you will be required to apply for certain options for Life, Spouse Life, Long-Term Disability and Critical Illness plans through an Evidence of Insurability health application process. Please see the Benefits Office for further information.

Exempt Employees and Physicians are not eligible for the Pay-In-Lieu of Benefit option.

Glossary

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Coordination of Benefits – Applies when you have health care coverage through more than one Health Care Plan. The order of benefit determination rules govern the order in which each Health Care Plan will pay a claim for benefits. The Health Care Plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The Health Care Plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total Allowable Expense.

Copay – The fixed amount, as determined by your insurance plan, you pay for healthcare services received.

Deductible – The amount you owe for healthcare services before your health insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Evidence of Insurability (EOI) – A statement of proof of an Employee's medical history. LFG uses this to determine his or her acceptance for insurance or an increased amount **of insurance.**

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Fee Schedule – A listing of the fees normally charged by a given healthcare provider for specific therapies and procedures.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," so funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or rollover into the next plan year.

- Healthcare FSA – A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- Dependent Care FSA – A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.
- Limited Use FSA – Designed to complement a Health Savings Account, a Limited Use FSA allows for reimbursement of eligible dental and vision expenses.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Savings Account (HSA) – A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in a HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable if you change jobs.

High Deductible Health Plan (HDHP) – A plan option that provides choice, flexibility and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, there are no copays and all qualified employee-paid medical expenses count toward your deductible and your out-of-pocket maximum.

New Hire Enrollment – New hire enrollment takes place within 30 days of a new employee's hire date.

Network – A group of physicians, hospitals and other healthcare providers that have agreed to provide medical services to a health insurance plan's member at discounted costs.

- In-Network – Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- Out-of-Network – Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- Non-Participating – Providers that have declined entering into a contract with your insurance provider. They may not accept any insurance and you could pay for all costs out of pocket.

Glossary

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage, make changes or decline coverage.

Out-of-Pocket Maximum – The most you pay during a policy period (usually a 12-month period) before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred or specialty.

- Generic Drugs – Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- Preferred Drugs – Brand-name drugs on your provider's approved list (available online).
- Non-Preferred Drugs – Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- Specialty Drugs – Prescription medications used to treat complex, chronic and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered.
- Prior Authorization – A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- Step Therapy – The goal of a Step Therapy Program is to steer employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

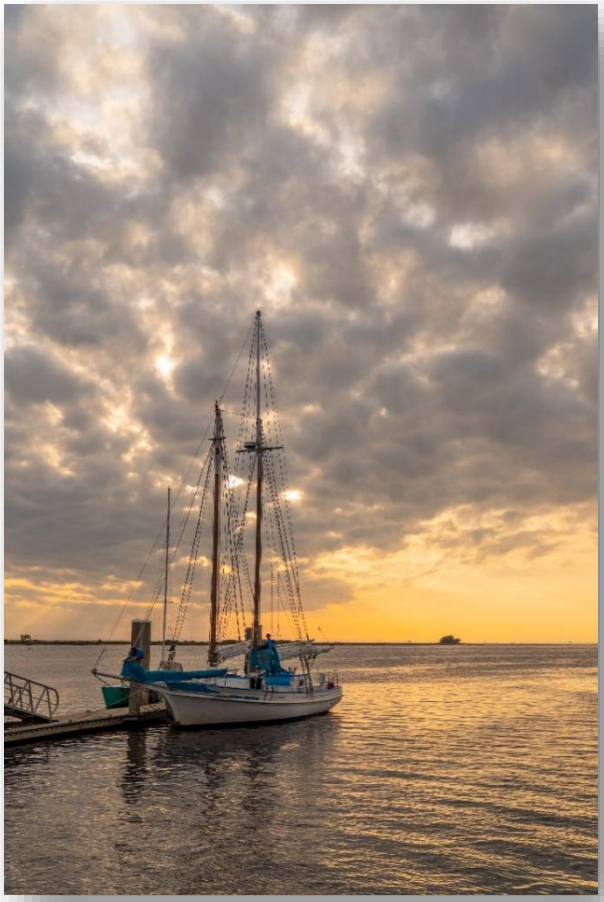
Qualifying Life Event (QLE) – QLEs are those situations that cause a change in your life and affect your health insurance options or requirements. A QLE must have an impact on your insurance needs or change what health insurance plans you qualify for and would trigger a special enrollment period making you eligible to select a new individual insurance policy.

Reasonable and Customary Allowance (R&C) – Also known as the UCR (Usual, Customary, and Reasonable) amount. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, your insurance carrier provides you with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) – The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Tobacco – Refers to any tobacco product including cigarettes, cigars, pipes, all forms of smokeless tobacco, clove cigarettes, and any other smoking devices that use tobacco (such as hookahs) or simulate the use of tobacco, (such as electronic cigarettes).



Required Notices

Important Notice from Memorial Hospital at Gulfport & Physician Clinics About Your Prescription Drug Coverage and Medicare under the Select Administrative Services (SAS) and Memorial Outpatient Pharmacy / Express Scripts Plan(s)

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

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

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

2. Memorial Hospital at Gulfport & Physician Clinics has determined that the prescription drug coverage offered by the Select Administrative Services (SAS) and Memorial Outpatient Pharmacy / Express Scripts plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) 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 Memorial Hospital at Gulfport & Physician Clinics coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current Memorial Hospital at Gulfport & Physician Clinics coverage, be aware that you and your dependents will 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 Memorial Hospital at Gulfport & Physician Clinics 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 nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage...

Contact the person listed at the end of these notices for further information. **NOTE**: You'll get 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 Memorial Hospital at Gulfport & Physician Clinics 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 drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2022
Name of Entity/Sender:	Memorial at Gulfport & Physician Clinics
Contact—Position/Office:	Human Resources
Address:	P.O. Box 1810 Gulfport, MS 39502
Phone Number:	228-865-3306

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 228-865-3306.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 228-865-3306.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 31 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 228-865-3306.

Important Contacts

MEDICAL
Select Administrative Services (SAS)
228-865-0514 or 800-847-6621
https://sas.vbagateway.com/
Group #: 18902

PHARMACY
Express Scripts
Memorial Outpatient Pharmacy
228-865-3525

ACCIDENT & CRITICAL ILLNESS
Transamerica
855-244-8318
www.transamerica.com

DENTAL
Select Administrative Services
228-865-0514 or 800-847-6621
https://sas.vbagateway.com/
Group #: 18902

VISION
AlwaysCare
888-400-9304
www.AlwaysAssist.com

TERM LIFE AND AD&D
Lincoln Financial Group
855-818-2883
Group #: MEMHOSGULF

DISABILITY
Lincoln Financial Group
855-818-2883
Group #: MEMHOSGULF

RETIREMENT
Voya
800 584-6001
www.voya.com | www.planwithease
Tim Roling - Financial Advisor Rep
228-867-5181
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We are here to help you! Please contact the Benefits Department should you have questions or need assistance. You are welcome to contact the vendors directly as well. We are all here for YOU!

– Benny from Benefits

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