2021 Benefit Guide

Medical | Dental | Vision | Life | Disability | Critical Illness | Accident | 401K | EAP

MEMORIAL HOSPITAL
And Health Care Center
Sponsored by the Sisters of the Little Company of Mary, Inc.

Welcome to Your Benefits!

Memorial Hospital is pleased to offer our employees a comprehensive benefits program. These health and welfare benefits are designed to protect you and your family while you are an active employee. At Memorial Hospital and Health Care Center, we take our mission to “Be for Others” to heart. It is why it is so important to offer our employees the best benefits package.

Table of Contents

This booklet is intended for illustration and informational purposes only. The plan documents, insurance certificates and policies will serve as the governing documents to determine plan eligibility, benefits and payments. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern.

Eligibility

Eligibility for Employees

Health and welfare plans are available to all employees who meet the definition of full-time, active employee. An employee is considered to be eligible if he or she is at a status to work at least 30 hours per week and is on the regular payroll of the employer for that work; or a status of .6 weekend option benefits for employees working 24 hours per week.

Dependents

	Medical	Dental	Vision
Spouse	Eligible*	Eligible	Eligible
Child(ren)	Eligible for medical, dental and vision up to age 26 regardless of martial or student status.		

** Working Spouse Rule (applies to medical only): A spouse of an Employee who is eligible for other primary Medical plan coverage, but who fails to enroll for that coverage, is not eligible for coverage under this Medical Plan. The spouse can be eligible under this Medical Plan if this Medical Plan would be secondary or his/ her employer denies coverage per the eligibility provisions in that employer's Medical plan. Proof of said denial is required. Read more on page 15.*

Newly Eligible Employees

As a newly eligible employee, your plan eligibility date is the 1st day of the month following or coincident with regular employment. Newly eligible employees have up to 30 days from their date of hire to enroll or waive benefits. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period unless you experience a qualifying life event.

Qualifying Life Events

It is important that you make your choices carefully, since changes to those elections can generally only be made during the annual open enrollment period. Exceptions will be made for changes in family status during the year, allowing you to make a midyear benefit change. A family status change includes one or more of the following:

- Marriage
- Divorce
- Birth or adoption
- Death of a dependent
- Change in your spouse's employment
- Loss or gain of coverage by a spouse

If you have a family status change, you must change your benefit elections within 30 days of the qualifying event (with the exception of adoption or birth of a child, in which case you have 60 days to request changes).

Otherwise, you will need to wait until the next annual open enrollment period. Please contact Human Resources if one of the above scenarios applies to you during the year.

COBRA Continuation Coverage

When you or any of your dependents no longer meet the eligibility requirements for health and welfare plans, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

Claims Overview

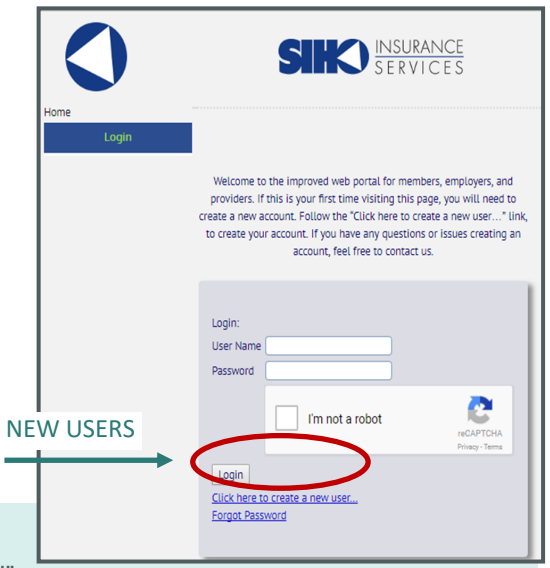
SIHO

Our medical claims administrator for 2021 is SIHO. In addition to paying claims, SIHO also handles the pre-certification of certain procedures. Although the physician normally handles pre-cert, you are ultimately responsible to make sure the procedure is approved. If pre-certification is not received there will be a $250 penalty.

MEMBER ACCESS PORTAL

As a feature of your health care benefits, SIHO provides secure internet access to give you information you need anytime you need it. Some of these features include:

- **Claims:** SIHO provides quick access to your claims status and eligibility information. You can track your medical claims as they move through the SIHO claims processing system.
- **Utilization:** View up-to-date information on Deductibles, Out-of-Pocket Limits & Preventive Health Benefits usage.
- **Plan Documents:** Verify benefits related to your current plan.



Visit **https://my.siho.org/** to access the Member Access Portal.

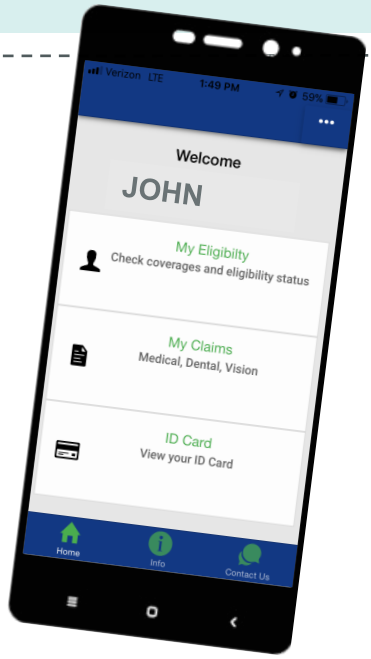
Select Login. If you are a new user, select "Click here to create a new user id" and follow the on-screen instructions.

You may be directed to select a specific health plan when creating your account. If you are unsure which plan you should select, please contact **SIHO Member Services: (812) 378-7070**

SIHO MOBILE APP

Want to look up the status of a medical claim? Or email your health insurance ID card? SIHO mobile puts all the most popular online features of the mobile web portal at your fingertips. Available for iPhone, iPad, iPod Touch and Android devices.

- **View Your Member ID card:** You can view the information on the front and back of your ID card. You can also email the card information to your provider or whomever requires it at any time.
- **Look Up Claims:** See your recent claims– up to ten per screen. Get a detailed view of each one, or look up specific medical, dental and pharmacy claims by member name.
- **Security**: You must always sign in with your User Name and Password to access the features in this app. Without that information, no one can reach your personal data.



Download the app by using the QR codes!

Medical Network

Memorial Hospital provides you three medical plan options: the Health Plan Choice, the Copay Health Plan, and the HSA Health Plan. The most significant differences between the plans are the deductibles and out-of-pocket maximums. Please review the tables on the following page for a summary of each plan.

Patoka Valley Health Care Cooperative

Memorial Hospital And Health Care Center
Sponsored by the Sisters of the Little Company of Mary, Inc.

Tier 1– Memorial Hospital and Patoka Valley

Our employees receive discounts through Patoka Valley Health Care Cooperative (PVHCC). This Tier provides the highest level of benefits to you. This should be your first place to go for care.

Patoka Valley Health Care Cooperative (PVHCC)

812-683-3332 **OR** 800-318-1590 PVcooperative.com

Procedures that can be done at Memorial Hospital and Health Care Center should be done at the hospital to be covered under Tier 1. (x-ray, therapy, minor office surgery, lab work, and ultrasounds are exceptions).

encoreconnect
Emerge. Evolve. Excel.

Cigna

Tier 2– Encore (Indiana) and Cigna (Out of Indiana)

To receive the Tier 2 benefit, an approved PVHCC referral must be obtained PRIOR to seeing a provider or receiving services outside of the PVHCC Network. Services from each non PVHCC Provider/Facility will require a separate approved referral. Referrals must be renewed annually.

However, the following do NOT require a referral:

- Employees and dependents who reside outside of the PVHCC network
- Dependents outside the PVHCC network
- Treatments while traveling outside the PVHCC network
- Routine, hospital-confined, newborn care

Encore Connect—select Encore Combined or Encore Health Network as your networks

(317) 621-4250 www.encoreconnect.com

Cigna

(866) 259-5377 www.mycigna.com

Tier 3– Out-of-Network

This tier includes care outside of PVHCC when a referral is not obtained. Also, any care obtained outside of the PVHCC, Encore, or Cigna networks.

Medical Benefit Plans

Health Plan Choice			
	Tier 1 (MHHCC / PVHCC)	**Tier 2 Encore (Indiana) / Cigna (Out of Indiana)**	**Tier 3 (Out-of-Network)**
Calendar Year Deductible	$1,200 single / $2,400 family	$3,000 single / $6,000 family	$5,000 single / $10,000 family
Out-of-Pocket Maximum *Includes copays, deductible and coinsurance*	$5,000 single / $10,000 family	$7,500 single / $15,000 family	Unlimited *deductible is separate*
Physician Office Visit	10% after deductible	20% after deductible	50% after deductible
Specialist Office Visit	10% after deductible	20% after deductible	50% after deductible
Preventive Care Services	Covered in full	Covered in full	Not Covered
In-Patient/Out-Patient Services	10% after deductible	20% after deductible	50% after deductible
Emergency Room Services	$250 copay / 10% coinsurance	$250 copay / 20% coinsurance	$250 copay / 20% coinsurance
Urgent Care	$125 copay / 10% coinsurance	$125 copay / 20% coinsurance	$125 copay / 50% coinsurance

Copay Health Plan			
	Tier 1 (MHHCC / PVHCC)	**Tier 2 Encore (Indiana) / Cigna (Out of Indiana)**	**Tier 3 (Out-of-Network)**
Calendar Year Deductible	$4,000 single / $8,000 family	$6,000 single / $12,000 family	$8,000 single / $16,000 family
Out-of-Pocket Maximum *Includes copays, deductible and coinsurance*	$5,000 single / $10,000 family	$7,500 single / $15,000 family	Unlimited *deductible is separate*
Physician Office Visit	$35 copay	$35 copay	50% after deductible
Specialist Office Visit	$35 copay	$35 copay	50% after deductible
Preventive Care Services	Covered in full	Covered in full	Not Covered
In-Patient/Out-Patient Services	10% after deductible	20% after deductible	50% after deductible
Emergency Room Services	$250 copay	$250 copay / 20% coinsurance	$250 copay / 20% coinsurance
Urgent Care	$125 copay	$125 copay / 20% coinsurance	$125 copay / 50% coinsurance

HSA Health Plan			
	Tier 1 (MHHCC / PVHCC)	**Tier 2 Encore (Indiana) / Cigna (Out of Indiana)**	**Tier 3 (Out-of-Network)**
Calendar Year Deductible	$3,100 single / $6,200 family	$5,000 single / $10,000 family	$6,000 single / $12,400 family
Out-of-Pocket Maximum *Includes copays, deductible and coinsurance*	$5,000 single / $10,000 family	$6,900 single / $13,800 family	Unlimited *deductible is separate*
Physician Office Visit	10% after deductible	20% after deductible	50% after deductible
Specialist Office Visit	10% after deductible	20% after deductible	50% after deductible
Preventive Care Services	Covered in full	Covered in full	Not Covered
In-Patient/Out-Patient Services	10% after deductible	20% after deductible	50% after deductible
Emergency Room Services	10% after deductible	20% after deductible	20% after deductible
Urgent Care	10% after deductible	20% after deductible	50% after deductible

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Medical Contributions

Your health and your wallet can both be benefited when you focus on your health and wellness. As you can see below, you'll save money on your per-pay check cost for medical benefits by participating in the health screening as part of Memorial Hospital's wellness program. See below for details.

Health Plan Choice				
	Full-Time Regular Employees		Weekend Option Rates (Semi-Monthly)	
	WHAT YOU PAY (NO WELLNESS)	WHAT YOU PAY (WITH WELLNESS)	WHAT YOU PAY (NO WELLNESS)	WHAT YOU PAY (WITH WELLNESS)
Employee only	$67.88	$58.62	$184.72	$159.52
Employee + Spouse	$188.86	$163.10	$313.76	$271.26
Employee + Child(ren)	$177.31	$153.12	$282.47	$243.94
Employee + Family	$216.91	$187.32	$391.28	$337.91

Copay Health Plan				
	Full-Time Regular Employees		Weekend Option Rates (Semi-Monthly)	
	WHAT YOU PAY (NO WELLNESS)	WHAT YOU PAY (WITH WELLNESS)	WHAT YOU PAY (NO WELLNESS)	WHAT YOU PAY (WITH WELLNESS)
Employee only	$46.13	$39.84	$112.68	$97.31
Employee + Spouse	$110.99	$95.85	$191.29	$165.20
Employee + Child(ren)	$99.89	$86.27	$172.16	$148.68
Employee + Family	$138.46	$119.57	$238.66	$206.11

HSA Health Plan				
	Full-Time Regular Employees		Weekend Option Rates (Semi-Monthly)	
	WHAT YOU PAY (NO WELLNESS)	WHAT YOU PAY (WITH WELLNESS)	WHAT YOU PAY (NO WELLNESS)	WHAT YOU PAY (WITH WELLNESS)
Employee only	$35.59	$30.74	$91.33	$78.87
Employee + Spouse	$90.60	$78.24	$155.03	$133.88
Employee + Child(ren)	$81.53	$70.41	$139.33	$120.33
Employee + Family	$113.01	$97.60	$193.42	$167.04

Pharmacy Benefits Overview

Pharmacy benefits are an important component of your health care. If you enroll in a medical plan through Memorial Hospital, you automatically receive prescription benefits according to the plan you enroll in, as shown below.

Health Plan Choice

	30 day supply		31-60 day supply		61-90 day supply	
	MHHCC Pharmacy	National Pharmacy Network	MHHCC Pharmacy	National Pharmacy Network	MHHCC Pharmacy	National Pharmacy Network
Preferred Free Generic Rx List	Free	N/A	Free	N/A	Free	N/A
Deductible	Waived	$100	Waived	Not Covered	Waived	Not Covered
Generic	Greater of $5 or 15%	Greater of $15 or 25%	Greater of $10 or 15%	Not Covered	Greater of $15 or 15%	Not Covered
Single Source Brand Only *(No generic available)*	Greater of $10 or 20%	Greater of $50 or 35%	Greater of $20 or 20%	Not Covered	Greater of $30 or 20%	Not Covered
Multi-Source Brands *(Generic available)*	Greater of $10 or 20%	100% of discounted rate	Greater of $20 or 20%	Not Covered	Greater of $30 or 20%	Not Covered
Specialty	Greater of $10 or 20% (Max. $250)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Copay Health Plan

	30 day supply		31-60 day supply		61-90 day supply	
	MHHCC Pharmacy	National Pharmacy Network	MHHCC Pharmacy	National Pharmacy Network	MHHCC Pharmacy	National Pharmacy Network
Preferred Free Generic Rx List	Free	N/A	Free	N/A	Free	N/A
Deductible	Waived	$100	Waived	Not Covered	Waived	Not Covered
Generic	Greater of $5 or 15%	Greater of $15 or 25%	Greater of $10 or 15%	Not Covered	Greater of $15 or 15%	Not Covered
Single Source Brand Only *(No generic available)*	Greater of $10 or 20%	Greater of $50 or 35%	Greater of $20 or 20%	Not Covered	Greater of $30 or 20%	Not Covered
Multi-Source Brands *(Generic available)*	Greater of $10 or 20%	100% of discounted rate	Greater of $20 or 20%	Not Covered	Greater of $30 or 20%	Not Covered
Specialty	Greater of $10 or 20% (Max. $250)	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

HSA Health Plan

	30 day supply		31-60 day supply		61-90 day supply	
	MHHCC Pharmacy	National Pharmacy Network	MHHCC Pharmacy	National Pharmacy Network	MHHCC Pharmacy	National Pharmacy Network
Preferred Free Generic Rx List	Free	N/A	Free	N/A	Free	N/A
Deductible	Included in medical ded.		Included in medical ded.	Not Covered	Included in medical ded.	Not Covered
Generic	20% after ded.		20% after ded.	Not Covered	20% after ded.	Not Covered
Single Source Brand Only *(No generic available)*	20% after ded.		20% after ded.	Not Covered	20% after ded.	Not Covered
Multi-Source Brands *(Generic available)*	20% after ded.		20% after ded.	Not Covered	20% after ded.	Not Covered
Specialty	20% after ded.		Not Covered	Not Covered	Not Covered	Not Covered

Pharmacy Benefits Overview

WELCOME TO MHCC EMPLOYEE PHARMACY

GENERAL INFORMATION

- Employee Pharmacy Direct Line: 812-996-0421
- Employee Refill Voicemail Line: 812-996-8557
- Operating Hours 7am to 6pm Monday-Friday

NEW PHARMACY USERS:

- The employee pharmacy fills prescriptions for insured employees and their insured dependents.
- Select over the counter medications can be purchased at a reduced cost for any MHCC employee (a list of items is available on the pharmacy tab on the HUB)
- The first time you come to the MHCC employee pharmacy window (located on the second floor of the Barrett Building), please complete the NEW patient information sheet (information such as insurance cards, allergies, and adverse drug reactions history are needed to fill your prescriptions)
- We ask that you allow 24 hours for most refills and 72 hours for 90 day supplies or transfers from other pharmacies.
- Please present any manufacturer coupon on savings cards at the time of prescription drop off. **The pharmacy does process most coupon cards.**
- If you need to talk with the employee pharmacy staff, please call: 996-0421 rather than the main inpatient pharmacy line.

REFILLS:

- Refills may be ordered by using the employee refill line (996-8557), the **WINRXREFILL.com** site (see pharmacy for information on registration), by completing the refill request slip at the pharmacy window, or by using the email link on the HUB under the pharmacy tab.
- Pick up for all maintenance should occur during normal operating hours.

AFTER HOURS:

- Please note EMERGENCY prescription fills are available after hours for meds such as antibiotics or urgent pain medications. There could be a delay in processing time after hours due to staff availability.
- For after-hour emergencies, you may contact the main input pharmacy at (812) 996-0424

We look forward to serving you and meeting your prescription needs!

Teladoc Overview

Available to all employees who participate in the Health plan.

We understand it may not always be convenient to go to the doctor, which is why we offer you the opportunity to video chat with a doctor for non-emergency situations. Teladoc gives you 24/7/365 access to a doctor through the convenience of phone or video consults. It's an affordable option for quality medical care.

Teladoc

Get the Care You Need

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Bronchitis
- Sinusitis
- Respiratory infection
- Strep Throat
- Urinary Tract Infections
- And more!

When can I use Teladoc?

- When you need care now
- If your doctor is unavailable
- If you're considering the ER or urgent care center for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short term prescription refills

Talk to a doctor anytime for free!

Teladoc.com
1-800-Teladoc (835-2362)
Facebook.com/Teladoc
Teladoc.com/mobile

Employee Clinic & Wellness Overview

Memorial Hospital and Health Care Center understands that keeping a healthy and happy workforce is important for the success of our business and we are committed to the well-being of our most valuable asset…our employees.

Memorial Health Employer Services is designed to supplement your current medical care by collaborating with your Primary Care Provider to offer the below services. Memorial Health Employer Services is open to all insured employees, spouses, and dependents.

- Same day acute/illness visits
- Immunizations
- X-Ray
- Workers compensation/injuries
- Labs
- Education/disease management
  - ◊ Diabetes
  - ◊ Weight management
  - ◊ Nutrition
- Improve lifestyle and achieve individual health goals through wellness coaching
  - ◊ Weight, stress, sleep, blood pressure, nutrition and healthy eating, tobacco use, cholesterol, and diabetes

Memorial Health Employer Services

Hours of Operation:	Location and Phone:
Monday 7:30 a.m.— 5:30 p.m.	695 W 2nd Street
Tuesday 7:30 a.m.— 4:00 p.m.	Suite A1
Wednesday 7:30 a.m.— 5:30 p.m.	Jasper, IN
Thursday 7:30 a.m.— 4:00 p.m.	812-996-5750, opt 1
Friday 7:30 a.m.— 12:00 p.m.	

Memorial Health Employer Services is staffed with a healthcare provider and clinical staff to target potential health risks and guide you in making smarter health and lifestyle choices.

DON'T MISS OUT ON OUR HEALTH AND WELLNESS SCREENING BENEFIT

Take advantage of wellness rates on your medical benefits by participating in health screening programs!

Who is eligible for the health screening?

- All insured and non-insured employees
- All spouses
- All volunteers

How can I save on premiums?

Participate in the annual health screening and screening result session. Results do not impact your premium discount. Screenings may also take place at your primary care provider office.

Employee Nurse Navigator Program

The Employee Nurse Navigator is a health advocate who can provide personalized support, information, and resources to help you manage your healthcare. See the HUB for more details.

A complete list of Employee Wellness Programs is available on the HUB.

Know Where to Go for Health Care

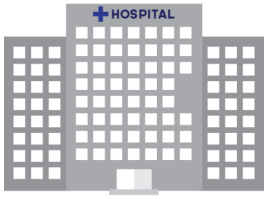
Get the care you need, when and where you need it.

If you or a loved one comes down with a minor illness or injury, like strep throat or the flu, it's important to know what your treatment options are. Review the table below so you KNOW where to GO.

	PRIMARY CARE OFFICE OR MEMORIAL HEALTH EMPLOYER SERVICES	HUNTINGBURG URGENT CARE	MEMORIAL HOSPITAL EMERGENCY DEPARTMENT
Animal Bites*	✓	✓	• Sudden loss of consciousness • Signs of heart attack (sudden/ severe chest pain or pressure) • Signs of stroke (numbness of face, arm or leg on one side of body, difficulty talking) • Severe shortness of breath • High fever with stiff neck, mental confusion, and/or difficulty breathing • Coughing up or vomiting blood • Cut or wound that won't stop bleeding Poisoning • Stab wound • Sudden, severe abdominal pain • Trauma to the head • Suicidal feelings • Partial or total amputation of limb • Broken or exposed bone
Stitches*	✓	✓	
X-Ray*	✓	✓	
Back Pain	✓	✓	
Mild Asthma	✓	✓	
Headache/Migraine	✓	✓	
Sprain/Strain	✓	✓	
Nausea, Vomiting	✓	✓	
Bumps, Cuts, Scrapes	✓	✓	
Burning with Urination	✓	✓	
Cough, Sore Throat	✓	✓	
Ear or Sinus Infection	✓	✓	
Eye Swelling, Redness	✓	✓	
Minor Allergic Reaction	✓	✓	
Minor Fever, Colds	✓	✓	
Rash, Minor Burns	✓	✓	
Possible Broken Bone	✓	✓	

Animal bites, stitches, and x-ray services may not be available at all primary care offices. Please check with the office for availability.

5-10x



Emergency Room

1x

Office/Urgent Care

AVOID THE HIGH COST OF THE EMERGENCY ROOM

Not only will you potentially wait MUCH longer for care, but you'll pay 5 to 10 times as much as you would for an office or urgent care visit.

HSA Overview

A Health Savings Account, commonly known as an "HSA," is an individual account you can open, add money to, and spend on eligible health care expenses. An HSA is unique because money used for eligible expenses is not taxed, investment earnings are not taxed, money spent on eligible expenses is not taxed, and the money rolls over year to year. You own the account and you control how money is spent. Contributions can be made with pre-tax dollars via payroll deduction or using post-tax dollars, allowing you to claim a deduction on your tax return.

Setting up your HSA

If you are eligible for an HSA Account (by electing HSA Health plan), you will receive a Welcome Kit at your home address with registration information. We partner with Wage Works for Health Savings Accounts. It is important to get your HSA set up as quickly as possible. Money cannot be deposited until the account is set up.

Adding Money

The government sets the annual dollar maximum that can be made to an HSA depending on the level of coverage you have under your health insurance. Coverage of two or more people is considered family coverage. People who are age 55 or older can make additional catch-up contributions.

Keep in mind that the family tax cap is the maximum you and your spouse can contribute into your HSAs. (So your contribution to your HSA + their contribution to the HSA + any employer or other monies contributed to either of your HSA has to be at or under $7,000 combined).

Using HSA Money

HSA money can be used tax-free for any eligible health care expenses. In general, eligible health care expenses are those that qualify toward the deductibles, copays, and coinsurance with your health insurance. You decide when to spend money from your HSA. If you pay out of pocket for an eligible medical expense, you can choose not to reimburse yourself and let the money in your HSA build up, or you can reimburse yourself for the expense from your HSA later. If you use your HSA money for expenses that are not eligible, you will pay a 20% penalty plus income tax on the amount. Once you turn age 65, you may use your HSA money for any expense, medical or not, but you will pay income taxes on those non-medical expenses.

Eligibility

- You must be covered under our high deductible health plan (HDHP).
- You have no other health coverage except what is permitted under Other Health Coverage (See Publication 969 located at www.irs.gov).
- You are not enrolled in Medicare
- You haven't used the VA (See Publication 969 located at www.irs.gov).
- You cannot be claimed as a dependent on someone else's (current year's) tax return.

Eligible Expenses

The money in your HSA must be used for eligible medical, dental, vision, and prescription drug expenses. If you use money for a dental, vision or medical expense that is not covered by the medical plan, it is important you understand your medical plan deductible will still need to be met if an expense is incurred.

	Employer 2021 Contribution	IRS 2021 Contribution Limit
Employee Only	$500	$3,600
Employee + Spouse	$500	$7,200
Employee +Child(ren)	$500	$7,200
Family	$500	$7,200
55+ Catch Up	n/a	$1,000
Employee with Health Plan Choice or Health Plan	$0	$0

For a full list of eligible expenses, go to www.irs.gov and search for publication 502.

Flexible Spending Accounts

Healthcare Flexible Spending Account

A Flexible Spending Account (FSA) allows you to set aside money from your paycheck before income taxes (Federal, Social Security, Medicare, state and local taxes, if applicable) are withheld. This money is available to pay for eligible expenses, such as copayments, deductibles, eye glasses, contact lenses and other health-related expenses that are not reimbursed by insurance. Flexible Spending Accounts are administered by Wage Works (a partner of ADP).

If you elect the Health Plan Choice, Copay Health Plan or waive medical coverage, you may elect the Full Health Care FSA. If you elect the HSA Health Plan, you may not elect a Health Care FSA.

How Does It Work?

You decide how much to contribute to your Health FSA on a plan year basis, up to **$2,750.** Your annual election will be divided by the number of pay periods and deducted evenly on a pre-tax basis from each paycheck throughout the plan year.

Things to Consider Before You Contribute To an FSA

- Be sure to fund the account wisely as Health FSAs are subject to a "use it or lose it" rule. All funds must be used by march 15th of the following plan year and submitted for reimbursement by March 31st. Any unused funds are forfeited.
- You cannot take income tax deductions for expenses you pay with your Health FSA &/or Dependent Care FSA.
- You cannot stop or change contributions to your FSA during the year unless you have a change in family status consistent with your change in contributions.

Dependent Care Flexible Spending Account

The Dependent Care FSA allows you to set aside money from your paycheck on a pre-tax basis for daycare expenses to allow you and your spouse to work or attend school full-time. Eligible dependents are your tax dependent children under 13 years of age or a child over 13, spouse or elderly parent residing in your home, who is physically or mentally unable to care for himself or herself. Under the Dependent Care FSA, if you are married and file a joint return, or if you file a single or head of household return, the annual IRS limit is $5,000. If you are married and file separate returns, you can each elect $2,500 for the plan year. You and your spouse must be employed or your spouse must be a full-time student to be eligible to participate.

Claims Reimbursement

You have several options for requesting reimbursement from your Dependent Care FSA:

- **Online:** https://myspendingsaccount.wageworks.com; **Fax:** 866-643-2219

Things to Consider Before You Contribute to A Dependent Care FSA

- Be sure to fund the account wisely. Due to the favorable tax treatment of FSAs, the IRS requires that you forfeit any balance in the Dependent Care FSA.
- You cannot take income tax deductions for expenses you pay with your Dependent Care FSA.
- You cannot stop or change contributions to your Dependent Care FSA during the year unless you have a change in status consistent with your change in contributions.

Visit irs.gov/publications/p502 to view eligible FSA expenses | Visit wageworks.com to view eligible Dependent Care FSA expenses.

The debit card is not available for Dependent Care FSAs. For Dependent Care FSA claims, pay for an eligible expense out of your pocket, fax, mail or submit online a reimbursement request along with a receipt for the expense. WageWorks (a partner of ADP) will then process your request and promptly reimburse you through direct deposit or by check.

Dental Benefits

Aside from protecting your smile, dental care ensures good oral and overall health. Several studies suggest that oral diseases, such as gum disease, can affect other areas of your body including your heart. Please note that you can visit providers both inside and outside of the Paramount Dental network, but you'll save money by using participating providers. **Find participating dentists at www.insuringsmiles.com.**

PARAMOUNT DENTAL OPTIONS		
PLAN FEATURE	**BASE PLAN (IN-OR OUT-OF-NETWORK)**	**BUY UP PLAN (IN-OR OUT-OF-NETWORK)**
Deductible - Individual/Family *Waived for Preventive Services*	$50/$100	$50/$100
TYPE 1 - Preventive Services *Cleanings, Routine Exams, X-Rays, Fluoride Treatment for Children (2x per year up to age 19), Space Maintainers, Topical Sealants for Children; limited to two routine exams in 12 months and cleanings every 6 months*	100% - Deductible is waived	100% - Deductible is waived
TYPE 2 - Basic Services *Basic Restorative, Amalgams, Fillings, Simple Extractions, Root Canal Therapy*	80% after deductible	80% after deductible
TYPE 3 - Major Services *Crowns, Core Build up, Removable Dentures*	50% after deductible	50% after deductible
Orthodontia Coverage *For adults and children*	$1,000 lifetime maximum per person (not to exceed the maximum monthly installment)	$2,000 lifetime maximum per person (not to exceed the maximum monthly installment)
Maximum Annual Benefit	$1,000	$2,000

**If you visit a provider that is outside of the Paramount dentist network, you can be balance billed for any amount that exceeds the "usual and customary amount" determined by Paramount Dental.*

DENTAL RATES FOR FULL-TIME REGULAR EMPLOYEES		
	BASE DENTAL PLAN	**BUY UP DENTAL PLAN**
Employee Only	$5.96	$9.25
Employee + Spouse	$10.60	$17.51
Employee + Child(ren)	$10.56	$19.38
Employee + Family	$12.66	$24.89

DENTAL RATES FOR WEEKEND OPTION		
	BASE DENTAL PLAN	**BUY UP DENTAL PLAN**
Employee Only	$6.45	$9.74
Employee + Spouse	$13.56	$20.47
Employee + Child(ren)	$17.39	$26.21
Employee + Family	$24.02	$36.25

Vision Benefits

Routine eye exams will help maintain your vision as well as detect various eye problems and concerns about your overall health. You have the choice of seeing the provider of your choice. However, keep in mind that by using an in-network provider, your plan has a better benefit and saves you money! Visit www.vsp.com to find a provider in the **VSP Choice network.**

VSP VISION OPTIONS				
PLAN FEATURE	**BASE PLAN**		**BUY UP PLAN**	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Exam Copay - Once every 12 months based on a calendar year	$15 copay	N/A	$15 copay	N/A
Exam Allowance - Once every 12 months based on a calendar year	Covered in full after $15 copay	Up to $45	Covered in full after $15 copay	Up to $45
Lenses - Once every 12 months based on a calendar year **- Single Vision** **- Bifocal** **- Trifocal** **- Lenticular**	Covered 100% after $25 copay	Up to $30 allowance Up to $50 allowance Up to $65 allowance Up to $100 allowance	Covered 100% after $25 copay	Up to $30 allowance Up to $50 allowance Up to $65 allowance Up to $100 allowance
Frames	Up to $150 allowance $80 allowance at Costco, Sam's Club & Walmart	Up to $70 allowance	Up to $200 allowance $110 allowance at Costco, Sam's Club & Walmart	Up to $70 allowance
Contact Lenses* - Once every 12 months based on calendar year, in lieu of frames and lenses **- Elective Contacts** **- Medically Necessary**	Covered up to $130 Covered in full	Up to $105 allowance Up to $210 allowance	Covered up to $170 Covered in full	Up to $105 allowance Up to $210 allowance
Additional Lens Enhancements	Polycarbonate for children Rimless mounting for all		Polycarbonate for children Rimless mounting for all UV protection for all Anti-Reflective Lenses after $40 copay	

VISION RATES FOR FULL-TIME REGULAR EMPLOYEES			VISION RATES FOR WEEKEND OPTION	
	BASE VISION PLAN	**BUY UP VISION PLAN**	**BASE VISION PLAN**	**BUY UP VISION PLAN**
Employee Only	$0.85	$4.42	$2.20	$5.77
Employee + Spouse	$1.80	$7.50	$3.52	$9.23
Employee + Child(ren)	$2.81	$8.63	$3.60	$9.42
Employee + Family	$3.77	$13.43	$5.97	$15.63

Save up to 60% on Brand-name Hearing Aids with TrueHearing!

TrueHearing makes hearing aids affordable by providing exclusive savings to all VSP Vision Care members. You can save up to 60% on a pair of hearing aids with TruHearing. What's more, your dependents and even extended family members are eligible too.

Walmart, Sam's Club and Costco retailers are now among participating network providers!

Life and Disability Benefits

Life Insurance Options

Employer Paid Basic Life Insurance

For eligible employees working 32 or more hours per week, Memorial Hospital pays 100% of the cost of Basic Life coverage and Accidental Death & Dismemberment (AD&D) insurance.

There is no additional cost to you. Life Insurance provides a monetary benefit to your beneficiary in the event of your death while you are employed.

PLEASE NOTE: It is important to keep your beneficiary information up-to-date. Please be sure to verify or update this information at open enrollment or when there is a status change. Examples of when you may want to update your beneficiaries are birth, adoption, marriage, or divorce.

EMPLOYEE COVERAGE	BENEFIT AMOUNT
Basic Life Insurance and Accidental Death and Dismemberment	1x your earnings up to $150,000

Employer Paid Long-Term Disability

Long-Term Disability Insurance provides income protection in the event you become disabled and are unable to work for an extended period of time.

Memorial Hospital pays the premiums for Long-Term Disability (LTD) insurance after full-time employment of one year.

LONG-TERM DISABILITY BENEFIT SUMMARY	
Benefit Amount	60% of covered earnings up to maximum benefit
Maximum Benefit	$12,500 per month
Benefit Duration	See the summary plan description for details
Elimination Period	180 consecutive days of total disability

Voluntary benefits can only be elected annually. Please see page 20 for more information.

Employee Paid Short-Term Disability

For employees working at least 20 hours per week, the Unum disability plan can provide coverage when you are sick or injured and unable to work. If you are unable to work for a short period of time, the STD plan will pay 60% of your weekly salary, up to $5,000 per week. Benefit payments begin 14 days after you become sick or injured.*

** NOTE: This benefit includes a pre-existing limitation that excludes illness or injuries for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 12 months just prior to the date your coverage begins and the disability begins in the first 12 months after the coverage effective date.*

Your Voluntary Benefits

Voluntary Whole Life Insurance

Whole Life insurance can provide financial support for families after the death of a loved one. Coverage is available for your dependents, even if you don't elect coverage for yourself. This coverage provides protection for a lifetime, with guaranteed renewal year after year. If you purchase this coverage, rates will not go up as you age, and coverage is portable, so you can keep it even if you leave Memorial Hospital, as long as you continue making payments to Unum.

Supplemental Life Insurance

You can purchase additional Supplemental Term Life Insurance for yourself, your spouse, and your children in the amounts shown below.

COVERAGE TYPE	BENEFIT AMOUNTS
Employee	1-5x salary, not to exceed $500,000. Guaranteed issue amount is $175,000.
Spouse	$5,000 to $150,000, not to exceed 50% of the employee's amount. Guaranteed issue amount is $25,000.
Child(ren)	Live birth to 6 months: $1,000 6 months to 19 years (23 years if full-time student): $2,000-$10,000, not to exceed 50% of the employee's amount.

Supplementing Your Medical Plan

Critical Illness Insurance

If serious illness strikes, Unum's Critical Illness Insurance provides cash to help with the extra expenses associated with your recovery. If you elect this coverage and are diagnosed with a covered illness, you get a lump-sum cash benefit — even if you receive benefits from other insurance.

Coverage Amounts

- Employee – up to $30,000 ($20,000 guaranteed issue)
- Spouse – up to $30,000 ($10,000 guaranteed issue)
- Child – 25% of the employee amount

Covered Illnesses Include

- Heart Attack
- End Stage Renal (Kidney) Failure
- Stroke
- Coronary Artery Bypass Surgery
- Major Organ Transplant
- Cancer and Carcinoma in Situ

Accident Insurance

The Accident Insurance plan provides benefits to help cover the costs associated with unexpected bills. When a covered accident occurs, the last thing you should have to worry about is paying for the charges that may be accumulating while you're not at work. Those costs can add up — fast.

If you buy this insurance through Unum and get hurt in a covered accident, they send you a check for covered injuries and let you decide the best way to spend it.

Examples of Covered Injuries

- Broken bones
- Burns
- Torn ligaments
- Concussions
- Eye injuries
- Ruptured discs

ENROLL IN YOUR BENEFITS USING ENROLL VB

(These can only be elected annually!)

Voluntary benefits which include:

- **Supplemental Life Insurance**
- **Voluntary Whole Life Insurance**
- **Accident Death & Dismemberment**
- **Critical Illness Insurance**
- **Accident Insurance**
- **Short Term Disability**

How to ENROLL - You are asked to choose one of the enrollment methods listed below to accept or waive the coverage offered to you and your family, then checkout to complete your enrollment:

1. **Self Service Online:** Enroll from links in communication emails you will be receiving or click here **www.enrollvb.com/mhhcc** - you will be taken to EnrollVB Connect to enroll.

Existing Policyholders - No action is required to maintain coverage if you are a current policyholder. Increases to existing policies can be elected up to the maximum guaranteed acceptance plan limit,.

Value Added Programs

Tuition Reimbursement Program

The Tuition Reimbursement Program is designed to give employees the opportunity to increase their knowledge and skills through participation in educational programs. The program helps you contribute to our organization by becoming more effective in your current assignments as well as by preparing you for promotional opportunities.

- **Eligibility:** Employees must be employed with a specific assigned status of at least 48 hours per pay period for six consecutive months. The six month requirement is waived for employees taking academic courses toward a degree for a critical shortage area. If academic courses are recommended by the director or vice-president at the time of hire, the employee may enroll in the class before six months of employment is completed; however, tuition reimbursement may not be received before six months of employment has been completed.
- **Requirements:** The program of study must: (A) benefit the hospital, and either (B) be related to the employee's present job, or (C) enhance the employee's potential for advancement to a position to which the employee can reasonably be expected to be promoted within Memorial Hospital and Health Care Center.

See full program details in Policy Stat.

Student Loan Buyback Program

Memorial Hospital and Health Care Center strives to be proactive in recruiting, assisting, and encouraging qualified individuals to enter into critically needed health care fields. This program was designed to offset educational expenses by reimbursing approved monthly student loan obligations in trade for time worked at Memorial Hospital and Health Care Center.

The student loan buy-back benefit is available to employees recruited by Memorial Hospital and Health Care Center for critical shortage areas who have existing loans. This benefit may not be used in conjunction with the Tuition Reimbursement Program.

See full program details in Policy Stat.

Retirement Savings Plan

Our 401(k) is a long term savings plan that is designed to accumulate money towards retirement. You choose the percentage amount they want taken from your check every payday to contribute to the plan. This money is then invested in such things as money market funds, growth funds, and index based stock funds, which will accumulate value over time.

Memorial Hospital offers a generous matching contribution of $.50 on the $1.00 up to 4% of your compensation. To receive the hospital's full match, you will need to contribute a minimum of 4%. For example, if you contribute 3%, the hospital will match 1.5%. If you contribute 10%, the hospital will still match only 2%.

- **Eligibility:** You must be at least 18 years old and be classified at a status of .1 or above. PRN or on-call employees are ineligible; however, if you should change status to a .1 or above, you would become eligible.
- **Effective date:** The first of the month following date of hire or status change.
- **Vesting:** Employee Contributions are 100%. Employer contributions are vested 100% after 2 years of service.
- **Open Enrollment:** Takes place the last 2 weeks of February and August with an effective date of the 1st pay period of March and September.

Additional Benefits for MHHCC Employees

Gift Shop Discounts

Professional Membership Dues

Adoption Assistance

Discounts at Area Businesses

Employee Assistance Programs

We are interested in your total well-being. That is why we offer an Employee Assistance Program.
This program provides a counseling service that helps you manage problems before they adversely affect your personal life, health and job performance. This is a free and confidential service provided to Memorial Hospital & Health Care Center caregivers, their spouses and dependent children up to age 26.

Memorial Counseling Center is the primary service provider for our Employee Assistance Program (EAP). If you wish to see a provider, outside of Memorial Counseling, please contact Human Resources.

8 hours of FREE counseling for each eligible family member*

Memorial Counseling provides individual, marital, and family therapy for a variety of issues. Commonly treated (but not limited to) issues are:

- Depression
- Anxiety
- Stress
- Life Changes/Adjustments
- Work-related problems
- Marital/family problems
- Grief/Loss
- Communication difficulties

Confidentiality

No information, including your name, can be released without written consent. The only exception would be when it is the duty of the counselor to warn someone of a serious threat or the mandated reporting of child or elder abuse.

How to Get Started

- Call 812-996-5780 (option 1) to set up an initial assessment. Be sure to let them know that you are a caregiver at Memorial Hospital & Health Care Center and you are interested in utilizing your EAP Benefit
- If you or your family members are already involved in treatment with another provider, or have questions about the use of Memorial Counseling Center for EAP Services, please contact Jamie Williams (812-996-0523), Angie Hobson (812-996-0635), Pat Todd (812-996-5241) or Rich Pea (812-996-5743) in Human Resources for specific guidance.

Location and Hours

Memorial Counseling Center Medical Arts Building

- 721 West 13 Street, Suite 121
  Jasper, IN 47546
- Monday-Thursday 8am-5pm
- Friday 8am-4pm

**If counseling continues beyond 8 hours, claims would be filed with the caregivers medical insurance. Please follow all guidelines from the medical plan in regards to finding counselors in the network, referrals, etc.*

Important Notices And Rules

WORKING SPOUSE RULE

Effective January 1, 2001, Memorial Hospital implemented the Working Spouse Rule. The Working Spouse Rule means if a spouse of a Memorial Hospital employee is eligible for coverage under his/her employer's health plan, the spouse must enroll in his/her employer's plan before he/she is eligible to enroll in the Memorial Hospital plan. Memorial Hospital will coordinate benefits as a secondary payer for the spouse.

Q: How will this affect my children's coverage? Your children's coverage will not be affected by the Working Spouse Rule. Either spouse or both may cover the children.

Q: Can my spouse select dental, vision etc. insurance as primary with Memorial? Yes, the Working Spouse Rule only applies to Medical Insurance.

Q: What if a spouse is eligible for health insurance through his/her employer but selects Memorial Hospital coverage as their primary coverage? Any claims for the spouse will be denied.

Q: How will Benefits be coordinated if my spouse elects his/her insurance as primary and Memorial Hospital insurance as secondary? Your spouse must meet the deductible with his/her insurance first and then Memorial Hospital will pay as secondary payer. When a spouse submits a claim to Memorial Hospital insurance, the claim MUST accompany an Explanation of Benefits form from his/her primary insurance before any benefits will be paid.

Q: Why is Memorial Hospital adopting the Working Spouse Rule? Memorial Hospital implemented the Working Spouse Rule for cost containment thereby affording us the ability to continue to offer our employees insurance at an affordable cost. If your spouse's insurance company requires a Certificate of Creditable Coverage or a statement verifying that Memorial Hospital will adopt the Working Spouse Rule, please contact Human Resources and documentation will be forwarded to your spouse's insurance company.

If you have any questions, please contact Jamie at 812-996-0523 or Angie at 812-996-0635

NOTE: The required Working Spouse Form is on the HUB under the Human Resources Tab. You may also call Human Resources for a copy of this form.

PRIVACY NOTICE OF MEMORIAL HOSPITAL AND HEALTH CARE CENTER GROUP HEALTH PLAN

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully.

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY LAW about the duties and privacy practices of MEMORIAL HOSPITAL AND HEALTH CARE CENTER GROUP HEALTH PLAN (the "Plan") to protect the privacy of your medical information. The Plan provides health and/or dental benefits to you as described in your summary plan description(s). The Plan receives and maintains your medical information in the course of providing these health benefits to you. The Plan hires business associates, such as Benefit Planners, to help it provide these benefits to you. These business associates also receive and maintain your medical information in the course of assisting the Plan. The Plan is sponsored by MEMORIAL HOSPITAL AND HEALTH CARE CENTER (the "Plan Sponsor").

THE EFFECTIVE DATE OF THIS NOTICE IS APRIL 14, 2003. The Plan is required to follow the terms of this notice until it is replaced. The Plan reserves the right to change the terms of this notice at any time. If the Plan makes changes to this notice, the Plan will revise it and send a new notice to all subscribers covered by the Plan at that time. The Plan reserves the right to make the new changes apply to all your medical information maintained by the Plan before and after the effective date of the new notice.

Purposes for which the Plan May Use or Disclose Your Medical

Information Without Your Consent or Authorization

The Plan may use and disclose your medical information for the following purposes:

- Health Care Providers' Treatment Purposes. For example, the Plan may disclose your medical information to your doctor, at the doctor's request, for your treatment by him.
- Payment. For example, the Plan may use or disclose your medical information to pay claims for covered health care services or to provide eligibility information to your doctor when you receive treatment.
- Health Care Operations. For example, the Plan may use or disclose your medical information (i) to conduct quality assessment and improvement activities, (ii) for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of a contract of health insurance, (iii) to authorize business associates to perform data aggregation services, (iv) to engage in care coordination or case management, and (v) to manage, plan or develop the Plans' business.
- Health Services. The Plan may use your medical information to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan may disclose your medical information to its business associates to assist the Plan in these activities.
- As required by law. For example, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records. The Plan may also disclose your medical information as authorized by and to the extent necessary to comply with workers' compensation or other similar laws.
- To Business Associates. The Plan may disclose your medical information to business associates the Plan hires to assist the Plan. Each business associate of the Plan must agree in writing to ensure the continuing confidentiality and security of your medical information.
- To Plan Sponsor. The Plan may disclose to the Plan Sponsor, in summary form, claims history and other similar information. Such summary information does not disclose your name or other distinguishing characteristics. The Plan may also disclose to the Plan Sponsor the fact that you are enrolled in, or disenrolled from the Plan. The Plan may disclose your medical information to the Plan Sponsor for Plan administrative functions that the Plan Sponsor provides to the Plan if the Plan Sponsor agrees in writing to ensure the continuing confidentiality and security of your medical information. The Plan Sponsor must also agree not to use or disclose your medical information for employment-related activities or for any other benefit or benefit plans of the Plan Sponsor.

PRIVACY NOTICE OF MEMORIAL HOSPITAL AND HEALTH CARE CENTER GROUP HEALTH PLAN (CONT.)

The Plan may also use and disclose your medical information as follows:

- To comply with legal proceedings, such as a court or administrative order or subpoena.
- To law enforcement officials for limited law enforcement purposes.
- To a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you cannot give your agreement to the Plan to do this.
- To your personal representatives appointed by you or designated by applicable law.
- For research purposes in limited circumstances.
- To a coroner, medical examiner, or funeral director about a deceased person.
- To an organ procurement organization in limited circumstances.
- To avert a serious threat to your health or safety or the health or safety of others.

- To a governmental agency authorized to oversee the health care system or government programs.
- To federal officials for lawful intelligence, counterintelligence and other national security purposes.
- To public health authorities for public health purposes.
- To appropriate military authorities, if you are a member of the armed forces.

Uses and Disclosures with Your Permission

The Plan will not use or disclose your medical information for any other purposes unless you give the Plan your written authorization to do so. If you give the Plan written authorization to use or disclose your medical information for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your medical information the Plan maintains, unless the Plan has taken action in reliance on your authorization.

Your Rights

You may make a written request to the Plan to do one or more of the following concerning your medical information that the Plan maintains:

- To put additional restrictions on the Plan's use and disclosure of your medical information. The Plan does not have to agree to your request.
- To communicate with you in confidence about your medical information by a different means or at a different location than the Plan is currently doing. The Plan does not have to agree to your request unless such confidential communications are necessary to avoid endangering you and your request continues to allow the Plan to collect premiums and pay claims. Your request must specify the alternative means or location to communicate with you in confidence. Even though you requested that we communicate with you in confidence, the Plan may give subscribers cost information.
- To see and get copies of your medical information. In limited cases, the Plan does not have to agree to your request.
- To correct your medical information. In some cases, the Plan does not have to agree to your request.
- To receive a list of disclosures of your medical information that the Plan and its business associates made for certain purposes for the last 6 years (but not for disclosures before April 14, 2003).
- To send you a paper copy of this notice if you received this notice by e-mail or on the internet.

If you want to exercise any of these rights described in this notice, please contact the Contact Office (below). The Plan will give you the necessary information and forms for you to complete and return to the Contact Office. In some cases, the Plan may charge you a nominal, cost-based fee to carry out your request.

Complaints

If you believe your privacy rights have been violated by the Plan, you have the right to complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with the Plan at our Contact Office (below). We will not retaliate against you if you choose to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

Contact Office

To request additional copies of this notice or to receive more information about our privacy practices or your rights, please contact us at the following:

- Privacy Officer Telephone Number: (812) 996-0534
- Fax Number: (812) 996-0535
- Email: privacyoffice@mhhcc.org

Note to All Employees

Certain Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with the required disclosures related to our employee benefits plan. If you have any questions or need further assistance, please contact your Plan Administrator as follows:

January 2021
Memorial Hospital and Healthcare Center
Human Resources
800 West 9th Street
Jasper, IN 47546
812-996-0237

Notice Regarding Special Enrollment Rights

If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan for the remainder of the Plan Year, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan for the remainder of the Plan Year, except as otherwise provided below.

(a.) If you decline enrollment for yourself or your dependents because you or your dependent had other health insurance or group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Health Program within **30 days** of the loss of that coverage. For this purpose, "loss of coverage" will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage.

However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer's Plan, you must provide a written statement from the administrator of the other health plan that you no longer have that coverage.

(b.) You are eligible to enroll yourself and your Eligible Dependent in the Health Program within **30 days** of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption.

(c.) You are eligible to enroll yourself and your Eligible Dependent in the Plan within **60 days** after either:

(1.) You or your Eligible Dependent's Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or

(2.) You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.

Notice Regarding Women's Health and Cancer Rights Act (Janet's Law)

On October 21, 1998, Congress passed a Federal Law known as the Women's Health and Cancer Rights Act. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient, for:

Reconstruction of the breast on which the mastectomy was performed;
Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please call your plan administrator.

Important Notices And Rules

Notice Regarding Patient Protection Rights

The Memorial Hospital and Health Center's group health plan allows members to designate a Primary Care Provider. The following paragraphs outline certain protections under the Patient Protection and Affordable Care Act (Affordable Care Act) and only apply when the Plan requires or allows the designation of a Primary Care Provider.

You will have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the Plan's network. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals or notifying primary care provider or Plan of treatment decisions.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology healthcare professionals, please contact the insurer.

HIPAA Privacy

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy Practices that was previously given to you. A copy of this notice is available upon request.

Health Insurance Marketplace Coverage Options and Your Health Coverage

There is an additional way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.83 percent of your household income for 2021 (9.78 percent for 2020), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resources Department. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **www.HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Notice of Rescission of Coverage

Under Health Care Reform, your coverage may be rescinded (i.e., retroactively revoked) due to fraud or intentional misrepresentation regarding health benefits or due to failure to pay premiums. A 30-day advance notice will be provided before coverage can be rescinded.

Summary of Benefits & Coverage (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The Summary of Benefits & Coverage (SBC) is a document intended to help people understand their health coverage and compare health plans when shopping for coverage. The federal government requires all healthcare insurers and group healthcare sponsors to provide this document to plan participants. SBCs will be created for each medical plan offered. Group health plan sponsors must provide a copy of the SBC to each employee eligible for coverage under the plan. The SBC includes:

- A summary of the services covered by the plan
- A summary of the services not covered by the plan
- A glossary of terms commonly used in health insurance
- The copays and/or deductibles required by the plan, but not the premium
- Information about members' rights to continue coverage
- Information about members' appeal rights
- Examples of how the plan will pay for certain services

Important Notices And Rules

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, 2020. Contact **your State for more information on eligibility:**

KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx** Phone: 1-855-459-6328 Email: **KIHIPP.PROGRAM@ky.gov** KCHIP Website: **https://kidshealth.ky.gov/Pages/index.aspx** Phone: 1-877-524-4718 Kentucky Medicaid Website: **https://chfs.ky.gov**	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
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp** Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/** Medicaid Phone: 609-631-2392 CHIP Website: **http://www.njfamilycare.org/index.html** CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: **http://www.maine.gov/dhhs/ofi/public-assistance/index.html** Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: **https://www.maine.gov/dhhs/ofi/applications-forms** Phone: 1-800-977-6740 TTY: Maine relay 711	Website: **https://www.health.ny.gov/health_care/medicaid/** Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA - Medicaid**
Website: **http://www.mass.gov/eohhs/gov/departments/masshealth/** Phone: 1-800-862-4840	Website: **https://medicaid.ncdhhs.gov/** Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA - Medicaid**
Website: **https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp** Phone: 1-800-657-3739	Website: **http://www.nd.gov/dhs/services/medicalserv/medicaid/** Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** Phone: 573-751-2005	Website: **http://www.insureoklahoma.org** Phone: 1-888-365-3742

MONTANA – Medicaid	OREGON – Medicaid
Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** Phone: 1-800-694-3084	Website: **http://healthcare.oregon.gov/Pages/index.aspx** **http://www.oregonhealthcare.gov/index-es.html** Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: **http://www.ACCESSNebraska.ne.gov** Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: **https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx** Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Medicaid Website: **http://dhcfp.nv.gov** Medicaid Phone: 1-800-992-0900	Website: **http://www.eohhs.ri.gov/** Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: **https://www.scdhhs.gov** Phone: 1-888-549-0820	Website: **https://www.coverva.org/hipp/** Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON - Medicaid**
Website: **http://dss.sd.gov** Phone: 1-888-828-0059	Website: **http://www.hca.wa.gov/** Phone: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: **http://gethipptexas.com/** Phone: 1-800-440-0493	Website: **http://mywvhipp.com/** Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: **https://medicaid.utah.gov/** CHIP Website: **http://health.utah.gov/chip** Phone: 1-877-543-7669	Website:**https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf** Phone: 1-800-362-3002
VERMONT - Medicaid	**WYOMING – Medicaid**
Website: **http://www.greenmountaincare.org/** Phone: 1-800-250-8427	Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/** Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023

COBRA Rates

Medical	Health Choice	Copay	HSA
Employee	$1,119.30	$689.19	$562.12
Employee + Spouse	$1,914.39	$1,177.32	$948.16
Employee + Child(ren)	$1,725.84	$1,061.14	$852.08
Family	$2,385.78	$1,468.84	$1,182.93

Dental	Base	Buy Up
Employee	$30.52	$40.13
Employee + Spouse	$64.11	$84.29
Employee + Child(ren)	$82.24	$108.05
Family	$113.56	$148.56

Vision	Base	Buy Up
Employee	$9.76	$17.03
Employee + Spouse	$15.62	$27.24
Employee + Child(ren)	$15.94	$27.83
Family	$26.45	$46.16

Contacts

BENEFIT CONTACT INFORMATION			
BENEFIT PLAN	**COMPANY NAME**	**PHONE NUMBER**	**WEBSITE**
Medical	SIHO	(812) 378-7070	www.siho.org
Medical Networks	Patoka Valley Encore Cigna	(800) 318-1590 (317) 621-4250 (866) 259-5377	www.pvccooperative.com www.encoreconnect.com www.mycigna.com
Pharmacy	Magellan	(800) 424-0472	www.magellanrx.com
Dental	Paramount Dental	(800) 727-1444	www.insuringsmiles.com
Vision	VSP	(800) 877-7195	www.vsp.com
Health Savings Account	Wage Works	Customer Service: (888) 557-3156 Claims Fax: (866) 643-2219	https://myspendingaccount.wageworks.com
Flexible Spending Accounts	Wage Works	Customer Service: (888) 557-3156 Claims Fax: (866) 643-2219	https://myspendingaccount.wageworks.com
Life & Disability	Unum	(800) 421-0344	www.unum.com
Accident Insurance	Unum	(800) 421-0344	www.unum.com
Critical Illness Insurance	Unum	(800) 421-0344	www.unum.com
Human Resources	Angie Hobson Jamie Williams	(812) 996-0635 (812) 996-0523	ahobson@mhhcc.org jawillia@mhhcc.org

When contacting any of the companies above, it is important to have the insurance card or ID number(s) of the subscriber for the coverage you are calling about as well as any appropriate paperwork, such as an explanation of benefits, a denial letter, receipts, etc.

This booklet is intended for illustrative and for information purposes only. The plan documents, insurance certificates and policies will serve as the governing documents. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern. The company reserves the right to change or terminate at any time, in whole or in part, the employee benefit package, with respect to all or any class of employees or former employees.