MEMORIAL HOSPITAL
And Health Care Center

2024-2025

EMPLOYEE BENEFITS GUIDE

December 23, 2024 – September 30, 2025

IMPORTANT INFORMATION ENCLOSED

v16

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 34 for more details.

Contacts

Benefits Section of Human Resources

(812) 450-2025 | benefitquestions1@deaconess.com
Office Hours: 8:00 am to 5:30 pm (EST)

Leave of Absence Section of Human Resources

(812) 450-8258 | HRLOA@deaconess.com
Office Hours: 8:00 am to 4:00 pm (EST)

Deaconess OneCare HEALTH PLAN

Deaconess OneCare (844) 378-7103
deaconessonecare.com
OneCare Provider Directory: onecarecollaborative.com

Optum Rx®

Optum Rx (800) 506-4605
optumrx.com

Deaconess EMPLOYEE WELLNESS
POWERED BY APPLIED HEALTH ANALYTICS

Deaconess Wellness Department
(812) 450-1FIT(1348) | wellness@deaconess.com
MyWellness Portal Help Desk
(800) 581-9910

Memorial Counseling Center
Employee Assistance Program (EAP)

Memorial Counseling Center EAP
(812) 996-5780 (option 1)
Monday-Thursday 8am-5pm & Friday 8am-4pm (EST)

Deaconess
Employee Assistance Program (EAP)

Deaconess EAP (812) 471-4611 or (800) 874-7104
deaconess.com/EAP

supportlinc
Employee Assistance Program (EAP)

SupportLinc by CuraLinc (EAP)
(888) 881-LINC (5462) | supportlinc.com
Group Code: deaconess

HRI DENTAL & VISION

HRI Dental & Vision (800) 727-1444
insuringsmiles.com

vsp vision care

VSP Vision Care
(800) 877-7195 | vsp.com

Employee Benefits Corporation

Employee Benefits Corporation
Flexible Spending (FSA), Dependent Care (DCAP), Health Reimbursement (HRA)
(800) 346-2126 | ebcflex.com

THE HARTFORD

The Hartford
Life and Accidental Death & Dismemberment
(888) 563-1124
Short-Term Disability, Long-Term Disability, FMLA
(888) 277-4767
thehartford.com/employee-benefits/employees
Critical Illness, Accident & Hospital Indemnity
(866) 547-4205
myhealthhub.app/thehartford
Policy # 402724

Fidelity NetBenefits®

Fidelity
(800) 343-0860 | fidelity.com/atwork

Nationwide® is on your side

Nationwide Pet Insurance
(800) 540-2016 | benefits.petinsurance.com/deaconess

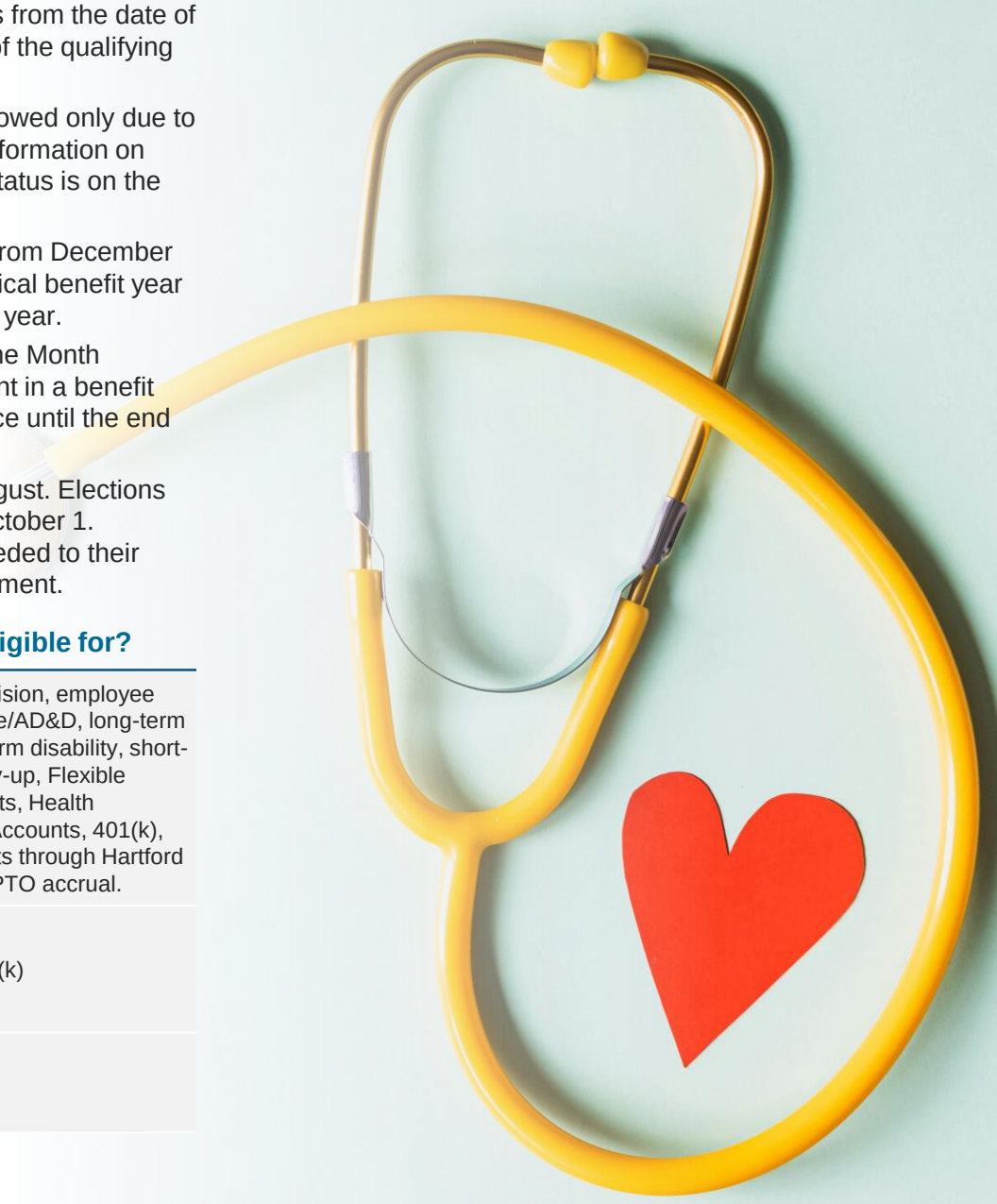
tuition.io
education assistance benefits

tuition.io
(855) 353-9395 | deaconess.tuition.io

Benefit Eligibility Information

The Deaconess Employee benefits program offers you the flexibility to choose the options that best suit your needs.

- Benefit enrollment is required 30 days from the date of hire, benefit eligible date or the date of the qualifying event if making mid-year changes.
- Mid-Year changes to elections are allowed only due to a change in family status. Detailed information on what qualifies as a change in family status is on the next page.
- Benefit Year for the transition will be from December 23, 2024 – September 30, 2025. Typical benefit year will be October 1-September 30 each year.
- Coverage is effective on the First of the Month following one full month of employment in a benefit eligible position and will remain in force until the end of the plan year.
- Annual Enrollment is each year in August. Elections made during this time are effective October 1. Employees can make changes as needed to their benefit elections during Annual Enrollment.



Which benefit programs am I eligible for?

Employees authorized to work 40 or more hours per pay period are eligible for:	Medical, dental, vision, employee and dependent life/AD&D, long-term disability, short-term disability, short-term disability buy-up, Flexible Spending Accounts, Health Reimbursement Accounts, 401(k), Voluntary Products through Hartford and Nationwide, PTO accrual.
Employees authorized to work fewer than 40 hours per pay period are eligible for:	PTO accrual, 401(k)
Employees authorized to work DSS and Temporary are eligible for:	401(k)

Eligible Dependents

Spouse	Someone you are currently, legally married to in accordance with state law recognized in Indiana. It does not include common law marriage, domestic partner, roommate, etc.
Child	Natural born children, stepchildren, legally adopted children and children for whom you are a legal guardian up to age 26 regardless of student, marital or job status

Dependent Eligibility Verification

Attention: MHHCC Employees wanting to **keep** or **add** spouses and dependents will need to provide supporting documentation to verify eligibility.

Additional information on "How-To" submit Dependent Verification Documents to follow closer to enrollment.

TYPES OF REQUIRED DOCUMENTS	
SPOUSE You will need to submit the item from List A **and** one item from List B. The document from List B must be dated within the last 6 months & have the dependent's name on it.	
List A	**List B**
• **Marriage Certificate**	• Bank or Credit Card Statement with a Common Address
	• Mortgage or Lease Statement with a Common Address
	• Motor Vehicle Statement with a Common Address
	• Current Federal Tax Return w/ Spouse Listed (you can hide any financial information)
	• Utility Bill with a Common Address
CHILD You will need to submit the item from List A. If your Child is a stepchild, you will need to submit your marriage certificate with Spouse listed as well as an item from List B for spouses.	
List A	
• Adoption Certificate or Adoption Placement Agreement	• Documentation of Legal Guardianship
• Birth Certificate with Parent's Name Listed	• Hospital Birth Record (within 90 Days of Birth)
• Documentation of Legal Custody	• Qualified Medical Child Support Order

Making Mid-Year Changes to Benefits

Outside of your initial benefit enrollment and Annual Enrollment periods, you may make changes to your benefits within **30-days** following a family status event, including one of the following:

- Adoption
- Birth of Child
- Establish Legal Guardianship
- Death of Dependent
- Dependent Gains/Loses Other Coverage
- Divorce/Legal Separation
- Employee Gains/Loses Other Coverage
- Enrollment in Health Exchange
- Gain of CHIPRA Coverage
- Marriage
- Spouse Gains/Loses Other Coverage

All information you need to know to make an informed decision is in the Forms & Plan Documents Section of Benefits in UKG.

How to submit a Life Event: Access the benefits section in UKG, and then select, "Declare an Event." You will use the **date of the event** as the effective date. This event will go to a pending status until the required documentation is submitted.
Documentation: For mid-year events, you will need to submit documentation showing the loss or gain of coverage with the effective date of change. If you are adding dependents, you will need to provide the documentation listed on this page.

All mid-year events/applicable dependent changes will remain in a pending status until all verification documents are received by Dependent Verification Services. Mid-year election changes will be denied if required documents are not received within 30 days from when the event is declared.

If you do not experience one of the above events, you may **NOT** make changes to your benefit elections until the next annual enrollment. If you have any questions regarding a family status change or required documentation, contact the Benefits Office at 812-450-2025.

Important Notes:

- The Provider Network is location based on primary residence of the employee; all dependents need to have the address they generally reside written under their information in UKG.
- If you are unable to enroll online, please contact the Benefits Office at before your 30-day deadline!
- In the event of separation of employment or reduction in hours to a non-benefit eligible status, all insurance coverage ends at midnight the last day physically worked.
- **Any change in coverage elections shall be effective as of the date of the change in status, change in coverage, or change in cost; unless otherwise required by law.**

Employee Benefits Corporation will notify the dependent regarding the Consolidated Omnibus Budget Reconciliation Act. Under COBRA, coverage may be continued for dependent children up to 36 months if they no longer qualify as the employee's dependent under the insurance plan.

Documentation is required within 30 days of the family status change in order to fulfill the Consolidated Omnibus Budget Reconciliation Act (COBRA) requirements.

Medical Insurance

Why the OneCare Network

Deaconess values the ability to provide employees and their families with competitive benefits, including access to a network of high-quality providers. In a climate where the cost to provide employee benefits continues to rise for employers nationwide, our partnership with the OneCare Network has enabled Deaconess to continue to provide competitive benefits at competitive rates. As we remain committed to the health and wellbeing of our employees and their families, we remain committed to the Deaconess OneCare Network.

Across a participating provider network, improved coordination of care helps ensure that patients receive the right care at the right time. What does that mean for our employees? Better care, better health outcomes, and a reduced overall cost of care. By participating in the network it enables Deaconess to offer employees and their families access to high quality providers who work together to improve the coordination of care for employees.

Network coverage depends on where you live. Refer to the next page to understand the networks that apply to you.

Should you require care from a non-OneCare network provider due to not having coverage available based on specialty or other factors, your services could be paid at the preferred network level (tier 1). However, those non-OneCare services must be pre-approved and discussed with OneCare representatives.

Notice for covered Dependents that live outside the Employee's primary network coverage area:
Dependents that are covered and live outside of the Employee's primary network service area will be allowed to access the Employee's travel network located on the back of the ID card. If services are obtained while the dependent is away from home or traveling, services will be applied to the employee's primary or secondary network. These services will be based upon the Employee's network level of coverage(s).

Emergency coverage while traveling: Employees and their covered dependents will have access to the plan's travel network located on the back of the ID card when traveling outside the primary network coverage if emergency care is required. Should you require emergency care, services rendered will be paid at the highest network tier of coverage for you and your covered dependents.

Definitions:

Copay: a fixed amount you pay for a covered health service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: the dollar amount (for individual or family) a Participant is responsible to pay each year before the Plan begins to pay for certain services.

Co-insurance: the percentage of the cost of covered expenses a Participant must pay after meeting any applicable deductible.

Out-of-pocket maximum: the maximum amount a participant pays for covered medical expenses (including expenses for covered dependents, if applicable) in a Benefit Period. When the out-of-pocket maximum is reached, the Plan pays 100% of eligible covered expenses for the rest of the Benefit Period.

Deaconess OneCare HEALTH PLAN

Which Medical Network Do YOU Have Access To?

No Referrals Required!

Networks are based on the Employee's Residence

	Employee Home Address	Tier 1 Network(s) [1, 2]	Tier 2 Network(s)	Travel Network
Employees residing within the **OneCare Service Area** & **Patoka Valley Service Area** *(see Medical Plan Summary on Page 10)*	**Indiana Counties:** Crawford, Daviess, Dubois, Martin, Orange, Perry, Pike, Spencer	OneCare & Patoka Valley Health Care Cooperative	encore COMBINED	UnitedHealthcare® Options PPO Network
Employees Residing **outside** the **OneCare Service Area** *(see Medical Plan Summary on Page 10)*	**Indiana:** All Other Counties	OneCare	encore COMBINED	UnitedHealthcare® Options PPO Network
Employees Residing **outside** the **OneCare Service Area** *(see Medical Plan Summary on Page 10)*	Employees residing in **Illinois** or **Kentucky** (except Henderson & Union County)	OneCare	UnitedHealthcare® Options PPO Network	UnitedHealthcare® Options PPO Network
Employees Residing **outside** the **OneCare Service Area** *(see Medical Plan Summary on Page 10)*	Employees residing outside Indiana, Illinois & Kentucky	OneCare	UnitedHealthcare® Options PPO Network	UnitedHealthcare® Options PPO Network
Employees residing within the **OneCare Service Area** *(see Medical Plan Summary on Page 11)*	**Indiana Counties:** Warrick, Gibson, Vanderburgh, Posey **Kentucky Counties:** Henderson & Union	OneCare		UnitedHealthcare® Options PPO Network

[1] Tier 1 Network also includes access to Indiana University (IU) Health Network & Vanderbilt University Medical Center (VUMC) Network Providers.

[2] Deaconess Members accessing the Patoka Valley Health Care Cooperative are not required to obtain a referral. In addition, the following facilities will NOT be considered in-network for Deaconess members.

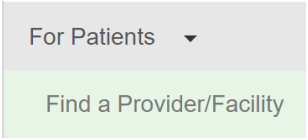
- Ascension Health St. Vincent – Evansville/Warrick Indiana
- Daviess Community hospital – Washington Indiana
- Digestive Care Center – Evansville/Warrick/Jasper Indiana

How to Find a Provider in Your Network:

OneCare

onecarecollaborative.com
Phone: 1.812.426.9402

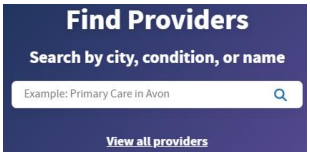
1. Go to 'For Patients'
2. Select 'Find a Provider/Facility'
3. Start your search



Indiana University Health

iuhealth.org/find-providers

1. Search by city, condition, or name
2. You can also click on 'View all providers' for a complete list of providers



VANDERBILT HEALTH

vanderbilthealth.com

1. Select 'Find a Doctor'
2. Start your search

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encore COMBINED

encoreconnect.com/provider-search
Phone: 1.888.574.8180

1. Select the 'Encore Combined' tile,
2. Select the 'Deaconess Health System'
3. Start your search

Patoka Valley Health Care Cooperative

pvcooperative.com/Directory.html

Select the 'Choose an Option' to find the Kind of Doctor you are searching for.

UnitedHealthcare® Options PPO Network

whyuhc.com/strategicalliance

1. Select the 'Search the Provider Network' tile,
2. Search for Providers and Services or Find Care by Category.

Medical & Pharmacy Plan Premiums

Full Time Employees Authorized to work 60+ hours per pay period	**Advantage Plan** Bi-Weekly Rates (26)	**Standard Plan** Bi-Weekly Rates (26)
Employee	$107.44	$73.09
Employee + Spouse	$228.32	$145.85
Employee + Child(ren)	$183.51	$126.82
Family	$288.76	$182.24

Part Time Employees Authorized to work 40-59 hours per pay period	**Advantage Plan** Bi-Weekly Rates (26)	**Standard Plan** Bi-Weekly Rates (26)
Employee	$129.00	$93.36
Employee + Spouse	$282.02	$197.97
Employee + Child(ren)	$229.83	$180.66
Family	$360.20	$253.20

Wellness Incentives (see below)	Bi-Weekly Earning (26) to offset Medical/Pharmacy Premiums
Employee Incentive	$33.93
Spouse Incentive	$11.30

Employee Wellness Program & Incentives

In an effort to promote a healthy lifestyle, all employees and spouses enrolled in a medical option for health insurance coverage have the option of participating in the Deaconess Wellness Incentive Program.

The **Wellness Incentive** is a biweekly incentive credit that is used to offset medical insurance premiums. It is not a discount. You will see the full premium rate deducted from each of your paychecks, and the credit(s) are added as an earning.

For those transitioning from MHHCC health plans, if you have completed the wellness requirements for 2024 you will receive the employee and spouse, if applicable, credit for the plan year December 23, 2024 thru September 30, 2025.

To continue receiving the Wellness Incentive for the plan year beginning October 1, 2025 the following must be completed AND submitted by August 1, 2025:

Annual Wellness Visit with your Primary Care Provider (August 2, 2024 – August 1, 2025)

- *Must contain height, weight, blood pressure, cholesterol, and glucose for all; and A1C for those who have diabetes.*

For more information, please contact the MHHCC Wellness Department *at employeewellness@mhhcc.org.*

Medical Premium Assistance (MPA)

The Medical Premium Assistance Program provides financial assistance to Full-Time employees by providing those who qualify with a **20% savings on their medical premiums**.

Family income less than **400% of 2023 Federal Poverty Guidelines**:

Family Size*	1	2	3	4	5	6
Max Income	$58,320	$78,880	$99,440	$120,000	$140,560	$161,120

**As determined by number of dependents and income on your 2023 federal tax return*

Full-Time employees (authorized 60+ hours/pay period) will be eligible to apply during enrollment (Annual Enrollment, New Hire Enrollment, Life Event Enrollment, and Authorized Hours Changes Part Time to Full Time).

For more information on the **Medical Premium Assistance** Program
Contact MHHCC Benefits at (812) 996-0635

Medical Plan Summary

Subscribers Residing **outside** the **OneCare Service Area**
(and their Dependents)

	Advantage Plan			Standard Plan		
	OneCare / PVHCC	Encore Combined / Options PPO[1]	Out-of-Network	OneCare / PVHCC	Encore Combined / Options PPO[1]	Out-of-Network
Annual Deductible						
Per Covered Person	$800		Not Covered	$1,200		Not Covered
Family Limit	$1,600			$2,400		
Out-of-Pocket Maximum						
Per Covered Person	$3,000	$5,100	Not Covered	$3,500	$5,100	Not Covered
Family Limit	$6,000	$10,200		$7,000	$10,200	
Office Visit						
Primary Care (PCP) Office Visit	$20 Copay	$40 Copay	Not Covered [2]	25%*	35%*	Not Covered [2]
Primary Care Services (Diagnostic & Procedures)	20%	30%				
Specialist (SPC) Office Visit	$35 Copay	$55 Copay				
Specialist Services (Diagnostic & Procedures)	20%	30%				
Urgent Care Office Visit	$35 Copay	30%*				
Urgent Care Services (Diagnostic & Procedures)	20%	30%*				
Preventive Health Benefits (PHB)						
Wellness Benefit (PHB Guidelines)	Covered in Full		Not Covered	Covered in Full		Not Covered
Routine Eye Exam	Covered in Full			Covered in Full		
Inpatient/Outpatient Services						
Emergency Room Services (True Emergency)	20%*			25%*		
Ambulance	20%*			25%*		
Emergency Room Services (Non-Emergent)	$300 Copay +20%* Coins.	$300 Copay +30%* Coins.	Not Covered	$300 Copay +25%* Coins.	$300 Copay +35%* Coins	Not Covered
Inpatient Hospital / Facility / Physician Services	20%*	30%*	Not Covered	25%*	35%*	Not Covered
Outpatient Hospital / Facility Services	20%					
Outpatient Physician Services	20%*					
Therapy Services						
Occupational Therapy^ *^Benefit Period Maximum: 30 Visits per Condition.*	20%*	30%*	Not Covered	25%*	35%*	Not Covered
Physical Therapy^ *^Benefit Period Maximum: 30 Visits per Condition.*						
Speech Therapy^ *^Benefit Period Maximum: 30 Visits per Condition.*						
Chiropractic Office Visit & Manipulation‡ *‡Benefit Period Maximum: 20 Visits.*	$35 Copay	$55 Copay				
Mental Health/Substance Abuse						
Office Visit	$20 Copay	$20 Copay	Not Covered	25%*	25%*	Not Covered
Intensive Outpatient (IOP)	20%	20%				
Inpatient	20%*	20%*				
Other Services						
Durable Medical Equipment (DME); Prosthetics; Orthotics; Home Health Care	20%*	30%*	Not Covered	25%*	35%*	Not Covered
Diabetes Training Program *(Copayment is waived if part of a Deaconess Wellness Care Plan.)*	$35 Copay	Not Covered		$20 Copay	Not Covered	

* After Deductible

[1] For employees residing in Indiana, the Encore Combined network applies. For employees residing outside of Indiana, the UHC Options PPO network applies.

[2] Urgent Care Center services are covered at the Encore Combined or UHC Options PPO benefit level for required Urgent Care while traveling in an area where there is not a OneCare Provider or an Encore Combined Provider (those residing in Indiana) or a UHC Options PPO Network Provider (those residing outside Indiana).

Medical Plan Summary

Subscribers Residing **within** the **OneCare Service Area**
(and their Dependents)

	Advantage Plan		Standard Plan	
	OneCare	**Out-of-Network**	**OneCare**	**Out-of-Network**
Annual Deductible				
Per Covered Person	$800	Not Covered	$1,200	Not Covered
Family Limit	$1,600		$2,400	
Out-of-Pocket Maximum				
Per Covered Person	$3,000	Not Covered	$3,500	Not Covered
Family Limit	$6,000		$7,000	
Office Visit				
Primary Care (PCP) Office Visit	$20 Copay	Not Covered [1]	25%*	Not Covered [1]
Primary Care Services (Diagnostic & Procedures)	20%			
Specialist (SPC) Office Visit	$35 Copay			
Specialist Services (Diagnostic & Procedures)	20%			
Urgent Care Office Visit	$35 Copay			
Urgent Care Services (Diagnostic & Procedures)	20%			
Preventive Health Benefits (PHB)				
Wellness Benefit (PHB Guidelines)	Covered in Full	Not Covered	Covered in Full	Not Covered
Routine Eye Exam	Covered in Full		Covered in Full	
Inpatient/Outpatient Services				
Emergency Room Services (True Emergency)	20%*		25%*	
Ambulance	20%*		25%*	
Emergency Room Services (Non-Emergent)	$300 Copay +20%* Coins.	Not Covered	$300 Copay +25%* Coins.	Not Covered
Inpatient Hospital / Facility / Physician Services	20%*		25%*	
Outpatient Hospital / Facility Services	20%			
Outpatient Physician Services	20%*			
Therapy Services				
Occupational Therapy^ *^Benefit Period Maximum: 30 Visits per Condition.*	20%*	Not Covered	25%*	Not Covered
Physical Therapy^ *^Benefit Period Maximum: 30 Visits per Condition.*				
Speech Therapy^ *^Benefit Period Maximum: 30 Visits per Condition.*				
Chiropractic Office Visit & Manipulation‡ *‡Benefit Period Maximum: 20 Visits.*	$35 Copay			
Mental Health/Substance Abuse				
Office Visit	$20 Copay	Not Covered	25%*	Not Covered
Intensive Outpatient (IOP)	20%			
Inpatient	20%*			
Other Services				
Durable Medical Equipment (DME); Prosthetics; Orthotics; Home Health Care	20%*		25%*	
Diabetes Training Program *(Copayment is waived if part of a Deaconess Wellness Care Plan.)*	$35 Copay		$20 Copay	

* After Deductible

[1] Urgent Care Center services are covered at the OneCare benefit level for those who require Urgent Care outside the OneCare area while traveling.

Additional Care Options

Memorial Hospital and Health Care Center | Employee Clinic

Memorial Health Employer Services (MHES) provides the below services and is open to all insured employees, spouses, dependents, and will collaborate with your Primary Care Provider, if applicable.

Effective 12/23/24 visits completed thru MHES are processed by OneCare and deductibles and copays apply.

You may contact Memorial Health Employer Services at (812) 996-5750. The hours are Monday-Friday 7:30am-4:00pm.

Services Provided

- ✓ Same day acute/illness visits
- ✓ Immunizations
- ✓ X-Ray
- ✓ Workers compensation/injuries
- ✓ Labs
- ✓ Education/disease management
  - Diabetes
  - Weight management
  - Nutrition

Deaconess Clinic | On-Demand Video Visits

Deaconess Clinic On-Demand Video Visits provide consultation, diagnosis and/or treatment for patients ages 0 and older.

Patients receive the same level of care as they would at an in-person visit at a walk-in clinic. During an On-Demand Video Visit, a patient can be at home, in their office or anywhere else and receive on-demand, quality, telehealth services, via the internet using their computer, tablet or smartphone.

Providers are available to treat and diagnose non-emergency medical issues 24/7 in all 50 United States. And if prescriptions are necessary, they can be sent right to your pharmacy of choice.

You will communicate directly with a KeyCare provider by secure, live and interactive video conference. This is a convenient option to diagnose and treat minor illnesses from anywhere in the United States.

This service is free for employees/families enrolled in the Deaconess employee health plan.

Deaconess Clinic
ON-DEMAND VIDEO VISITS

Symptoms/Conditions to use On-Demand Video Visits

- ✓ Allergies
- ✓ Back Pain
- ✓ Bites or Stings
- ✓ Bumps, Cuts & Scraps
- ✓ Burns - Minor
- ✓ Colds
- ✓ Constipation
- ✓ Coughs & Flu
- ✓ Fevers
- ✓ Headaches
- ✓ Nausea
- ✓ Minor Allergic Reactions
- ✓ Pink Eye
- ✓ Rash
- ✓ Sinus Infection
- ✓ Sore Throat
- ✓ Sprains and Strains
- ✓ Tooth Pain
- ✓ Urinary Tract Infections
- ✓ Vomiting

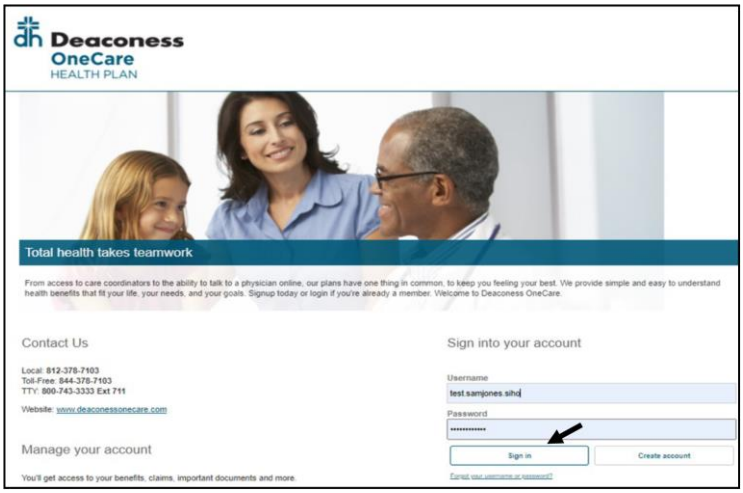
On-Demand Video Visits are available 24 hours a day, 7 days a week, in all 50 states.

Start a Deaconess Clinic On-Demand Video Visit here: deaconess.com/urgentcare or in your MyChart Account.

**Deaconess Clinic Urgent Care is included at no cost for members enrolled in a Deaconess Health Medical Plan.*

**If enrolled in another medical plan, visits will be billed to applicable insurance carrier.*

Accessing Your Member Portal



Visit deaconessonecare.com to access the member portal.

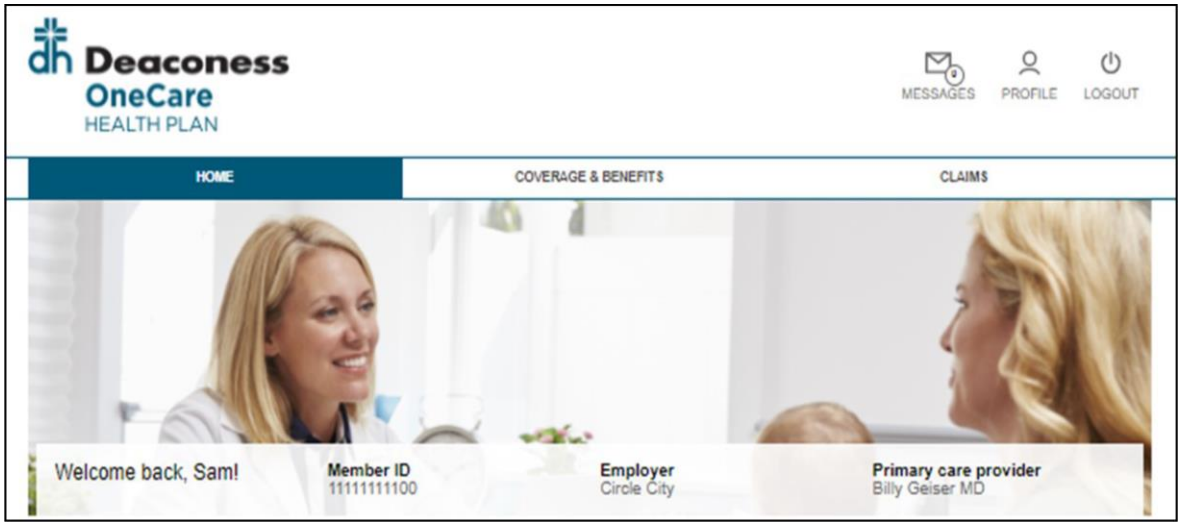
Existing users, click “Sign in”. If you are a new user, click “Create account”.

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 us.

Member Services
Member.Services@DeaconessOnecare.com
(844) 378-7103

As a feature of your health care benefits, we provide secure internet access to give you information you need anytime you need it.

Some of the following features.

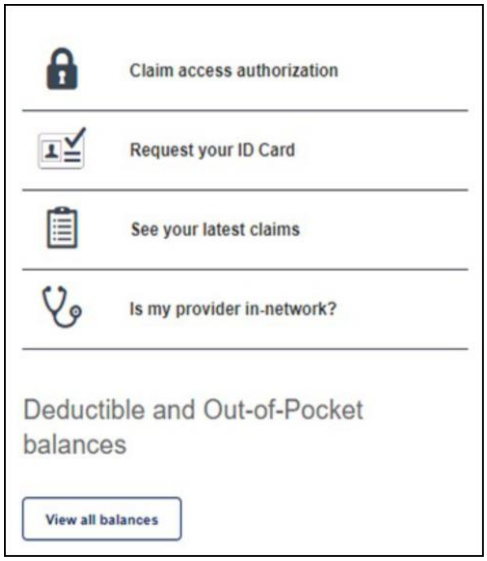


Claims
We provide quick access to your claims status and eligibility information. You can track your medical claims as they move through the claims processing system.

Utilization
View up-to-date information on Deductibles, Out-of-Pocket Limits & Preventive Health Benefits usage.

Provider Lookup
Search for healthcare providers in your network by Specialty, Name or Location.

Plan Documents
Verify benefits related to your current plan.



Prescription Drug Benefits

The Prescription Drug benefits which follow apply to both the Advantage and the Standard options.

	Deaconess Family Pharmacy (includes MHHCC Pharmacy)	Optum Network Pharmacy	Optum Home Delivery/Specialty
Maximum Out-of-Pocket	$2,200 Per Covered Person $4,400 Family Limit		
30 Day Supply or Less			
Generic	10%: $7 Min to $35 Max	20%: $15 Min to $50 Max	Use Optum network pharmacy
Preferred Brand [1]	20%: $45 Min to $60 Max	30%: $60 Min to $80 Max	
Non-Preferred Brand [1]	25%: $70 Min to $85 Max	30%: $95 Min to $120 Max	
Generic Specialty Medication	25%: $175 Max	Not Covered [2]	25%: $175 Max
Branded Specialty Medication	25%: $275 Max	Not Covered [2]	25%: $275 Max
Smoking Cessation Medications [1, 3]	$0	$0	Use Optum network pharmacy
Over 30 Day, Up to 90 Day Supply			
Generic	10%: $20 Min to $75 Max	Not Covered--You pay 100%	10%: $20 Min to $75 Max
Preferred Brand [1]	20%: $110 Min to $150 Max		20%: $110 Min to $150 Max
Non-Preferred Brand [1]	25%: $175 Min to $210 Max		25%: $175 Min to $210 Max
Specialty Medication	Not Covered		Not Covered
Smoking Cessation Medications [1, 3]	$0		$0
Diabetic testing supplies are covered under the prescription drug benefit. Excluded drugs approved via clinical override will process at 100% member responsibility			

[1] If a Generic equivalent is available and either a Preferred Brand or Non-Preferred Brand drug is dispensed, the Covered Person pays the applicable cost share plus the difference in cost between the Generic version and the drug received.

[2] Fills of designated Specialty Medications will only be covered by the Plan if filled by the Deaconess Specialty Pharmacy, including MHHCC Pharmacy, or Optum Specialty pharmacy. However, for Members who are COBRA beneficiaries, Retirees or Eligible Dependents of a Retiree and who reside in a state outside the Deaconess Family Pharmacy's service area, fills of designated Specialty Medications will be covered, with the Deaconess Family Pharmacy member cost-sharing applied, if filled through Optum Specialty pharmacy.

[3] All FDA-approved tobacco cessation medications, when prescribed by a physician, are covered, including over-the-counter medications. A Covered Person may obtain up to two 90-day treatment regimens per year; quantity limits may apply.

[4] Walgreens is excluded from the Deaconess network.

OptumRx Website

You may find additional information about your prescription benefit at www.optumrx.com. You must first create an account, as follows:

1. For new accounts, click on the "Register or Login" button.
2. To create your Healthsafe ID account, enter the required information from your Prescription card.
3. Create your user credentials.

Once your account has been created you will have access to the following information:

- Overview of your plan and benefits
- Drug coverage and pricing, including co-pays
- Direct member reimbursement form
- Prescription history
- Order Status
- Participating pharmacies

If you have any questions regarding your prescription benefit or to find an Optum Network pharmacy, do not hesitate to call the Optum Customer Service Help Desk at 800-506-4605.

Deaconess Family Pharmacy Quick Facts

Deaconess Family Pharmacy operates four full-service outpatient pharmacy locations for your convenience:

Deaconess Family Pharmacy Jasper Located within Memorial Hospital 800 W. 9th Street Jasper 812-996-0421	**Pharmacy Hours for Jasper:** Monday-Friday 7:00 AM – 6 PM Saturday & Sunday Closed After-hour emergencies: 812-996-0424
Deaconess Family Pharmacy Midtown Located within Deaconess Hospital Midtown 600 Mary Street, Evansville Quickest access is via the West Entrance; follow the signs to the pharmacy. Access and parking are also available at the rear of the building along Edgar Street.	**Pharmacy Hours for Midtown:** Monday-Friday 7:00 AM – 7:30 PM Saturday 10:00 AM – 4:00 PM Sunday Closed
Deaconess Family Pharmacy Gateway Located at 4209 Gateway Boulevard, Newburgh, on the first floor or Gateway MOB2. Drive-thru service is available.	**Pharmacy Hours for Gateway:** Monday-Friday 7:00 AM – 7:30 PM Saturday 10:00 AM – 4:00 PM Sunday Closed
Deaconess Family Pharmacy Henderson Located on the ground floor of the South Tower inside Deaconess Hospital Henderson at 1305 N. Elm Street, Henderson, KY.	**Pharmacy Hours for Henderson:** Monday to Friday 6:00 AM – 6:00 PM Saturday 10:00 AM – 4:00 PM Sunday Closed *Prescription processing is Monday through Friday 8:00 AM – 4:30 PM*

You may contact Deaconess Family Pharmacy at 812-450-DRUG (450-3784)
Follow the prompts to select the desired pharmacy location.

Mail Order, 90-Day Supplies

Mail service for 90-day supplies is available from any Deaconess Family Pharmacy, including MHHCC Pharmacy, or Optum Home Delivery. If supplied by DFP, prescriptions for a 90-day supply can be mailed at no additional cost to addresses in Indiana, Kentucky and Illinois. Prescriptions for less than a 90-day supply will incur a $5 mailing charge per shipment. Contact the Deaconess Pharmacy staff for more information.

Step Therapies/Quantity Limits/Formulary Exclusions

Prior authorization is required for certain medications. Quantity limits apply to certain medications. For some medications, you may need to try another therapeutically equivalent drug before the prescribed medication will be covered. Items excluded from formulary will require a change to an equivalent alternative.

Specialty Pharmacy

There are certain complex medications that have special storage and handling requirements. These include costly injectable and oral medications and select chemotherapeutic medications. They are considered specialty medications.

You can fill specialty medications at Deaconess Specialty Pharmacy (including MHHCC Pharmacy) or Optum Specialty Pharmacy (phone 855-427-4682).

You must participate in the manufacturer's copay support program that applies to your medication. The amount covered by the copay card will not count towards your deductible or OOP maximum. Only your OOP cost will be applied to your deductible and OOP maximum.

Important Notes

- 90-day supplies are available at any Deaconess Family Pharmacy, including MHHCC Pharmacy, or Optum Home Delivery.
- Excluded (non-formulary) drugs approved via clinical override will process at 100% member responsibility.
- Pre-authorization is required for certain medications. Quantity limits apply to certain medications. Before some medications are covered, certain criteria must be met or another drug in the same therapeutic class must have been tried. Formulary exclusions will require a change to an equivalent alternative.

Deaconess Clinic
WELLNESS SOLUTIONS

Annual Wellness Screening | Earning Your Incentive

The purpose of the wellness screening is to provide awareness and understanding of your health risks and offer ways to improve your overall health. *If you are a diabetic, an A1C is required to obtain any free supplies.*

To continue receiving the Wellness Incentive for the plan year beginning October 1, 2025
Employees **and** Spouses must complete the following:

Complete an annual visit with your Primary Care Provider

Your PCP must complete the following:

- Measure your height and weight
- Calculate your body mass index
- Blood pressure reading
- Obtain your lipid profile consisting of total cholesterol, HDL, LDL, triglycerides, and blood glucose levels

Additionally, an A1C must be completed if you are diabetic.

Must be completed by August 1, 2025

Complete online submission form

After your PCP appointment, fill out this form:
deaconess.com/For-You/Employees/Employee-Benefit-Services/Employee-Wellness/

Link is also available on MHHCC Hub.

Must be submitted by August 1, 2025

Education and Resources

Deaconess offers many health promotion and management programs to employees and their spouses through the Deaconess Wellness Solutions Department. Online education & opportunities to obtain HRA credit, will be available in 2025 on the DHS MyWellness Portal.

Frequently Asked Questions

Q. What tests should be conducted during the wellness screening?
A. Your PCP should obtain total cholesterol, HDL-cholesterol, LDL-cholesterol, triglycerides, blood glucose levels. If diabetic, an A1C will be performed. They will also take your blood pressure and measure your height, weight and BMI. They will not test for hepatitis, HIV or illegal drugs.

Q. I'm pregnant. Should I get my wellness screening with my PCP now or wait until I have my baby?
A. To participate in wellness incentives, you must complete an annual visit with your PCP during the current benefit year. You will need a minimum of a blood pressure entered by your PCP. **Your OBGYN visits will not count for the incentive, it must be with a PCP**.

Q. I'm post-partum. Do I still need to complete a wellness screening with my PCP? What if I am breastfeeding?
A. To participate in wellness incentives, you must complete an annual PCP (not OBGYN) visit during the current benefit year. The screening will include blood work. If you see your PCP, you are still required to get labs. Fasting is highly recommended for best results. Please refer to the question below in regards to fasting. If you are breastfeeding, we recommend that you fast, if possible.

Q. Do I need to fast before my *annual PCP visit?*
A. Yes, for the best results, you should only drink water and do not eat at all during the twelve hours prior to your screening appointment. Fasting means no food, gum, mints, or liquids other than water. Please drink plenty of water and take any medications as long as no food is required.

Q. Are my wellness screening results confidential?
A. Only you and the healthcare professionals who assist you with your programming will have access to your personal results in order to provide the advice necessary for you to understand your health status and the steps you can take to improve it. You may request a release of information if you would like to send your results to another clinician assisting with your care.

Q. Does my spouse need to complete an annual wellness exam with a PCP?
A. Yes, if your spouse is on the insurance and you are wanting the incentive for them as well, they will need to complete this.

Q. If I cover my spouse under my Deaconess medical plan, will I get a bigger incentive if my spouse also gets a wellness screening?
A. You will both receive a Wellness Incentive if you both (employee and spouse) complete the wellness incentive requirements.

Q. If I don't have medical coverage through Deaconess Hospital, am I required to get a wellness screening?
A. If you do not participate in a Deaconess medical plan, you are not required to get a wellness screening.

Q. Will I still receive my insurance even if risk factors are identified at my screening?
A. All employees eligible for medical insurance will receive coverage regardless of any risk factors identified during their annual exam.

Health Reimbursement Account (HRA)

Deaconess medical insurance plans include a Health Reimbursement Account (HRA) through EBC. The HRA is a tax-free account funded by wellness activities that allow EBC to reimburse qualified, eligible medical expenses incurred by you and your covered dependents. Once an individual covered on the health plan incurs $700 in medical expenses including copayments, deductible and coinsurance, reimbursement will occur. Families will also receive reimbursement if their combined medical expenses exceed $1,400. An employee and spouse can each earn $400 HRA dollars annually ($800 maximum per year). Any unused funds will roll over at the end of each plan year up to a maximum of $6,000.

FSA/HRA - Employee Benefits Corporation
Phone: 1.800.346.2126
Website: www.ebcflex.com

Employee Benefits Corporation

EBC Mobile: Your Benefits, Anytime, Anywhere

Download EBC Mobile in the App Store or Google Play for on-the-go access to everything you need to manage your EBC administered benefit accounts, all in one place.

When receiving a medical service, present your Deaconess OneCare insurance card to your provider. Your provider will send the claim to Deaconess OneCare.

Deaconess OneCare will process the claim and notify EBC what you will owe for the service.

If your claim qualifies as an eligible expense, EBC will issue a check in your name reimbursing you for the Expense.

You pay the provider.

Flexible Spending Accounts (FSA)

A flexible spending account (FSA) is a spending account that lets you set aside money on a pre-tax basis to pay for qualified expenses. With an FSA, a portion of your paycheck is deposited in one or more account on a pre-tax basis. You can then use these funds to pay for out-of-pocket eligible expenses.

Health Care FSA

- Used for healthcare expenses not covered by insurance.
- The annual minimum election is $100 and the plan maximum $3,200.
- Debit card for pharmacy, dental and vision expenses. A debit card will be mailed to the employees' home address.
- If enrolled in the medical plan, medical claims will be auto-substantiated and reimbursement is sent to you for all eligible claims.
- If not enrolled in the medical plan, employees will need to submit all medical claims manually to receive reimbursement.

Dependent Care FSA

- Used for Child Care and Adult Care Expenses.
- The annual minimum elections is $100 and the plan maximum $5,000.
- Licensed and private sitters may be used as long as a receipt, with the sitter's Tax ID Number or Social Security Number clearly listed, is turned in with the claim form.
- For dependent care expenses, there is also a dependent care tax credit, which, for some people, may provide greater savings than the flexible spending account. Please consult an independent financial or tax advisor for which dependent care option best fits your needs.

Eligible FSA Expenses can be found at ebcflex.com/eligibleexpenses

Important Note about FSA Balances after the Plan Year Ends:

You have through December 31 to submit old claims to EBC for expenses incurred prior to October 1. The claims are submitted manually to receive reimbursement. All FSA funds that are not claimed for the Plan Year from October 1 through September 30 will be forfeited after December 31.

However, HRA funds will rollover every plan year until the max of $6,000 is met.

Q. If I have both FSA & HRA, then in what order shall I receive reimbursement for medical expenses?

A. The Health Care FSA funds will be used for pre-deductible medical expenses. Once you met $700 in out-of-pocket medical expenses, your HRA will be used next. After you have exhausted all of your HRA funds, the claims will be processed from your remaining Health Care FSA for payment.

Any expense reimbursed through the HRA cannot also be claimed to the FSA. If you do not have an HRA, your health care claims will be sent to EBC for automatic payment from your FSA account.

If you do not want medical claims automatically paid out of your Health Care FSA, you will need to contact EBC at 1-800-346-2126. You cannot stop automatic payments from coming out of the HRA.

Q. How do I view balances and claims for my HRA and Health Care FSA?

A. You can view current balances and submitted claims, file new claims, and more by going to the EBC Website: ebcflex.com, link in UKG Benefits portal. The UKG Benefits login page can be found on deaconess.com/employees.

Q. Where do I find a manual claim form?

A. The Health Care and Dependent Care FSA use the same claim form. Manual claim form can be found on My EBC Account.

HRA pays automatically and claims are not filed manually.

Q. What if I have multiple medical insurance plans? How will I receive the correct reimbursement?

A. You need to contact EBC to set up coordination of benefits. EBC can be reached at 1-800-346-2126.

Q. How do I get reimbursed for my Dependent Care FSA? Does it work the same as my Health Care FSA?

A. You cannot use your EBC Benefits Card to pay for dependent care expenses. You must pay for your dependent care expenses up front and submit a claim form with documentation of the expense to EBC to receive reimbursement. Employees can receive reimbursement via paper checks or bank direct deposit.

Q. Is there an App that I can download to submit my claims?

A. Yes, you can search for the Employee Benefits Corporation "EBC Mobile" in your App Store.

Q. Can you have a Healthcare FSA & Deaconess HRA?

A. Yes.

FSA/HRA - Employee Benefits Corporation
Phone: 1.800.346.2126
Website: www.ebcflex.com

Employee Assistance Program (EAP)

Memorial Counseling Center EAP

Memorial Counseling Center EAP provides employees and eligible family members with a comprehensive EAP to help with a variety of personal and work life matters.

The EAP is a free and confidential resource available 24/7.

Each eligible family member may receive up to **8 hours** of free counseling.

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

How to Access:

Memorial Counseling Center Medical Arts Building

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

Call **1.812.996.5780 (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.

Memorial Counseling provides services for individuals, married couples, and families for a variety of situations. Common situations included, but are not limited to:

- Anxiety
- Depression
- Stress
- Life Changes / Adjustments
- Marital / Family Issues
- Grief Loss
- Interpersonal / Communication Issues

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 Human Resources.

Deaconess EAP

Deaconess EAP is also available as an alternative employee assistance program offering assessment, short-term counseling, referral (if necessary) and follow-up services to employees and members of their household who want help dealing with life changes or personal problems.

Those wanting to use the Deaconess EAP are allowed **five (5) sessions** per topic addressed.

How to Access:

Deaconess EAP counselors are available when you need them.

For your convenience, day and evening appointments may be arranged.

In an emergency, you can reach an EAP counselor 24-hours a day, 7 days a week.

Call: **1.812.471.4611** or **1.800.874.7104**.

Click/Scan Here to schedule an appointment:

Schedule your appointment online

Deaconess EAP

SupportLinc | Employee Assistance Program

In addition to the Employee Assistance Program through the Memorial Counseling Center, Employees also have access to additional emotional wellbeing and work-life balance resources from **SupportLinc**.

SupportLinc offers expert guidance to help address and resolve everyday issues

In-the-moment support
Reach a licensed clinician by phone 24/7/365 for immediate assistance.

Short-term counseling
Access in-person or video counseling sessions to resolve concerns such as stress, anxiety, depression, relationship issues, work related pressures, or substance abuse.

Legal consultation
By phone or in-person with a local attorney.

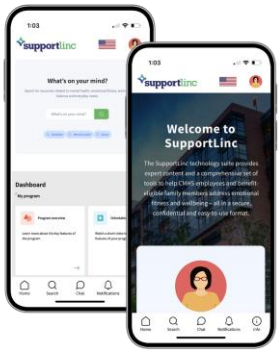
Financial expertise
Planning and consultation with a licensed financial counselor.

supportlinc

Convenience resources
Referrals for child and elder care, home repair, housing needs, education, pet care and so much more.

Confidentiality
SupportLinc ensures no one will know you have accessed the program without your written permission except as required by law.

Web portal and mobile app
- The one-stop shop for program services, information and more.
- Discover on-demand training to boost wellbeing and life balance.
- Find search engines, financial calculators and career resources.
- Explore thousands of articles, tip sheets, self-assessments and videos.



Convenient, on-the-go support
- **Textcoach®** Personalized coaching with a licensed counselor on mobile or desktop
- **Animo** Self-guided resources to improve focus, wellbeing and emotional fitness
- **Virtual Support Connect** Moderated group therapy sessions on an anonymous, chat-based platform

How to Access:
All assistance is available 24 hours a day, seven days a week with confidential support, guidance, and resources.

Call (888) 881-LINC (5462) or
Visit supportlinc.com (Group Code: **deaconess**).

Download the SupportLinc eConnect® App.

Download on the App Store | GET IT ON Google Play

Available to:
All employees and their family members (including spouses and children, up to age 26).

Cost:
Calling our EAP is **Free**, including **up to six (6) counseling sessions and access to online content**.

Occasionally, services beyond those covered by the EAP will have a cost, and any costs associated with a service will be fully explained.

Dental Insurance

Using the Plan

You and your family have the opportunity to enroll in a dental plan through HRI Dental.

HRI Dental members enjoy:

- No deductibles.
- No claim forms.
- No pre-existing conditions.
- No balance billing.
- Large provider network.
- Dependents covered up to age 26.
- Routine cleanings, exams, X-rays and fluoride covered.
- High annual maximum.

Visit **insuringsmiles.com** to see if your dentist is a part of our network.

Every time you use Dental Health Options, you will receive an Explanation of Benefits that confirms claim status. You may also request your dentist to submit a Pre-Treatment estimate prior to treatment so that you may know exactly how much your out-of-pocket expenses may be. This is a free service.

Other Benefits include:

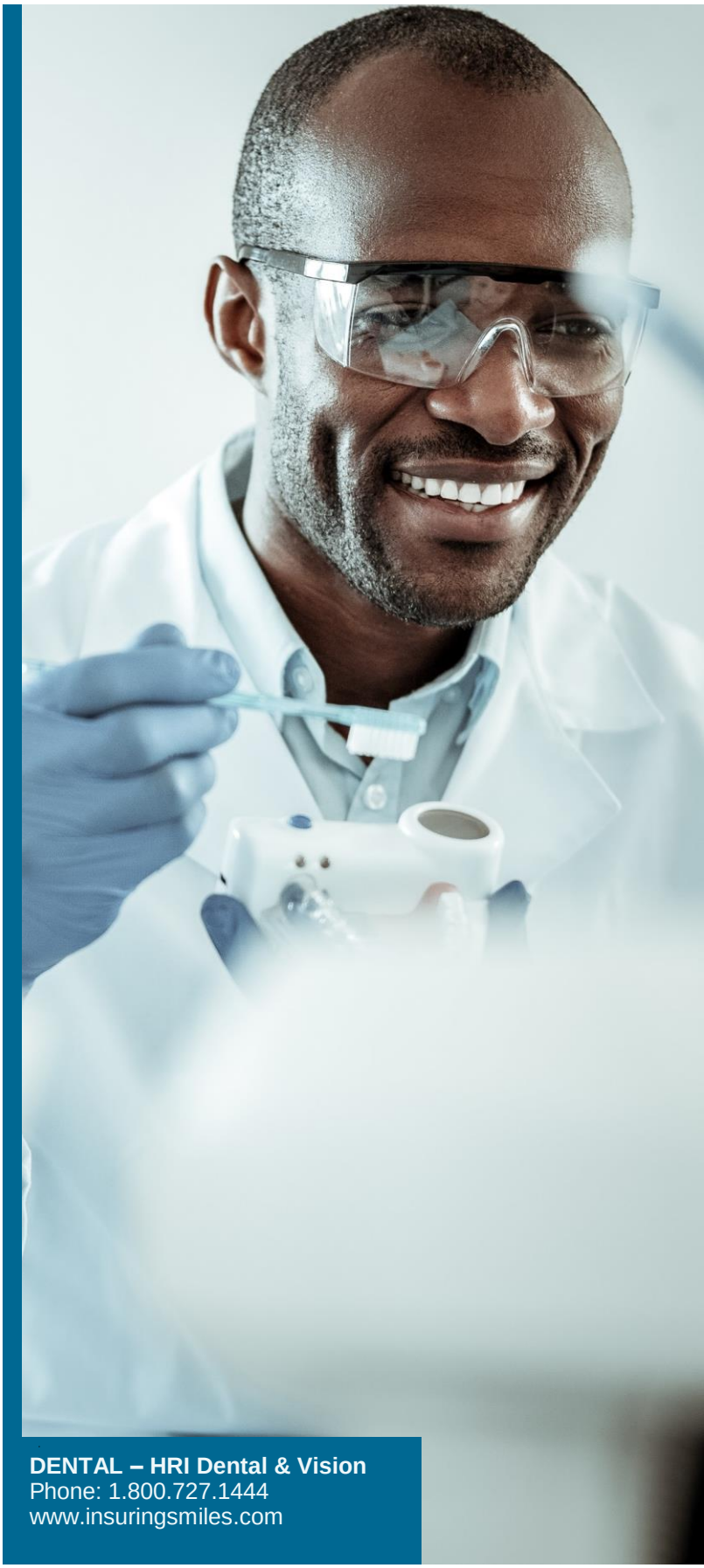
- Dependents covered up to age 26, regardless of student status
- High Annual Maximum – that amount is per person per contract year
- Orthodontic services are payable at 50% up to the lifetime maximum benefit of $2,000* on the Prime Plan

Important Note: *Once an individual has exhausted his/her lifetime maximum benefits under any HRI Dental & Vision plan, additional charges will be excluded.

This includes current dental benefits received from the MHHCC HRI Dental plan(s).

HRI DENTAL &VISION

Learn more about HRI Dental Benefits



DENTAL – HRI Dental & Vision
Phone: 1.800.727.1444
www.insuringsmiles.com

Dental Insurance

	Prime Plan (DHO 4)		Basic Plan (DHO 6)	
Plan Annual Maximum Benefit	**$2,000**		**$1,000**	
Diagnostic & Preventive	**In-Network**	**Out-of-Network***	**In-Network**	**Out-of-Network***
Exams (periodic, limited, comprehensive)	100%	100%	100%	100%
Radiographs (full mouth series, panoramic, bitewings)	100%	100%	100%	100%
Fluoride	100%	100%	100%	100%
Routine teeth cleaning	100%	100%	100%	100%
Sealants	100%	100%	100%	100%
Restorative & Prosthodontics				
Core build ups	80%	80%	50%	50%
Crowns (porcelain, ceramic, stainless steel)	80%	80%	50%	50%
Filings (silver or white) *anterior and posterior teeth*	80%	80%	50%	50%
Protective restorations	80%	80%	50%	50%
Removable dentures	50%	50%	50%	50%
Endodontics & Periodontics				
Root canal therapy (anterior, posterior)	80%	80%	50%	50%
Root canal therapy (retreatment)	80%	80%	50%	50%
Scaling and root planning	80%	80%	50%	50%
Full mouth debridement	50%	50%	50%	50%
Periodontal maintenance	50%	50%	50%	50%
Oral Surgery				
Frenectomy	80%	80%	50%	50%
Simple extractions	80%	80%	50%	50%
Impactions	80%	80%	50%	50%
Surgical extractions	80%	80%	50%	50%
Miscellaneous				
Emergency palliative treatment	50%	50%	50%	50%
Anesthesia (general and IV sedation)	50%	50%	50%	50%
Athletic mouth guards	50%	50%	50%	50%
Orthodontia				
Lifetime Orthodontic benefit (adult/dependent)	Included ($2,000 Lifetime Maximum)		Not Included	

View your benefit summary for a list of complete benefits.

Coverage for some procedures is limited by age, frequency, or specific teeth.

Procedures listed herein are payable up to the lifetime maximum benefit, not to exceed the maximum monthly installment. To receive maximum benefit, the patient must be in active orthodontic treatment a minimum of two years while covered by the Plan. Once an individual has exhausted his/her lifetime maximum benefit under any Plan, additional charges will be excluded.

*In-network dentists have agreed to accept discounts on covered dental services which allows for your benefit dollars to go further. Whereas out-of-network dentists are under no obligation to accept contracted fees. If there is a difference between the allowed reimbursement and the amount the dentist charges for the service, you are responsible for this difference. Therefore, your coinsurance may vary from the figures outlined above.

Your Employer will sponsor your plan and select your individual annual maximum dollar level, of which the benefit accumulation period is the Plan year. Your employer will also collect your portion of the premiums via payroll deduction and define eligibility requirements. You may not add, drop or change coverage during each contract period unless a qualifying event occurs. If a statement in this summary conflicts with a statement in the Certificate, the terms of the Certificate will control. All plans are issued subject to certain exclusions, limitations and restrictions such as frequency and age limitations. These exclusions, limitations and restrictions, and a listing of all covered services by ADA code, are described in your Certificate, which is available on our website or by calling HRI at 800-727-1444.

Cost Per Paycheck (Bi-Weekly)	Prime Plan (DHO 4)	Basic Plan (DHO 6)
Employee	$8.91	$6.87
Employee + Spouse	$19.42	$15.00
Employee + Children	$19.42	$15.00
Family	$29.21	$22.57

Vision Insurance

Using the Plan

Deaconess provides Vision coverage through the **VSP Choice network**. Enroll in VSP® Vision Care to get personalized care from a VSP network doctor at low out-of-pocket costs.

Using Your Benefit Is Easy!

Create an account on vsp.com to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

Value and Savings You Love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

Provider Choices You Want.

It's easy to find a nearby in-network doctor. Maximize your coverage with bonus offers and savings that are exclusive to Premier Program locations—including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

Quality Vision Care You Need.

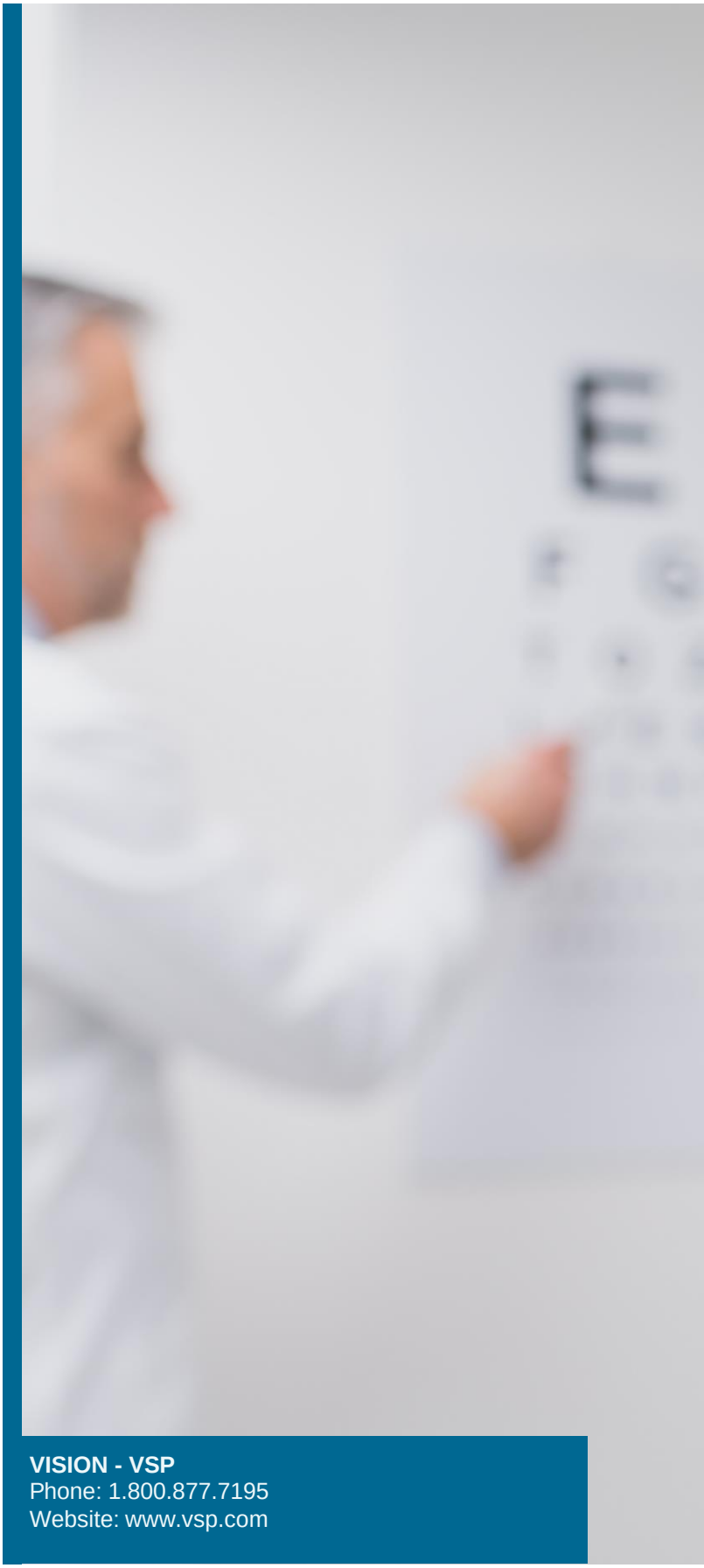
You'll get great care from a VSP network doctor, including a WellVision Exam®. This comprehensive eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

TruHearing Hearing Aid Discount Program

VSP® Vision Care members can save up to 60% on the latest brand-name prescription and over-the-counter hearing aids. Dependents and even extended family members are eligible for exclusive savings too.

Contact TruHearing. Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call **877.396.7194** with questions.

Cost Per Paycheck (Bi-Weekly)	**Premier**	**Base**
Employee	$5.31	$2.66
Employee + Spouse	$10.61	$5.31
Employee + Children	$11.35	$5.69
Family	$18.15	$9.09



VISION - VSP
Phone: 1.800.877.7195
Website: www.vsp.com

vsp vision care

Vision Insurance

Premier Plan *with a VSP Choice Network Provider*		
Benefit	**Description**	**Copay**
WellVision Exam®	• Focuses on your eyes and overall wellness *Every plan year**	$10
Prescription Glasses		$25
Frame+	• $150 frame allowance • $200 featured frame brands allowance • 20% savings on the amount over your allowance • $80 Walmart®/Sam's Club®/Costco® frame allowance *Every plan year**	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children *Every plan year**	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses *Average savings of 30% on other lens enhancements* *Every plan year**	$0 $95-$105 $150-$175
Contacts *(Instead of Glasses)*	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) *Every plan year**	Up to $60
Essential Medical Eye Care	• Retinal screening for members with Diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details. *Available as Needed*	$0 per screening $20 per exam
VSP EasyOptions *(members can choose one of these upgrades)*	• Additional $100 frame allowance, or • Progressive lenses, or • Light-reactive lenses, or • Anti-glare coating, or •Additional $70 contact lens allowance. *Every plan year**	

Base Plan *with a VSP Choice Network Provider*		
Benefit	**Description**	**Copay**
WellVision Exam®	• Focuses on your eyes and overall wellness *Every plan year**	$10
Prescription Glasses		$25
Frame+	• $150 frame allowance • $200 featured frame brands allowance • 20% savings on the amount over your allowance • $80 Walmart®/Sam's Club®/Costco® frame allowance *Every other plan year**	Included in Prescription Glasses
Lenses	•Single vision, lined bifocal, and lined trifocal lenses •Impact-resistant lenses for dependent children *Every plan year**	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses *Average savings of 30% on other lens enhancements* *Every plan year**	$0 $95-$105 $150-$175
Contacts *(Instead of Glasses)*	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) *Every plan year**	Up to $60
Essential Medical Eye Care	• Retinal screening for members with Diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details. *Available as Needed*	$0 per screening $20 per exam

vsp vision care

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

- Exam..... up to $45
- Frame .....up to $70
- Single Vision Lenses .....up to $30
- Lined Bifocal Lenses ..... up to $50
- Lined Trifocal Lenses ..... up to $65
- Progressive Lenses..... up to $50
- Contacts ..... up to $105

**Plan year begins annually on October 1st*

Life and AD&D Insurance

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

Deaconess provides, at no cost to you, basic life insurance and accidental death and dismemberment (AD&D) insurance to those that work 40+ hours per pay period (0.5 FTE).

The AD&D benefit provides a payment in the same amount as the employee's basic life coverage if there is loss of life in an accident. It also provides a benefit for a debilitating injury due to a covered accident.

	Life Coverage	AD&D Coverage
Benefit [2]	1 times your annual earnings Maximum $500,000 *(Rounded to the next higher $1,000)*	AD&D; Included

[2] Percentage by which original amount of coverage will be reduced 35% at age 70; 45% at age 80

Optional Employee Life and Accidental Death and Dismemberment (AD&D) and Dependent Life Insurance

	Life Coverage	AD&D Coverage
Employee	Benefit [2]: 1, 2 or 3 times Your annual Earnings Maximum: The lesser of 3x earnings or $500,000 *(Rounded to the next higher $1,000)*	AD&D; Included
Spouse	Benefit [2]: Increments of $5,000 Maximum: The lesser of 50% of Employee Basic & Supplemental coverage or $50,000	AD&D; Included
Child(ren)	Benefit: $10,000	AD&D; Included

[2] Percentage by which original amount of coverage will be reduced 35% at age 70; 45% at age 80

Optional Life & AD&D Rates Per $1,000

(26 pay periods)

EE Age (Oct 1st)	Employee	Spouse
<25	$0.022	$0.038
25-29	$0.022	$0.038
30-34	$0.026	$0.048
35-39	$0.035	$0.064
40-44	$0.048	$0.091
45-49	$0.073	$0.139
50-54	$0.106	$0.219
55-59	$0.150	$0.333
60-64	$0.258	$0.438
65-69	$0.402	$0.697
70-74	$0.666	$1.217
75+	$1.174	$2.206
Child(ren)	$0.29 / pay period regardless of the number of children covered. *Children are covered to age 26.*	

Learn more on how Life Insurance could help protect your loved ones and secure your family's future.

THE HARTFORD

LIFE and AD&D INSURANCE – The Hartford
Phone: 1.888.563.1124
Policy #: 402724
Website: thehartford.com/employee-benefits/employees

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

Short & Long-Term Disability

Employees authorized 40 or more hours a pay period are automatically enrolled in Short-term disability and Long-term disability coverage at no charge. **There is a 90-day waiting period for newly benefit eligible employees.**

**Salaried supervisor and physician disability benefits are outlined in the Income Continuation Guidelines or physician contract.*

Contact the Benefits Office with any questions regarding salaried supervisor or physician disability benefits.

Employees transitioning from MHHCC on 12/23/24 will have a 90-day waiting period only if they have not been employed by MHHCC for >90 days.

SHORT-TERM DISABILITY & LONG-TERM DISABILITY – The Hartford
Phone: 1.888.277.4767
Policy #: 402724
Website: thehartford.com/employee-benefits/employees

Short-Term Disability (STD)

In the event of a short-term disability (STD), you have financial protection paid for by Deaconess. Our Short-term disability benefit provides 60% of base weekly income starting on the 8th day after your injury or sickness. You are automatically enrolled in Basic STD coverage at no cost to you.

You can choose more STD coverage with the Buy-up STD plan that's paid by you through payroll deductions.

STD Coverage Level	Benefit Percentage (Percent of your earnings)	Maximum	Sickness Benefit Starts	Injury Benefit Starts	Benefit Duration
Core	60%	$1,500	On the 8th day	On the 8th day	26 weeks
Buy-Up	70%	$2,500	On the 8th day	On the 8th day	26 weeks

Long Disability (LTD)

Long-term disability benefit provides 60% of base monthly income when disabled more than 180 days.

Benefit Percentage (Percent of your earnings)	Maximum	Minimum (Based on Monthly income loss before the deduction of other income benefits)	Benefit Starts	Benefit Duration
60%	$10,000	The greater of $100 or 10% of the benefit	After 180 days disabled	Disabled before: Age 63 Benefit Duration: as long as you are disabled Benefit Duration maximum: The greater of your Social Security normal retirement age or 3.5 years

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

Additional Coverage

Optional benefits available for purchase

Hospital indemnity insurance pays a benefit when you are hospitalized to pay out-of-pocket expenses and extra bills. The benefit is paid directly to you in a lump sum based on the length and level of care needed. Read full benefits highlights located on MHHCC Hub.

Hospital Indemnity Cost Per Paycheck (Bi-Weekly)	High	Low
Employee	$9.35	$6.17
Employee + Spouse	$17.78	$11.27
Employee + Children	$14.31	$9.59
Family	$23.42	$14.78

Hospital Indemnity can help you pay for everyday expenses along your road to recovery.

Accident insurance pays specific amounts for expenses related to nonwork-related accidents and injuries. Hospitalization, physical therapy, intensive care, transportation and lodging are some of the out-of-pocket expenses covered. Read full benefits highlights located on MHHCC Hub.

High	Low	Accident Insurance Cost Per Paycheck (Bi-Weekly)
$5.09	$2.98	**Employee**
$8.01	$4.66	**Employee + Spouse**
$8.18	$5.00	**Employee + Children**
$13.01	$7.85	**Family**

See how this Accident Insurance coverage can help when you need it most.

Critical illness insurance works with medical insurance by helping you pay the direct and indirect costs of a critical illness or event. Conditions covered include heart attack, stroke, major organ transplant, end stage renal failure, paralysis and some types of cancer. The premiums will be determined by a number of factors including demographics and the amount of coverage. Read full benefits highlights located on MHHCC Hub.

You never know if a serious illness might happen. Protect your future finances with Critical Illness Insurance.

CRITICAL ILLNESS, ACCIDENT & HOSPITAL INDEMNITY – The Hartford
Phone: 1.866.547.4205
Policy #: 402724
Website: myhealthhub.app/thehartford

THE HARTFORD

Pet Insurance

Nationwide® pet insurance

My Pet Protection® coverage highlights: My Pet Protection offers a choice of reimbursement options so you can find coverage that fits your budget. All plans have a $250 annual deductible and $7,500 maximum annual benefit. Coverage includes*:

- Accidents
- Illnesses
- Hereditary and congenital conditions
- Cancer
- Dental diseases
- Behavioral treatments
- Rx therapeutic diets and supplements
- And more

Plus, every My Pet Protection policy includes these additional benefits to maximize your value:

- Lost pet advertising and reward
- Emergency boarding and kenneling fees
- Lost pet due to theft
- Mortality benefit

Included with every policy

VetHelpline®

- Unlimited, 24/7 virtual pet care in an app
- Advice from licensed veterinary professionals
- Support for any pet health concern

PetRxExpress℠

- Save time and money by filing pet prescriptions at participating in-store retail pharmacies across the U.S.
- Pharmacy submits claims directly to Nationwide
- More than 4,700 pharmacy locations

Nationwide®

Get a fast, no-obligation quote starting December 23, 2024.

PET INSURANCE – Nationwide
Phone: 1.877.738.7874
Website: benefits.petinsurance.com/deaconess

Payactiv

Work today, Get paid tomorrow

Access Anytime

- Get up to 50% of earned wages
- Transfer to your bank or card
- Get cash at Walmart®[1]
- Use Uber® rides, Amazon Cash®
- Pay bills directly from the app

Spend Smarter

- Easily track earnings, bills, and spending in one place
- See what's safe to spend now
- Be alerted of low balance
- Auto transfer from earned wages

Save As You Go

- See what you can set aside safely
- Achieve your savings goals with every paycheck
- Talk to financial coaches for advice

How it works *(After 12/23/2024)*

1. Create a Payactiv account with your employee ID.
2. Enjoy free unlimited access with direct deposit to the Payactiv Visa® Card*.
3. For everyone else without direct deposit to the Payactiv card, the program fee is $1 for single or multiple transactions on the day you access funds, capped at $5 for a bi-weekly pay period ($3 for weekly pay periods).

**This is a Payactiv Visa® Prepaid Card issued by Central Bank of Kansas City, Member FDIC, pursuant to a license from Visa® U.S.A. Inc.*

[1] $1.99 processing fee for cash pick up at Walmart® or instant deposit to a card other than the Payactiv Card.

The Payactiv Visa® Prepaid Card is issued by Central Bank of Kansas City, Member FDIC, pursuant to a license from Visa U.S.A. Inc. Certain fees, terms, and conditions are associated with the approval, maintenance, and use of the Card. You should consult your Cardholder Agreement and the Fee Schedule at Payactiv.com/card411. If you have questions regarding the Card or such fees, terms, and conditions, you can contact us toll-free at 1(877) 747-5862, 24 hours a day, 7 days a week.

Scan QR code to learn more at bit.ly/payactiv-deaconess-health

payactiv

EARNED WAGE ACCESS – Payactiv
Phone: 1.877.937.6966
Website: bit.ly/payactiv-deaconess-health

Download the Payactiv app

Deaconess Health System
Summary of 401(k) Employee Benefits

Under a 401(k) plan, as an employee, you can contribute a percentage of your pay into one or more funds on a menu of investment options, which includes a wide variety risk/return profiles. Employees can direct 1% to 75% of their paycheck into the 401(k) on a pretax or after tax basis. Fidelity Investments will mail New Hires an enrollment packet to your home address 2-4 weeks after your hire date.

Important Notice – Please Read

MHHCC employees hired after 12/23/24 will be automatically enrolled into the 401(k) plan at a 3% pretax contribution into the appropriate target date fund. If you do not wish to participant in the 401(k) plan, then you will need to contact Fidelity Investments to waive your contributions within the first 10 days of hire. Contact information is below.

MHHCC employees transitioning 12/23/24 will continue the same deferral percentage as their MHHCC plan.

Employer Match

Deaconess will match a portion of the employee's first 6% of contributions. 100% of the first 1% plus 50% of the next 5%. If employee contributes 6%, Deaconess Match will equal 3.5%.

You are eligible to receive the matching contribution when you have completed 12 months of continuous employment, including MHHCC service.

Employer Match Deposits

Employer contributions will be deposited into accounts each pay period once eligibility requirement is met.

Employer Contribution Vesting

Employee is 100% vested after two years of employment.

After-Tax Contributions and Roth 401(k) In-Plan Conversion

This option lets the employee contribute to the after tax account in excess of the 401(k) individual contributions IRS limit. Then these contributions can convert to the Roth source within the plan, which allows them to grow tax free going forward. Employees can direct 1-10% of their pay and you must contact Fidelity to setup this option.

Automatic Deferral Increases

Deaconess utilizes the Annual Increase Program through Fidelity which automatically increases your contributions to your 401(k) account each year. If employees are enrolled in the 401(k) Plan, Deaconess will increase your deferral by 1% every year in January until you are contributing 6%.

Fidelity NetBenefits®

How to Access the Accounts, Make Changes, or Ask Questions

Employees can make changes to the 401(k) plan at any time by contacting Fidelity, making changes online at fidelity.com/atwork, or through the NetBenefits app that can be downloaded to any device. **Beneficiary designations for the 401(k) are separate from the designations made in UKG and need to be listed in Fidelity.**

Fidelity offers the services of a Retirement Planner who can meet individually to discuss retirement options:

Tony Davis
email: tony.davis@fmr.com
Phone: 1.502.322.0806

Fidelity Investments
website: www.fidelity.com/atwork
Phone: 1.800.343.0860

Important Notices:
*For full plan details, reference the Deaconess Illinois 401(k) Plan Summary Plan Description.
Last Reviewed: 1/9/2025

Paid Time Off (PTO)

Employees accrue PTO based on hours paid and length of service. Employees must use PTO for a scheduled or non-scheduled absence.

Employees authorized 40 or more hours a pay period must use PTO during the first seven days before Short-Term Disability will begin to pay.

PTO is **ONLY** paid out upon termination if any one of the following criteria are met:

- At least two years of seniority (includes MHHCC service)
- Employed in the state of Illinois

An employee reducing authorized hours from Full time (>60 hours) to Part time will be paid out available PTO in excess of their part time annual authorized hours accrual.

See chart below.

Years of Service	0-4 years	4-14 years	14+ years
Accrual Rate Per Hour:	0.0885	0.1078	0.1269
Max. Bank Accrual:	368	448	528
Paid Hours	Accrual per Pay Period* (Annual Accrual)		
↓	↓	↓	↓
80	7.08 (184)	8.62 (224)	10.15 (264)
72	6.37 (166)	7.76 (202)	9.14 (238)
64	5.66 (147)	6.90 (179)	8.12 (211)
56	4.96 (129)	6.03 (157)	7.11 (185)
48	4.25 (110)	5.17 (134)	6.09 (158)
40	3.54 (92)	4.31 (112)	5.08 (132)

*Hours will vary based on actual hours worked

Employee Services

MEDICATION ASSISTANCE PROGRAM

The Medication Assistance Program works with drug companies and foundations that can help you get your medications at no or reduced cost when you need help.

Call **1.812.450.2319** for more information.

GLUCOMETER

If you have health insurance through Deaconess, you or your eligible dependents who are diabetic can receive a Contour Next meter at no cost.

Simply call **1.800.401.8440** and provide code **CTR-OPX**. Ascensia will take care of the rest.

DEACONESS RN ON CALL

Offered to all Deaconess employees and immediate family. Registered nurses are available 24 hours a day to answer your questions about any acute illness or injury.

Call **1.812.450.7681** or **1.800.967.6795**.

DEACONESS EMPLOYEE WELLNESS

The employee wellness department offers online education and HRA credit.

Please call **1.812.450.1348 and press #2** if you have any questions.

FREE BREAST PUMPS

Each breastfeeding mother qualifies for one Medela or Spectra breast pump per plan year covered at 100%!

Call Deaconess Home Medical Equipment at Gateway, **1.812.842.3789**, for more information.

Employees not on Deaconess medical insurance, please check with your insurance provider.

MHHCC PERKS PROGRAM

See The Hub for a list of discounts being offered to employees. Your hospital ID is required to receive the discount

EMPLOYEE SPECIAL DISCOUNTS

Tickets at Work – This page provides discounts on tickets, hotel rooms, rental cars, as well as other things like movie tickets and sporting events both locally and nationally.

Visit ticketsatwork.com and choose “Become a Member”. On the next page, choose “Company Code” and complete the form to create an account with “Deaconess” as the company code.

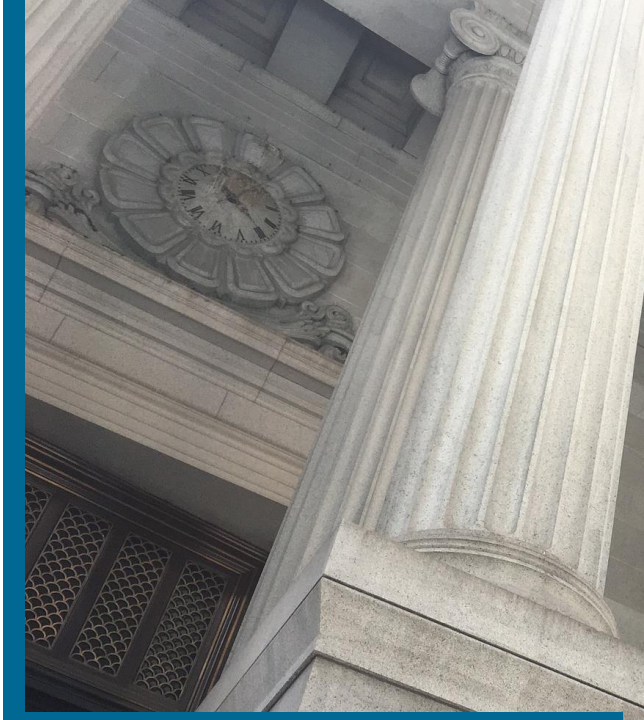
Educational Assistance

Student Loan Wellness Program

Deaconess knows student loan debt and college expenses also affect many of our employees, whether related to their own education or for current or future needs of their family members. That's why Deaconess provides a **Student Loan Wellness Program** from **Tuition.io**.

This service is free for every Deaconess employee and includes:

- Personalized, live, 1-on-1 student loan coaching (via email, chat or calls), helping families set goals for paying off debt or saving for college—or both!
- Information and assistance with public service loan forgiveness programs related to employment at a non-profit organization (like Deaconess).
- A marketplace for refinancing existing student loans.
- A clean dashboard of information, displaying all current student debt, loan payoff projection options, repayment tools, recent transactions and more.
- Detailed information about 529 savings plans and other college finance options for children in your family.



EDUCATIONAL ASSISTANCE - Tuition.IO
Phone: 1.855.353.9395
Website: deaconess.tuition.io

When you sign up with Tuition.io, you'll have access to a full suite of tools to help you manage and ultimately eliminate your student loan debt. If you're the parent of college-bound children, Tuition.io will help you find ways to save and pay for their education.

Start your journey by setting up an account at **deaconess.tuition.io**. Contact **Tuition.io** at **1.855.353.9395** with questions.

Student Loan Repayment

Deaconess is pleased to offer its employees a special student loan repayment program. This program, along with other educational assistance programs, can help Deaconess employees reduce their student loan burden.

Deaconess employees within the following professions may be eligible for student loan repayment.

- Medical Technologists and other Laboratory Professionals
- Medical Imaging Professionals
- Radiation Therapy
- Inpatient/Bedside Registered Nurses
- Certified Surgical Techs
- Pharmacists
- Respiratory Therapists

- Full-time employees receive $100/month (those working at least 30 hours per week).
- Part-time employees receive $50/month (those working at least 20 hours per week).
- At this time, only student loans taken out as part of an undergraduate program are eligible for this program.
- New hires are eligible the month following completion of the Tuition.io enrollment process.
- Payments are made directly to your student loans through the Tuition.io site, A notification is sent to you each time a payment is made by Deaconess.
- Employees are eligible for payments until loans are paid off (or a maximum of 10 years).
- This program is based on current employment status and requires a commitment of three years from the first payment.

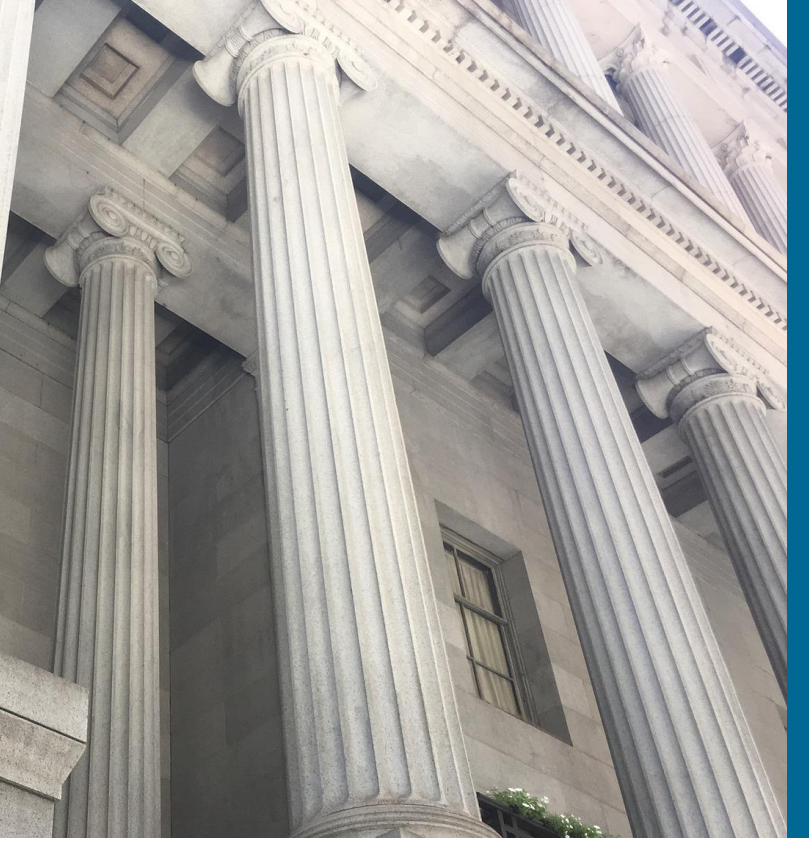
For example, if you participate but then leave Deaconess within three years, the payback plan is as follows:

- <1 year = 100% payback
- >1 year but <2 years = 67% payback
- >2 years but <3 years = 33% payback

- Payments stop if the employee moves to an ineligible position within the health system, but the employee will not have to pay back funds if they remain at Deaconess.
- Employees are ineligible for loan repayment payments for six months following any warning notice.

Next step for eligible employees: Please register with Tuition.io at **deaconess.tuition.io/register**. Enter your current student loan Information, Once this process is complete, payments will begin the following month.

If you have questions, please call Deaconess Human Resources - Benefits Department at 812-450-2025 or email BenefitQuestions1@deaconess.com



Educational Assistance

Tuition Reimbursement

Explore the opportunities at Deaconess and learn how to advance your career.

- All full-time and part-time employees authorized to work at least 40 hours per pay period are eligible to receive
- $5,250 per calendar year while enrolled in undergraduate or graduate level classes.
- Employees pay for classes up front and are reimbursed when they complete the class with the required grade.
- Employees must upload his/her final grade(s) AND an itemized bill showing the semester's charges in Tuition.io. The employee will receive payment as a nontaxable earning on his/her regular payroll check within six weeks of submission of the documentation.
- The amount of tuition assistance received by employees is considered by the hospital to be an interest-free loan and is to be repaid through continued active employment.

After 12/23/24 go to **Tuition.io** or call **1.855.353.9395** for more information.

You can also email questions to:
_HRTuitionReimbursement@deaconess.com

Step-Up Program

Employees can apply for Step-Up and, if selected, will be paid their normal wages for the time spent in enrolled class hours/clinical hours up to a maximum of 18 hours per week. Prior to participation in the program, employees must be accepted and enrolled into an accredited program as defined by Deaconess and agree to pursue course work designed to achieve the necessary licensure or accreditation.

STEP UP
Deaconess Career Education and Advancement

The Step-Up Program is open to employees enrolled in the following programs:

- Certified Medical Assisting/Registered
- Medical Assisting *(please contact HR regarding qualified programs)*
- Licensed Practical Nurse
- Certified Surgical Technologist
- Respiratory Therapy
- Registered Nurse
- Echo Sonography
- Rad Tech
- Certified Coding Specialist
- Paramedic
- Medical Technologist
- Nuclear Medicine Technologist
- Diagnostic Medical Sonography

Managers will try to reasonably accommodate each employee's schedule so the employee may attend his/her enrolled class/clinical hours each week. The employee will continue working at Deaconess for the balance of his/her authorized hours.

Upon completion of course requirements, the employee must achieve the necessary license or certification and be in good standing in order to be placed in an available position. The employee must agree to repay the program costs by remaining employed full-time at Deaconess for three years after the licensure or accreditation is obtained.

After 12/23/24 you can find more information and the Step-Up Application on MHHCC Hub or scanning the QR Code.

For more information you can email: _HRStepUpProgram@deaconess.com

Important Notice from Deaconess Health System, Inc. About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Deaconess OneCare has determined that the prescription drug coverage offered by the **Deaconess Health System, Inc.** is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

A description of your current prescription drug benefits can be found in the Deaconess Health System Summary Plan Document or ask your HR Department for more information.

If you do decide to join a Medicare prescription drug plan and drop your current Deaconess Health System, Inc. coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the **Deaconess Health System, Inc.** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **Deaconess Health System, Inc.** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date: September 4, 2024
Name of Entity/Sender: Deaconess Health System, Inc.
Contact—Position/Office: Sheri Brown – HR Manager
Address: 600 Mary Street, Evansville, IN 47747
Phone Number: 1-812-450-2025

CMS Form 10182-CC **Updated April 1, 2011**

Notice of Special Enrollment Rights

This notice is being provided to help you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Marriage, Birth or Adoption

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

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact the plan administrator (see cover page for contact information).

Newborns' and Mothers' Health Protection Act

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

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members.

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member or an embryo lawfully held by a member receive assistive reproductive services.

Mental Health Parity & Addiction Act

The Mental Health Parity and Addiction Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more Information regarding the criteria for medical necessity determinations made under your employer's plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (see cover page for contact information).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those establishes for other benefits under the plan. If you would like more information on WHCRA benefits, contact your plan administrator (see cover page for contact information).

Michelle's Law

When a dependent child loses student status for purposes of the group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier.

For additional information, contact your plan administrator (see cover page for contact information).

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed and Services Employment and Re-Employment rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short Term or Long Term Disability or Accidental Death & Dismemberment coverage you may have. A full explanation of USERRA and your rights is beyond the scope of this document. If you want to know more, please see the Summary Plan Description (SPD) for any of our group insurance coverage or go to this site: http://www.dol.gov/vets/programs/userra/main.htm

An alternative source is VETS. You can contact them at 1-866-4-USA-DOL or visit this site: http;//www.dol.gov/vets

An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1][2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description contact the HR Service Center at askhrservicecenter@perdoceoed.com.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name **Deaconess Health System, Inc.**		**4. Employer Identification Number (EIN)** **35-1532889**
5. Employer address **600 Mary Street**		**6. Employer phone number** **(812) 450-2025**
7. City **Evansville**	**8. State** **IN**	**9. Zip Code** **47710**
10. Who can we contact about health coverage at this job? **Human Resources**		
11. Phone number (if different from above)	**12. Email address** **BenefitQuestions1@deaconess.com**	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All Employees. Eligible Employees are:
  - ☑ Some employees. Eligible employees are: [Employees authorized to work 40 or more hours per pay period]
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are: [Spouses include someone you are currently, legally married to in accordance with state law recognized in Indiana. Children include Natural born children, stepchildren, legally adopted children and children for whom you are a legal guardian up to age 26]
  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends this coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, STORED, DISCLOSED, OR TRANSMITTED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how protected health information and/or electronic protected health information ("ePHI") (collectively, "PHI") may be used, stored, disclosed, or transmitted by us or your Group Health Plan to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your PHI, and describes your rights to access, amend, manage, or transmit your PHI.

PHI is individually identifiable health information, including demographic information, collected from you or stored, created, received, or transmitted by a health care provider, a health plan, your employer (when functioning on behalf of the Group Health Plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you. The above-referenced entities may also be referred to as covered entities.

In addition to the above-listed entities, their business associates and contractors must comply with HIPAA standards regarding their handling of PHI. A business associate is any person or group that generates, stores, receives or transmits PHI on behalf of a covered entity with which they are affiliated. In order for the business associates and contractors to remain compliant, they must be vigilant about consistency and evaluating and modifying its HIPAA security and compliance strategy. Prior to performing a service related to the use, storage, disclosure, or transmittal of PHI, a business associate must sign a Business Associate Agreement. The business associates may be subject to the same penalties and fines as a covered entity in the event that they are not in compliance with HIPAA regulations. Business Associate Agreements must comply with HIPAA Omnibus Rule.

Sufficient training should be held to inform staff of the definitions and procedure changes as a result of the HIPAA Omnibus Rule. Business associates are required to implement training for their employees and all instructional efforts must be documented.

This Notice of Privacy Practices had been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about this Notice or the policies and procedures described in this Notice, please contact Member Services by mail at Deaconess OneCare Health Plan, P.O. Box 407, Columbus, IN 47202-0407, or by phone toll-free at (844) 378-7103, or if local, at (812) 378-7103.

EFFECTIVE DATE

This Notice of Privacy Practices becomes effective on January 1, 2021.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your PHI. We are obligated to: provide you with a copy of this Notice of our legal duties and of our privacy practices related to your PHI; abide by the terms of the Notice that is currently in effect; and notify you in the event of a breach of your unsecured PHI. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI that we maintain. If we make a material change to our Notice, we will make the revised Notice available by posting on our website at www.deaconessonecare.com.

PERMISSIBLE USES AND DISCLOSURES OF PHI

The following is a description of how we are most likely to use and/or disclose your PHI.

TPO (Treatment, Payment, and Health Care Operations) Uses

To avoid interfering with an individual's access to quality health care or the efficient payment for such health care, we have the right to use, store, disclose, and transmit your PHI for all activities that are included within the definitions of "treatment", "payment", and "health care operations" as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.

- *Treatment*: Treatment generally means the provision, coordination, or management of health care and related services among health care providers, or by a health care provider with a third-party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.
- *Payment:* We will use or disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your PHI when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.
- *Health Care Operations:* We will use or disclose your PHI to support the Plan's business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your PHI: (i) to provide you with information about a disease management program; (ii) to respond to a customer service inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

De-Identified Health Information

There are no restrictions on the use or disclosure of de-identified health information. De-identified health information neither identifies nor provides a reasonable basis to identify an individual. There are two ways to de-identify information, either: (1) a formal determination by a qualified statistician; or (2) the removal of specified identifiers of the individual and of the individual's relatives, household members, and employers is required, and is adequate only if the covered entity has no actual knowledge that the remaining information could be used to identify the individual.

OTHER PERMISSIBLE USES AND DISCLOSURES OF PHI

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your PHI.

Required by Law

We may use or disclose your PHI to the extent the law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

Public Health Activities

We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

Health Oversight Activities
We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

Abuse or Neglect
We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence when required by law.

Legal Proceedings
We may disclose your PHI: (i) in the course of any judicial or administrative proceeding; (ii) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (iii) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your PHI in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

Law Enforcement
Under certain conditions, we also may disclose your PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (i) it is required by law or some other legal process; (ii) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (iii) it is necessary to provide evidence of a crime that occurred on our premises.

Coroners, Medical Examiners, Funeral Directors; Organ Donation Organizations
We may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.

Research
We may disclose your PHI to researchers when an institutional review board or privacy board has: (i) reviewed the research proposal and established protocols to ensure the privacy of the information; and (ii) approved the research.

To Prevent a Serious Threat to Health or Safety
Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security, Protective Services
Under certain conditions, we may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

Inmates
If you are an inmate of a correctional institution, we may disclose your PHI to the correctional institution or to a law enforcement official for: (i) the institution to provide health care to you; (ii) your health and safety and the health and safety of others; or (iii) the safety and security of the correctional institution.

Workers' Compensation
We may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Emergency Situations
We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will disclose only the PHI that is directly relevant to the person's involvement in your care.

Fundraising Activities
We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

Group Health Plan Disclosures
We may disclose your PHI to a sponsor of the Group Health Plan – such as an employer or other entity – that is providing a health care program to you. We can disclose your PHI to that entity if that entity has contracted with us to administer your health care program on its behalf.

Underwriting Purposes
We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing in the underwriting process your PHI that is genetic information.

Others Involved in Your Health Care
Using our best judgment, we may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law. If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

USES AND DISCLOSURES OF YOUR PHI THAT REQUIRE YOUR AUTHORIZATION

Sale of PHI
We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing
We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes
We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

REQUIRED DISCLOSURES OF YOUR PHI

The following is a description of disclosures that we are required by law to make.

Disclosures to the Secretary of the U.S. Department of Health and Human Services

We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

Disclosures to You

We are required to disclose to you most of your PHI in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than payment and health care operations and are not disclosed through a signed authorization. We will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose PHI to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney). Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

Business Associates

We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management. Examples of our business associates would be our Third Party Administrator, SIHO Insurance Services, which will be handling many of the functions in connection with the operation of our Group Health Plan; the retail pharmacy; and the mail order pharmacy.

Other Covered Entities

We may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and we may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

Plan Sponsor

We may disclose your PHI to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

POTENTIAL IMPACT OF STATE LAW

The HIPAA Privacy Rule regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

YOUR RIGHTS

The following is a description of your rights with respect to your PHI.

Right to Request a Restriction

You have the right to request a restriction on the PHI we use or disclose about you for payment or health care operations. We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you. You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for restriction to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

Right to Request Confidential Communications

If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail. You may make such a request by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for confidential communications to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us: (1) that you want us to communicate your PHI with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the PHI in a manner inconsistent with your instructions would put you in danger.

We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your PHI could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (e.g., an Explanation of Benefits, or "EOB"). Unless you have made other payment arrangements, the EOB (in which your PHI might be included) will be released to the plan participant.

Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed promptly, usually within two business days.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI might be disclosed (such as through an EOB). Therefore, it is extremely important that you contact the designated contact listed on the first page of this Notice as soon as you determine that you need to restrict disclosures of your PHI.

If you terminate your request for confidential communications, the restriction will be removed for all your PHI that we hold, including PHI that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your PHI will endanger you.

Right to Inspect and Copy

You have the right to inspect and copy your PHI that is contained in a "designated record set." Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy your PHI that is contained in a designated record set, you must submit your request to the designated contact listed on the first page of this Notice. It is important that you contact the designated contact to request an inspection and copying so that we can begin to process your request. Requests sent to persons, offices, other than the designated contact might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact the designated contact listed on the first page of this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

Right to Amend

If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by contacting the designated contact listed on the first page of this Notice. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to the designated contact so that we can begin to process your request. Requests sent to persons or offices, other than the designated contact might delay processing the request.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

Right of an Accounting

You have a right to an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by submitting your request in writing to the designated contact listed on the first page of this Notice. It is important that you direct your request for an accounting to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

Your request may be for disclosures made up to 6 years before the date of your request. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

Right to a Copy of This Notice

You have the right to request a copy of this Notice at any time by contacting the designated contact listed on the first page of this Notice. If you receive this Notice on our Website or by electronic mail, you also are entitled to request a paper copy of this Notice.

COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us at the number listed on the first page of this Notice. A copy of a complaint form is available from this contact office. You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem. We will not penalize or any other way retaliate against you for filing a complaint with the Secretary or with us.

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US 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.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2024, 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 1/31/2026)

Illinois Consumer Coverage Disclosure Act

Employer Name:	**DEACONESS HEALTH SYSTEM, INC**
Employer State of Situs:	**INDIANA**
Plan Year:	**2024-2025**

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2024 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	N
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Y
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	N
4	Durable Medical Equipment	Ambulatory	Pg. 13	Y
5	Hospice	Ambulatory	Pg. 28	Y
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Y
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Y
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Y
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	N
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Y
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Y
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	N
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Y
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Y
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Y
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Y
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Y
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Y
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Y
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Y (travel and lodging are not covered)
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Y
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Y
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Y
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Y
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Y
26	Tele-Psychiatry	MH/SUD	Pg. 11	Y
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Y (prior authorization required)
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	N
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	Y
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Y
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Y
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Y
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Y
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Y
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Y
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Y
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Y
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Y
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Y
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Y
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Y
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Y

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

Deaconess Clinic
WELLNESS SOLUTIONS

NOTICE REGARDING WELLNESS PROGRAM

Deaconess Wellness Program

Deaconess Employee Wellness is a voluntary wellness program available to all beneficiaries including spouses. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. The labs needed include a blood test for Blood Glucose, Total Cholesterol, HDL, LDL, Triglycerides, and Diabetes. The blood tests are conducted to check for areas of improvement for Hypertension, Glucose, Tobacco, BMI, Cholesterol, Diabetes, and Asthma. There is an option for you to submit an annual physical exam with a Primary Care Provider to count for your wellness incentive. You are not required to complete or submit information regarding your annual PCP exam. Employees that submit proof of an annual physical with a Primary Care provider will receive dollars in their biweekly paycheck to help off-set medical insurance premium costs.

The Health Risk Assessment is also an available option through earnings of an HRA (Health Reimbursement Account). The health risk assessment will ask a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). Employees and spouses are also eligible to receive up to $400 each by completing wellness activities for their Health Reimbursement Account. All incentives and dollars earned will be used for the following benefit year.

You are not required to complete the Health Risk Assessment or to participate in the blood test or other medical examinations.

The information from your Health Risk Assessment and PCP annual exam will be used to provide you with information to help you understand your current health and potential risks. You are also encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although Wellness Solutions may use aggregate information it collects to design a program based on identified health risks in the workplace, Wellness Solutions will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for the purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are the staff employed by Wellness Solutions and individuals employed by the services you authorize. These services may include but are not limited to Deaconess MTM Clinic, and OneCare Care Advisor. In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs that involves information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Wellness Solutions Practice Manager at (812) 450-1348.

Notes

Notes

MEMORIAL HOSPITAL
And Health Care Center

800 West 9th Street ▲ Jasper, IN 47546 ▲ 812/996-2345

www.mhhcc.org

This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.