



Hospital Sisters
HEALTH SYSTEM

Your Flexplan Benefits Guide

2018



FLEXPLAN

The benefits of choice

benefits.hshs.org

Illinois

2018 Flexplan Benefits Guide

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This guide provides highlights of your 2018 HSHS benefits.

If you have questions about eligibility or how your benefit programs work that are not answered in this guide, contact the HSHS Colleague Service Center. In addition, you may use these telephone and online resources to get answers about specific types of questions – during enrollment and as the year unfolds.

Availability of Summary Health Information

Hospital Sisters Health System offers two medical coverage options. As required by the Patient Protection and Affordable Care Act, your plan makes available a Summary of Benefits and Coverage (SBC) for each option. The SBCs are available on the HSHS Benefits Website at benefits.hshs.org. A paper copy is also available, free of charge, by contacting the HSHS Colleague Service Center.

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The benefit plans outlined in this guide are intended, designed and administered as “church plans” as defined by federal tax law and ERISA (Employee Retirement Income Security Act of 1974). This means that the plans are designed to benefit colleagues of church-sponsored entities, and are administered by one or more individuals who are appointed to their position by a church-sponsored governance body. Because the plans are “church plans,” certain federal laws do not apply, including but not limited to ERISA.

This benefit guide is intended to be only an overview of Hospital Sisters Health System benefits. More details about how the HSHS Healthy Plan, dental, vision, life insurance, accidental death and dismemberment insurance, disability coverages and health care and dependent care flexible spending accounts work are included in the summary plan descriptions for those benefits. Hospital Sisters Health System reserves the right to change, suspend or end benefit plans at any time.

This guide does not apply to Kiara colleagues, colleagues who are represented by St. John’s carpenters and painters unions, temporary and leased colleagues and medical residents. This guide also does not apply to colleagues who reside in Wisconsin and have the HSHS/Prevea360 provider network and Dean Health Plan as administrator of the medical plan.

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Your Choices at a Glance

Benefit	Options
Medical and Prescription Drug Coverage - Aetna	<ul style="list-style-type: none"> • Basic Option • High Option • Waive coverage.
Dental Coverage - Cigna	<ul style="list-style-type: none"> • Basic Option • High Option • Waive coverage.
Vision	<ul style="list-style-type: none"> • Cigna Vision Discount Program - Discounts on eye exams, frames and lenses are provided through participating providers for those enrolled in dental coverage. • Aetna Vision Discount Program - Discounts on routine eye exams and purchases of frames, lenses and contacts. • Vision Service Plan (VSP) - Benefits provided for eye exams, frames and lenses when visiting in- and out-of-network providers. • Choose no coverage for Vision Service Plan.
Health Care FSA - Tri-Star Systems	<ul style="list-style-type: none"> • Set aside up to \$2,600 annually in pre-tax pay to cover eligible health care expenses (with \$5 per pay period minimum to participate). • Choose no coverage.
Dependent Care FSA - Tri-Star Systems	<ul style="list-style-type: none"> • Set aside up to \$5,000 annually in pre-tax pay to cover eligible dependent day care expenses required so you can work (with \$5 per pay period minimum to participate). • Choose no coverage.
Colleague Basic Life and AD&D Insurance - Securian	<ul style="list-style-type: none"> • Basic term life coverage provided automatically at no cost to you: 1½ x pay, to \$50,000 maximum benefit. • Coverage includes equal amount of AD&D.
Voluntary AD&D Coverage - Securian	<ul style="list-style-type: none"> • Five coverage options (colleague-paid) - from \$50,000 to \$250,000 - with colleague only or family coverage. • Choose no voluntary AD&D coverage.

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Your Choices at a Glance continued

Benefit	Options
Supplemental Life Insurance - Securian	<p>Colleague-paid coverage options:</p> <ul style="list-style-type: none"> • Colleague: 1 x pay to 8 x pay, to a \$1 million maximum benefit. • Spouse: \$5,000 to \$50,000, in \$5,000 increments. • Children: \$2,500 to \$10,000, each covered child in \$2,500 increments (same amount for each covered child). • Choose no supplemental life insurance.
Short-Term Disability (STD) and Long-Term Disability (LTD) - Unum	<p>Automatically provided at no cost to you:</p> <ul style="list-style-type: none"> • STD: 70% of pay when disability keeps you from working for more than seven consecutive calendar days, with benefits payable for up to 26 weeks. • LTD: Up to 60% of pay when disability keeps you from working for more than 180 days.
Paid Time Off (PTO) Plan	<p>During 2018 annual enrollment (October 30 - November 13, 2017), non-management colleagues who are regularly scheduled (budgeted) to work at least 32 hours per pay period and are not physicians may:</p> <ul style="list-style-type: none"> • Declare they will cash-in up to 40 hours of PTO for the coming calendar year - time declared in 2017, accrued in 2018, and cashed-in during 2018 paid at 100% straight time pay. • Make no declaration about cashing in PTO in the coming year - decisions can be made later but will be paid at 90% straight time pay.



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Who Is Eligible

You are eligible to participate in Flexplan benefits, except short-term disability, the first day of the pay period following two full biweekly pay periods of active employment in a benefits-eligible status, whether you are a new hire or change to a benefits-eligible status. You are eligible for short-term disability coverage after 90 days of active employment. Generally, you are eligible for coverage under the Flexplan if you are a:

Full-time colleague ...	Regularly scheduled (budgeted) to work 72 hours or more per pay period.
Part-time colleague ...	Regularly scheduled (budgeted) to work between 32 and 71 hours per pay period.

Your Family

You can enroll eligible family members for medical, dental, vision, life and AD&D coverage. Eligible dependents include:

- Your spouse to whom you are legally married.
As a Catholic entity, HSHS understands marriage as designed by God to be between one man and one woman, but is providing benefits under protest to spouses as defined and as required by the civil law.
- Dependent children up to age 26.
- Unmarried dependent child of any age who has a physical or mental disability and is incapable of self-sustaining employment, as long as the disability begins before the child reaches age 26; you must provide proof of the child's disability.

Eligible children include: your natural born children, stepchildren, adopted children or children in the process of being adopted, children for whom you are legal guardian and children of a legally-domiciled adult (for medical, dental, and vision coverage only). A dependent's child (your grandchild) who lives in your home and is dependent on you for primary support is also eligible; however, when the dependent (your child) reaches the plan's age limits, the grandchild's eligibility ends.

Legally-Domiciled Adults (LDAs)

Legally-domiciled adults (LDAs) and any eligible children that live with you may be eligible for coverage under your medical, dental and vision plan. An LDA is someone with whom you have an ongoing, exclusive and committed romantic relationship similar to marriage or an adult who is your tax dependent who lives with you. You must submit a notarized Legally Domiciled Adult Affidavit to the HSHS Colleague Service Center for proof that your LDA meets the HSHS criteria for coverage before coverage can begin. You will be notified when your LDA's eligibility has been verified.

You can find more information about legally-domiciled adults (LDAs) on the HSHS Benefits Website at benefits.hshs.org.

If you are enrolling a dependent under your Flexplan benefits for the first time, you will be asked to provide proof of your dependent's eligibility for coverage. You are required to submit this documentation within 30 days of enrollment. Examples of proof for a child may include the child's birth certificate or adoption decree. If you are enrolling a spouse, a copy of your marriage license will be required.

The plan will honor any Qualified Medical Child Support Order (QMCSO) issued by a domestic relations court. QMCSOs should be forwarded to the HSHS Colleague Service Center.

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If You and Your Spouse or LDA Both Work for HSHS

- Health, Dental and Vision Coverage - You may each enroll for coverage as a colleague, or one of you may be enrolled as a dependent of your spouse or LDA. You may not be covered as both a colleague and a dependent. Only one of you may cover your dependent children.
- Supplemental Life Insurance - You cannot elect coverage for your spouse or LDA, and only one of you may cover your dependent children.
- Voluntary AD&D - You may each elect colleague coverage, but only one of you may elect family coverage.
- Health Care FSA - You may each elect separate health care flexible spending accounts, but you cannot submit the same expense for reimbursement.
- Dependent Care FSA - You may each elect separate dependent care flexible spending accounts, but your combined election cannot exceed the \$5,000 annual maximum contribution.

If You Are Rehired

If you terminate employment after becoming eligible for Flexplan benefits and you are rehired within 90 days, you can participate in Flexplan benefits on your rehire date. If you are rehired within 30 days of your termination date, your prior Flexplan elections will be re-instated.



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Enrolling for Coverage

When you are ready to enroll for benefits:

1. Start your Internet browser and go to www.ezenroll.com.

You can also reach this site by clicking “Enroll” from benefits.hshs.org. Enter your Tri-Star account number or Social Security number (without dashes). If you already have a password established with Tri-Star, enter it in the password field. Otherwise, enter the last 4 digits of your Social Security number as your password. Click the “Submit” button.

2. Read the authorization statement, and then click “Continue” to go to the “Welcome” page.

3. Read and follow the on-screen instructions.

- Any current benefit elections you have will be displayed. During this time, you may also make changes to your personal, dependent, and/or beneficiary information, if applicable.
- Increases to supplemental life for you and/or your spouse may require the completion of an Evidence of Insurability form and approval by Securian prior to the increase going into effect. The Evidence of Insurability (EOI) form will be mailed directly to you from Securian. Return the completed form to Securian.

4. Print a copy of your online benefit elections summary.

If you make a mistake or wish to make further changes to your benefit selections, you can do so during the enrollment period. Simply sign back in and repeat the enrollment process again.

Visit Our Benefits Website

Review your benefits, learn what’s new, and make informed choices by using the resources on the HSHS Benefits Website!

Go to benefits.hshs.org to explore and find important benefit information.

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Coverage Options

When you enroll in medical (including prescription drug coverage), dental or vision coverage, you can choose from these coverage levels:

- Colleague only.
- Colleague + Spouse or LDA.
- Colleague + Child(ren).
- Colleague + Spouse/LDA and Child(ren).

You can choose different coverage levels for medical, dental and vision coverage – for example medical coverage for your family and dental and vision for just you. You can also waive medical, dental or vision coverage.

If You Do Not Enroll

If you are a new hire and you do not enroll by your enrollment deadline, you will have the following coverage by default:

- Basic life and AD&D insurance.
- Short-term disability coverage.
- Long-term disability coverage.
- Basic medical option for yourself only with after-tax deductions for your portion of the cost of this coverage.

This coverage will remain in effect for the 2018 calendar year. You cannot choose new options during the year unless you have a qualifying change in status.

Making Changes During the Year

Based on IRS rules, you can generally make changes during the year only if you have a qualifying change in your family or employment status, for example due to a marriage, birth, or change in job or location. Please see the HSHS Flexible Benefits Plan Summary Plan Description for more information.

Benefit changes must be consistent with the eligible life event. You must complete any necessary forms to make changes within 30 days of the life event in order to change your benefit elections. Colleagues should contact the HSHS Colleague Service Center.

If You Transfer to Another HSHS Facility

Your Flexplan benefits continue unchanged as long as you continue to meet eligibility requirements described on [page 5](#) and you do not change your primary home residence to one in Wisconsin. If your primary home residence changes to Wisconsin, your medical plan option will automatically change to the corresponding HSHS Healthy Plan option for Wisconsin. You cannot make changes to your benefit elections if you transfer. This is not a qualifying event for making changes during the year.

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Your Health and Well-Being

HSHS provides benefits and programs and other resources for your physical health and well-being, including:

- Preventive care benefits to keep you healthy.
- Medical and prescription drug coverage.
- LiveWELL Wellness Program.

And, there is a health care flexible spending account (FSA) to help you stretch your health care dollars. Read more about the health care and dependent care FSAs on [page 34](#).

Preventive Care Benefits

Because we work in health care, we probably know better than most how adopting a healthy lifestyle – eating nutritious foods, exercising and getting regular checkups – can help us stay well and avoid unpleasant surprises. When you have regular exams and take care of yourself, you can help keep more serious problems from developing. This can save time, money and worry ... and most importantly help you feel your best.

When you enroll in a medical option, HSHS pays for physical exams and health screenings to help you identify health risks early if you use a HSHS Preferred or Other Aetna provider. All HSHS medical options provide full preventive care coverage, with no annual cap on preventive care benefits. See the list of covered preventive care services on [page 21](#).

Healthy Partners

Healthy Partners serves members who visit the emergency room often and those with chronic conditions such as congestive heart failure, COPD, diabetes, high cholesterol, high blood pressure and coronary artery disease. The program also helps members transition care after a hospital stay.

Colleagues and their family members who are eligible for the program will be contacted by a care manager who will be available for telephone consultations and in-office visits at HSHS in Springfield, Illinois, St. Mary's in Decatur, Illinois and St. Vincent in Green Bay, Wisconsin. Participation in the program is voluntary and the program is strictly confidential; no identifying personal health information will be shared with HSHS.

The program's care managers will assist patients following a hospital stay or emergency room visit with education on their health condition, scheduling and preparing for doctor appointments, reviewing and managing medication needs and keeping a check on symptoms and their health condition.

HSHS is pleased to provide additional support to colleagues and family members through Healthy Partners.

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PerkSpot

PerkSpot gives you access to hundreds of exclusive discounts at some of your favorite national and local merchants, including discounts on:

- Automotive
- Beauty & Fragrance
- Books & Media
- Financial & Life Services
- Health & Wellness
- Home Services
- Sports & Outdoors
- Tickets
- Travel

Check out your savings from work, home, or on-the-go with any device!

Visit <http://benefits.hshs.org/Discounts-and-Forms> for more information.

Anytime Care Program

HSHS colleagues and dependents covered under the HSHS Healthy Plan have access to care 24 hours a day, 7 days a week. You can visit with a doctor with our Anytime Care program anytime, online or via the telephone. There is no cost to use the service for colleagues and eligible dependents enrolled in the HSHS Healthy Plan. **All medical options pay 100%, and the deductible does not apply.**

Contact the HSHS Anytime Care program to visit with a provider about many conditions, including allergies, asthma, cold and flu symptoms, rashes, and sinus infections. The service is available online at www.anytimecare.com, or you can call 1-844-391-4747 and speak with a provider.

The Anytime Care program is available to HSHS Healthy Plan participants (colleagues and dependents) in Arizona, California, Florida, Georgia, Illinois, Indiana, Iowa, Kentucky, Minnesota, Montana, Nebraska, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Utah, Washington, and Wisconsin. The HSHS Healthy Plan covers virtual care visits through the HSHS Anytime Care program only. Other virtual care programs are not covered by the HSHS Healthy Plan.

Visit Anytimecare.com

1. Select **Start Visit Now**: (HSHS Healthy Plan participants: disregard the \$29.00 pricing. A discount will be applied after Step 4 is completed, making your visit free).
2. Read through the **Emergency Check** and Select **Continue**.
3. Complete **Personal Information** and, if you are an HSHS Healthy Plan participant, select **HSHS Healthy Plan Participants** from the Program drop down.
4. Enter Your Member ID: This is your HSHS 6 digit Employee ID Number.

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LiveWELL Wellness Program

As a health system, our colleagues often encourage patients to make healthy lifestyle choices. Our wellness program — LiveWELL — is designed to empower you to live a life that's healthy, active and rewarding, so you can be a better role model for our patients and set a higher standard for the future of health care here at HSHS.

LiveWELL is available to all HSHS benefits-eligible colleagues and to spouses and legally-domiciled adults (LDAs) enrolled in the HSHS Healthy Plan.

You'll earn points and rewards for taking steps to improve your physical, emotional, financial and work well-being. The program helps you improve in the areas you care about with interactive technology that's fun and easy to use on your computer, tablet or phone.

You must enroll in the program to participate. To enroll, visit <http://hshs.limeade.com>.

- **For benefits-eligible colleagues:** Enter your work email address, your employee ID, your date of birth and follow the remaining login instructions. (You can find your Employee ID (six digit) number located on your HSHS ID badge; please include leading zeros)
- **For spouses/LDAs enrolled in the HSHS Healthy Plan:** Enter your personal/preferred email address, create and enter your user ID, enter your date of birth and follow the remaining login instructions. (To create your user ID, use the eligible colleague's ID with an appended "s" plus your date of birth - example: 012345s01011990)

LiveWELL

Complete Challenges to Earn Rewards

Each year, you'll have the opportunity to complete challenges to earn points and receive cash incentives.

- **Level 1:** Earn 1,000 points to receive \$15 per pay period
- **Level 2:** Earn 2,500 points to receive \$20 per pay period
- **Level 3:** Earn 5,000 points to receive \$25 per pay period

Have your spouse/LDA participate to earn twice the reward! (LDAs are eligible to earn points beginning January 1, 2018.)



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Medical and Prescription Drug Coverage

You have two Preferred Provider Organization (PPO) medical options through the HSHS Healthy Plan:

- Basic Option.
- High Option.

You may also choose to waive medical coverage.

About Your Medical Options

Both HSHS Healthy Plan options cover the same basic medical services. Your share of the cost of the medical services you receive differs. In general, as you increase the plan level (move from Basic to High) your biweekly payroll cost for coverage increases, while your cost of care (deductible amounts and coinsurance levels) decreases.

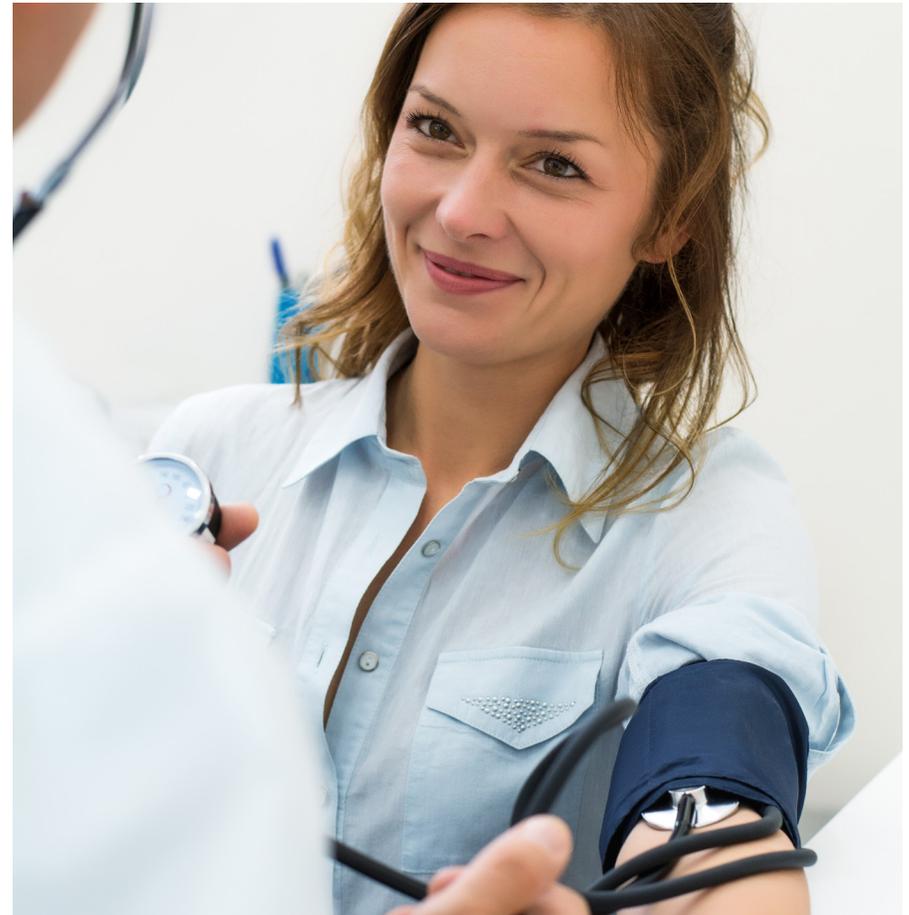
Both of the medical options offer a network of doctors, hospitals and health care specialists who deliver quality care according to network standards and have agreed to low, preferred rates for covered services.

There are three medical claims benefit tiers:

- HSHS Preferred
- Other Aetna
- Out-of-Network

You will receive the plan's best benefit when you use HSHS Preferred network providers.

Note: Care received from particular facilities will not be covered by the HSHS Healthy Plan. See the list of facilities excluded from HSHS Healthy Plan coverage on [page 14](#).



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Using In-Network Providers

For purposes of the HSHS Healthy Plan, network providers include:

- HSHS Facilities, HSHS Medical Group providers, Prairie Cardiovascular Consultants, HSHS Preferred Specialists, and HSHS Preferred Primary Care Physicians.
- Aetna network providers who are not excluded from HSHS Healthy Plan benefits. See [page 14](#).

When you use HSHS, HSHS Preferred or Other Aetna providers, you receive:

- Protection against unexpected charges above reasonable and customary (R&C), since HSHS and network providers charge preferred rates well within R&C limits.
- Freedom from claim forms, since HSHS and network providers file claims and bill the plan for payment — as a result, your money isn't tied up waiting for reimbursement.
- Savings through lower rates for services negotiated by Aetna, the network administrator.

Using Out-of-Network Providers

You have the flexibility to go outside the network, but you receive a lower level of benefit and pay more. If your out-of-network provider's charge exceeds the R&C rate, you will be responsible for paying the amount above R&C as well as the deductible and/or coinsurance amount that applies to the medical option you select. Any amounts you pay that are above R&C will not apply to your deductible or annual medical out-of-pocket limit.

Need Help Finding a Provider?

- To locate a provider in the HSHS Preferred or Other Aetna networks, go to benefits.hshs.org to find the link to Aetna's DocFind provider locator. HSHS Preferred providers will be listed on the Best Results for Your Plan tab. Other Aetna providers will be shown on the All Other Results tab.
- You may also call Aetna at 1-800-345-9474 for assistance in locating a provider.
- For assistance locating an HSHS Preferred Primary Care Physician, go to benefits.hshs.org, or call 217-492-9605. A patient care technician can help you schedule your first visit.

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Facilities Excluded from HSHS Healthy Plan Coverage

The HSHS Healthy Plan will not pay benefits for services received from particular facilities. HSHS is proud of our facilities, and we want to encourage colleagues to use HSHS facilities for their care. The utilization of our own facilities invests in our people and our organization, helping to build a stronger system of care in the communities we serve.

Abraham Lincoln Memorial Hospital (Lincoln, IL)

Anderson Hospital (Maryville, IL)

Apex Physical Therapy - All the following locations are excluded except for HSHS Holy Family Greenville locations (Beardstown, Belleville, Bethalto, Breese, Chester, Collinsville, Columbia, Glen Carbon, Effingham, Forsyth, Freeburg, Gillespie, Godfrey, Granite City, Highland, Lebanon, Lincoln, Litchfield, Maryville, Mascoutah, Mt Zion, O'Fallon, Paris, Smithton, Troy, Waterloo, Wood River, IL)

Aspirus (Wassau, Weston, WI)

ATI Physical Therapy Locations (Springfield, IL)

BJC Facilities

- Alton Memorial (Alton, IL)
- Alton Memorial Hospital Sports Performance Center (Alton, IL)
- BJC Home Care Services (Alton, IL and Park Hills, St. Louis, Sullivan, MO)
- BJC Home Medical Equipment (Alton, IL and Park Hills, St. Louis, Sullivan, MO)
- BJC Hospice (Alton, IL and Park Hills, St. Louis, Sullivan, MO)
- BJC Rehabilitation and Spine Center (St. Louis, MO)
- Barnes-Jewish Extended Care (St. Louis, MO and Clayton, MO)
- Barnes-Jewish Hospital (St. Louis, MO)
- Barnes-Jewish Hospital - Physical Medicine and Rehabilitation (St. Louis, MO)
- Barnes-Jewish St. Peters Hospital, (St. Peters, MO)
- Barnes-Jewish St. Peters Hospital Therapy Services (St. Peters, MO)
- Barnes-Jewish West County Hospital (St. Louis, MO)
- Barnes-Jewish West County Hospital STAR: Sports Therapy and Rehabilitation (Creve Coeur, MO and Chesterfield, MO)
- Boone Hospital Center (Columbia, MO)
- Boone Hospital Home Care (Columbia, MO)
- Boone Hospital Therapy (Columbia, MO)
- Christian Hospital (St. Louis, MO)
- Christian Hospital Northeast (St. Louis, MO)

BJC Facilities Continued

- Christian Hospital Outpatient Therapies (Florissant, MO)
- Eunice Smith Home (Alton, IL)
- Heart Care Institute (St. Louis, MO)
- Heart Care Institute Ambulatory Services (St. Louis, MO)
- Heart Care Institute Intensive Cardiac Rehab (St. Louis, MO)
- Human Motion Institute Rehabilitation Services (Alton, IL)
- Memorial Hospital (Belleville, IL)
- Memorial Hospital East (Shiloh, IL)
- Milliken Hand Center (Chesterfield, St. Louis, MO)
- Missouri Baptist Medical Center (St. Louis, MO)
- Missouri Baptist Medical Center Outpatient Rehabilitation (St. Louis, MO)
- Missouri Baptist Sullivan Hospital (Sullivan, MO)
- Missouri Baptist Sullivan Hospital Sports, Fitness and Rehabilitation Center (Sullivan, Cuba, MO) also known as Sports and Rehab Center - Cuba and Sullivan Sports & Rehab Center
- Northwest HealthCare (Florissant, MO)
- Parkland Health Center (Farmington, MO)
- Parkland Health Center Therapy Services (Bonne Terre, Farmington, MO)
- Progress West Hospital (O'Fallon, MO)
- St. Louis Children's Hospital (St. Louis, MO)
- St. Louis Children's Hospital - Pediatric Rehabilitation (Chesterfield, St. Louis, MO)
- The Rehabilitation Institute of St. Louis (St. Louis, MO)
- Transitional Care Program (Sullivan, MO)
- Transitional Care Unit (Alton, IL)
- Twin Rivers MRI (Alton, IL)
- Village North Health Center, also known as Village North Retirement Community, Rehabilitation and Nursing Center (St. Louis, MO)

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Facilities Excluded from HSHS Healthy Plan Coverage continued

<p>Carle Hospital (Champaign, IL) Decatur Memorial Hospital (Decatur, IL) Effingham Surgical Center (Effingham, IL) Elite Imaging (Fairview Heights, IL) Express Care - Anderson (Highland, Collinsville, Glen Carbon, Bethalto, IL) Fayette County Hospital (Vandalia, IL) Lakeview Medical Center (Marshfield, WI) Marshfield Clinic Center (Eau Claire, WI) Marshfield Clinic Center (Marshfield, WI) Marshfield Clinic Center (Minocqua, WI) Marshfield Clinic Center (Wausau WI) Mayo-Bloomer Hospital (Bloomer, WI) Mayo-Franciscan Skemp Hospital (Lacrosse, WI) Mayo-Osseo Hospital (Osseo, WI)</p>	<p>Mayo-Red Cedar Hospital (Menomonie, WI) Mayo Luther Midelfort Hospital (Eau Claire, WI) Mayo Northland Hospital (Barron, WI) MedExpress Locations (All locations, IL/MO) Memorial Medical Center (Springfield, IL) Ministry St. Clare Hospital (Weston, WI) Ministry St. Joseph's Hospital (Marshfield, WI) Orthopedic Center of Illinois (OCI) (Springfield, IL) Passavant Hospital (Jacksonville, IL) Phoenix Physical Therapy (Swansea, Highland, East Alton, Greenville, Breese, Vandalia, Shelbyville, IL) Sara Busch Lincoln (Mattoon, IL) Springfield Clinic - except Effingham location (Springfield, IL) Taylorville Memorial Hospital (Taylorville, IL)</p>
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Using HSHS Services

Because HSHS is proud of the service our colleagues deliver to patients and equally proud of our facilities, the medical options offer preferred benefits when you or your dependents choose care at an HSHS hospital or receive care from an HSHS Preferred Primary Care Physician or HSHS Preferred Specialist. The plan provides an incentive to use HSHS Facilities and HSHS Preferred Primary Care Physicians whenever you can — with no deductibles and lower coinsurance and out-of-pocket maximums.

You pay the lowest amount out of your pocket for primary care physician services when you receive care from an HSHS Preferred Primary Care Physician provider. For purposes of the HSHS Healthy Plan, a primary care physician includes family medicine, internal medicine, general practice physicians, and pediatricians plus nurse practitioners and physician assistants.

When you need care from a specialist, you will receive the Plan's best benefit when you receive care from an HSHS Preferred network provider. Lesser benefits apply to services received from Other Aetna network providers.

There will be no exceptions to cover care received from Other Aetna primary care physicians at the HSHS Preferred Primary Care Physician benefit level. Similarly, there will be no exceptions to cover care received from Other Aetna Specialists at the HSHS Preferred Specialist benefit level.

As you consider options, keep in mind:

- Except for weight loss surgery, when no HSHS Facility offers the inpatient service or outpatient service you need within 65 miles of your home and the care is received more than 65 miles from an HSHS Facility that provides the required service — the HSHS deductibles and out-of-pocket maximums for your option apply. This special provision applies to hospital facility charges only and does not apply when the service is received from an out-of-network provider. Requests should be submitted prior to receiving the inpatient or outpatient service. If that is not possible, requests for claims adjustments must be submitted within one year of the date of service.
- Emergency room care – for true medical emergencies, care is covered at the same benefit level, whether you go to HSHS or another facility, regardless of whether that facility participates in the Aetna PPO network. True emergencies may include seizures, loss of consciousness, severe and/or persistent chest pain, severe bleeding and shortness of breath.

To receive the HSHS Facility benefit level, care must be billed under an HSHS provider ID number on a UB form.

We are proud of the services our colleagues and partners deliver to patients, and we hope this offers an additional incentive to consider an HSHS provider when you or a family member needs specialty care.

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Is It a Facility or Professional Service?

The benefits provided by the HSHS Healthy Plan differ based on whether you obtain services from an HSHS Preferred provider, an Other Aetna Network provider or an out-of-network provider. The Plan's benefits also differ depending on whether the service is provided and billed as a facility service or as a professional service.

Examples of Typical Facility and Professional Services

Inpatient hospital stay for surgery

- Typically, the hospital (facility) will bill for room and board for the days you stay in the hospital, the operating room, the anesthesia you receive (but not the anesthesiologist's services), any prescription drugs you receive while in the hospital, any supplies used for your care, blood tests and other lab work plus any imaging services, like x-rays or CAT scans you may have while in the hospital. All of these services are usually billed as facility services.
- Physicians' fees for your surgery, administration of anesthesia, consultations while you are in the hospital, or to read imaging results or analyze tissue samples are usually billed as professional services.

Outpatient surgery

- The hospital or ambulatory surgical center will bill for the operating room, the anesthesia you receive, any supplies used for your care, blood tests and other lab work and any imaging services you receive. All of these services are usually billed as facility services.
- Physicians' fees for your surgery, administration of anesthesia, or to read imaging results or analyze tissue samples are usually billed as professional services.

Physician's office visit

The majority of services that occur in a physician's office are billed as professional services. These include the office visit itself, removal of lesions, biopsies and other procedures performed by your physician.

- The exceptions are lab work, like blood tests, and strep tests which may be billed by your physician as professional services but often are billed as facility services by another party. Some physicians utilize providers like LabCorp, Quest or a hospital lab for processing lab work or may refer you to one of these providers.
- EKGs and similar tests and imaging services received in a physician's office may be billed by your physician as professional services or may be billed as facility services.

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Lab and Imaging Services

To minimize your out-of-pocket expense for lab services, be sure to use an HSHS facility or Quest Diagnostics for all your lab services. (Quest Diagnostics is an HSHS Preferred network provider).

You will receive the best benefit for lab and imaging services, like x-rays, CAT scans and MRIs if you and all of your doctors use HSHS facilities or Quest Diagnostics for all of your lab and imaging needs. If Other Aetna facility providers perform or bill for your lab or imaging services, the Other Aetna PPO Provider deductible applies, plus lower plan coinsurance and a higher out-of-pocket limit. The highest out-of-network deductible and out-of-pocket limit plus the lowest plan coinsurance applies to lab and imaging services received from out-of-network providers.

Remember, there will be no coverage for lab or imaging services performed or billed by particular excluded facilities. This applies even if your lab or imaging results occur at your network physician's office, but your physician uses one of the excluded facilities for your services or if your network physician directs you to an excluded facility for services. See [page 14](#) for a list of the excluded facilities.

Inform all of your doctors to send all of your lab work to an HSHS Facility or Quest Diagnostics. If they send your lab work to another facility or provider for processing, you will receive reduced or no benefits for those services.

Prior Authorization

Prior authorization from Aetna is required for many services, such as hospital stays, skilled nursing facility stays, behavioral health and substance abuse stays, home health care, private duty nursing, residential facility stays, and hospice. HSHS Preferred and Other Aetna providers will handle prior authorization for you. If the network provider does not obtain the prior authorization, you will not be responsible for any applicable penalties.

For services with other providers, you will be responsible for making sure prior authorization is obtained. If prior authorization is not obtained, your benefits will be reduced by 30%. Call Aetna at 1-800-345-9474 for more information.

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Get Support from Aetna

For assistance during annual enrollment and throughout the year, call 1-800-345-9474. An Aetna customer service representative will be available to answer your questions.

If you are enrolling in the HSHS Healthy Plan for the first time, you will receive an Aetna ID card. Once you receive your Aetna ID card, register on Aetna Navigator at www.aetna.com (select the Log in/Register box). Once you are registered, you can:

- Find a provider
- Save on health-related products and services
- View benefits, deductibles and plan limits
- Get instant access to claims and Explanation of Benefits statements
- Find forms and view/print ID cards
- Get help from Ann, Aetna's virtual assistant

Connect to Savings

Aetna offers discounts on a host of health and wellness products and services. You can receive discounts on hearing exams and hearing aids. Aetna also provides discounts on natural therapy services, such as massage therapy and acupuncture, as well as discounts on over-the-counter vitamins, nutritional supplements and other health products.

Need help to get in shape? You can get discounts on gym memberships at participating GlobalFit gyms, home exercise equipment and on weight-management programs, such as Jenny Craig, CalorieKing and Nutrisystem. Visit www.aetna.com for more information and to connect to savings for your health and wellness.

You can also find flyers on Aetna's discount programs on the HSHS Benefits website, benefits.hshs.org.

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Key Health Care Terms

Deductible	Dollar amount you must pay for covered care each calendar year before the medical plan pays benefits for many services. The deductible does not apply to doctor office visit charges for HSHS Preferred physicians, covered preventive care, lab and x-ray services unless provided or billed by Other Aetna facilities or Out-of-Network providers, emergency room facility charges for true emergencies, or HSHS Facility and HSHS Preferred PCP charges. A family limit applies to the amount of individual deductibles your family must meet in total. A separate annual, per person, deductible applies to prescription drug benefits.
Coinsurance	Percentage of the cost for eligible medical expenses that you pay after you meet the deductible. For example, if you are admitted to an HSHS Facility for care and you are enrolled in the High Option, the plan pays 85% of covered costs and you pay the remaining 15% up to the plan's out-of-pocket maximum. The 15% is your coinsurance.
Network Providers	Providers who have agreed to lower rates negotiated by Aetna. You receive the highest level of benefit when you use HSHS Facilities, HSHS Preferred Primary Care Physicians, and HSHS Preferred Specialist Physicians. The next highest benefit level applies to Other Aetna network providers.
Out-of-Network Providers	Providers who do not participate in the HSHS Preferred or Other Aetna network for HSHS. When you use out-of-network providers, you receive the plan's lowest level of benefit, and generally you pay more for services. Note: There is no coverage for particular health care facilities .
Out-of-Pocket Maximum	Maximum dollar amount that you pay for eligible expenses in a calendar year. The plan pays 100% of eligible expenses for the rest of the calendar year after the out-of-pocket maximum is reached — providing financial protection for you by limiting your out-of-pocket expenses in a given calendar year.
<ul style="list-style-type: none"> Medical Services Prescription Drugs 	<p>The annual deductible for medical services applies to the medical out-of-pocket maximum. However, out-of-network costs that exceed usual and customary limits, costs for services not covered by the HSHS Healthy Plan and benefit reductions as a result of not complying with pre-certification do not apply to the out-of-pocket maximum. If you enroll your spouse/LDA and/or children, a family out-of-pocket limit applies for all eligible expenses your family has. Note: charges for services provided by excluded facilities do not apply to your deductible or out-of-pocket maximum.</p> <p>A separate out-of-pocket maximum applies to prescription drug benefits. The prescription drug deductible applies to the prescription drug out-of-pocket maximum.</p>
Reasonable & Customary (R&C)	The usual cost or "going rate" for a particular health service in your geographic area — R&C applies to non-network charges.

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Compare Your Medical Plan Options

Wellness/Preventive Care

Both HSHS medical options pay 100% of charges, with no deductible, for the following preventive services when received from an HSHS Preferred or Other Aetna provider:

- Periodic recommended pediatric and annual adult examinations, including screenings for tobacco use and health education/counseling.
- Routine pediatric and adult immunizations and inoculations for infectious disease, as medically necessary.
- Mammogram annually.
- Prostate specific antigen (PSA) test.
- Colorectal cancer screening.
- Digital rectal exam (prostate exam).
- Gynecological examination – including pelvic and manual breast exams, Pap test, and urinalysis.
- Human papillomavirus (HPV) DNA testing for women age 30 and older, regardless of Pap smear results.
- Hearing screening.
- Colonoscopies and sigmoidoscopies.
- For those who use tobacco products, two tobacco cessation attempts per year. Each attempt includes:
 - Up to four tobacco cessation counseling sessions of at least 10 minutes each
 - FDA-approved tobacco cessation medication for a 90-day treatment regimen when prescribed by a health care provider.

- With prior authorization from Aetna, diabetes education sessions for individuals diagnosed with diabetes.
- The following diagnostic lab tests when ordered at the time of a covered preventive care visit: cholesterol screening, blood glucose, complete blood count (CBC), thyroid and fecal occult blood tests.

In 2018, the HSHS Healthy Plan will continue to cover contraceptives only when medically necessary.

The HSHS Healthy Plan will not cover:

- Physical exams and related tests and reports solely for the purpose of obtaining or maintaining employment, insurance, governmental licensure, attending camp, participating in sports, admission to school and for premarital purposes.
- Vaccinations and inoculations required solely for travel or recreational purposes.

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Compare Your Medical Plan Options

Deductibles and Your Out-of-Pocket Maximums

- Amounts that apply to any deductible category are credited to all other deductible categories.
- Amounts that apply to any out-of-pocket maximum category are credited to all other out-of-pocket maximum categories. For example, if you receive covered services from an Other Aetna Specialist Physician that result in your meeting \$500 of the Other Aetna Network Specialist Physician out-of-pocket maximum, \$500 will also be credited to the out-of-pocket maximums that apply to HSHS Facility, HSHS Preferred PCP, HSHS Preferred Specialist, Other Aetna PCP, Other Aetna Facility, and Out-of-Network services.
- No deductible applies to services you receive from an HSHS Facility or an HSHS Preferred Primary Care Physician.

Basic	HSHS Preferred			Other Aetna			Out of Network
	Facility	Primary Care Physician	Specialist Physician	Facility	Primary Care Physician	Specialist Physician	Facility or Professional
Annual Medical Deductible	<i>all cross apply</i>						
Per Individual	None	None	\$1,800	\$3,600	\$3,600	\$3,600	\$7,000
Family Limit	None	None	\$3,600	\$7,200	\$7,200	\$7,200	\$14,000
Annual Medical Out-of-Pocket Limit (includes medical deductible)	<i>all cross apply</i>						
Per Individual	\$3,800	\$3,800	\$3,800	\$5,400	\$5,400	\$5,400	\$14,000
Family Limit	\$7,600	\$7,600	\$7,600	\$10,800	\$10,800	\$10,800	\$28,000

High	HSHS Preferred			Other Aetna			Out of Network
	Facility	Primary Care Physician	Specialist Physician	Facility	Primary Care Physician	Specialist Physician	Facility or Professional
Annual Medical Deductible	<i>all cross apply</i>						
Per Individual	None	None	\$900	\$1,800	\$1,800	\$1,800	\$3,500
Family Limit	None	None	\$1,800	\$3,600	\$3,600	\$3,600	\$7,000
Annual Medical Out-of-Pocket Limit (includes medical deductible)	<i>all cross apply</i>						
Per Individual	\$3,000	\$3,000	\$3,000	\$6,000	\$6,000	\$6,000	\$12,000
Family Limit	\$6,000	\$6,000	\$6,000	\$12,000	\$12,000	\$12,000	\$24,000

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Covered Care and Services

The percentages in the following table are the percentages the plan pays. These do not reflect any services not covered by the plan, benefit reductions caused by not complying with precertification, or out-of-network charges that exceed reasonable and customary limits for which you are also responsible.

	Basic							High						
	HSHS Preferred			Other Aetna			Out of Network	HSHS Preferred			Other Aetna			Out of Network
	Facility	Primary Care Physician	Specialist Physician	Facility	Primary Care Physician	Specialist Physician	Facility or Professional	Facility	Primary Care Physician	Specialist Physician	Facility	Primary Care Physician	Specialist Physician	Facility or Professional
Wellness and Preventive Care	100% no deductible						No coverage	100% no deductible						No coverage
Annual Medical Deductible	<i>all cross apply</i>							<i>all cross apply</i>						
Per Individual	None	None	\$1,800	\$3,600	\$3,600	\$3,600	\$7,000	None	None	\$900	\$1,800	\$1,800	\$1,800	\$3,500
Family Limit	None	None	\$3,600	\$7,200	\$7,200	\$7,200	\$14,000	None	None	\$1,800	\$3,600	\$3,600	\$3,600	\$7,000
Annual Medical Out-of-Pocket Limit (includes medical deductible)	<i>all cross apply</i>							<i>all cross apply</i>						
Per Individual	\$3,800	\$3,800	\$3,800	\$5,400	\$5,400	\$5,400	\$14,000	\$3,000	\$3,000	\$3,000	\$6,000	\$6,000	\$6,000	\$12,000
Family Limit	\$7,600	\$7,600	\$7,600	\$10,800	\$10,800	\$10,800	\$28,000	\$6,000	\$6,000	\$6,000	\$12,000	\$12,000	\$12,000	\$24,000
Physician Charges														
Office Visit Charge/Allergy Serums/ Injections	N/A	HSHS: 100% ¹ Non-HSHS: 90%	HSHS: 100% ¹ Non-HSHS: 80%	N/A	75%*	75%*	50%*	N/A	HSHS: 100% ¹ Non-HSHS: 95%	HSHS: 100% ¹ Non-HSHS: 90%	N/A	85%*	85%*	50%*
Spinal Manipulation (up to 10 visits per calendar year)	N/A	N/A	80%*	N/A	N/A	75%*	50%*	N/A	N/A	90%*	N/A	N/A	85%*	50%*
Surgery/Procedure/All Other	N/A	90%	80%*	N/A	75%*	75%*	50%*	N/A	95%	90%*	N/A	85%*	85%*	50%*
Outpatient Imaging and Lab														
Advanced Imaging ²	75%	75%	75%	55%*	75%	75%	50%*	85%	85%	85%	65%*	85%	85%	50%*
Other Imaging & Lab	75%	75%	75%	55%*	75%	75%	50%*	85%	85%	85%	65%*	85%	85%	50%*
Hospital/Facility Charges IP/OP	75%	N/A	N/A	55%*	N/A	N/A	50%*	85%	N/A	N/A	65%*	N/A	N/A	50%*

* after Annual Medical Deductible is met

¹ HSHS includes HSHS Medical Group and Prairie Cardiovascular Consultant providers.

² Advanced imaging includes PET, CAT, MRI, MRA, bone density and sleep study.

³ Same as HSHS means that the HSHS deductible, Coinsurance percentage, and out-of-pocket maximum apply.

⁴ Therapy Services include physical, occupational and speech therapy, radiation therapy, chemotherapy and electroconvulsive therapy.

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Covered Care and Services continued

	Basic							High						
	HSHS Preferred			Other Aetna			Out of Network	HSHS Preferred			Other Aetna			Out of Network
	Facility	Primary Care Physician	Specialist Physician	Facility	Primary Care Physician	Specialist Physician	Facility or Professional	Facility	Primary Care Physician	Specialist Physician	Facility	Primary Care Physician	Specialist Physician	Facility or Professional
Emergency Room Care														
True Emergency	\$100 copay then 75%	N/A	75%*	Same as HSHS ³	N/A	Same as HSHS ³	Same as HSHS ³	\$100 copay then 85%	N/A	85%*	Same as HSHS ³	N/A	Same as HSHS ³	Same as HSHS ³
Other Conditions	\$300 copay then 70%	N/A	70%*	55%*	N/A	70%*	50%*	\$300 copay then 70%	N/A	70%*	65%*	N/A	70%*	50%*
Ambulance	75%	N/A	75%	75%	N/A	75%	75%	85%	N/A	85%	85%	N/A	85%	85%
Private Duty Nursing	75%	75%	75%	75%	75%	75%	50%*	85%	85%	85%	85%	85%	85%	50%*
Home Health Services and Hospice	75%	75%	75%	75%	75%	75%	50%*	85%	85%	85%	85%	85%	85%	50%*
Virtual Care Office Visit	N/A	100%	N/A	N/A	N/A	N/A	N/A	N/A	100%	N/A	N/A	N/A	N/A	N/A
Mental Health and Substance Abuse														
Office Visits	N/A	90%	80%	N/A	75%	75%	50%*	N/A	95%	90%	N/A	85%	85%	50%*
Other Outpatient	75%	90%	80%	75%	75%	75%	50%*	85%	95%	90%	85%	85%	85%	50%*
Inpatient	75%	90%	80%	75%	75%	75%	50%*	85%	95%	90%	85%	85%	85%	50%*
Outpatient Therapy Services⁴, Outpatient Cardiac Rehab, DME	75%	N/A	75%	75%	N/A	75%	50%*	85%	N/A	85%	85%	N/A	85%	50%*
Other Covered Services	75%	N/A	75%	75%	N/A	75%	50%*	85%	N/A	85%	85%	N/A	85%	50%*
Lifetime Benefit Maximum	Unlimited							Unlimited						

* after Annual Medical Deductible is met

¹ HSHS includes HSHS Medical Group and Prairie Cardiovascular Consultant providers.

² Advanced imaging includes PET, CAT, MRI, MRA, bone density and sleep study.

³ Same as HSHS means that the HSHS deductible, Coinsurance percentage, and out-of-pocket maximum apply.

⁴ Therapy Services include physical, occupational and speech therapy, radiation therapy, chemotherapy and electroconvulsive therapy.

Prescription Drug Coverage

Medical Option	Basic	High
	Annual Deductible	\$400 per person
Annual Out-of-Pocket Maximum	\$1,600 per person \$3,200 family limit	\$1,300 per person \$2,600 family limit
Generic: Preferred Brand: Non-preferred (non-formulary) Brand Retail: Non-Preferred (non-formulary) Brand Mail Service:	80% after deductible 70% after deductible \$15 per prescription, then the plan pays 70% after deductible (up to 30-day supply per fill) \$45 per prescription, then the plan pays 70% after deductible (up to 90-day supply per fill)	

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More About the Medical Plan's Prescription Drug Coverage

When you enroll in an HSHS Healthy Plan medical option, you will automatically have prescription drug coverage. If you take any medications regularly, prescription drug costs can add up to a significant part of your overall health care expenses. Knowing how your medical plan's prescription drug coverage works and what to do to manage costs can help you make good buying decisions and lower your out-of-pocket costs.

The program features coverage for both prescriptions you fill at your participating local retail pharmacy and a mail service. After you meet the separate prescription drug deductible for your medical plan option, you pay coinsurance. When you reach the prescription drug out-of-pocket maximum for your medical plan option, the plan pays the full cost of your prescriptions for the rest of the calendar year, with the exception of the ancillary fee that applies when you receive a brand-name drug for which a direct generic equivalent exists.

Prescription drug benefits feature a formulary or preferred drug list for brand-name drugs. Your cost for brand-name drugs will be lower when you use a drug on the Express Scripts preferred drug list. For brand-name drugs that are not on the list, you will pay an additional \$15 per prescription for prescriptions filled at a retail pharmacy (up to 30-day supply) and an additional \$45 for prescriptions filled through mail service.

For support during enrollment and throughout the year:

- Visit www.express-scripts.com/HSHS.
- Call 1-800-841-5345 to speak with a member services representative.

See www.express-scripts.com/HSHS for the top 200 medications on the 2018 Formulary List or use the Formulary look-up option on that site to determine if a medication has preferred status.

Retail Pharmacy

It's easy to purchase your prescription in the Express Scripts network.

- Simply present your Express Scripts card to the pharmacist.
- Pay your part of the prescription cost; no claim forms are required.

You can buy up to a 30-day supply of medication. To find out if a pharmacy is part of the Express Scripts network, ask your pharmacy or visit www.express-scripts.com/HSHS.

You must use a network pharmacy to receive the prescription drug benefit. Claims from non-network pharmacies will not be accepted.

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More About the Medical Plan's Prescription Drug Coverage

Mail Service

Use the mail service option through Express Scripts to purchase any prescribed drugs you take to treat an ongoing medical condition, such as high blood pressure or diabetes. In fact, you are required to use mail service after having a maintenance medication filled two times at a retail pharmacy. When you use mail service:

- You can get a 90-day supply of your medication at one time, rather than the 30-day supply available at a retail pharmacy.
- You benefit from the convenience of home delivery with no cost for standard delivery.
- You will generally pay less than you would at the retail pharmacy. That's because you don't pay a dispensing fee for mail service, while a dispensing fee is included in the cost of your retail prescriptions and mail service generally has a lower price because it buys in very large quantities.

Remember:

After a maintenance prescription is filled twice at a retail pharmacy, you must use mail service for subsequent refills to be covered by the HSHS Healthy Plan's prescription drug coverage.

Ancillary Fee

If you receive a brand-name drug when a generic is available, you are responsible for paying the difference in price between the brand-name drug and its generic equivalent. You will also be responsible for your generic coinsurance, and if you choose a non-preferred (non-formulary) brand-name drug, an additional copay. The difference in price between the brand-name drug and its generic equivalent is the ancillary fee, and you will be responsible for the ancillary fee, even if your physician writes "dispense as written" (DAW1) on your prescription.

For example, if you choose a 30-day supply of Avapro, a non-formulary brand-name drug, you will pay an ancillary fee of about \$163.17 (the difference in price between Avapro and its generic equivalent, Irbesartan), plus a \$15 copay for using a non-formulary medication. This is in addition to your normal deductible and coinsurance.

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It's easy to order by mail!

Ask your doctor to write a prescription for up to a 90-day supply, plus refills for up to one year (if applicable). To fill the prescription, you may:

- Ask your doctor to send the prescription electronically or call 1-888-327-9791 for instructions on how to fax the prescription. Your doctor must have your member ID number to fax your prescription.
- To transfer a current retail prescription to home delivery, call Express Scripts toll-free at 1-800-753-8065. You will need to have your prescription number handy when you call.
- Home delivery refills and renewals can be ordered through the Express Scripts website after registering at www.express-scripts.com. Include your home delivery copayment (acceptable forms include credit/debit card, electronic check, money order, MasterPass or PayPal).

Your medication will arrive by mail within 8 days of mailing your initial prescription.

To get refills, you can sign up for automatic refills and Express Scripts will automatically refill for you. You can also order a refill online or by phone anytime, 24 hours a day, 7 days a week, but be sure to order when you have 30 days (or one month) of medication remaining so you don't run out.

If you have questions about ordering for home delivery, call the member services number on your Express Scripts member ID card.



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Specialty Medications through Express Scripts

If you take any oral or injectable specialty medications, that are self-administered drugs, you must purchase these medications through the Express Scripts specialty pharmacy. Specialty medications include those used to treat multiple sclerosis, hepatitis C, rheumatoid arthritis, hemophilia and self-administered oral cancer medications.

You may fill your initial prescription at a retail pharmacy. After that, subsequent refills must be placed through the specialty pharmacy. The Express Scripts specialty pharmacy provides better discounts than retail costs. You'll also receive delivery of specialty medication and supplies to your home, doctor's office, or any other location, usually within 24 hours - and you have access to call center assistance, so you can talk toll-free with pharmacists and nurses.

Access the Express Scripts Mobile App

You can manage your prescription benefit while on the go. With your member ID number handy, go to www.express-scripts.com or download the Express Scripts Mobile App from your device's store.

- Click *Register now*.
- Complete the requested information, including personal information and member ID, and create your user name and password.
- Click *Register now*.

Use the app to locate a pharmacy, view your prescription ID card, track the order status of your prescription home delivery, refill and renew prescriptions and check drug interactions.

Managing Prescription Drug Costs

During the year, use the mail service for convenience and to save on your cost for maintenance medications. You can check out your options and the cost savings at www.express-scripts.com. The Price a Medication Tool not only lets you see how much a drug costs at retail in comparison to mail service, it also lists any generic and therapeutically equivalent medications, with their prices, so that you can discuss alternatives with your doctor if you want.

In addition, if you participate in the Health Care FSA, you can use this account to fund your share of the cost of covered prescriptions and save on taxes!

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When Prior Authorization or Step Therapy Is Required

To encourage safe and cost-effective medication use, Express Scripts may require prior authorization or step therapy for certain prescription drugs. Benefit determinations for medications are based on a review of your medical history and current condition by an Express Scripts team.

If you attempt to fill a prescription for a medication included in the prior authorization or step therapy program and the program criteria have not been met, your claim will be rejected. The pharmacy will receive a message that prior authorization or step therapy is required, along with a phone number that the pharmacy should contact for further information. You can still choose to purchase the medication, but you will be responsible for the full cost.

Prior Authorization

If your medication is included in the prior authorization program, your physician will need to get approval through Express Scripts before it will be covered by the HSHS Healthy Plan. If you are prescribed a medication that is part of the program, your physician can submit a prior authorization request form so your prescription can be considered for coverage. Your physician will need to submit a new request to Express Scripts when an existing authorization expires.

If your request is not approved, you may want to talk to your physician to find out if another medication might work for you. If your request is denied, you can still purchase the medication, but you will be responsible for the full cost.

Step Therapy

Under this program, a “step” approach is required to receive coverage for certain medications. This means that you may need to first try a proven cost-effective medication before a more costly treatment, if needed, is covered.

If your physician determines that the first-line medication is not appropriate or effective for you, your HSHS Healthy Plan prescription drug benefit will cover the medication that is subject to step therapy when certain conditions are met and approval has been obtained from Express Scripts.

If you start taking a medication that is included in the step therapy program, your physician will need to write you a prescription for a first-line medication or submit a prior authorization request for the prescription before you can receive HSHS Healthy Plan prescription drug coverage for the medication.

To see a sample list of medications included in each program, go to www.express-scripts.com. Your physician can obtain a prior authorization request form by calling 1-800-698-3757. If you have questions about the prior authorization or step therapy program, call 1-800-698-3757.

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Selecting Your Medical Plan Option

Before choosing a medical plan option, you'll want to think about who you will cover, the types of health needs you anticipate during 2018, and your costs.

Specifically, the two types of costs are:

- Your cost of coverage – that's your biweekly paycheck net contribution for each option based on your regularly scheduled (budgeted) work hours and the coverage level you choose.
- Your cost of care or out-of-pocket cost – deductible and coinsurance amounts for the option you select based on the services you receive and where you receive your care; choosing to use an HSHS Facility, HSHS Preferred Primary Care Physician, HSHS Preferred Specialist, Other Aetna provider or going outside of the Aetna PPO network for care affects this cost.

HSHS Healthy Plan Cost Estimator

The calculator offers an easy way to compare relative costs under your medical plan options before you make your enrollment decisions.

Get started:

Go to benefits.hshs.org and click the *HSHS Healthy Plan Cost Estimator* link.

There are four easy steps:

- 1** In Step 1, indicate your work location, who you plan to cover, and your regularly scheduled/budgeted work hours per pay period.
- 2** Then, enter your expected plan usage. You can use the “pre-filled example” or customize the scenario by estimating how often you and each family member will use specific health services in 2018.
- 3** Once you complete Step 2, you'll see your total cost for each option.
- 4** Then, use the results to see how contributing to a Health Care FSA might help you save in taxes.

Because costs vary by provider and not all possible medical services are included in the tool, your actual costs may vary.

Not sure what services you'll need in 2018?

No one can predict exactly what their health care needs will be in the coming year. Sometimes past history can help you think that through.

If you're enrolled in an HSHS medical option, you can get your medical history at www.aetna.com and your prescription drug history at www.express-scripts.com/HSHS.

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Dental Coverage

The Flexplan provides two dental plan options to help you care for your teeth and gums:

- Basic Option.
- High Option.

What the Dental Plan Covers

The dental options provide coverage for preventive and diagnostic services, basic and major care. When you enroll in the High Option, orthodontia is also covered for you and your eligible dependents.

Cigna contracts with dentists and other dental care providers in all of the communities where HSHS is located. If you use network dentists, you can save money. Go to myCigna.com to see which dental offices participate in the Cigna DPPO network.

Benefits are based on reasonable and customary (R&C) – the usual cost or “going rate” for a particular dental service in your geographic area. You are responsible for any charges that exceed R&C.

When you use Cigna DPPO network dentists, you receive protection against charges above R&C, since network dentists charge preferred rates well within R&C limits.

The chart on this page highlights some commonly used services and shows how the dental plan options compare.

Dental Option	Basic	High
Annual Deductible	\$50/person, up to \$150/family maximum	\$25/person, up to \$75/family maximum
Annual maximum benefit	\$800/person	\$1,500/person (not including orthodontia)
Preventive care and diagnostic services , including: <ul style="list-style-type: none"> • Up to two exams in a calendar year. • Up to two cleanings in a calendar year. • Complete set of x-rays in a 36-month period. • Up to two fluoride treatments for children under age 19 in a 12-month period. 	100% R&C, no deductible	100% R&C, no deductible
Basic care services , including: <ul style="list-style-type: none"> • Fillings. • Extractions. • Root canal therapy. • Oral surgery. • Repair of dentures and bridges. 	85% R&C after deductible	85% R&C after deductible
Major care services , including: <ul style="list-style-type: none"> • Crowns. • Bridges. • Dentures. 	50% R&C after deductible	50% R&C after deductible
Orthodontia	Not covered	50% R&C after annual deductible and additional \$25 charge \$1,500/person lifetime maximum benefit

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Vision Coverage

You have three vision coverage options available to you.

VSP Vision Plan

The VSP Vision Plan provides coverage for eye exams, lenses, frames and contact lenses plus discounts on many vision services and products. No deductible applies to VSP vision benefits.

The chart on this page highlights some commonly used services and shows the vision plan's benefits.

The VSP Vision Plan also provides hearing aid discounts through TruHearing®. With TruHearing, VSP members can save up to \$2,400 on a pair of hearing aids.

If you have questions about the VSP Vision Plan, contact Vision Service Plan (VSP) at 1-800-877-7195 or go to www.vsp.com.

Cigna Vision and Aetna Vision Discount Programs

Colleagues who enroll in Flexplan dental coverage have the Cigna Vision discount program. Additionally, if you are enrolled in HSHS Healthy Plan coverage you have access to the Aetna Vision discounts program. The vision discount programs provide savings on routine eye exams and purchases of frames and lenses, including contacts. To view discount information for vision care services for Cigna Vision and Aetna Vision, go to benefits.hshs.org. To find a Cigna Vision provider, go to www.cigna.com. To locate an Aetna Vision provider, go to www.aetna.com.

Note: The HSHS Healthy Plan covers medically necessary vision services, like diabetic retinopathy exams and cataract surgery.

	VSP Network Providers	Other Providers
Vision Exams (once every 12 months)	Covered in full after \$15 copay	Up to \$45 reimbursement
Lenses (once per 12 months) <ul style="list-style-type: none"> • Single Vision • Bifocal • Trifocal • Lenticular • Progressive Bifocals <ul style="list-style-type: none"> - Standard - Premium • UV Coating • Tint • Scratch Resistance • Anti-reflective (standard) • Basic Polycarbonate 	Covered in full Covered in full Covered in full Covered in full \$55 copay \$95-\$105 copay \$16 copay \$0-\$15 copay \$17 copay \$41 copay Children - \$0 copay Adults - \$31-\$35 copay 20% - 25% discount	Reimbursement Up to \$30 Up to \$50 Up to \$65 Up to \$100 Up to \$55 Up to \$55 Not covered Not covered Not covered Not covered Not covered Not covered
Frames (once every 12 months)	\$150 allowance 20% off balance	Up to \$70 reimbursement
Contact Lenses (once every 12 months in lieu of frames and lenses) <ul style="list-style-type: none"> • Medically Necessary • Elective • Fit & Follow up 	\$0 copay \$130 allowance \$0 copay	Reimbursement Up to \$210 Up to \$105 Not covered
Other	<ul style="list-style-type: none"> • Prescription sunglasses: 20% discount • Low vision aid: 75% of cost up to \$1,000 every 2 years • Laser surgery: 15% discount off regular price (5% off promotional price) at select providers 	Not covered

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Flexible Spending Accounts (FSAs)

Flexplan offers two flexible spending accounts:

- Health Care FSA.
- Dependent Care FSA.

How FSAs Work

- You contribute to the account(s) with pre-tax dollars deducted from your paycheck. This lowers your taxable income, and you don't pay taxes on the money you use from your account(s).
- When you enroll, you decide how much to set aside in your account(s) during the calendar year for:
 - Health care expenses for services you or your dependents receive between January 1, 2018, and March 15, 2019.
 - Dependent day care expenses for services you receive between January 1, 2018, and December 31, 2018.
- When you have an eligible expense, you file a claim to reimburse yourself from your account.

FSAs are like a sale. Money you set aside in the accounts is taken off the top of your pay before taxes are withheld. If you pay income taxes and Social Security taxes, at a minimum this is probably like a “20% sale” on most of the health or dependent care services you buy. The savings could be more, depending on your income tax rate.

If your annual contribution to your Health Care FSA is ...	Your savings at 22.65% tax rate (federal and Social Security) would be ...*	Your savings on just Social Security taxes and Medicare taxes would be ...*
\$100	\$22.65	\$7.65
\$250	\$56.63	\$19.12
\$500	\$113.25	\$38.25
\$1,000	\$226.50	\$76.50
\$2,500	\$566.25	\$191.25

* These savings are based on a Social Security tax rate of 6.2%, a Medicare tax rate of 1.45% and a 15% federal tax rate. State taxes are not considered in the above example.

For the Dependent Care FSA, it's important to compare the tax savings you might have under the FSA to what you might save using the federal dependent day care tax credit. See [page 37](#) for more information.

Know the “Use It or Lose It” Rule

Based on IRS regulations, you must use all the money in your Dependent Care FSA by December 31, 2018. For the Health Care FSA, HSHS offers a grace period that lets you use your 2018 FSA for expenses incurred up to March 15, 2019.

Keep in mind that these time limits apply based on the date of service, not the date billed.

For both accounts, you have until May 1, 2019, to claim reimbursement. If you do not, the money left in your account(s) is forfeited.

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Health Care FSA

You can set aside up to \$2,600 per year in a Health Care FSA for eligible medical, prescription drug, dental and vision expenses. The minimum contribution to participate is \$5 per pay period.

► FOCUS: Does the Health Care FSA Make Sense for You?

Consider the tax break you get when you use the FSAs to pay for expenses you would have to pay out-of-pocket anyway. Think about:

- What you're likely to pay in deductibles and coinsurance for medical and dental services.
- Your share of prescription drug costs.
- Eye exams, glasses and contacts.
- Whether you are expecting any extraordinary costs - for surgery, for example, or braces for you or your children.

Use the [online estimator tool](#) to find out. The Healthy Plan Cost Estimator has a built-in Health Care FSA estimator. Add in your estimated dental and vision expenses to decide if it makes sense to enroll in the Health Care FSA, based on your estimated tax savings.

Eligible Health Care Expenses

You can use the account for your eligible health care expenses and those of your legal spouse and for your child(ren) up to age 26.

Generally, if you are divorced or separated, you can use the account for the expenses for which you are responsible for your child even if you do not claim the child as your dependent on your tax return.

A list of eligible health care expenses is available in Internal Revenue Service Publication 502. Go to www.irs.gov, select Forms and Publications and view or download IRS Publication 502, Medical and Dental Expenses.



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Using the Benny Card

You can pay eligible Health Care FSA expenses conveniently with the Benny card. The card works like a debit card. Use it to pay eligible expenses at the pharmacy, hospital or your doctor or other health care provider's office.

Through the card, you access money you have elected to set aside each pay period in a Health Care FSA. Simply, use the Benny card to pay for expenses directly, without having to wait for reimbursement, by swiping the card at the provider or merchant's card machine and selecting "credit."

Keep all documentation related to each expense in case it is requested by the IRS or Tri-Star Systems to substantiate your claim.

Because this is very important, you may want to keep documentation with your other tax records.

If you do not currently participate in the Health Care FSA, but enroll for 2018, you will automatically receive two cards in your name. You may share one of the cards with your qualified family member also covered under the Health Care FSA. Each of you should immediately sign the card with your name and follow the instructions to activate the card.

If you currently have a Benny card and will continue participating in the Health Care FSA for 2018, hold on to your card. You can use it for qualifying expenses you have during the 2018 plan year. If you lose a card, you will pay \$5 from your available Health Care FSA balance for each replacement card.

If you don't want to use the Benny card, you can still file eligible claims using Tri-Star Systems' website. See [page 38](#) for details. For more information about the Benny card, visit Tri-Star Systems' website at www.tri-starsystems.com.

Reminder: If you choose to use the Benny card, be sure to have a valid and working e-mail address. Correspondence about your Benny card will be sent through e-mail during the year.

If your employment ends with HSHS, the Benny card is automatically canceled, and you can no longer use it for Health Care FSA expenses.

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Dependent Care FSA

You can use the Dependent Care FSA to help pay yourself back with pre-tax dollars for the cost of eligible day care for your dependents while you work. If you are married, the care must be needed so you and your spouse can work, or for you to work while your spouse attends school full-time. Your eligible dependents are:

- Children under age 13 who will live with you for more than half of 2018 and will not provide over half of their own support.
- Anyone physically or mentally incapable of caring for himself or herself who will live with you for more than half of 2018, will regularly spend at least 8 hours each day in your home, and for whom you will provide over half the support in 2018, such as an elderly parent or a disabled spouse or dependent who is incapable of self-care.

How Much You Can Set Aside

If single or married and filing joint tax return	Up to \$5,000
If married and filing joint tax return and your spouse's employer offers a dependent care account	Up to \$5,000 between both accounts
If married and filing separate tax returns	Up to \$2,500

The minimum contribution to participate is \$5 per pay period.

► FOCUS: Does the Dependent Care FSA Make Sense for You?

- Do you have eligible dependent children who need day care?
- Do you have a parent living with you who needs supervised care?
- Consider the tax break you get on reimbursed dollars when you use the FSA to pay for dependent day care expenses you would have to pay out-of-pocket anyway while you are working.

Use the Dependent Care FSA Estimator on benefits.hshs.org to compare your possible FSA tax savings to the dependent care tax credit.

For a complete listing of eligible expenses, go to www.irs.gov, select Forms and Publications and view or download IRS Publication 503, Child and Dependent Care Expenses. While this publication is useful in determining dependent day care expenses that are eligible for reimbursement from the Dependent Care FSA, the dollar limits that apply to the federal dependent care tax credit are different from those that apply to the Dependent Care FSA.

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About the Dependent Care FSA and Taxes

As you consider a Dependent Care FSA, think about what works best for you – the FSA or the dependent care tax credit provided by federal law. It is important to keep in mind that you cannot take the tax credit for any amounts that are reimbursed through an FSA. In most cases, the Dependent Care FSA provides more savings than the tax credit.

Generally, you will save more on federal taxes using the Dependent Care FSA in these situations:

- You are eligible for the Earned Income Tax Credit if you have less than \$3,500 in investment income and both your earned income and adjusted gross income (or the income of you and your spouse, if you are married filing jointly) are less than the amounts for 2017 set forth in the following table depending on your number of children:

- You are single, not eligible for the Earned Income Tax credit and have one dependent, you file your taxes as head of household and your household taxable income is approximately \$31,000 or more.
- You are married, not eligible for the Earned Income Tax credit and have one dependent, you file a joint return and your household taxable income is approximately \$34,000 or more.

Dollar amounts are based on federal tax law effective for 2017. These are just guidelines and do not take into account state taxes, which might affect your decision.

If you have questions about tax savings, you may want to consult a tax advisor.

Use the online [Dependent Care FSA Estimator](#) to compare your possible FSA tax savings to the dependent care tax credit.

Number of Children	If Single/Head of Household Income Less Than ...	If Married Filing Jointly Income Less Than ...
1	\$39,617	\$45,207
2	\$45,007	\$50,597
3 or more	\$48,340	\$53,930

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Filing FSA Claims

You have three options for filing your FSA claims:

- You can use [Tri-Star's website](#) to submit claims for reimbursement.
- You can use the Benny card to pay eligible Health Care FSA expenses. See [page 35](#) for more information.
- You can get a claim form online at benefits.hshs.org and submit it with receipts for your expenses.

Claims will be processed as soon as administratively possible. Claims for the Health Care FSA are paid up to the annual amount you are depositing in your Health Care FSA. Claims for the Dependent Care FSA are paid up to the amount you have in your account at any time during the year.

You have until May 1, 2019 to submit claims for eligible expenses.

- For the Health Care FSA, it is expenses you incur between January 1, 2018, and March 15, 2019.
- For the Dependent Care FSA, it is expenses you incur between January 1, 2018, and December 31, 2018.

If your employment ends during 2018, only expenses for services received through your benefit end date are eligible for reimbursement. The benefit end date is the last day of the pay period in which an individual's employment is terminated.

Reimbursements from your account(s) are directly deposited to your designated bank account on the Monday following submissions received by the preceding Friday. Direct deposit is required. You will receive an explanation of payment via email. You are required to keep a valid, working email address on file with Tri-Star.

If You Have 2017 Health Care FSA Dollars Left on December 31, 2017

Your 2017 FSA will be used first for eligible services received between January 1 and March 15, 2018. For example, if you have \$200 in your 2017 Health Care FSA after expenses for services received through December 31, 2017, have been paid and you receive additional services before March 15, 2018, with eligible expenses of \$200, that expense will be reimbursed from your 2017 Health Care FSA.

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Employee Assistance Program

The Employee Assistance Program (EAP) provides you and your eligible dependents with support to manage the stress and challenges of life. The program is available to all HSHS colleagues without enrollment, and there is no cost to you.

All services are confidential and provided by professional counselors. The EAP team includes family therapists, clinical social workers, marriage and family therapists, professional counselors and clinical psychologists.

Services include support for:

- Physical and emotional illness
- Marital, relationship and family concerns
- Grief and bereavement
- Career and job issues
- Stress
- Drug and alcohol abuse
- Gambling

For more information or to schedule an appointment, contact ComPsych at 1-877-327-7429 or visit www.guidanceresources.com (enter "HSHS4U" for the organization web ID).



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Basic Life and AD&D Insurance

Hospital Sisters Health System provides basic life insurance and accidental death and dismemberment (AD&D) coverage at no cost to you.

Basic Life and AD&D Coverage

You automatically receive basic coverage of 1½ times your annual salary, to a maximum of \$50,000. Your annual salary is based on your rate of pay and regularly scheduled hours as of October 1, 2017.

You are not required to provide evidence of insurability – or proof of good health – for basic life and AD&D coverage.

Living Care Benefit

The living care benefit is available to provide financial assistance if you become terminally ill by letting you receive a part of your life insurance benefit while you are living.

Colleagues can receive up to 100% of their basic life insurance amount for up to 24 months prior to the expected date of death. Unlike life insurance benefits, living care benefits may be subject to taxes, so you are encouraged to consult a tax advisor before applying for this benefit.

Voluntary Accidental Death and Dismemberment (AD&D) Coverage

In addition to the basic AD&D insurance coverage provided by HSHS, you can purchase more coverage separate from life insurance for you and for your family through Securian. Your cost for voluntary AD&D coverage is paid on a pre-tax basis.

You may purchase coverage just for you or for you and your family. You select one of the coverage amounts for yourself; that benefit is paid in the event of your accidental loss of life.

For losses other than accidental loss of life, the Voluntary AD&D benefit will be based on the coverage you elect, the makeup of your family (if you elect family coverage), and the type of accidental loss. If you select family coverage, your covered dependents have coverage amounts based on your coverage amount. Dependent benefits for accidental loss of life are based on your covered family at the time of an accidental loss.

- **You and spouse only:** Your legal spouse is covered for 60% of your coverage amount.
- **You, spouse and children:** Your legal spouse is covered for 50% of your coverage amount and each child is covered for 15% of your coverage amount.
- **You and children only:** Each child is covered for 20% of your coverage amount.

Other plan features include: seatbelt and airbag benefit, education benefit (when family coverage is elected), occupational HIV or hepatitis benefit (for you only), child care benefit, increased child dismemberment benefit, psychological therapy benefit and rehabilitation benefit.

To learn more about coverage under this plan, see the plan's Summary of Plan Description (SPD).

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Supplemental Life Insurance Options: You, Your Spouse and Your Dependent Children

You also have additional life insurance options you can purchase through Securian, including:

- **Supplemental life insurance for you** from one to eight times your pay, up to \$1 million in additional coverage.
- **Supplemental life insurance for your legal spouse** in \$5,000 increments from \$5,000 to \$50,000. If your spouse is also a colleague and eligible for basic life insurance, you cannot elect supplemental life insurance for your spouse.
- **Supplemental life insurance for your eligible dependent children** in \$2,500 increments from \$2,500 to \$10,000. When you select supplemental children's life insurance, each child from live birth is covered for the same amount — so if you choose \$5,000 children's life insurance, each child would have \$5,000 in coverage.

You pay for supplemental life insurance with after-tax payroll deductions. Premiums for your coverage are age-based and differ for smokers and non-smokers. Spouse premiums are also age-rated; for children the premiums are a flat amount — regardless of the number of children.

You are required to provide an Evidence of Insurability (EOI) form if you wish to increase your coverage during annual enrollment or if you are a newly-eligible colleague and you elect coverage that is more than three times your pay or \$350,000.

You are also required to provide Evidence of Insurability if you elect to increase your spouse's life insurance coverage or if, as a newly-eligible colleague, you elect coverage for your spouse that is more than \$20,000.

► FOCUS: Choosing Your Options

- Determine how much of your current paycheck is used for day-to-day living expenses for your household. This can provide a guideline for the amount of income you need life insurance to replace.
- Think about how many people depend on you for financial support.
- Consider any financial obligations, like a home mortgage.
- Look at what savings and investments you have.
- Consider all your options:
 - Basic life and AD&D coverage.
 - Voluntary AD&D.
 - Supplemental life coverage.

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Disability Coverage

Disability benefits help protect you and your family by providing a portion of your income if you become disabled and are unable to work because of a personal illness or injury. HSHS provides two types of disability insurance for your financial protection.

Short-Term Disability (STD)

HSHS provides short-term disability coverage at no cost to you. Benefits are payable if you are away from work because of a personal injury or illness, including pregnancy.

STD Coverage

Benefit	When benefits begin	How long benefits last
70% of base pay ... based on budgeted/regularly scheduled hours and any shift differential.	Next regularly scheduled work day following seven consecutive days of absence due to disability.	Up to 26 weeks of disability, when combined with any Extended Illness Benefits (EIB) paid.

If You Have an EIB Balance as of December 31, 2017

Your Extended Illness Benefit hours are available for you to use for sickness or illness after December 31, 2017. Like STD, EIB will begin on the next regularly scheduled work day following seven consecutive calendar days of absence due to disability. The STD benefit is payable after you exhaust any accrued EIB balance. Once your EIB hours are used, the STD program will provide a continuous benefit of 70% of your base pay for the rest of your first 26 weeks of disability.

STD is available only for work absences due to your own illness or injury. You may use Paid Time Off (PTO) to receive pay for any regularly scheduled work days that fall within the first seven consecutive calendar days of absence when STD benefits are not payable. You may also use PTO to supplement your pay while receiving STD benefits. The combination of PTO and STD payments cannot exceed 100% of your regular pay.

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Long-Term Disability (LTD)

If your disability extends beyond 26 weeks, you may be eligible for long-term disability benefits.

LTD coverage	
Benefit	Up to 60% of annual base pay
When benefits begin	After 180 days of disability
Minimum benefit	10% of your gross benefit or \$100, whichever is greater
Maximum benefit	\$10,000/month

Pre-Existing Conditions

The LTD plan does not cover a pre-existing condition. You have a pre-existing condition if:

- You received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the six months just prior to your effective date of coverage; or you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the six months just prior to your effective date of coverage; and
- The disability begins in the first 12 months after your effective date of coverage unless you have been treatment-free for six consecutive months after your effective date of coverage.

Definition of Disability for Long-Term Disability

You are considered to be disabled if you:

- Cannot perform the main duties of your regular occupation due to your illness or injury, and
- Have a loss of 20% or more of your earnings due to that illness or injury.

After benefits have been paid for 24 months, you are considered disabled if you cannot perform the key duties of any gainful occupation for which you are reasonably qualified by training, education, or experience. Department directors and above and physicians have “own occupation” definition for duration of disability. You must be under the regular care of a physician to be considered disabled.

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How Long LTD Benefits Continue

- If you are disabled before age 60, you are eligible to receive LTD benefits until you are no longer disabled or to age 65, whichever is earlier.
- If you are disabled between age 60 and 69, benefits continue for the number of months shown in the chart, as long as you continue to be disabled.

If you are disabled at	Benefits continue for up to
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

- The lifetime cumulative maximum benefit period for all disabilities due to mental illness is 24 months.

LTD Plan Exclusions

Benefits are not provided for disabilities due to:

- Intentionally self-inflicted injuries.
- Active participation in a riot.
- Loss of a professional license, occupational license or certification.
- Commission of a crime for which you have been convicted.
- War, declared or undeclared, or any act of war.
- Any period of disability during which you are incarcerated.



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Cashing in Paid Time Off (PTO)

If you are a non-management colleague who is regularly scheduled (budgeted) to work at least 32 hours per pay period and not a physician, during annual enrollment each year you can declare the number of PTO hours — up to a maximum of 40 hours — that you want to cash in during the following year. By making this declaration during annual enrollment, you will receive the PTO hours you cash-in at 100% of your straight time rate of pay. Keep in mind that:

- You may only request payment for hours that will accrue in 2018.
- You cannot cancel your 2018 PTO cash-in declaration after 2017 annual enrollment ends.

If you do not make a declaration during the 2018 annual enrollment period or declare that you wish to cash-in less than 40 hours and later choose to cash-in more hours, the additional PTO hours you decide to cash in will be paid at 90% of your straight time rate of pay in accordance with IRS guidelines.

Please contact your Human Resources department to cash-in any undeclared PTO hours.

If You Make No Declaration or Become Eligible for PTO After the 2018 Annual Enrollment Period Ends

You will be allowed to cash in up to 40 PTO hours. You will be paid at 90% of your straight time rate of pay in 2018 for any hours that you cash-in during 2018.

Please contact your Human Resources department to cash-in any undeclared PTO hours.

How the Cash-in Policy Works

During annual enrollment for 2018, if you declare that you will cash in:	Based on IRS guidelines, you will be paid:	For example:
Up to 40 of the PTO hours you will accrue in 2018.	100% of your straight time rate of pay for the number of hours you declare.	If you declare 40 PTO hours, you will be paid 100% of your straight time rate of pay for 40 PTO hours in 2018.
Less than 40 PTO hours.	<ul style="list-style-type: none"> • 100% of your straight time rate for the number of hours you declare. 	<ul style="list-style-type: none"> • If you declare 30 PTO hours, you will be paid 100% of your straight time rate of pay for 30 PTO hours.
And, you later choose to cash in more hours.	<ul style="list-style-type: none"> • 90% of your straight time rate of pay for the number of hours you cash in later. 	<ul style="list-style-type: none"> • If you cash in 10 hours that you did not declare, you will be paid 90% of your straight time rate of pay for 10 hours.

If you are going to transfer to another HSHS Facility or move to a management position that is not qualified to cash in PTO at 100%, you will need to request payment for PTO hours before you transfer or move to the new position.

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Cost of Coverage

You and HSHS share the cost of your Flexplan benefits. You pay your share of most Flexplan benefit costs before federal, state and Social Security taxes are calculated.

If you elect supplemental life insurance for yourself, your spouse or your child(ren), you pay for this coverage with after-tax deductions. Premiums for supplemental life coverage for you and your spouse are age-based; for children the premiums are a flat amount, regardless of the number of children.

HSHS pays for:	You pay for:	You and HSHS share the cost of:
<ul style="list-style-type: none"> • Basic Life and AD&D Insurance • Short-Term and Long-Term Disability Coverage 	<ul style="list-style-type: none"> • Vision • Flexible Spending Accounts • Voluntary AD&D • Supplemental Life 	<ul style="list-style-type: none"> • Medical • Dental

See the following charts for your 2018 dental, vision and medical coverage costs.

Medical	2018 Biweekly Colleague Medical Insurance Deductions			
	Colleague Only	Colleague + Spouse/LDA	Colleague + Child(ren)	Colleague + Spouse/LDA + Child(ren)
72+ hours				
Basic	\$22.91	\$89.65	\$58.31	\$122.45
High	\$57.12	\$159.78	\$118.18	\$218.24
48-71 hours				
Basic	\$37.49	\$117.40	\$82.91	\$160.34
High	\$71.70	\$187.53	\$142.78	\$256.13
32-47 hours				
Basic	\$56.44	\$145.14	\$107.50	\$198.24
High	\$90.65	\$215.27	\$167.37	\$294.03

Vision	2018 Biweekly Colleague Vision Plan Deductions			
	Colleague Only	Colleague + Spouse/LDA	Colleague + Child(ren)	Colleague + Spouse/LDA + Child(ren)
	\$3.72	\$7.43	\$7.96	\$12.71

Dental	2018 Biweekly Colleague Dental Plan Deductions			
	Colleague Only	Colleague + Spouse/LDA	Colleague + Child(ren)	Colleague + Spouse/LDA + Child(ren)
72+ hours				
Basic	\$1.60	\$13.72	\$10.26	\$22.35
High	\$6.72	\$24.24	\$25.57	\$43.07
48-71 hours				
Basic	\$4.05	\$16.91	\$13.24	\$26.08
High	\$9.17	\$27.43	\$28.55	\$46.80
32-47 hours				
Basic	\$5.54	\$18.48	\$14.78	\$27.72
High	\$10.66	\$29.00	\$30.09	\$48.44

Note: Coverage for an eligible legally-domiciled adult (LDA) may be taxed. Visit benefits.hshs.org for more information.

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Special Enrollment Rights

Based on IRS rules, if you waive HSHS medical coverage for yourself or your dependents (including your spouse), you may be able to enroll yourself and your dependents in the HSHS Healthy Plan during the year if:

- You or your dependents lose coverage under another medical plan because you become ineligible for the other plan coverage. Loss of coverage may occur due to an employer stopping contributions toward your other medical coverage or your dependents' other medical coverage.
- You acquire a new spouse or a new dependent as a result of a marriage, birth, adoption or placement for adoption.

You may enroll yourself or dependents within 30 days of losing other medical coverage or acquiring a new spouse or dependent.

HSHS provides a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days - instead of 30 - from the date of the Medicaid/CHIP eligibility change to request enrollment in HSHS Healthy Plan benefits.

For additional information, please see the CHIP model notice beginning on [page 48](#).

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PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your state for more information on eligibility.

ALABAMA - Medicaid	GEORGIA - Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/medicaid -Click on Health Insurance Premium Payment (HIPP) Phone: 1-404-656-4507
ALASKA - Medicaid	INDIANA - Medicaid
The AK Health Insurance Premium Payment Program: Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility Website: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
ARKANSAS - Medicaid	IOWA - Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
COLORADO - Medicaid	KANSAS - Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
FLORIDA - Medicaid	KENTUCKY - Medicaid
Website: http://flmedicaidtprecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570

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LOUISIANA - Medicaid	NEW HAMPSHIRE - Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 1-603-271-5218
MAINE - Medicaid	NEW JERSEY - Medicaid and CHIP
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS - Medicaid and CHIP	NEW YORK - Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA - Medicaid	NORTH CAROLINA - Medicaid
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.ncdhhs.gov/dma Phone: 1-919-855-4100
MISSOURI - Medicaid	NORTH DAKOTA - Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1-573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MONTANA - Medicaid	OKLAHOMA - Medicaid and CHIP
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
NEBRASKA - Medicaid	OREGON - Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402- 473-7000 Omaha: 1-402-595-1178	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEVADA - Medicaid	PENNSYLVANIA - Medicaid
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462

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RHODE ISLAND - Medicaid	VIRGINIA - Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH CAROLINA - Medicaid	WASHINGTON - Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA - Medicaid	WEST VIRGINIA - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://mywvhipp.com/ Phone: 1-855-MyWVHIPP (1-855-699-8447)
TEXAS - Medicaid	WISCONSIN - Medicaid and CHIP
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
UTAH - Medicaid and CHIP	WYOMING - Medicaid
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://wyequalitycare.acs-inc.com/ Phone: 1-307-777-7531
VERMONT- Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

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

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

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If you have questions about ...	Contact ...
Enrolling or your Flexplan benefits	The HSHS Colleague Service Center 1-855-FYI-HSHS, fyi@hshs.org
Medical <ul style="list-style-type: none"> • Customer Service • Claim information • ID cards • Provider locator • Treatment pre-approval 	Aetna www.aetna.com 1-800-345-9474 benefits.hshs.org
Prescription Drugs	Express Scripts www.express-scripts.com/HSHS 1-800-841-5345
Dental <ul style="list-style-type: none"> • Claim information • Dental providers 	Cigna HealthCare www.cigna.com 1-800-244-6224
Vision	Vision Service Plan (VSP) www.vsp.com 1-800-877-7195
Flexible Spending Accounts <ul style="list-style-type: none"> • Health Care FSA • Dependent Care FSA 	Tri-Star Systems www.tri-starsystems.com 1-800-727-0182 (phone) 1-800-315-0737 (fax)
Disability Insurance <ul style="list-style-type: none"> • Short-Term Disability • Long-Term Disability 	UNUM www.unum.com 1-866-295-3007 Monday - Friday, 7 a.m.- 7 p.m. CST

