Hospital Sisters
HEALTH SYSTEM

2020

Flexplan Benefits Guide

LET'S GET STARTED

FLEXPLAN
The benefits of choice

benefits.hshs.org
Wisconsin

2020 Flexplan Benefits Guide

This guide provides highlights of your 2020 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 can be found on the HSHS Benefits Website at **benefits.hshs.org**. You can also request a paper copy, free of charge, by contacting the HSHS Colleague Service Center.

Inside this Guide

How to Use this Guide

This guide is designed to help you learn about your Flexplan benefits. Use the menu on each page to move between sections. When you see a link in the text, you can click on it to go directly to another page or website to find out more. You can also use the Next and Previous links on each page to move within sections, the Take Me Back link to return to the last page you visited, or the Contents link to return to this page.

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. Certain state and local laws may be applicable.

This benefits 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, health care and dependent care flexible spending accounts and retirement work are included in the summary plan descriptions for those benefits. Hospital Sisters Health System reserves the right to change, suspend, freeze or end benefit plans at any time.

This guide does not apply to colleagues whose primary home residence zip code is not in Wisconsin. 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.

2020 Flexplan Benefits Guide

Your Choices at a Glance

Benefit	Options
Coverage for Medical (Dean Health Plan) and Prescription Drugs (OptumRx)	• Basic Option • High Option • Waive coverage.
Dental Coverage – Cigna	• Basic Option • High Option • Waive coverage.
Vision	• Cigna Vision Discount Program – Discounts on eye exams, frames and lenses are provided through participating providers for those enrolled in dental coverage. • 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	• Set aside up to $2,700 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	• 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	• 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	• Five coverage options (colleague-paid) – from $50,000 to $250,000 – with colleague only or family coverage. • Choose no voluntary AD&D coverage.

Continued ▶

Your Choices at a Glance continued

Benefit	Options
Supplemental Life Insurance – Securian	Colleague-paid coverage options: • 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	Automatically provided at no cost to you: • 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	During 2020 annual enrollment (November 1 - 14, 2019), non-management and management colleagues who are regularly scheduled (budgeted) to work at least 32 hours per pay period and are not physicians may: • Declare they will cash-in up to 40 hours of PTO for the coming calendar year – time declared in 2019, accrued in 2020, and cashed-in during 2020 will be 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.

Who Is Eligible

You are eligible to participate in Flexplan benefits, unless noted elsewhere, the first day of the pay period following two full biweekly pay periods of active employment in a benefit-eligible status, whether you are a new hire or change to a benefit-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 and qualifies as a dependent under federal tax guidelines, 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.

Continued ▶

2020 Flexplan Benefits Guide

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 reinstated.

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 Social Security number (without dashes). Your password is the last 4 digits of your Social Security number. 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.**
   - Enter or update dependent information, if applicable, and beneficiary designations.
   - Make or change your benefit elections.
   - Enrollment in supplemental life insurance and/or any 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 elections, you can do so during the enrollment period. Simply sign back in and repeat the enrollment process again. The last changes you make before 11:59 p.m. on the last day of the enrollment period will be your elections for the plan year. You cannot choose new options during the year, unless you have a qualifying change in status.

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.

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 2020 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. Benefit changes must be consistent with the eligible life event. Please see the HSHS Flexplan Summary Plan Description for more information.

You must contact the HSHS Colleague Service Center and complete the necessary forms within 30 days of the life event in order to change your benefit elections.

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 outside of Wisconsin. If your primary home residence changes to one outside of Wisconsin, your medical plan option will automatically change to the corresponding HSHS Healthy Plan option administered by Aetna. You cannot make changes to your benefit elections if you transfer. This is not a qualifying event for making changes during the year.

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 30**.

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 network 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 18**.

Healthy Partners

Bridging the Gap to Better Health

Healthy Partners is a team of registered nurses partnering with those facing chronic conditions, such as heart disease, diabetes, COPD, asthma, high blood pressure, and high cholesterol, as well as patients needing care following a hospital stay or visit to the Emergency Department. Healthy Partners' nurses work with you, your support system, and your primary care physician to coordinate your health care. Services offered include creating custom care plans designed specifically for your health needs, teaching you skills to manage your health, providing education on medications and treatment, scheduling follow-up appointments, and much more.

Healthy Partners' goal is to keep you healthy and out of the hospital and Emergency Department. Participation in the program is free, voluntary and strictly confidential; no identifying personal health information will be shared with HSHS.

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 St. Vincent Hospital 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.

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

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 Alabama, Arizona, California, Florida, Georgia, Illinois, Indiana, Iowa, Kentucky, Minnesota, Montana, Nebraska, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Utah, Washington, and Wisconsin. This list may be updated during the year. Visit **www.anytimecare.com** or the mobile app and look under "Learn More" for a complete and current listing. 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

Visit **www.anytimecare.com** or download the HSHS Anytime Care app.

1. Select ***Get Started***.
2. Enter the patient's information and click ***Sign Up***.
3. Enter the requested profile information and then select ***Continue***.
4. Choose a provider or see the first available provider and complete the list of questions.
5. Wait for the provider to start your visit.

** If you are covered by the HSHS Healthy Plan and your Anytime Care account is showing an incorrect fee of $29/visit (not a $0 visit), please call Anytime Care at 844-391-4747.*

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 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 benefit-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.

New hires/newly benefit-eligible colleagues will receive a welcome email from Limeade when you are able to access the program. You must enroll in the program to participate. To enroll, visit **http://hshs.limeade.com** and click "Get Started," or download the Limeade app (use code HSHS4U).

- For benefit-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)

Hospital Sisters HEALTH SYSTEM | LiveWELL

Complete Challenges to Earn Rewards

Each year, you'll have the opportunity to complete activities to earn points and receive wellness incentives — $390 or more a year!

- **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

Earn at your own pace! There's no deadline to complete "Level 1" during the September 2019 to September 2020 program period. Have your spouse/LDA participate to earn twice the reward!

More Ways to Engage

- Look for challenges to earn a LiveWELL FastPass. The FastPass will let you skip to the next level in the program!
- Join the HSHS LiveWELL Community Feed for more support. Through this internal social media platform, you can personalize your profile, share updates and interact with other colleagues by "liking" and commenting on posts.

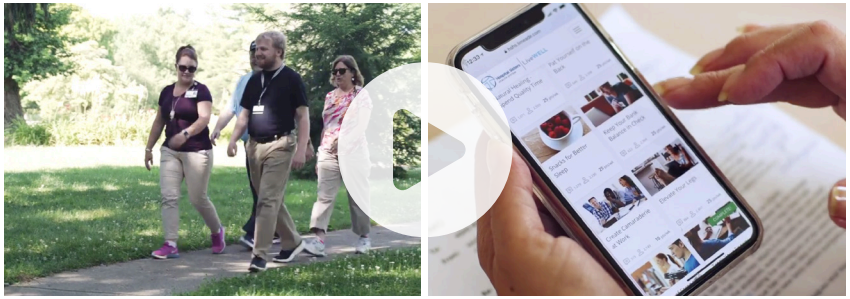
When You Can Earn

LiveWELL participants earn points from September to September each year. Wellness incentive dollars are paid on a calendar year basis.

Take A Look!

See how our HSHS colleagues are getting active and getting results through LiveWELL!

Watch the video

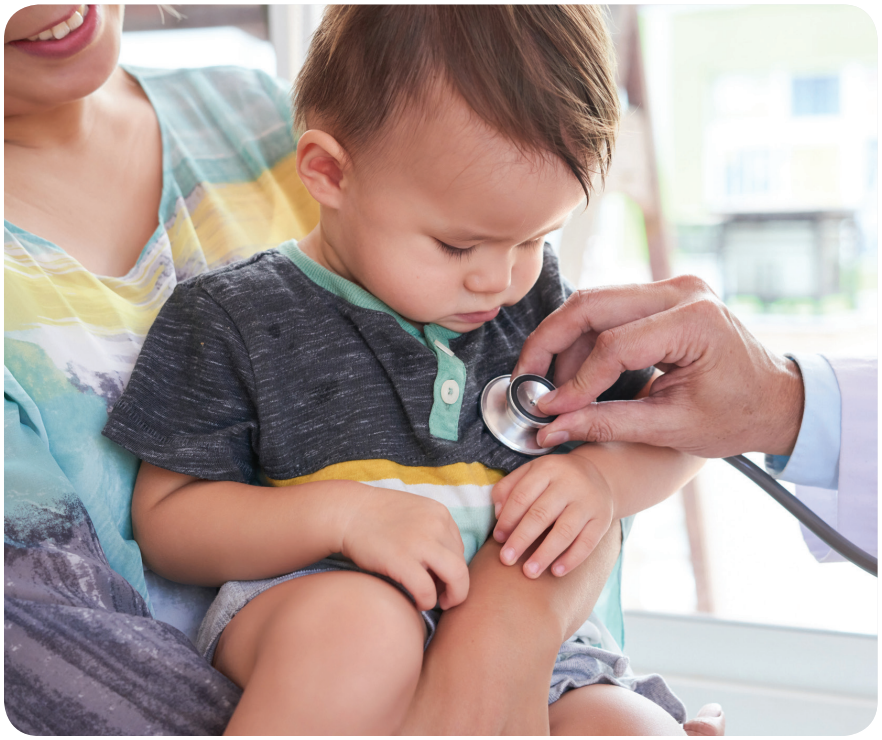


Medical and Prescription Drug Coverage

You have two Exclusive Provider Organization (EPO) 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 only cover services received from network providers, in most cases. Out-of-network services without a referral/prior authorization will not be covered.

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

HSHS Healthy Plan Provider Networks

Generally, you need to use providers in your designated network to have your medical care covered by the HSHS Healthy Plan. Colleagues in Wisconsin use one of the following networks, depending on the zip code of your primary home residence:

- HSHS/Prevea360 network service area.
- HSHS/Prevea360/HealthEOS network service area.

Using Network Providers

Your medical options will be Exclusive Provider Organization (EPO) options that, in most cases, only cover services received from HSHS/Prevea360 network providers. This means, if you receive care outside the network, you will most likely be responsible for the full cost of care.

To locate network providers, visit benefits.hshs.org/Find-a-Provider.

How to Determine Your Network Service Area

Generally, you need to receive care inside your designated network to have coverage for your medical care through the HSHS Healthy Plan. Your network is determined by your home zip code.

You are inside the **HSHS/Prevea360 network service area** if you live in one of the following zip codes:

53001	53075	54131	54180	54217	54247	54703	54742
53011	53081	54137	54201	54220	54301	54720	54745
53013	53082	54139	54202	54221	54302	54722	54747
53015	53083	54140	54204	54226	54303	54724	54748
53020	53085	54141	54205	54227	54304	54726	54751
53023	53093	54153	54207	54228	54305	54727	54755
53026	54101	54154	54208	54229	54306	54728	54757
53031	54106	54155	54209	54230	54307	54729	54758
53042	54107	54157	54210	54232	54308	54730	54768
53044	54111	54161	54211	54234	54311	54732	54770
53061	54112	54162	54212	54235	54313	54736	54771
53062	54115	54165	54213	54240	54324	54737	54772
53063	54124	54166	54214	54241	54344	54738	54773
53070	54126	54171	54215	54245	54701	54739	
53073	54130	54173	54216	54246	54702	54741	

If the zip code for your home residence is not listed here and you live in Wisconsin, you live in the HSHS/Prevea360/HealthEOS network service area.

If you have a dependent enrolled in HSHS Healthy Plan coverage who lives outside Wisconsin, the national MultiPlan network will apply; see **page 16**.

When You Need Care from a Non-Network Provider

Out-of-network services will not be covered unless you first obtain a referral from your network provider and prior authorization from Dean Health Plan. Your network provider will need to submit a referral request to Dean Health. If HealthEOS is your primary network, you need a referral if the provider required for your care is not in the HSHS/Prevea360/HealthEOS network or if the services require prior authorization per the summary plan description. In order for services to be covered, the referral needs to be reviewed and approved prior to services being received.

If you have questions about the referral process, contact Dean Health Plan at 1-888-895-1188.

The exceptions to this policy are for required urgent care when you are traveling outside your network service area and emergency care. For care required to treat an urgent situation while you are traveling outside your network service area or an emergency medical condition, the HSHS Healthy Plan provides the same benefit level regardless of the provider who provides your care.

When You Move Inside/Outside the HSHS/Prevea360 Network Service Area

If you currently reside inside the HSHS/Prevea360 network service area and move to a Wisconsin zip code that is outside that network service area, your assigned network will change to HSHS/Prevea360/HealthEOS. Your medical plan option and coverage level will remain the same, and any amounts that have been credited toward the deductibles or out-of-pocket maximums will continue to apply.

The same rules apply if you move your primary residence from a zip code outside the HSHS/Prevea360 network service area in Wisconsin to one inside the HSHS/Prevea360 network service area.

If Your Dependent Lives Outside Wisconsin

If you have a dependent who lives outside Wisconsin, such as a child attending college, you can register your dependent with Dean Health Plan after you receive your Dean Health Plan ID card. Once your dependent is registered, the national MultiPlan network will apply for your dependent's HSHS Healthy Plan coverage.

You or your dependent must register your dependent with Dean Health Plan before any services your dependent receives from a MultiPlan provider who is not an HSHS/Prevea360 provider will be covered.

Your registered dependent can receive services within the MultiPlan network at the in-network HSHS Healthy Plan benefit level. If there is no MultiPlan network provider within 65 miles of your dependent's home address that can provide the service your dependent requires, that service, if otherwise covered by the plan, will be covered at the in-network benefit. Prior authorization from Dean Health Plan is required.

To locate a MultiPlan network provider, follow these steps:

1. **Go to deancare.com/HSHS.**
2. **Under "Out-of-area dependents", click "Find a MultiPlan Provider".**
3. **Enter your search criteria and follow the instructions to find a provider.**

5 Ways to Save

Learn tips to help you save money on health care.
Watch the video

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 visits, preventive care, lab and X-ray services, emergency room facility charges for true emergencies, or Network Facility 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 a Network 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 for services. The HSHS Healthy Plan provides benefits for covered services provided by network providers.
Out-of-Network Providers	Providers who do not participate in the Dean Health Plan provider networks for HSHS. When you use out-of-network providers, services without a referral/prior authorization will not be covered, unless the services are for required urgent care when you are traveling outside your network service area or emergency care.
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.
• **Medical Services**	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.
• **Prescription Drugs**	A separate out-of-pocket maximum applies to prescription drug benefits. The prescription drug deductible applies to the prescription drug out-of-pocket maximum.
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.

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 a network 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 every 12 months.
- 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.
- 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.

The HSHS Healthy Plan will 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 recreational purposes.

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 a Network Specialist Physician that result in your meeting $500 of the Network Specialist Physician out-of-pocket maximum, $500 will also be credited to the out-of-pocket maximums that apply to Network Facility and Network PCP services.
- No deductible applies to services you receive from a Network Facility.

	Network			Out of Network
Basic	Facility	Primary Care Physician	Specialist Physician	Facility or Professional
Annual Medical Deductible		*all cross apply*		
Per Individual	None	None	$1,800	No Coverage
Family Limit	None	None	$3,600	No Coverage
Annual Medical Out-of-Pocket Limit (includes medical deductible)		*all cross apply*		
Per Individual	$3,800	$3,800	$3,800	No Coverage
Family Limit	$7,600	$7,600	$7,600	No Coverage

	Network			Out of Network
High	Facility	Primary Care Physician	Specialist Physician	Facility or Professional
Annual Medical Deductible		*all cross apply*		
Per Individual	None	None	$900	No Coverage
Family Limit	None	None	$1,800	No Coverage
Annual Medical Out-of-Pocket Limit (includes medical deductible)		*all cross apply*		
Per Individual	$3,000	$3,000	$3,000	No Coverage
Family Limit	$6,000	$6,000	$6,000	No Coverage

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			
	Network			Out of Network	Network			Out of Network
	Facility	Primary Care Physician [1]	Specialist Physician	Facility or Professional	Facility	Primary Care Physician [1]	Specialist Physician	Facility or Professional
Wellness and Preventive Care	100% no deductible			No coverage	100% no deductible			No coverage
Annual Medical Deductible	All cross apply				All cross apply			
Per Individual	None	None	$1,800	No coverage	None	None	$900	No coverage
Family Limit	None	None	$3,600	No coverage	None	None	$1,800	No coverage
Annual Medical Out-of-Pocket Limit (includes medical deductible)	All cross apply				All cross apply			
Per Individual	$3,800	$3,800	$3,800	No coverage	$3,000	$3,000	$3,000	No coverage
Family Limit	$7,600	$7,600	$7,600	No coverage	$6,000	$6,000	$6,000	No coverage
Physician Charges								
Office Visit Charge/Allergy Serums/Injections	N/A	95%	75%	No coverage	N/A	95%	85%	No coverage
Spinal Manipulation (up to 10 visits per calendar year)	N/A	95%*	75%*	No coverage	N/A	95%*	85%*	No coverage
Surgery/Procedure/All Other	N/A	95%	75%*	No coverage	N/A	95%	85%*	No coverage
Outpatient Imaging and Lab								
Advanced Imaging [2]	75%	75%	75%	No coverage	85%	85%	85%	No coverage
Other Imaging & Lab	75%	75%	75%	No coverage	85%	85%	85%	No coverage
Hospital/Facility Charges IP/OP	75%	N/A	N/A	No coverage	85%	N/A	N/A	No coverage

** after Annual Medical Deductible is met*
[1] Professional provider who is a general practice physician, family practice physician, internal medicine physician or pediatrician
[2] Advanced imaging includes PET, CAT, MRI, MRA, bone density and sleep study. Prior approval required.
[3] Therapy Services include physical, occupational and speech therapy, radiation therapy, chemotherapy and electroconvulsive therapy.

Continued ▶

Covered Care and Services continued

	BASIC				HIGH			
	Network			Out of Network	Network			Out of Network
	Facility	Primary Care Physician [1]	Specialist Physician	Facility or Professional	Facility	Primary Care Physician [1]	Specialist Physician	Facility or Professional
Emergency Room Care								
True Emergency	$100 copay then 75%	N/A	75%*	Same as Network	$100 copay then 85%	N/A	85%*	Same as Network
Other Condition	$300 copay then 70%	N/A	70%*	No coverage	$300 copay then 70%	N/A	70%*	No coverage
Ambulance	75%	95%	75%	Same as Network	85%	95%	85%	Same as Network
Mental Health and SA								
Office Visits	N/A	95%	75%	No coverage	N/A	95%	85%	No coverage
Other Outpatient	75%	95%	75%	No coverage	85%	95%	85%	No coverage
Inpatient	75%	95%	75%	No coverage	85%	95%	85%	No coverage
Outpatient Therapy Services[3] / Cardiac Rehab / Dialysis / DME	75%	95%	75%	No coverage	85%	95%	85%	No coverage
Hearing Aid	75%	95%	75%	No coverage	85%	95%	85%	No coverage
	Covers $1,400 per hearing aid every 3 years				Covers $1,400 per hearing aid every 3 years			
Other Covered Services	75%	95%	75%	No coverage	85%	95%	85%	No coverage
Lifetime Benefit Maximum	Unlimited				Unlimited			

** after Annual Medical Deductible is met*
[1] Professional provider who is a general practice physician, family practice physician, internal medicine physician or pediatrician
[2] Advanced imaging includes PET, CAT, MRI, MRA, bone density and sleep study. Prior approval required.
[3] 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	$150 per person
Annual Out-of-Pocket Maximum	$1,600 per person $3,200 family limit	$1,300 per person $2,600 family limit
Generic:	80% after deductible	
Preferred Brand:	70% after deductible	
Non-preferred (non-formulary) Brand Retail:	$15 per prescription, then the plan pays 70% after deductible (up to 30-day supply per fill)	
Non-Preferred (non-formulary) Brand Mail Service:	$45 per prescription, then the plan pays 70% after deductible (up to 90-day supply per fill)	

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 prescriptions you fill at an HSHS pharmacy or a participating local retail pharmacy and through 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 OptumRx Premium 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 a 30-day supply) and an additional $45 for prescriptions filled through mail service.

You can view the formulary on the OptumRx annual enrollment website, **https://www.optumrx.com/oe_HSHS/landing**, beginning November 1, 2019, or at **www.optumrx.com** beginning in 2020.

For support during the 2020 annual enrollment period or to enroll as a new hire:

- Visit **https://www.optumrx.com/oe_HSHS/landing**.
- Call 1-844-720-0030 to speak with a member services representative Monday - Friday, from 8 a.m. to 8 p.m. CST.

For ongoing support beginning in 2020:

- Visit **www.optumrx.com** and register on the site.
- Call 1-844-720-0030 to speak with a member services representative anytime.

Retail Pharmacy

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

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

You can receive up to a 30-day supply of medication. To find out if a pharmacy is part of the OptumRx network, ask your pharmacy or visit:

- **https://www.optumrx.com/oe_HSHS/landing** during the 2020 annual enrollment period or if you are a new hire.
- **www.optumrx.com** beginning January 1, 2020 if you are enrolled in the HSHS Healthy Plan for 2020.

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

More About the Medical Plan's Prescription Drug Coverage

Mail Service

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

- You can get up to 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. Mail service also 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 an HSHS pharmacy or mail service for subsequent refills to be covered by the HSHS Healthy Plan's prescription drug coverage.

Visit an HSHS Pharmacy

HSHS pharmacies can be found in select HSHS facilities and elsewhere in the communities we serve. You can save time in your day by getting your prescription filled at or close to your work location. Experience the ease and convenience of using an HSHS pharmacy.

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.

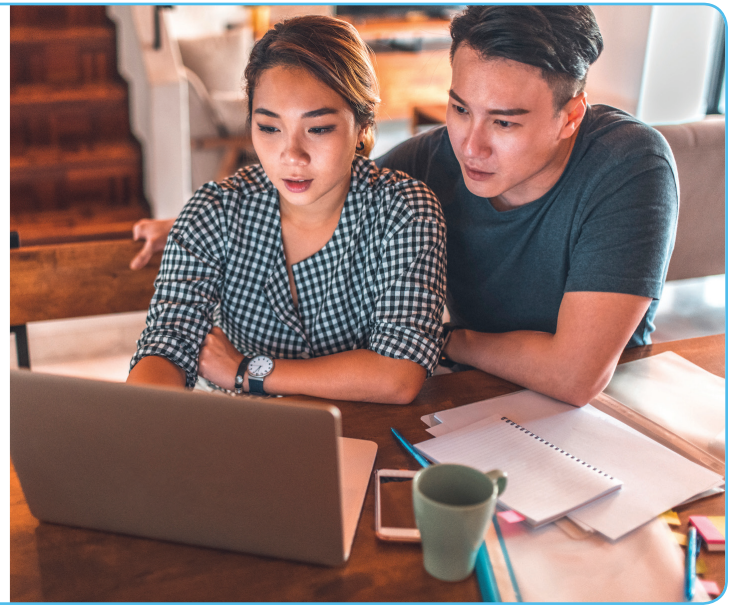
For example, if you choose a 30-day supply of Avapro, a non-formulary brand-name drug, you will pay an ancillary fee of about $134 (the difference in price between Avapro and its generic equivalent, Irbesartan), plus a $15 copay for using a non-formulary medication. This is in addition to your normal deductible and coinsurance.

Continued ▶

It's easy to order by mail!

1. ePrescribe: Your doctor can send an electronic prescription to OptumRx.
2. Online: Log in to the OptumRx website. You can link from **benefits.hshs.org** or find the website address on your member ID card.
3. Phone: Call OptumRx Member Services at 1-844-720-0030.
4. Mail: Complete the new prescription mail-in order form and mail it to OptumRx, P.O. Box 2975, Mission, KS 66201. You can find it on the OptumRx website, or you can call OptumRx Member Services and ask for the form to be mailed to you.

Manage your medication home delivery on the go. Order and track your prescriptions online or with the OptumRx app.



Specialty Medications through OptumRx

If you take any oral or injectable specialty medications, that are self-administered drugs, you must purchase these medications through an HSHS pharmacy or the OptumRx 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, which 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.

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.optumrx.com**. You will be able to 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!

Access the OptumRx Mobile App

During the year, you can manage your prescription benefit while on the go with the OptumRx mobile app. With your member ID number handy, go to **www.optumrx.com** or download the OptumRx mobile app from your device's store.

Use the app to locate a pharmacy, search drug prices at multiple pharmacies, view your prescription ID card, transfer a prescription to home delivery, track the order status of your prescription home delivery, refill and renew prescriptions and manage medication reminders.

You can also access a complete profile of your prescriptions when you view My Medicine Cabinet. All of your recent and past prescriptions are in the palm of your hand.

When Prior Authorization or Step Therapy Is Required

To encourage safe and cost-effective medication use, OptumRx 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 OptumRx 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 OptumRx 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 OptumRx 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 OptumRx.

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.

Beginning in 2020, your physician can request prior authorization by visiting the OptumRx online portal **optumrx.com**. If you have questions about the prior authorization or step therapy program, call 1-844-720-0030 to speak with a member services representative.

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 2020, and your costs.

Specifically, the two types of costs are:

- Your cost of coverage – that's the biweekly amount deducted from your paycheck 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.

Not sure what services you'll need?

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

If you're enrolled in an HSHS medical option, you can get your medical history by accessing the Member Portal at **deancare.com/aso.**

Know the Basics

Understand how your medical plan works and how it differs from other types of medical plans.

Watch the video

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: • 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: • 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: • 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

Vision Coverage

You have two 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 Discount Program

Colleagues who enroll in Flexplan dental coverage have the Cigna Vision discount program. The vision discount program provides savings on routine eye exams and purchases of frames and lenses, including contacts. To view discount information for vision care services for Cigna Vision, go to **benefits.hshs.org**. To find a Cigna Vision provider, go to **www.cigna.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 calendar year)	Covered in full after $15 copay	Up to $45 reimbursement
Lenses (once every calendar year)		Reimbursement
• Single Vision	Covered in full	Up to $30
• Bifocal	Covered in full	Up to $50
• Trifocal	Covered in full	Up to $65
• Lenticular	Covered in full	Up to $100
• Progressive Bifocals		
- Standard	$0 copay	Up to $50
- Premium	$95-$105 copay	Up to $50
- Custom	$150-$175 copay	Up to $50
• UV Coating	$16 copay	Not covered
• Tint	$0-$15 copay	Not covered
• Scratch Resistance	$17 copay	Not covered
• Anti-reflective (standard)	$41 copay	Not covered
• Basic Polycarbonate	Children: $0 copay Adults: $31-$35 copay	Not covered
• Other Lens Enhancements	20% - 25% discount	Not covered
Frames (once every calendar year)	$150 allowance $170 allowance for featured frames 20% off balance $150 Costco allowance	Up to $70 reimbursement
Contact Lenses (once every calendar year in lieu of frames and lenses)		Reimbursement
• Medically Necessary	$0 copay	Up to $210
• Elective	$130 allowance	Up to $105
• Fit & Follow up	$0 copay	Not covered
Other	• 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

Flexible Spending Accounts (FSAs)

Flexplan offers two flexible spending accounts:

- Health Care FSA.
- Dependent Care FSA.

How FSAs Work

FSAs are like a sale. Money you set aside in the accounts is taken off the top of your pay before taxes are withheld.

- 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, 2020, and March 15, 2021.
  - Dependent day care expenses for services you receive between January 1, 2020, and December 31, 2020.
- When you have an eligible expense, you file a claim to reimburse yourself from your account.

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 33** 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, 2020. For the Health Care FSA, HSHS offers a grace period that lets you use your 2020 FSA for expenses incurred up to March 15, 2021.

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, 2021, to claim reimbursement. If you do not, the money left in your account(s) is forfeited.

Save with an FSA

HSHS offers a Health Care FSA and a Dependent Care FSA. Learn how they work and how they can help you save money.

Watch the video

Health Care FSA

You can set aside up to $2,700 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.

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 Instructions and view or download IRS Publication 502, Medical and Dental Expenses.

Please note: abortions, sterilizations, contraceptives, sexual reassignment, in-vitro fertilization, artificial insemination, or embryonic implantation procedures are not considered eligible Health Care FSA expenses due to HSHS ethics/philosophy.

Continued ▶

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 2020, 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 2020, hold on to your card. You can use it for qualifying expenses you have during the 2020 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 34** 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.

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 2020 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 2020, will regularly spend at least 8 hours each day in your home, and for whom you will provide over half the support in 2020, 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.

For a complete listing of eligible expenses, go to **www.IRS.gov**, select Forms and Instructions 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.

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

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 32** 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, 2021 to submit claims for eligible expenses.

- For the Health Care FSA, it is expenses you incur between January 1, 2020, and March 15, 2021.
- For the Dependent Care FSA, it is expenses you incur between January 1, 2020, and December 31, 2020.

If your employment ends during 2020, 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 into your designated bank account. Deposits are generally made to your bank account on the Monday following receipt of the claim by the preceding Thursday. 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 2019 Health Care FSA Dollars Left on December 31, 2019

After December 31, 2019 any remaining 2019 Health Care FSA dollars will not be accessible on your Benny card. In order to use any remaining 2019 Health Care FSA dollars for eligible services received between January 1 and March 15, 2020, you must submit your claims using your Tri-Star account or by submitting a claim form to Tri-Star.

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

Plus, there's more! Through the EAP, you can also access financial and legal resources and support for work-life balance.

For more information or to schedule an appointment, contact Prevea Behavioral Care at 1-920-272-1200 or 1-888-2PREVEA.

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, 2019.

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 Plan Description (SPD).

Supplemental Life Insurance Options: Cover Yourself, 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.

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, 2019

Your Extended Illness Benefit hours are available for you to use for sickness or illness after December 31, 2019 with an approved short-term disability claim. 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 must 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.

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 monthly earnings
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.

Continued ▶

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.

Retirement Program

HSHS provides a comprehensive retirement program to help you build savings now so you can have financial resources in the future. Our retirement program includes a Pension Plan and a 403(b) Retirement Savings Plan.

Eligibility

- HSHS colleagues hired prior to July 1, 2014 are eligible for:
  - HSHS Pension Plan with a Traditional Pension Benefit – allows you to earn a benefit based on a defined benefit formula using your pay and years of service.
  - HSHS 403(b) Retirement Savings Plan – provides an opportunity to build on your pension benefit through your contributions and investment earnings.
- HSHS colleagues hired or rehired on or after July 1, 2014 are eligible for:
  - HSHS Pension Plan with a Cash Balance Benefit – features an account balance that shows the value of your accumulated benefit. HSHS credits your account each year with contribution credits and interest credits.
  - HSHS 403(b) Retirement Savings Plan – provides an opportunity to save with contributions, including matching contributions from HSHS.

Preparing to Retire?

Understand what you need to know and do for a successful retirement.

Watch the video

Participating in the Plan

All colleagues of designated Affiliates of Hospital Sisters Health System are eligible for eligible Retirement Plan(s), except for:

- Temporary or leased colleagues, as classified by the Internal Revenue Service (IRS).
- Colleagues who are members of a collective bargaining unit whose contract provides for membership in another retirement plan.

Additionally, medical residents are not eligible for HSHS Pension Plan benefits, but they can participate in the non-matching HSHS 403(b) Retirement Savings Plan.

For more information, you can review the Retirement Program guides, available on **benefits.hshs.org**.

Get Help Planning for Retirement

Meet with a Transamerica Retirement Solutions retirement planning consultant to learn how your retirement plan can help you achieve your retirement savings goals.

Go to **benefits.hshs.org/retirement** to schedule your appointment today!

Note: Not available to colleagues of Prairie Cardiovascular Consultants.

HSHS-Mercer Benefits Central for Pension Plan Participants

Hospital Sisters HEALTH SYSTEM | MERCER BenefitsCentral

Looking for HSHS Pension Plan information? Visit HSHS-Mercer Benefits Central to:

- Designate beneficiaries.
- Review estimated current pension benefits.
- Generate future pension estimates.
- Request payment of pension benefits.

You can also review your personal profile and contact information and access pre-retirement planning educational materials. For more help, you can speak with a pension expert, live or through the chat feature.

All HSHS Pension Plan participants, as well as those alternate payees, surviving spouses and beneficiaries who are in pay status have access to HSHS-Mercer Benefits Central. Alternate payees, surviving spouses and beneficiaries who are not yet in pay status and colleagues who have been employed at HSHS for less than 12 months and/or have yet to work 1,000 hours or more in a calendar year will not have access to the portal.

To register your account, go to **benefits.hshs.org/pension**.

Cashing in Paid Time Off (PTO)

If you are a non-management or 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 2020.
- You cannot cancel your 2020 PTO cash-in declaration after annual enrollment for 2020 ends.

If you do not make a declaration during the 2020 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 2020 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 2020 for any hours that you cash-in during 2020.

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

How the Cash-in Policy Works

During annual enrollment for 2020, 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 2020.	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 2020.
Less than 40 PTO hours	• 100% of your straight time rate for the number of hours you declare.	• 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	• 90% of your straight time rate of pay for the number of hours you cash in later.	• 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, your declared PTO cash hours must be paid out before your transfer and may not be carried over to the the new HSHS Facility.

2020 Flexplan Benefits Guide

Education Assistance

Colleagues continuing their education or taking additional classes can get financial support from the HSHS Education Assistance Program.

Full-time and part-time HSHS colleagues are eligible for the program at date of hire.

Based on your employment classification:	HSHS may provide educational assistance per calendar year up to:
Full-Time	$4,000
Part-Time I	$3,000
Part-Time II	$2,000

HSHS Discount Program (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 **https://hshs.perkspot.com/login** for more information.

Adoption Assistance

For colleagues seeking to grow their families through adoption, HSHS provides financial support for eligible adoption expenses. Colleagues who have been employed with HSHS and eligible for Flexplan benefits for at least six months will be able to receive reimbursement up to $7,500 per child.

Eligible expenses include:	Expenses NOT included:
• Application fees • Home studies • Agency and placement fees • Legal fees and court costs • Immigration, immunization and translation fees • Transportation, meals and lodging • Parent, child and family adoption counseling	• Embryo adoption or surrogacy fees • Voluntary donations or contributions • Legal fees incurred to obtain custody or guardianship of your own child or step child • Legal fees incurred to adopt a step child • Personal items for the child • Expenses that have been or will be reimbursed through other reimbursement programs

HSHS will reimburse expenses after the colleague finalizes the adoption and provides a copy of the adoption decree. The colleague must be employed by HSHS at the time the reimbursement is made (if HSHS employs both parents, only one colleague can utilize the financial reimbursement benefit).

Please contact the HSHS Colleague Service Center for additional help or details surrounding adoption assistance.

2020 Flexplan Benefits Guide

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.

See the following charts for your 2020 medical, dental and vision coverage costs.

HSHS pays for:

- Basic Life and AD&D Insurance
- Short-Term and Long-Term Disability Coverage
- Anytime Care Program
- Education Assistance
- Adoption Assistance
- Employee Assistance Program
- LiveWELL Wellness Program
- HSHS Pension Plan

You pay for:

- Vision
- Flexible Spending Accounts
- Voluntary AD&D
- Supplemental Life

While HSHS pays the majority of the cost, you and HSHS share the cost of:

- Medical
- Dental

Biweekly Colleague Medical Insurance Deductions

Medical	Colleague Only	Colleague + Spouse/LDA	Colleague + Child(ren)	Colleague + Spouse/ LDA + Child(ren)
72+ hours				
Basic	$23.97	$95.62	$61.79	$130.60
High	$59.36	$168.15	$123.71	$229.68
48-71 hours				
Basic	$39.85	$125.83	$88.57	$171.87
High	$75.23	$198.37	$150.49	$270.95
32-47 hours				
Basic	$60.48	$156.05	$115.36	$213.13
High	$95.87	$228.58	$177.28	$312.21

Biweekly Colleague Dental Plan Deductions

Dental	Colleague Only	Colleague + Spouse/LDA	Colleague + Child(ren)	Colleague + Spouse/ LDA + Child(ren)
72+ hours				
Basic	$1.61	$13.84	$10.35	$22.54
High	$6.78	$24.45	$25.79	$43.44
48-71 hours				
Basic	$4.08	$17.05	$13.35	$26.30
High	$9.25	$27.66	$28.79	$47.20
32-47 hours				
Basic	$5.59	$18.64	$14.91	$27.96
High	$10.75	$29.25	$30.36	$48.85

Biweekly Colleague Vision Plan Deductions

Vision	Colleague Only	Colleague + Spouse/LDA	Colleague + Child(ren)	Colleague + Spouse/ LDA + Child(ren)
	$3.72	$7.43	$7.96	$12.71

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

Legal Notices

Special Enrollment Rights

Based on IRS rules, if you waive HSHS medical coverage for yourself or your dependents (including your spouse/LDA), 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/LDA 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/LDA 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 47**.

You must contact the HSHS Colleague Service Center and complete the necessary forms within 30 days of loss of other plan coverage or within 60 days from the date of the Medicaid/CHIP eligibility change in order to enroll in/change your benefit elections.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your state for more information on eligibility.

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
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/Hawki Phone: 1-800-257-8563
COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	KANSAS – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
FLORIDA – Medicaid	KENTUCKY – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: https://chfs.ky.gov Phone: 1-800-635-2570

Continued ▶

LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 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: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ 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://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462

Continued ▶

RHODE ISLAND – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)	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: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.hca.wa.gov/ 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**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: 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 July 31, 2019, or for more information on special enrollment rights, contact either:

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

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

2020 Flexplan Benefits Guide

Contact Information

If you have questions about ...	Contact ...
Enrolling or your Flexplan benefits	The HSHS Colleague Service Center 1-855-FYI-HSHS, **fyi@hshs.org**

Medical
• Customer Service
  • Claim information
  • ID cards
• Provider locator
• Treatment pre-approval
• 24/7 Nurse line (Prevea Care After Hours)
	Dean Health Plan
	deancare.com/aso
	1-888-895-1188
	(7:30 a.m. to 5 p.m. CST, Monday - Thursday, and 8 a.m. - 4:30 p.m. CST, Fridays)
	benefits.hshs.org/Find-a-Provider
	1-920-496-4700 or 1-888-277-3832

Prescription Drugs	OptumRx During enrollment: **https://www.optumrx.com/oe_HSHS/landing** Beginning 1/1/2020: **www.optumrx.com** 1-844-720-0030
Dental • 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 • 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 • Short-Term Disability • Long-Term Disability	UNUM **www.unum.com** 1-866-295-3007, Monday – Friday, 7 a.m.- 7 p.m. CST
HSHS Pension Plan	HSHS-Mercer Benefits Central **benefits.hshs.org/pension** 1-855-FYI-HSHS, option 2
Employee Assistance Program	Prevea Behavioral Care 1-920-272-1200 or 1-888-2PREVEA
HSHS Discount Program	The HSHS Colleague Service Center 1-855-FYI-HSHS, **fyi@hshs.org** **https://hshs.perkspot.com/login**

HSHS Colleague Service Center
Benefit Questions? 1-855-FYI-HSHS

You care for our patients. We care for you.

For additional help with enrolling or if you have questions about your Flexplan benefits,contact the HSHS Colleague Service Center.

You can speak to a benefits representative by calling 1-855-FYI-HSHS. Searchable FAQs are available at **benefits.hshs.org** for more support.

Watch the video to learn more.