Caregiver Benefits

2023 New Hire Guide

Medical, Dental, Vision, Flexible Spending Accounts, Health Savings and Reimbursement Accounts, Caregiver Assistance Program, Life/AD&D, Short Term and Long Term Disability, Voluntary Benefits, and Retirement

Introduction and Welcome

Welcome to St. Charles Health System! Our vision is "Creating America's healthiest community, together." We can do that because we have the highest quality caregivers, and that includes you! We take care of each other and our patients, and we are active in the communities we serve. To support you in this important work, St. Charles is pleased to provide you a comprehensive benefit package with choices to help you meet the needs of your family. Our benefits are meant to provide peace of mind to support you and your family towards health, and in times of need. Take some time to review these important benefits, and use this guide to help make informed decisions about your benefit options.

This is only a summary of the insurance and benefit programs we provide. Information is meant to be high level and does not include all plan provisions, exclusions and coverage details. Please refer to the Plan Documents or Summary Plan Descriptions for these details. If there is a discrepancy between what is stated in this booklet and the Plan Documents, the Plan Documents will govern.

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Highlights

You have access to comprehensive benefits provided by St. Charles Health System (SCHS). This guide provides additional details to help you make decisions about benefits that best fit the needs of you and your family. Here are some highlights of all the benefits offered, and what action you need to take to enroll for the benefit.

BENEFIT	DESCRIPTION	COST AND/OR CONTRIBUTION	ACTION YOU NEED TO TAKE
Medical and Pharmacy	Choice of three medical/pharmacy plans – with accounts to help you pay for out-of-pocket health care expenses: • Select PPO Plan • Caregiver Directed Health Plan • Prime PPO Plan	You pay a share of the cost and SCHS pays the rest Your cost depends on the medical plan elected	Enroll within 30 days of eligibility
Doctor on Demand	Access to virtual physician visits for those enrolled in our medical plans Includes physical and mental health care	Your cost or copay depends on your medical plan	Download the Doctor on Demand app, or visit their website, to complete your profile, which is required prior to your first visit
Vision	Comprehensive vision coverage with low out of pocket expenses when you use a VSP provider	You pay a share of the cost and SCHS pays the rest	Enroll within 30 days of eligibility
Dental	Dental benefits that include orthodontia	You pay a share of the cost and SCHS pays the rest	Enroll within 30 days of eligibility
Spending and Savings Accounts to pay for eligible out-of-pocket health care expenses	Health care Flexible Spending Account (HCFSA) Limited Purpose Health care Flexible Spending Account (LPFSA) Dependent Care Flexible Spending Account (DCFSA) Health Reimbursement Account (HRA) Health Savings Account (HSA)	You provide all FSA funding with pre-tax payroll deductions. SCHS puts money in your HSA or HRA; you may add funds to your HSA with pre-tax payroll deductions	Enroll in the FSAs within 30 days of eligibility HCFSA only available to those on the Select or Prime PPO plans LPFSA only available to those on the CDHP DCFSA is available to all You must be enrolled in the Select PPO to receive HRA contributions You must be enrolled in the CDHP to receive or make HSA contributions. You can start or change your HSA contribution amount at any time

BENEFIT	DESCRIPTION	COST AND/OR CONTRIBUTION	ACTION YOU NEED TO TAKE
Engage for Health **Wellness Program**	Resources and benefits available to caregivers and family to aid in the maintenance or improvement of their health and wellbeing	Participation is completely voluntary and no cost to you	New participants: Visit http://www.engageformyhealth.org or the Virgin Pulse app to enroll
Disability Insurance	Provides income when, because of an illness or accident, you are disabled and unable work. Coverage includes: • Short Term Disability (STD) • Long Term Disability (LTD)	SCHS provides both short and long term disability plans at no cost to you	No action required: you are automatically enrolled on the first of the month following 90 days of benefit eligible employment
Term Life and Accidental Death and Dismemberment (AD&D), Voluntary Term Life and AD&D, and Voluntary Whole Life Insurance	Life insurance pays a benefit in the event of your death. AD&D also pays a benefit in the event of your death if it was accidental. It also pays if you suffer dismemberment. Benefits are paid to your designated beneficiary. **SCHS provides:** • Basic Life and AD&D **You can also purchase:** • Voluntary Term Life - allows you to purchase coverage on yourself, your spouse and/or your children through the convenience of payroll deduction • Whole Life Insurance - allows you to purchase coverage on yourself, your spouse, children or grandchildren through the convenience of payroll deduction. You can accumulate cash value and premiums never change once enrolled	SCHS pays for your basic life and AD&D You pay the full premium for any additional coverage you choose to purchase through our Voluntary Term Life or Whole Life plans	Designate a beneficiary for Basic Life and AD&D insurance Enroll for voluntary or whole life coverage within 30 days of eligibility, and designate a beneficiary You may purchase after the 30 days, but you will be required to prove your good health and go through an approval process with UNUM
Voluntary Benefits	Critical Illness Insurance – provides a cash benefit if you have a covered illness Hospital Indemnity Insurance – provides a cash benefit if you are hospitalized Accident Insurance – provides a cash benefit for covered injuries and accident related expenses. You have the option to cover yourself or your family	You pay the full premium for any additional coverage you choose to purchase	Enroll within 30 days of eligibility

BENEFIT	DESCRIPTION	COST AND/OR CONTRIBUTION	ACTION YOU NEED TO TAKE
Air Ambulance	The AirLink Program provides a membership that ensures you have no out-of-pocket expenses if flown by AirLink or another AirMedCare Network participating provider	AirLink is available to benefit eligible caregivers and their family members who are enrolled in a SCHS medical plan	Enroll within 30 days of eligibility
Caregiver Assistance Program	Supports you and your family members when you need short-term counseling	SCHS provides these services no cost to you	No action required: you are automatically enrolled.
Retirement Benefits	Pre-tax payroll deductions will fund your retirement plan. SCHS will match a portion of your contributions after 12 months of employment (full or part-time positions).	You will be automatically enrolled at 6% of regular pay after 90 days of employment. You can elect to change this amount at any time	Set up your Fidelity Investment account and decide how to invest your funds
Additional Benefits and Resources	Worldwide travel assistance – help with emergencies when traveling 100 or more miles from home Life Planning & Financial and Legal Resources for those who are terminally ill UNUM Life Balance Employee Assistance Program - Supports you and your family members when you need short-term counseling, or help with legal, financial or other issues. Provides counseling, access to attorneys, financial planners, concierge services	SCHS provides at no cost to you	No action required: you are automatically enrolled and covered if you are enrolled for the SCHS LTD plan

Eligibility And Enrollment

WHEN COVERAGE BEGINS

For most benefits coverage begins on the first day of the calendar month following the start of your benefit-eligible employment. That includes coverage for eligible family members. If you have a change in who you cover through marriage, birth or adoption, your newly acquired family member will be covered on the date of birth, date of adoption, date placed for adoption, or the first day of the month following the date of marriage. For your basic life/AD&D, disability and retirement benefits, coverage begins on the first day of the calendar month following 90 days of benefit eligible employment.

To be eligible for coverage, you have to be positioned to work 40 or more hours per pay period, unless you are a member of an excluded class. Following are the classifications of employees by hours worked:

- **Full Time** – caregivers who are positioned to work 72 or more hours per pay period
- **Part Time 1** – caregivers who are positioned to work 60 to 71 hours per pay period
- **Part Time 2** – caregivers who are positioned to work 48 to 59 hours per pay period
- **Part Time 3** – caregivers who are positioned to work 40 to 47 hours per pay period

Premium cost shares will vary depending on your classification.

Excluded classes of employees who are not eligible for benefits regardless of the number of hours worked are: leased, contracted, temporary, seasonal or relief workers.

Note: Relief, temporary and seasonal workers are eligible to open and contribute to a 403(b) account, accrue paid sick leave (PSL) and are also eligible for the Caregiver Assistance Program (CAP).

If you are enrolling yourself and any eligible family members for the first time, you must make your elections and submit your enrollment within 30 days of your eligibility date. If you do not enroll within this time period, your next opportunity to enroll will be at our annual open enrollment, unless you and/or your eligible family members experience a “Qualified Change in Status” (see page 11 for more information). In this case, you may qualify for special enrollment rights if you provide Human Resources with all of the required enrollment and supporting documents within 30 days of your status change.

When you are first eligible for coverage you will need to make decisions about which benefits to elect and enroll in for coverage. You will be locked into your benefit elections for medical, dental, vision and flexible spending accounts for the entire calendar year unless you experience a “Qualified change in Family Status” (see page 10 for more details). You can also make changes each year during our open enrollment, with changes becoming effective on January 1 of the following year.

ENROLLMENT FOR BENEFITS IS THROUGH WORKDAY

Look for the invitation for enrollment (or open enrollment) in your Workday Inbox.

Note: Enrollment must be done within 30 days of your eligibility date. Please make sure and review your signed elections (all eligible family members enrolled, etc.) and if needed, print a copy for your records. If errors are identified outside of enrollment windows or grace periods, you will need to wait until the next Open Enrollment to make corrections.

WHO ARE THE FAMILY MEMBERS YOU CAN COVER FOR BENEFITS?

In addition to yourself, you can also cover:

- Your legally married spouse
- You and/or your spouse's children (until they turn age 26)*;
- You and/or your spouse's children*, regardless of age, who are physically or mentally incapable of self-support.

*In addition to your birth children, you can also cover step-children, adopted children (or placed for adoption), foster children for whom you are legally responsible, or any child you are required to provide coverage through court order. They do not have to be financially dependent on you or be claimed on your income taxes.

DOCUMENTATION REQUIRED FOR COVERAGE OF FAMILY MEMBERS

If you choose to cover your spouse or eligible children you will be required to provide supporting documentation either at the time of enrollment or in the future during an audit.

Please note: a social security number is required for all eligible family members enrolled in benefits. Following are the required documents:

COVERED FAMILY MEMBER	ACCEPTABLE DOCUMENTATION
Spouse	Marriage certificate **AND** Copy of your last year's 1040 federal income tax return showing filing status, as well as you and your spouse's signatures and filing dates. If you file separately, please also send the first two pages of your spouse's 1040 federal income tax return.
Biological Child(ren)	Birth Certificate
Step Children	Birth Certificate **AND** Marriage certificate **AND** Copy of your last year's 1040 federal income tax return showing filing status, as well as you and your spouse's signatures and filing dates. If you file separately, please also send the first two pages of your spouse's 1040 federal income tax return.
Other Child(ren) - (grandchild, niece/ nephew, brother/sister, etc.)	Court documents demonstrating legal guardianship.
Adopted Child(ren)	Official court/agency papers for a child placed with you for adoption **OR** Official court Adoption Agreement for an adopted child.

WHEN COVERAGE ENDS

For most benefits, coverage ends the last day of the month in which you or your covered family members lose eligibility. As the caregiver, that would be your termination date or reduction in hours or change to a non-benefitted position at SCHS. For family members that would be the last day of the month following a divorce or legal separation date, your child's 26th birthday, or the caregiver's termination date at SCHS. Life and disability benefits end on your last day worked.

If your coverage ends due to termination, reduction in hours, death, divorce or legal separation, or loss of dependent status, you and/or your covered family member may be able to continue your benefits. For more information refer to the "Continuation of Coverage" section on page 42.

What Do You Pay?

MEDICAL, DENTAL AND VISION PREMIUMS

Your share of our medical, dental and vision premiums, also known as contributions, are deducted from your paycheck 26 times per year. These premiums are taken from your paycheck before taxes. This means that you don't pay taxes on your premiums, including Social Security (FICA) tax, and federal income tax. This reduces your taxable earnings and you pay less in taxes. It also means that your election is binding for the calendar year, unless you experience a Qualified Change in Family Status, as described on page 11. For other benefits, such as Voluntary or Whole Life, Accident, Hospital or Critical illness insurance, your contributions will be taken on an after-tax basis.

Following are the premiums per pay period paid by you and St. Charles:

MEDICAL

Full Time: 0.9 to 1.0 FTE (72 to 80 hours per pay period)	CAREGIVER DIRECTED HEALTH PLAN		PRIME PPO PLAN		SELECT PPO PLAN	
	You Pay	SCHS Pays	You Pay	SCHS Pays	You Pay	SCHS Pays
Caregiver Only	$36.47	$328.27	$75.00	$424.98	$5.00	$316.13
Caregiver & Spouse	$100.18	$583.05	$184.14	$752.41	$44.10	$557.43
Caregiver & Family	$141.07	$746.64	$254.21	$962.63	$55.86	$725.71
Caregiver & Child(ren)	$99.75	$581.37	$183.42	$750.24	$39.49	$560.18
Part Time 1: 0.75 to 0.89 FTE (60 to 71 hours per pay period)	CAREGIVER DIRECTED HEALTH PLAN		PRIME PPO PLAN		SELECT PPO PLAN	
	You Pay	SCHS Pays	You Pay	SCHS Pays	You Pay	SCHS Pays
Caregiver Only	$36.47	$328.27	$75.00	$424.98	$43.35	$277.78
Caregiver & Spouse	$147.95	$535.28	$249.63	$686.92	$160.33	$441.20
Caregiver & Family	$219.51	$668.20	$361.74	$855.10	$209.11	$572.46
Caregiver & Child(ren)	$147.21	$533.91	$248.46	$685.20	$143.63	$456.05
Part Time 2: 0.6 to 0.74 FTE (48 to 59 hours per pay period)	CAREGIVER DIRECTED HEALTH PLAN		PRIME PPO PLAN		SELECT PPO PLAN	
	You Pay	SCHS Pays	You Pay	SCHS Pays	You Pay	SCHS Pays
Caregiver Only	$127.66	$237.08	$199.99	$299.99	$115.61	$205.52
Caregiver & Spouse	$302.83	$380.39	$461.93	$474.62	$296.70	$304.84
Caregiver & Family	$415.30	$472.41	$630.11	$586.73	$364.24	$417.33
Caregiver & Child(ren)	$301.67	$379.45	$460.19	$473.46	$266.03	$333.65
Part Time 3: 0.5 to 0.59 FTE (40 to 47 hours per pay period)	CAREGIVER DIRECTED HEALTH PLAN		PRIME PPO PLAN		SELECT PPO PLAN	
	You Pay	SCHS Pays	You Pay	SCHS Pays	You Pay	SCHS Pays
Caregiver Only	$164.13	$200.61	$249.99	$249.99	$144.51	$176.62
Caregiver & Spouse	$339.30	$343.92	$511.93	$424.62	$328.81	$272.72
Caregiver & Family	$451.76	$435.95	$680.11	$536.73	$393.14	$388.43
Caregiver & Child(ren)	$338.14	$342.98	$510.19	$423.46	$294.93	$304.75

DENTAL

Full Time: 0.9 to 1.0 FTE (72 to 80 hours per pay period)	You Pay	SCHS Pays
Caregiver Only	$1.43	$27.38
Caregiver & Spouse	$5.50	$50.28
Caregiver & Family	$9.28	$71.71
Caregiver & Child(ren)	$5.40	$49.73

Part Time 2: 0.6 to 0.74 FTE (48 to 59 hours per pay period)	You Pay	SCHS Pays
Caregiver Only	$8.60	$20.21
Caregiver & Spouse	$22.17	$33.62
Caregiver & Family	$34.76	$46.22
Caregiver & Child(ren)	$21.84	$33.29

Part Time 1: 0.75 to 0.89 FTE (60 to 71 hours per pay period)	You Pay	SCHS Pays
Caregiver Only	$1.43	$27.38
Caregiver & Spouse	$9.57	$46.22
Caregiver & Family	$17.14	$63.85
Caregiver & Child(ren)	$9.38	$45.75

Part Time 3: 0.5 to 0.59 FTE (40 to 47 hours per pay period)	You Pay	SCHS Pays
Caregiver Only	$11.46	$17.35
Caregiver & Spouse	$25.03	$30.76
Caregiver & Family	$37.63	$43.36
Caregiver & Child(ren)	$24.70	$30.43

VISION

Full Time: 0.9 to 1.0 FTE (72 to 80 hours per pay period)	You Pay	SCHS Pays
Caregiver Only	$0.47	$8.81
Caregiver & Spouse	$2.06	$17.87
Caregiver & Family	$2.60	$20.91
Caregiver & Child(ren)	$1.79	$16.33

Part Time 2: 0.6 to 0.74 FTE (48 to 59 hours per pay period)	You Pay	SCHS Pays
Caregiver Only	$2.78	$6.50
Caregiver & Spouse	$8.11	$11.82
Caregiver & Family	$9.90	$13.61
Caregiver & Child(ren)	$7.20	$10.92

Part Time 1: 0.75 to 0.89 FTE (60 to 71 hours per pay period)	You Pay	SCHS Pays
Caregiver Only	$0.47	$8.81
Caregiver & Spouse	$3.66	$16.27
Caregiver & Family	$4.73	$18.78
Caregiver & Child(ren)	$3.12	$15.00

Part Time 3: 0.5 to 0.59 FTE (40 to 47 hours per pay period)	You Pay	SCHS Pays
Caregiver Only	$3.71	$5.57
Caregiver & Spouse	$9.04	$10.89
Caregiver & Family	$10.83	$12.68
Caregiver & Child(ren)	$8.13	$9.99

Premiums for each plan may vary from year to year. You will be notified of any changes during each annual open enrollment period.

Qualified Change In Family Status

If you experience one of the following events during the calendar year, you will be allowed to make changes to your medical, dental and vision plan coverage and flexible spending account elections:

- Birth, adoption or placement for adoption of a child
- Death of an eligible family member (spouse or child)
- Gain or loss of eligibility for coverage for a family member
- Change in marital status
- You or your eligible family member gain or lose coverage under this or another plan
- Your eligible family member's annual enrollment period
- A court order requiring coverage for a child, such as a Qualified Medical Child Support Order (QMSCO)
- Change in employment status that affects your eligibility for benefits

For dependent daycare flexible spending accounts, in addition to the changes listed above, you are also allowed to make changes mid-year if you have a change in your work schedule that changes your need for childcare, a change in your child's care provider that has a financial impact, or if your daycare center or childcare provider closes or is no longer able to provide services.

If you intend to change your enrollment because of one of these situations, you have 30 days from the date of the change to make your changes in Workday, and submit any required enrollment and supporting documents.

Routine And Preventive Care

Our plans are designed to take care of you and your family when illness occurs. More importantly, our medical, dental and vision plans are designed to ensure you and your covered family members receive needed routine and preventive care. Making sure you have your routine physicals, teeth cleanings and routine vision exams help you catch health conditions sooner to reduce future needed treatment and recovery time. To keep costs down, we encourage you to use network providers.

ROUTINE MEDICAL CARE

Our medical plans cover routine exams, immunizations and needed screenings at 100% with no deductible or cost share so long as you seek care from a network provider. The Plans will cover services based on those recommended by the U.S. Preventive Care Task Force (USPCTF) and the recommendation of your personal physician. Following is a high level summary of the USPCTF guidelines:

ROUTINE PHYSICALS & WELLNESS EXAMS BASED ON AGE	RECOMMENDED SCHEDULE
0 to 18 months	Between 2 and 7 days, and at 2, 4, 6, 9, 12 and 15 months of age
3 to 6 years	Annually
7 to 18 years	Every 2 years
19 to 64 years	Every 1 to 3 years
65+ years	Annually

ROUTINE SCREENINGS	RECOMMENDED SCHEDULE
Blood Pressure	Every 1 to 3 years for adults age 18 and older
Cholesterol	Men: Beginning at age 35, every 1 to 5 years Women: Beginning at age 45, every 1 to 5 years
Breast Cancer using Mammography	Every 1 to 2 years for women beginning at age 40
Prostate Cancer	Men between ages 50 and 70 should discuss screening recommendations and frequency with their physician
Colon Cancer	Beginning at age 45, fecal occult blood test annually, sigmoidoscopy every 5 years or colonoscopy every 10 years.
Cervical Cancer	Every 3 years for women from age 21 to 65

Note: If a service is considered diagnostic or routine chronic care, your usual deductible, coinsurance and /or copayment will apply.

ROUTINE DENTAL AND VISION EXAMS

Our dental plan covers routine care at 100%. Well vision exams are paid in full when you use a VSP provider.

Common Terms

There are a few terms you should know to better understand how your plans work:

Annual Maximum – Dental Plan

This is the most the dental plan will pay each calendar year towards dental expenses for each covered individual. Once the plan has paid $2,000 you are responsible for future expenses for the rest of the calendar year.

Coinsurance

Once you have had health care expenses in excess of the deductible, the plan then pays a percentage of the cost of the treatment. This is known as “coinsurance” meaning that we co-insure: you pay some and the plan pays some.

Copayment or Copay

A set dollar amount you pay towards the cost of a particular type of service such as office visits or prescriptions.

Deductible

A deductible is the amount in a calendar year that you pay before the plan pays. Once you have had covered medical or dental charges that are more than the deductible the plan will pay a benefit. We call the action of meeting your deductible, “satisfying” your deductible. With the CDHP, if you cover more than one person on the plan, you will have to satisfy the family deductible before the plan begins to pay benefits.

Medical Plan Coverage Tiers

Your tier 1 provider list varies by the medical plan selected. Benefits vary by provider tier, with tier 1 having the highest level of benefits. If you choose to have care from a tier 1 provider, you will have the least out-of-pocket costs. Tier 2 benefits are lower than those of tier 1, and tier 3 (out-of-network) has the lowest level of benefits provided.

Tier 1 SCHS Custom Network Providers: CDHP and Prime PPO – This includes SCHS facilities, SCHS employed and affiliated providers, and select additional providers in the community to round out the network. Not all provider types or specialty care is available through this tier.

Tier 1 SCHS Custom Network Providers: Select PPO Plan – This includes SCHS facilities and SCHS employed and affiliated providers. This is a smaller list of tier 1 providers than the CDHP and Prime plan tier 1 list. Not all provider types or specialty care is available through this tier.

Tier 2 In-Network Providers – Regence PPO providers locally and across the country.

Tier 3 Out-of-Network Providers – Providers who are not contracted with either SCHS or Regence (these would be out-of-network providers). You may be billed by the out-of-network provider for balances beyond any deductible or coinsurance that is deemed by the Plan to be greater than a similar provider’s usual and customary charge. This is referred to as “balance billing”.

Out-of-Pocket Maximum – Medical Plans

The most you will pay out of your pocket in a calendar year for covered expenses before the plan then pays 100% for the rest of the calendar year. The medical plan out-of-pocket maximum includes any amount you pay towards the deductible, medical/pharmacy copayments and coinsurance. It does not include charges above the allowed amount or charges not covered by the Plan.

Premiums and Contributions

The monthly cost of insurance is known as the premium. Your contribution is your share of the premiums that are deducted from your paycheck that provides you with coverage. You pay a portion of the premiums for medical, dental and vision coverage for yourself and your eligible family members and SCHS pays the balance.

Medical Benefits

PLAN OPTIONS

Our medical and pharmacy benefits are administered by **Regence Blue Cross Blue Shield of Oregon (Regence)** and **CVS Caremark**. Both offer a nation-wide network of preferred providers and pharmacies for when you are traveling or have a child away at school. You have a choice of three medical plans to cover yourself and your eligible family members. Each option provides comprehensive medical and pharmacy benefits, and free preventive care.

We offer options so you can choose the plan that best fits the needs of you and your family. Carefully review the details of the three plan options. Consider the total cost of health care, including your payroll deductions, how much you will pay out of your pocket when you need care, and any funds that SCHS may contribute to an account to help you offset the cost of care. Think about how much health care you and your family members use, including doctor visits, pharmacy and any anticipated future care needs such as surgery or maternity care. This will help you decide how much you may need to save for future health care expenses.

If you take regular prescription drugs, keep in mind that if you choose the CDHP you are responsible for 100% of the cost of your medication until your deductible is satisfied. If you cover more than one person on the CDHP you have to meet the family deductible before the plan begins to pay for any services, other than preventive care. This means that either one or all covered family members must together meet the $3,000 family deductible before the CDHP will pay for any covered non-preventive services.

MAKE AN INFORMED DECISION

Take a deeper look at your benefit needs to make an educated choice between our three plans. Use this guide and these other tools to help in your decision making:

Consult Alex, our virtual benefits counselor. Alex will ask you questions about your benefit needs and make suggestions on which plan could make the most financial sense based on your response. He will also educate you about all of your benefit options to help you decide which benefits will meet your needs. Find Alex at: **https://www.myalex.com/StCharlesHealthSystem/2023**.

Online Benefits Guide (with voice guidance). You can review benefits at your own pace and at a time convenient for you. You can view the presentation at: **https://prezi.com/view/1twqPcwoOywfHRjvWcA3/**. Note: You must use one of the following web browsers to access our online guide: Chrome, Firefox, Edge, Safari (and not Internet Explorer)

HOW TO FIND A MEDICAL PROVIDER:

Before you have your Regence ID Card:

Tier 1 – visit **https://stcharleshealthsystem.sharepoint.com/HealthPlanAdministration/Documents/Regence.pdf** for a PDF list of providers.

Tier 2 – All Regence or Blue Cross Blue Shield PPO contracted providers

Visit **www.regence.com**

1) Select "**Find a Doctor**" at the bottom of the page
2) In the Pop-up box **choose a location** (address, city, zip code or "**use my current location**"), In the next pop-up box choose the Network Name: Under the Medical-Oregon and Clark County, WA Employer Sponsored Plans list, select "**Preferred Network**"
3) You will then have the option to search:
   - Doctors by Name – *a specific provider name*
   - Doctors by Specialty – *no specific name, but by specialty*
   - Places by Name – *hospitals, clinics or urgent care by name*
   - Places by Type – hospitals, *clinics or urgent care by type*

   Select one of these options.
4) Then follow the prompts. The provider list generated will include if the provider is accepting new patients, if they have languages in addition to English and their areas of focus. You can refine the search using the filters or change the search area to closer or further away from where you are.

Once you register with Regence.com or through the app, the providers listed will be specific to your plan and will indicate if they are in your plan's tier 1 network.

PLAN SUMMARY

SCHS ACCOUNT FUNDING	CAREGIVER DIRECTED HEALTH PLAN	PRIME PPO PLAN	SELECT PPO PLAN
Health Fund Account?	Health Savings Account	None	Health Reimbursement Account
SCHS Annual Dollars into the Account	Caregiver Only: $800 Caregiver & Spouse or Family: $1,600 Caregiver & Children: $2,100 Note: HSA contributions are half for those who work fewer than 60 hours per pay period	None	Caregiver Only: $1,800 Caregiver & Spouse or Family: $2,400 Caregiver & Children: $2,900
Annual Engage for Health Reward	Paid at the beginning of the calendar year based on completion of required tasks in prior year Up to $500 for caregiver and an additional $500 for spouse	Paid at the beginning of the calendar year based on completion of required tasks in prior year Up to $500 for caregiver and an additional $500 for spouse	Paid at the beginning of the calendar year based on completion of required tasks in prior year Up to $500 for caregiver and an additional $500 for spouse

MEDICAL BENEFITS	CDHP Tier 1 - SCHS PPO	CDHP Tier 2 - Regence PPO	CDHP Tier 3 - Out-of-Network	Prime Tier 1 - SCHS PPO	Prime Tier 2 - Regence PPO	Prime Tier 3 - Out-of-Network	Select Tier 1 - SCHS PPO	Select Tier 2 - Regence PPO	Select Tier 3 - Out-of-Network
Calendar Year Deductible									
Individual	Individual Only: $1,500			$500	$750	$1,000	$4,000	$5,000	$7,500
Family	Caregiver plus one or more family members: $3,000			$1,500	$2,250	$3,000	$8,000	$10,000	$15,000
Calendar Year Out-of-Pocket Maximum (Included Deductible) What's included in OOP Maximum? Deductible, coinsurance & pharmacy copays									
Individual	$2,700*	$5,000*	$7,500*	$3,000	$5,000	$8,000	$6,500	$7,900	$13,000
Individual with Family	$4,200*	$6,500*	$9,000*	N/A	N/A	N/A	N/A	N/A	N/A
Family	$6,600*	$12,900*	$21,000*	$9,000	$13,200	$24,000	$13,000	$15,800	$26,000
Preventive Care Visits									
Physician Visit	100% deductible waived	100% deductible waived	50% after deductible	100% deductible waived	100% deductible waived	50% after deductible	100% deductible waived	100% deductible waived	50% after deductible
Immunizations	100% deductible waived	100% deductible waived	50% after deductible	100% deductible waived	100% deductible waived	50% after deductible	100% deductible waived	100% deductible waived	50% after deductible
Preventive Screenings and Lab Work	100% deductible waived	100% deductible waived	50% after deductible	100% deductible waived	100% deductible waived	50% after deductible	100% deductible waived	100% deductible waived	50% after deductible
Outpatient Care									
Primary Care Physician Visits	80% after deductible	70% after deductible	50% after deductible	100% after $15 copay per visit, deductible wavied	100% after $35 copay per visit, deductible wavied	50% after deductible	100% after $25 copay per visit, deductible wavied	100% after $60 copay per visit, deductible wavied	50% after deductible
Specialist Visits	80% after deductible	70% after deductible	50% after deductible	100% after $25 copay per visit, deductible wavied	100% after $50 copay per visit, deductible wavied	50% after deductible	100% after $50 copay per visit, deductible wavied	100% after $100 copay per visit, deductible wavied	50% after deductible
Doctor on Demand Virtual Care Visits	100% after the deductible Doctor on Demand providers only			100% deductible waived with Doctor on Demand providers only			100% deductible waived with Doctor on Demand providers only		

*Deductibles and out-of-pocket maximums cross accumulate between network tiers.

MEDICAL BENEFITS	CAREGIVER DIRECTED HEALTH PLAN			PRIME PPO PLAN			SELECT PPO PLAN		
	Tier 1 - SCHS PPO	Tier 2 - Regence PPO	Tier 3 - Out-of-Network	Tier 1 - SCHS PPO	Tier 2 - Regence PPO	Tier 3 - Out-of-Network	Tier 1 - SCHS PPO	Tier 2 - Regence PPO	Tier 3 - Out-of-Network
Diagnostic Testing-Non-Routine Lab and Radiology Services *Independent Lab or x-ray facility*	80% after deductible	70% after deductible	50% after deductible	80%, deductible waived	70%, after deductible	50% after deductible	80% after deductible	70% after deductible	50% after deductible
Diagnostic Testing - Imaging Services (CT/ PET Scans, MRI's) *Pre-authorization required for PET Scan and Spinal MRI's*	80% after deductible	70% after deductible	50% after deductible	80%, deductible waived	70% after deductible	50% after deductible	80% after deductible	70% after deductible	50% after deductible
Urgent Care	80% after deductible	80% after deductible	80% after deductible	100% after $15 copay per visit, deductible wavied	100% after $50 copay per visit, deductible wavied	70% deductible waived	100% after $25 copay per visit, deductible wavied	100% after $60 copay per visit, deductible wavied	50% after deductible
Emergency Room Visits	80% after deductible	80% after deductible	80% after deductible	100% after $100 copay, deductible waived			100% after $300 copay, deductible waived		
Acupuncture and Spinal Manipulations Limited to combined $1,500 per calendar year	N/A	100% after deductible	50% after deductible	100% after $25 copay per visit, deductible waived	100% after $25 copay per visit, deductible waived	50% after deductible	Not Covered		
Physical, Occupational, Speech, Massage, Cardiac & Pulmonary Therapy, Speech, Cardiac, Vision & Pulmonary Therapy Limited to combined 50 visits per calendar year	80% after deductible	80% after deductible	50% after deductible	100% after $25 copay per visit, deductible wavied	100% after $25 copay per visit, deductible wavied	50% after deductible	100% after $50 copay per visit, deductible wavied	100% after $100 copay per visit, deductible wavied	50% after deductible
Outpatient Facility	80% after deductible	70% after deductible	50% after deductible	80% after deductible	70% after deductible	50% after deductible	80% after deductible	70% after deductible	50% after deductible
Inpatient Care									
Inpatient Facility	80% after deductible	70% after deductible	50% after deductible	80% after deductible	70% after deductible	50% after deductible	80% after deductible	70% after deductible	50% after deductible
Professional Care	80% after deductible	70% after deductible	50% after deductible	80% after deductible	70% after deductible	50% after deductible	80% after deductible	70% after deductible	50% after deductible
Behavioral Health									
Outpatient Professional	80% after deductible	70% after deductible	50% after deductible	100% after $15 copay per visit, deductible wavied	100% after $15 copay per visit, deductible wavied	50% after deductible	100% after $25 copay per visit, deductible wavied	100% after $25 copay per visit, deductible wavied	50% after deductible
Doctor on Demand Virtual Care Visits	100% after deductible with Doctor on Demand providers only			100% deductible waived with Doctor on Demand providers only			100% deductible waived with Doctor on Demand providers only		
Inpatient or Residental Care	80% after deductible	70% after deductible	50% after deductible	80% after deductible	70% after deductible	50% after deductible	80% after deductible	70% after deductible	50% after deductible
Partial Day Treatment	80% after deductible	70% after deductible	50% after deductible	80% after deductible	70% after deductible	50% after deductible	80% after deductible	70% after deductible	50% after deductible

PRIOR AUTHORIZATION – MEDICAL CARE

There are some services that both you and Regence want to know are medically necessary and covered by the Plan before care is provided. This includes certain surgeries, genetic testing, home health care, inpatient rehabilitation, inpatient and residential behavioral health care, specialty medications and high cost screenings (spinal MRI's and PET scans). The process works like this:

1. Your provider recommends care that needs prior authorization
2. Your provider sends information to Regence that describes what they are recommending, why and what other care may have already been tried
3. Regence's medical managers review the information, and if it meets their criteria, they approve the care
4. Notice of approval is sent to the provider and the patient
5. You schedule your services and receive the care

If the care is denied, Regence will provide a detailed explanation as to why and include their criteria for approval. Before issuing a denial, a Regence physician also reviews the case to provide an additional layer of oversight. If the care is not approved the next steps are:

1. Ask your physician to have a doctor-to-doctor conversation with Regence's physician. This can clear up questions, allow your physician to explain why the care is needed and what else has been tried.
2. You have the right to appeal the decision to Regence twice. On appeal, you will need to provide any additional information that proves the care is needed and meets Regence's criteria. You may need to get additional information from your provider or try other alternatives. Be sure to follow the instructions and timelines in the denial letter.
3. If after the second appeal the care is still denied, you have the right to review by an independent medical reviewer who is a specialty-matched physician not affiliated with Regence. Their decision is final.

PRIMARY CARE PROVIDER

Your Primary Care Provider (PCP) is the quarterback of your care – the hub for everything related to your health. That means that your PCP is an expert in your health goals. They help you navigate the health care system, translate test results and work with specialists when you need them to make sure you are getting the best in coordinated care. Your PCP is your partner in health and your biggest health care advocate – they make sure you get better, more personalized care.

We think it is important for everyone to have a PCP to provide support and care coordination, so we encourage you to select a physician and have a routine visit to establish your relationship. Examples of primary care physician types are internal medicine, family practice, or pediatricians for your children.

THINGS TO CONSIDER WHEN CHOOSING YOUR MEDICAL PLAN

Here is a handy chart that can help point you in the right direction when making your plan election:

CAREGIVER DIRECTED HEALTH PLAN (CDHP) WITH HSA	PRIME PPO PLAN	SELECT PPO PLAN WITH HRA
Premium: $$ **Deductible: $$**	**Premium: $$$** **Deductible: $**	**Premium: $** **Deductible: $$$**
Good choice if: • You prefer a higher deductible which enables you to pay less out of your paycheck • You would like to plan for the future by opening a tax-favored Health Savings Account, and you like that you own the account • You can plan for your health care needs and put funds into the Health Savings Account to cover them • You want coverage for weight loss surgery, TMJ or alternative care including acupuncture and chiropractic	Good choice if: • You like a lower deductible and are willing to pay more out of your paycheck for it • You have a lot of ongoing health care needs and are uncomfortable with having to pay expenses and be reimbursed from a SCHS funded account • You prefer predictable office visit and prescription drug copays • You want coverage for weight loss surgery, TMJ or alternative care including acupuncture and chiropractic	Good choice if: • You don't have a lot of health care needs and you are comfortable with a high deductible plan with low amounts out of your paycheck • You like that the high deductible is offset by the health reimbursement account dollars, and that you can accumulate the funds over time • You prefer predictable office visit and prescription drug copays • You are fine without coverage for weight loss surgery, TMJ or alternative care including acupuncture and chiropractic • You are comfortable with the provider choices in the more restrictive Tier 1 Select PPO network

HOW DO YOU DECIDE?

How do you ultimately decide which plan to select? Once you consider the differences in the network, how the CDHP works (particularly for those with medications) and how much health care you usually use, or are anticipating, typically your decision comes down to minimizing what comes out of your pocket if you have some expensive health care needs. Here is a quick outline of the financial differences for each plan based on deductible, SCHS contributions into the HSA or HRA, care provided by Tier 1 providers, and your payroll deductions.

Please note: the payroll deductions in this example are based on full-time premiums.

Scenario 1 – Caregiver Only Coverage	CAREGIVER DIRECTED HEALTH PLAN	PRIME PPO PLAN	SELECT PPO PLAN
Difference in deductible after SCHS account funding			
Calendar Year Deductible	$1,500	$500	$4,000
SCHS Dollars into an Account	$800 into an HSA	None	$1,800 into an HRA
Balance of Deductible to meet after applying SCHS account funds	$700	$500	$2,200
Difference in payroll deductions per year			
Annual Payroll Deductions	$948.24	$1,949.88	$129.96
How the payroll deductions compared with the CDHP Plan	Same	+$1,001.64	-$818.28
How the payroll deductions compare with the Prime PPO Plan	-$1,001.64	Same	-$1,819.92
How the payroll deductions compared with the Select PPO plan	+$818.28	+$1,819.92	Same

Scenario 2 – Caregiver and Family (Spouse & Children) Coverage	CAREGIVER DIRECTED HEALTH PLAN	PRIME PPO PLAN	SELECT PPO PLAN
Difference in deductible after SCHS account funding			
Calendar Year Deductible	$3,000	$500 per individual, but no more than $1,500 for all family members combined	$4,000 per individual, but no more than $8,000 for all family members combined
SCHS Dollars into an Account	$1,600 into an HSA	None	$2,400 into an HRA
Balance of Deductible to meet after applying SCHS account funds	$1,400	If 3 individuals in the family meet the deductible: $1,500 If 2 individuals in the family meet the deductible: $1,000 If one individual in the family meets the deductible: $500	If 2 individuals in the family meet the deductible: $5,600 If 1 individual in the family meet the deductible: $1,600
Difference in payroll deductions per year			
Annual Payroll Deductions	$3,667.80	$6,609.48	$1,452.24
How the payroll deductions compared with the CDHP Plan	Same	+$2,941.68	-$2,215.56
How the payroll deductions compare with the Prime PPO Plan	-$2,941.68	Same	-$5,157.24
How the payroll deductions compared with the Select PPO plan	+$2,215.56	+5,157.24	Same

Virtual Care

DOCTOR ON DEMAND – 24/7 DOCTOR VISITS

If you are covered on one of our medical plans, you have access to virtual physician visits 24/7/365. Care is provided through Regence's partnership with Doctor on Demand. You can also use Doctor on Demand for behavioral health care. All providers are board certified physicians and licensed providers who provide care when and where you need it – from the privacy of your home, car or office. SCHS covers the cost of your visit at 100% for the Select or Prime PPO plans. The CDHP will pay 100% after the deductible is satisfied. Doctor on Demand providers can treat most urgent care needs like:

Cough	Urinary tract infections	Stomach aches
Headache	Rashes	Flu (non-COVID)
Respiratory issues	Eye infections	And more!

You can have a visit by video conference (skype or facetime) or phone, and you can provide photos of rashes or eye infections. Simply download the App for your smartphone or access them through the web at **www.doctorondemand.com**. Doctor on Demand physicians can prescribe medication, sending the prescription to the pharmacy of your choice.

HOW TO SET UP A DOCTOR ON DEMAND VISIT:

- Call 800-997-6196, go online to **www.doctorondemand.com** or use their smartphone app.
- Have your ID card handy to verify your plan
- If this is your first visit, you will need to provide a short health history, or you can pre-register so this step is already taken care of!
- The physician will call you, usually within 20 minutes, by your choice of phone or video chat. You can also make an appointment for the time that works best for you. If you are scheduling a behavioral health visit, you will always make an appointment.

DOCTOR ON DEMAND BEHAVIORAL HEALTH CARE

In addition to medical care issues, you can also receive behavioral health counseling through Doctor on Demand. Just as with in-person visits, you can select your provider and have regular virtual sessions by video. They have a variety of provider types available who can provide talk therapy or medication management, or both! It usually takes between 1 and 3 days to schedule an appointment, and while this care is not available 24/7, there are expanded hours, with appointments available 7 days a week. You can visit the Doctor on Demand site or app and select the provider that best fits your care criteria prior to making your appointment.

HINGE HEALTH - VIRTUAL PHYSICAL THERAPY

Hinge Health provides all the tools you need to get moving again from the comfort of your home. You'll get exercise therapy tailored to your condition, wearable sensors for live feedback in the app, and a personal coach and a physical therapist. All at no cost to you or your eligible family members over age 18. This program can help:

- Those who need to conquer joint or muscle pain, or limited movement
- Recovery from a past injury or surgery
- Reducing stiffness in achy joints

Join for your back, knee, hip, neck, pelvic floor disorder or shoulder issues. To learn more call 855-902-2777, or apply after January 1, 2023 at **www.hingehealth.com/stcharles2023**

Health Support Programs

REGENCE HEALTH SUPPORT AND OTHER PROGRAMS

You will now have some new and exciting health support services, virtual care options and discount programs through our partnership with Regence. Following is an overview of these programs and services, who might benefit from them, and how to access them.

Livongo – Health Support for diabetes, pre-diabetes and high blood pressure

If you are living with diabetes or high blood pressure, you are keenly aware of how difficult it can be to monitor your glucose or blood pressure to keep your readings in normal ranges. Or maybe you are carrying a few extra pounds that put you at risk for diabetes. The Livongo program supports you to keep your readings in normal range, or help you lose weight so you don't become diabetic. If you qualify, you will receive:

- Personal health support from expert coaches
- Strategies to help make needed behavior changes
- Connected technology that delivers real-time results and remote monitoring
- Continuing education and content support

Participation is voluntary and you can opt out at any time. It is no cost to you or your eligible family members. Livongo will reach out to anyone who meets their participation criteria (based on claim data).

Regence Digital Connections – at Regence.com or from their smartphone App

The experience is the same whether you access through the website or App. Everything you need is in one place. Check your claims, view your benefits, find in-network providers, view your health care history, and chat with customer service. All of this is right from your own home screen – a convenient way to take care of yourself and save money along the way. One added feature of the app is that it includes a digital member ID card for easy access on the go.

GET STARTED!

Download the Regence app or go to regence.com to create an account. All you need is your member ID card to get started.

Care Management Plus

If you are facing a complex or sudden medical issue, the Regence case managers – experienced registered nurses and social workers – are here to answer questions and make sure you get the care you need. You will be paired with a single nurse who will act as your advocate, advisor and guide. They will partner with you and your physician to support your treatment plan based on your needs, support system and benefits. They take a holistic view of your health, looking at how all the pieces of your care experience work together.

In addition to complex and sudden issues, if you are managing a chronic disease you can benefit from an advocate who puts your care needs first. Your personal care nurse can help set up care conversations, help make appointments and answer your questions. They will work behind the scenes to address any potential gaps in care and to ensure you get the right care at the right time. This service is for caregivers and your covered family members.

REASONS REGENCE WILL REACH OUT

- You had a recent hospital stay
- You are preparing for a hospital stay
- You have a chronic condition
- We notice a gap in your care
- We want to share important information about a health condition
- You have had multiple hospitalizations or ER visits
- Your child has a NICU or PICU admission
- You are scheduled for, or are on the list for, a transplant

WHAT REGENCE CAN DO TO HELP

- Offer support, information and resources
- Coordinate complex care needs
- Answer questions about benefits and health conditions
- Make sure you are getting the right services, at the right time and place
- Work to establish the right care team through our single-nurse model
- Help manage a complex or chronic condition

Regence Advantages – Discount Programs

One advantage to being a Regence member is that you have access to discounts for many types of services. Here is a sample of the services where Regence has partnered to provide discounted and low cost services, outside our health plan benefits:

- Gym memberships
- Complementary and alternative care
- Vision care including Lasik surgery
- Hearing exams and aids
- Over the counter health and wellness products
- Fitbit – up to 20% off Fitbit smart watches and trackers, plus FB Premium at no cost
- Fun activities like skiing, sporting events, museums, etc.
- Weight management programs through Optavia and Jenny Craig
- Pet care through Banfield Pet Hospitals
- Funeral planning
- Home delivered meals and nutrition services
- Infertility care

To access your discounts, visit regence.com or view through your smartphone app. For more details, see the flyer posted on caregiver.net under the "explore St. Charles/Health Plan Administration/Regence" page.

Prescription Drugs

PHARMACY BENEFITS

	CAREGIVER DIRECTED HEALTH PLAN			PRIME PPO PLAN			SELECT PPO PLAN		
	SCHS Community Pharmacy	CVS Caremark Retail Pharmacy	CVS Caremark Mail Order Pharmacy	SCHS Community Pharmacy	CVS Caremark Retail Pharmacy	CVS Caremark Mail Order Pharmacy	SCHS Community Pharmacy	CVS Caremark Retail Pharmacy	CVS Caremark Mail Order Pharmacy
Maximum Days Supply	30 days or 90 days with 2.5x copay	30 days	90 days 30 days for specialty	30 days or 90 days with 2.5x copay	30 days	90 days with 2X copay 30 days for specialty	30 days or 90 days with 2.5x copay	30 days	90 days with 2X copay 30 days for specialty
Medical Deductible Applies?	Yes			No			No		
Generic**	100% after $5 copay	80% after deductible	80% after deductible	100% after $5 copay	100% after $10 copay	100% after $20 copay	100% after $5 copay	100% after $10 copay	100% after $20 copay
Preventive Generic/ Brand Drugs	Generic 100% no deductible Brand 100% after $20 copay, no deductible	80% after deductible	100% generic, 80% brand, no deductible	Regular copays apply	Regular copays apply	Regular copays apply	Regular copays apply	Regular copays apply	Regular copays apply
Preferred Brand	100% after $20 copay	80% after deductible	80% after deductible	100% after $30 copay	100% after $40 copay	100% after $80 copay	100% after $30 copay	100% after $40 copay	100% after $80 copay
Non-Preferred Brand	100% after $40 copay	80% after deductible	80% after deductible	100% after $50 copay	100% after $60 copay	100% after $120 copay	100% after $50 copay	100% after $60 copay	100% after $120 copay
Specialty Medications	100% after $100 copay	80% after deductible	80% after deductible	100% after $100 copay	100% after $150 copay	100% after $150 copay	100% after $100 copay	100% after $150 copay	100% after $150 copay

**Generic are required for medications where there is a generic alternative. If a brand is dispensed the patient will pay the difference in price between the brand and the generic, plus the brand copay. If there is a valid medical reason why the patient cannot take the generic drug, you may appeal to CVS Caremark and if approved, the penalty will be waived.

FORMULARY – PREFERRED BRAND DRUGS

Understanding your options when it comes to choosing your medications can help save you money. Generic medications are the lowest cost drugs and have the least cost sharing on our pharmacy plans. We have worked with CVS Caremark to create our preferred drug list (also called a formulary) to help you and your doctor when making decisions about which medications may be right for you. Before a drug is added to the CVS Caremark preferred drug list it is carefully evaluated by a team of physician and pharmacists. How effective is it? It is safe? Will it improve health? Are there other medications on the market that do the same thing, but cheaper and effectively? By choosing a preferred drug option you are choosing a lower copay or a lower cost medication. Non-preferred brand drugs are not in our formulary, so while you are free to use them, your cost will be higher. You can check to see if your medications are preferred by viewing the formulary list on the CVS website at:

https://www.caremark.com/portal/asset/Advanced_Control_Formulary.pdf

MAINTENANCE MEDICATIONS – HOW TO GET 90 DAYS SUPPLY

Many of the medications you take on a regular basis may be available for purchase 90 days at a time at either the St. Charles Community Pharmacy or through the convenience of home delivery through CVS Caremark. Both options save you trips to the pharmacy and money through lower drugs costs or copays.

PHARMACY MAIL ORDER – HOME DELIVERY THROUGH CVS CAREMARK

Home delivery is the most convenient way to get your maintenance medications. You can have a 90 day supply shipped to your home and you pay less than if you purchased it at a retail pharmacy 30 days at a time. The convenience of home delivery is a plus and you will receive refill reminders so you are never without your needed medications. Mail order is for drugs that you take regularly such as for treatment of high blood pressure, diabetes (including test strips and lancets), cholesterol, thyroid, depression, birth control and more. You can ask your provider to call in your refills to the CVS Caremark home delivery pharmacy, or call the CVS Caremark customer service number for assistance setting up your home delivery.

PRIOR AUTHORIZATION AND STEP THERAPY

Some medications are high cost and are not necessarily more effective. There are some medications that will require authorization prior to being dispensed. This is to ensure that you have tried lower cost and more proven treatments before using the higher cost medications. If you have not tried these treatments, CVS Caremark will work with you and your physician to have you try these medications first. This is called step therapy. You will be informed of the need for prior authorization or step therapy from your pharmacist when you fill the prescription. CVS Caremark will work with your physician to get the needed documentation to review the medication for coverage.

Dental Benefits

DELTA DENTAL OF OREGON (A MODA HEALTH COMPANY)

Our dental plan is through Delta Dental of Oregon and includes a nation-wide network of providers through their Delta Dental network. These dentists have agreed to provide care at a contracted, discounted fee. This saves money for both the plan and the patient, so we encourage you to use a Delta Dental network provider.

LOCATING A DELTA DENTAL NETWORK DENTIST IS EASY:

Visit their website at **www.deltadentalor.com** and click on "find a dentist", or call them at **888-217-2365**.

Preventive dental care is an important part of your overall health. Good oral health can reduce your risk of heart attack, pre-term labor for pregnant women, and can improve blood sugar control for diabetics. Our dental plan provides preventive care at 100% and the preventive care you receive does not go towards your annual benefit maximum. It is also the pathway for an annual increase (or to maintain your benefit level once you reach 100%) in coverage for basic services. You must have preventive and diagnostic services at least once per calendar year to increase to the next coverage level. If you don't, in the next calendar year coverage for basic services will drop to 70%.

Following is a summary of our dental plan:

BENEFIT	DELTA DENTAL NETWORK DENTIST	OUT-OF-NETWORK DENTIST*
Calendar Year Deductible Individual Family	Only applies to Major Services $25 $75	
Calendar Year Benefit Maximum	$2,000 per covered individual Does not include preventive care	
Class I – Preventive Care* Routine oral exam Cleanings Bitewing x-rays Fluoride treatment	100%	100%
Class II-Basic Services Fillings Root Canal Therapy Periodontal Therapy Oral surgery	You must have preventive care to increase your benefit % each year First Year: 70% Second Year: 80% Third Year: 90% Fourth Year: 100%	You must have preventive care to increase your benefit % each year First Year: 70% Second Year: 80% Third Year: 90% Fourth Year: 100%
Class III-Major Restorative Crowns Bridges Dentures Implants	50%	50%
Class IV-Orthodontia Children and Adults	50% to $3,000 per covered individual, lifetime	

*Out-of-Network dentists will be paid based on the 90th percentile of Usual, Customary and Reasonable (UCR). UCR is based on the amount providers in a geographic area usually charge for the same or similar services. The 90th percentile means that in 90% of cases what the dentist charges will be within the range of the UCR. Any amount charged by an out-of-network dentist over the UCR may be charged to the patient.

Vision Benefits

VISION SERVICE PLAN

Vision Service Plan (VSP) has a large nation-wide provider network. The VSP plan has two levels of coverage: VSP in-network benefits and out-of-network benefits. The Plan will pay a lot more if you use a VSP provider. VSP also offers member discounts (e.g. annual contact lens supply discount, additional savings on eyewear) through Eyeconic, their online eyewear website. If you use a VSP provider, they will only collect your copays and cost sharing at the time of service. They will also take care of filing your claim.

When you are ready to visit a VSP provider, simply:

- Choose your VSP provider and schedule an appointment
  - They will need the name, birth date and last four digits of the caregiver's social security number
- Attend your appointment
- The provider will file the claim and take care of all the paperwork
- You pay any out-of-pocket costs to them and you are done!

LOCATING A VSP PROVIDER IS EASY:

Simply visit **www.vsp.com**, set up a login and password by clicking on the "Member" tab. Once you are logged in you can:

- View your benefits, find an in-network doctor and much more
- Find a VSP network provider by: input your zip code or address then click "Search". You will see a list of providers by distance from your address or zip code.

LightCare

Another advantage to VSP is that you can use your annual lens and frame benefit to purchase ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts.

Vision Therapy

The vision therapy benefit with VSP provides treatment for members having severe visual problems associate with sensory and/or muscular deficiencies of the vision system. Coverage is limited and subject to prior authorization and approval by VSP. If the patient meets the benefit criteria for vision therapy, the VSP network doctor will submit a verification form to VSP to obtain Benefit Authorization.

Coverage for in network vision therapy will include the following:

SENSORIMOTOR EXAMINATION

VSP pays up to a maximum of $85 per service year for one approved sensorimotor exam. Doctors may not balance bill the patient for any amount over that approved by VSP. The $85 maximum will not go towards the yearly training allowance.

ORTHOPTIC AND/OR PLEOPTIC TRAINING (THERAPY SESSIONS)

The maximum vision therapy allowance is $750 per service year. VSP will pay 75% of the allowable amount for approved therapy sessions up to the $750 limit. The patient is responsible for the remaining 25%. Additional sessions not approved by VSP, or after $750 are handled privately between the doctor and the patient.

Out-of-network benefits will be limited to in network reimbursement rates and are subject to Benefit Authorization and VSP criteria.

Following is a summary of our vision plan options:

BENEFIT	VISION SERVICE PLAN	
Provider Type	**VSP Choice Network Provider**	**Out of Network Provider**
Well Vision Exam	Covered in Full Contact lens exam covered in full after no more than a $60 copay	$70 allowance Contact lens exam is not covered
Frequency of Well Vision Exam, Lenses and Frames	One per calendar year	
Frames	$250 allowance $270 allowance for featured frame brands 20% savings on any amount over the allowance $135 allowance at Costco or Walmart Covered in full for children under age 19 **LightCare**: $250 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts*	$115 allowance for frames **LightCare**: $115 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts
Lenses Single Vision Lined Bifocals Lined Trifocals Progressive lenses	Covered in full	$30 allowance $50 allowance $65 allowance $50 allowance
Lens Enhancements Anti-Glare coating Scratch resistant coating Impact Resistant lenses UV, High Index, Photchromic (children under 19 only) All other lens options	Covered in full Covered in full Covered in full Covered in full Average 30% discount	Not covered
Contact Lenses (Instead of glasses)	$250 allowance Covered in full for children under age 19	$200 allowance
Extra Savings Prescription Glasses & Sunglasses	20% discount from any VSP provider within 12 months of your last well vision exam	None
Laser Vision Correction Discount	Average 15% discount off regular price or 5% off promotional price from VSP contracted facilities	None

*LightCare benefits are not available at Walmart. LightCare glasses purchased from Costco will be limited to $135.

Tax-Free Accounts

SCHS offers a choice of three medical plans designed to provide for you and your family's health care needs. Each of our medical plans can be paired with a different type of tax-free account to help you manage your out-of-pocket expenses. We partner with Fidelity, who administers all of our tax-favored accounts: Flexible Spending, Health Reimbursement and Health Savings Accounts. Here are the accounts paired with each of our medical plans:

- Caregiver Directed Health Plan (CDHP): paired with a Health Savings Account (HSA) and a Limited Purpose Flexible Spending Account
- Prime PPO Plan: paired with a Health Care Flexible Spending Account
- Select PPO: paired with a Health Reimbursement Account and a Health Care Flexible Spending Account

Caregivers can also participate in the Dependent Care Flexible Spending Account regardless of their medical plan choice.

FLEXIBLE SPENDING ACCOUNTS

You are allowed to participate in the health care FSA even if you are not enrolled in our medical plan, and you may use the funds to pay expenses for your eligible family members, even if they are not enrolled in the SCHS medical plans.

To help you save money on out-of-pocket health and dependent care expenses, SCHS offers you participation in our Health Care and Dependent Care Flexible Spending Accounts (FSA). These accounts allow you to have funds taken out of your paycheck before taxes to help you pay for qualifying health and dependent care expenses. Participation is optional and you may enroll on your benefits eligibility date, annually during open enrollment, or if you have a qualified change in status.

Our FSA's are administered by Fidelity who will track your elections and manage reimbursements when you have expenses you wish to claim against your FSA. Our plan runs from January through December, so your funds must be used to pay for eligible expenses with service dates between January 1 and December 31. You will have 105 days at the end of the year to submit your expenses for reimbursement.

When making your FSA election, keep in mind that the funds are use it or lose it, meaning that you must use up the funds in your account by the end of the year. The exceptions are the Health Care and Limited Purpose FSAs, where you can roll over up to $610 into the next plan year. All other funds will be forfeited. Remember, you are not allowed to use health care funds to pay daycare expenses, or daycare funds to pay health expenses.

Health Care FSA – Select and Prime PPO

If you elect to participate in our Health Care FSA, you can have up to $3,050 taken out of your paycheck pre-tax to pay for qualified out-of-pocket medical, dental and vision care expenses. The amount of your election will be deducted from your paycheck in 26 equal installments, but the entire amount is available for you to access from the first day of coverage. This means that you can use your entire election to pay for qualified expenses at any time during the plan year even if the full amount has not been paid in.

You can only use your funds for qualified expenses that are allowed by the IRS. For a complete list of eligible expenses, go online to the IRS website and view their "Publication 502" at: **www.irs.gov/forms-pubs/about-publication-502** or call Fidelity at **800-343-0860**.

Here's a short summary of some of the things you can use your FSA funds to pay for:

- Medical or dental plan deductible
- Copays for medical or pharmacy expenses
- Coinsurance for medical, pharmacy or dental expenses
- Dental expenses in excess of your annual plan maximum
- Orthodontia expenses not paid by your dental plan
- Glasses or contacts expenses not paid by your vision plan
- Laser eye surgery
- Chiropractic or medically necessary massage therapy not covered by your plan
- Over the counter medications (like allergy, acid reflux or pain medications)
- Contact lenses and contact lens solution
- Band-Aids and other first aid supplies
- Reading glasses
- Pregnancy tests
- Menstrual products
- Thermometer
- Vitamins and supplements with a prescription from your doctor

Health Care Limited Purpose FSA (LPFSA) – CDHP Enrollees Only

If you are on the CDHP medical plan and elect to participate in our LPFSA, you can have up to $3,050 taken out of our paycheck pre-tax to pay for qualified out-of-pocket **dental and vision care expenses only**. The amount of your election will be deducted from your paycheck in 26 equal installments, but the entire amount is available for you to access from the first day of coverage. This means that you can use your entire election to pay for qualified expenses at any time during the plan year even if the full amount has not been paid in.

Dependent Care FSA

If you elect to participate in our Dependent Care FSA, you can have up to $5,000 per household, ($2,500 if married filing separately), taken out of our paycheck pre-tax to pay for qualified daycare expenses. The amount of your election will be deducted from your paycheck in 26 equal installments, and you can only claim what has been deducted.

You can use the dependent care FSA to pay for day care expenses that allow you and your spouse to work, attend school full time or look for work. If this criteria is not met, your DCFSA funds will be taxed. You can use the funds to pay for the dependent care costs of your children under age 13 who you claim as a dependent on your taxes, and some adult or elder care costs for a tax dependent.

Eligible expenses include:

- Daycare
- Pre-school
- Before and after school care
- Day camps
- Adult daycare facilities
- Wages paid to a nanny in or outside your home

Note: If you terminate your employment with SCHS, your FSA contributions will automatically stop. You can continue to submit claims for reimbursement up to the year-to-date amount you have in your account, provided the expenses are incurred in the current plan year and prior to your termination date. For the health care FSA, both regular and limited purpose, you may be able to continue your contributions on an after-tax basis through COBRA continuation or by having the remaining annual amount deducted pre-tax from your final paycheck.

HEALTH REIMBURSEMENT ACCOUNT (HRA) – SELECT PPO PLAN ONLY

If you are enrolled in the Select PPO Plan you will be automatically enrolled in the SCHS HRA benefit plan. An HRA is an account where only SCHS can add funds. SCHS will fund your HRA at the beginning of each year and you can only use these funds to pay for your medical and pharmacy plan deductible, copays or coinsurance. You cannot use the HRA for dental, vision or expenses not covered by the medical plan.

The contribution into your HRA depends on who you choose to cover on our Select PPO plan.

IF YOU COVER:	WE WILL PUT $ IN YOUR HRA:
Caregiver Only	$1,800
Caregiver and Child(ren)	$2,900
Caregiver and Spouse or Family	$2,400

You are allowed to roll over any unused HRA funds from year-to-year to a maximum of $6,500 individual or $13,000 family. Contributions for those hired mid-year will be prorated.

Your HRA is only active as long as you continue to be covered on the Select PPO plan. If you move to a different plan within SCHS, or if you leave SCHS, your HRA account balance is forfeited.

Engage for Health – Additional Funds into your HRA

St. Charles provides an opportunity for you and your spouse to participate in our Engage for Health wellness program that allows you to earn up to $500 each, which may be contributed to your HRA account. Wellness plan rewards earned this year are paid out and deposited into your HRA in January of the next plan year. You must remain in a benefit eligible position through December 31 of the reward earning year. Wellness plan rewards are available for caregivers and spouses enrolled under a St. Charles medical plan through December 31 of the rewards earning year.

How do the FSA and HRA plans work together?

If a caregiver has both an HRA and a health FSA, since they provide coverage for the same medical care expenses, amounts available under the HRA must be exhausted before reimbursement may be made from the health FSA. However, the FSA may reimburse an expense which is not reimbursable by the HRA before the HRA is exhausted.

ACCESSING YOUR FUNDS

Netbenefits Accesscard: Visa Debit Card – Health FSA, LPFSA, HRA or HSA

If you enroll for a health or limited purpose FSA, or have an HRA because you are enrolled in the Select PPO plan, or have an HSA if you are enrolled in the CDHP plan, you will be provided a VISA debit card that will be loaded with funds for each of these account types. We make it easy for you to use your account funds since all of your accounts will be loaded onto one card. Fidelity will keep track of your accounts and the balances. You may use this at your provider's office, to pay provider bills or at the time of care for medical or pharmacy copays, or other qualified out-of-pocket expenses.

Because the use of this plan is governed by the IRS, we have to have proof that what you used your debit card for is allowed by the IRS. So this will require you to send proof to Fidelity when they ask for it – we call it "substantiation". For FSA and HRA, auto-substantiation technology is used to attempt to electronically verify that the transaction meets the IRS rules. If the transaction cannot be auto-substantiated, paper follow-up will be required. In these instances, you will receive a notification from Fidelity Reimbursement Account Services if you need to submit a receipt. Keep your receipts, explanation of benefits or paperwork from your medical, dental or vision provider, or orthodontist so you have them handy. They need to include:

- The name of the patient;
- The name of the provider;
- A description of the service or items purchased;
- The date the services were provided or items were purchased; and
- The charge and/or out-of-pocket expense that was not paid by the Plan or other insurance.

Please note: If you do not submit a requested receipt in a timely manner, your NetBenefits Access card will be turned off until your previous usage can be substantiated.

You don't have to use your debit card – you can pay for services and then file for reimbursement. What you file will need to have the same detail as for substantiating a debit card use, listed above.

HOW TO FILE FSA OR HRA CLAIMS

To access your health, dependent care or HRA funds, or to send in paperwork to substantiate your use of your health FSA, and HRA debit cards, you have four ways to submit for reimbursement or substantiation:

1. Use the App to photograph and submit claims
2. Download a claim form and send in paper through the USPS
3. Download a claim form, scan your paperwork, and send via email
4. File a claim through the secure portal by uploading receipts from there

To make this process easier, we have arranged for Fidelity to have access to your medical, pharmacy, dental and vision plan payments so they can compare your submissions or debit card swipes with the out-of-pocket expenses after the plan payment. This saves you from having to provide explanation of benefit statements or vision plan receipts when you file your claims with Fidelity as they will attempt to electronically verify your expenses.

24/7 ACCESS

Use the mobile application and secure online portal for 24/7 access to information and to manage your FSA, HRA and HSA. Here's how you access the App and the Portal:

- Visit the App store or Google Play and download the NetBenefits App, or
- Go to **https://nb.fidelity.com/public/nb/schs/home** to access the portal from your phone, desktop or tablet.

You can reimburse yourself via direct deposit to a personal bank account, or via check, or you can pay your provider directly by choosing "Pay Someone Else", all done through the Fidelity online portal at **https://nb.fidelity.com/public/nb/schs/home**.

HEALTH SAVINGS ACCOUNT (HSA) – CDHP ENROLLEES ONLY

If you enroll in the CDHP, in most cases you can have a Health Savings Account (HSA). An HSA is a savings account for qualified health care expenses that is triple tax favored. You have to be participating in a qualified high deductible health plan (like our CDHP) in order to have funds put into an HSA. Those funds go in tax free, build tax free and you don't have to pay taxes on the funds when you use them*. You do not have to be participating in a qualified HDHP to take fund out of an HSA, only to put funds into it.

As a savings account, you own the account – once funds are deposited, they are yours! If you leave SCHS you get to keep them. Fidelity administers our HSA which provides you the ability to invest your HSA funds in the family of Fidelity investment accounts. So as your HSA builds, you can earn tax-free by investing the funds in your account.

*HSA funds are not typically taxed when used for IRS allowed health expenses. For a complete list of qualified expenses, refer to the IRS Publication 502. For complete IRS rules for HSA's visit www.irs.gov/publications/p969

Who *cannot* have an HSA?

There are strict rules from the IRS about who is allowed to have funds added to an HSA. You are **not allowed** to put funds into an HSA if:

- You are covered by any other health plan that is not an HSA qualified High Deductible Health Plan
- You are currently enrolled in Medicare or Tri-care
- You are claimed as a dependent on another person's tax return
- You have access to health FSA dollars as an eligible family member under your spouse or parent's health FSA plan (not limited purpose).

If one of these applies to you, you are not eligible for the funding of the HSA, but you can still choose to enroll in the CDHP.

HSA Contributions

The contribution into your HSA depends on who you choose to cover on our CDHP plan and your FTE. Here is the schedule of contributions and the maximum the IRS will allow for 2023, including the SCHS funds:

	SCHS CONTRIBUTION PER PAY PERIOD	SCHS TOTAL ANNUAL CONTRIBUTION (12 MONTHS)	IRS MAXIMUM ALLOWED (SCHS AND CAREGIVER COMBINED)
For those who work 60 to 80 hours per pay period			
Caregiver Only	$30.77	$800	$3,850
Caregiver and Child(ren)	$80.77	$2,100	$7,750
Caregiver and Spouse or Family	$61.54	$1,600	$7,750
For those who work 40 to 59 hours per pay period			
Caregiver Only	$15.38	$400	$3,850
Caregiver and Child(ren)	$40.38	$1,050	$7,750
Caregiver and Spouse or Family	$30.77	$800	$7,750

Contributions are deposited into your HSA 26 times per year. You may also contribute pre-tax dollars through payroll deduction, up to the IRS calendar year maximums listed. If you are over the age of 55 you can save an additional $1,000 per calendar year in catch up contributions. These maximums include the contribution by SCHS.

YOU HAVE TO OPEN AN HSA TO HAVE FUNDS PUT IN!

To have funds added to your HSA, once you enroll in the CDHP, you must go to Fidelity NetBenefits (**https://nb.fidelity.com/public/nb/schs/home**) to open your HSA. Registration and acceptance of the terms and conditions are required before you can receive or make HSA contributions.

Engage for Health – Additional Funds into your HSA

St. Charles provides an opportunity for you and your spouse to participate in our Engage for Health wellness program that allows you to earn up to $500 each, which may be contributed to your HSA account. Wellness plan rewards earned this year are paid out and deposited into your HSA in January of the next plan year. You must remain in a benefit eligible position through December 31 of the reward earning year. Wellness plan rewards are available for caregivers and spouses enrolled under a St. Charles medical plan through December 31 of the rewards earning year.

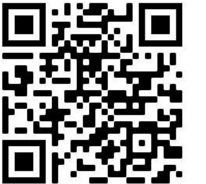
How to get funds out of your HSA

You can pay for qualified medical expenses and reimburse yourself anytime using your HSA money. As long as you opened your HSA before the expense was incurred, your reimbursement will be tax-free. You don't have to send in receipts or explanation of benefits to receive reimbursement, but you will need to keep the proof on file in the event the IRS audits you and needs proof that the funds coming out of your HSA are for qualified expenses. Here are the three ways you can get funds out of your HSA:

- Use your NetBenefits AccessCard (VISA debit card)
- Use Fidelity Track and Pay
- Use Apple Pay
- Use Fidelity BillPay
- Reimburse yourself by transferring funds online from your HSA to your personal bank account using electronic funds transfer, mail yourself a check through the transfer money feature, or write yourself a check from your Fidelity HSA checkbook. You will need to order checks in order to use the check writing feature.

Engage For Health

St. Charles is committed to improving the health and well being of the communities we serve, starting with our own caregivers and their families. Engage for Health is a comprehensive health and wellness program available to all St. Charles caregivers, family and friends, providing a variety of resources and benefits to help you maintain or improve your health and well-being. Engage for Health is completely voluntary and choosing not to participate has no impact on your employment status or health plan enrollment options.



Benefits and Eligibility

Following are some of the benefits available through Engage for Health:

RESOURCE	CAREGIVERS ENROLLED IN A SCHS MEDICAL PLAN	SPOUSES ENROLLED IN A SCHS MEDICAL PLAN	CAREGIVERS NOT ENROLLED IN A SCHS MEDICAL PLAN	CHILDREN AND FAMILY NOT ENROLLED IN A SCHS MEDICAL PLAN
Access to all of the Engage for Health program offerings through a secure portal at www.engageformyhealth.org and the free "Virgin Pulse" app	✗	✗	✗	✗
Tracking tools for sleep, nutrition, physical activity, biometrics, mood and more	✗	✗	✗	✗
Daily health tips	✗	✗	✗	✗
Personalized nutrition and sleep guides	✗	✗	✗	✗
Self-guided digital courses (known as Journeys) to receive daily support on various wellness related goals	✗	✗	✗	✗
Monthly healthy habit challenges	✗	✗	✗	
Headspace Health App	✗	✗	✗	✗
Ability to create and join social groups to connect online with others who have similar wellness interests	✗	✗	✗	✗
On-site (at SCHS) body composition testing	✗	✗	✗	
Wellness Coaching Services	✗	✗	✗	
Ability to earn an annual monetary reward of up to $500 per adult covered on the plan	✗	✗		
Onsite fitness centers	✗		✗	

For more information and to enroll in the wellness program, please create an account on the Engage for Health portal at www.engageformyhealth.org. If you have any questions, you may contact Engage for Health at **541-706-5950** or **engageforhealth@stcharleshealth care.org**.

Ancillary Benefits

BASIC TERM LIFE AND AD&D INSURANCE – UNUM

St. Charles provides basic life and accidental death and dismemberment (AD&D) insurance to benefit eligible caregivers at no cost to you. Coverage begins on the first of the month following 90 days of benefit eligible employment, and you are automatically enrolled when you become eligible for benefits.

Life and AD&D benefit

In the event of your death, the plan will pay your beneficiary:

- One times your annual base pay to a minimum of $35,000 and a maximum of $100,000*
- If your death is due to a covered accident, your beneficiary will receive an additional benefit equal to your life benefit.
  - If the accident results in dismemberment such a loss of limb(s), loss of eyesight, speech or hearing, the plan will also pay a benefit.

*For those whose life coverage is $50,000 or more, the IRS requires you to pay taxes on the premiums paid by SCHS. This is known as "imputed income" and will be added to your paycheck.

Benefits Decrease Starting at Age 70 – Life and AD&D benefits

Your benefit will reduce to 65% at age 70, 45% at age 75, 30% at 80 and 20% at age 85.

Example: One times your annual base pay is $100,000

At age 70, the benefit would reduce to $65,000

At age 75, the benefit would reduce to $45,000

Accelerated Death Benefit

If you are terminally ill, with a life expectancy of 12 months or less while you are covered by the plan, you can receive up to 75% of your life insurance benefit prior to your death. This provides some extra funds for medical bills, household expenses or a gathering of loved ones. This benefit is payable to the caregiver and will reduce the final amount of the death benefit when the caregiver passes away.

PORTABILITY OR CONVERSION

Take your Life and Voluntary Life plan with you when you leave. When you leave St. Charles you may be able to continue your life insurance through portability or conversion. Please contact St. Charles Benefits Team for more information. You must complete the paperwork and pay premiums within 31 days of your employment termination date to continue coverage.

Life and AD&D Beneficiary

You can have your life and AD&D benefits paid to anyone and we encourage you to appoint your beneficiary when you first become covered for life benefits. We also recommend that you review your beneficiary information at least annually, and remember to make changes when you have life events or relationship changes. If you do not appoint a beneficiary, your benefit will be paid in this order:

- Your surviving spouse; if none then
- Your surviving children in equal shares; if none then
- Your surviving parents; if none then
- Your surviving sibling in equal shares; if none then
- Your estate.

VOLUNTARY TERM LIFE AND AD&D INSURANCE

SCHS gives you the opportunity to purchase additional term life and AD&D coverage through payroll deduction, at affordable group rates and without having to prove your good health, up to the defined guaranteed issue amounts, so long as you enroll when you are first eligible. You are eligible for coverage on the first of the month following benefit eligible employment. This coverage is completely voluntary and paid 100% by you with after tax payroll deductions. You can purchase coverage for yourself, your spouse and your children. You have to purchase coverage on yourself to buy any for your eligible family members.

Your salary determines the maximum amount you can purchase and premiums are based on your age. As long as you enroll within 31 days of your initial eligibility date, you can purchase up to the guaranteed amount without having to prove your good health. If you choose to enroll for more, or after your initial eligibility period, you will have to prove your good health by completing an evidence of insurability (EOI) form, and be approved by UNUM. For the AD&D, you never have to prove good health, but if you want coverage, you have to enroll within 31 days of your eligibility date or wait until the next open enrollment.

GUARANTEE ISSUE: LOCK-IN FEATURE

If you purchase at least $10,000 when you are first eligible, you can increase your coverage during our annual open enrollment in increments of $10,000 up to $200,000. For your spouse the increase is in $5,000 increments up to $25,000 and for your children in $2,000 increments up to $10,000.

	CAREGIVER	SPOUSE	DEPENDENT CHILD(REN)
Voluntary Term Life Coverage Amounts	Increments of $10,000 to the lesser of 5 times your annual earnings or $500,000	Increments of $5,000 to the lesser of 100% of the caregiver amount or $500,000	Birth to 6 months: $1,000 6 months to age 26 increments of $2,000 to $10,000
Limitations	Benefits reduce to 65% at age 70, 45% at age 75, 30% at age 80, and 20% at age 85	Caregiver must enroll for spouse to enroll Benefits reduce to 65% at age 70, 45% at age 75, 30% at age 80, and 20% at age 85	Caregiver must enroll for children to enroll. Coverage is provided for unmarried dependent children from live birth to age 19. Unmarried dependent children from ages 19 to 26 are also eligible
Guaranteed Amount and Evidence of Insurability (EOI)	New hires can purchase up to the guaranteed amount of $200,000 with no EOI. Increasing coverage, or electing coverage after initial eligibility requires EOI for all coverage amounts unless exercising the lock-in feature during open enrollment.	New hires can purchase up to the guaranteed amount of $25,000 with no EOI. Increasing coverage, or electing coverage after initial eligibility requires EOI for all coverage amounts unless exercising the lock-in feature during open enrollment.	No EOI required
Voluntary AD&D Coverage Amounts	Increments of $10,000 to the lesser of 5 times your annual earnings or $500,000	Increments of $5,000 to the lesser of 100% of the caregiver amount or $500,000	Increments of $2,000 up to $10,000

VOLUNTARY WHOLE LIFE INSURANCE

Whole Life Insurance provides a fixed coverage amount with premiums and benefits that won't change as you grow older. The policy can build cash value over time — which you can apply toward a paid-in-full life policy or even borrow against later. Other benefits include guaranteed coverage, family options, payments for covered accident-related claims and early payouts for terminal illness.

- Whole Life is the ideal coverage for people who want coverage to stay consistent over their lifetime
- Premium payments and coverage amounts stay consistent throughout the life of the policy as long as you continue to pay the premiums
- You own the policy, so you can keep your coverage even if you leave SCHS by exercising the portability provision

You are eligible for coverage on the first of the month following benefit eligible employment. Coverage is completely voluntary and paid 100% by you with after tax payroll deductions. You can purchase coverage for yourself, your spouse and your children or grandchildren. You have to purchase coverage on yourself to buy any for your eligible family members. As long as you enroll within 31 days of your initial eligibility date, you can purchase up to the guaranteed issue amount without having to prove your good health. If you choose to enroll for more, or after your initial eligibility period, you will have to prove your good health by completing an evidence of insurability (EOI) form, and be approved by UNUM.

	CAREGIVER	SPOUSE	CHILD(REN) OR GRANDCHILD(REN)
Voluntary Whole Life Coverage Amounts	Increments of $2,000 to $300,000	Increments of $2,000 to $75,000	Increments of $5,000 to $50,000
Eligibility	Individual policy available up to age 80	Individual policy available up to age 80	Coverage is from age 14 days to 26 years
Guaranteed Issue (No Evidence of Insurability (EOI) needed)*	EOI is not required for coverage amounts with premiums up to $18 per week. The benefit amount will vary by age	Spouses can purchase coverage amounts with premiums between the $3 weekly minimum and the $10 weekly maximum*. The benefit amount will vary by age.	EOI is not required for coverage amounts with premiums up to $3 per week.

*Spouses will be required to answer one qualifying health question to make an election. A spouse may receive up to $3 weekly premium if UNUM approves their answer to the one question. Additional health questions are required for amounts over the $3 weekly premium.

PAID LEAVE OREGON

What is Paid Leave Oregon?

Paid Leave Oregon is insurance provided by the State of Oregon and funded by employer and employee taxes. You will pay premiums starting January 1, 2023 as required by the State, and benefits will begin on September 3, 2023. Benefits will be provided to Oregon employees who have earned $1,000 in wages working for any Oregon employer during the 12 months prior to their need for the benefit. Paid Leave Oregon will run concurrently with FMLA and OFLA when applicable.

WHAT CAN BENEFITS BE USED FOR?

Paid Leave Oregon provides paid leave to caregivers who need time off due to:

- Your own serious medical condition
- The serious medical condition of a qualified family member*
- Bonding time for the birth, adoption or foster care of a child for the first year after birth or placement
- Safe leave for victims of domestic violence, sexual assault, harassment or stalking (your own or that of your minor child)

*Family members include, spouse/domestic partner, child, parent, sibling, grandchild, grandparent, including in-law and step relationships, and affinity relationships (equivalent to a family relationship).

WHAT ARE THE PAID LEAVE OREGON BENEFITS?

- You can take up to 12 weeks off from work in a 12 month period. In some pregnancy-related situations, you may be able to take up to two more weeks for a total of 14 weeks
- You can take leave for a week, or a single day at a time
- While on leave, Paid Leave Oregon pays you a percent of your wages. The amount depends on how much you earn.
- Your job is protected if you've been with St. Charles for more than 90 days

HOW DOES THE PAID LEAVE OREGON WORK WITH OUR EXISTING STD AND PAID TIME OFF PLANS?

St. Charles will continue to offer STD to eligible caregivers. When receiving STD, you will continue to receive your maximum STD benefit, minus any benefit you are eligible to receive through Paid Leave Oregon. Keep in mind that our STD benefit is a percentage of base pay, and the Paid Leave Oregon is based on total compensation. If your Paid Leave Oregon benefit is higher than your STD benefit, no STD benefit will be paid. You can choose to use earned time off (ETO, PSL, CTO) to supplement your Paid Leave Oregon benefit up to 100% of your base wages.

SHORT TERM DISABILITY INSURANCE

St. Charles provides benefit eligible caregivers short term disability insurance at no cost to you, and you are automatically enrolled on the first of the month following 90 days of benefit eligible employment. Short term disability replaces a portion of your income if you are unable to work due to a non-job related illness or injury. Our plan is administered by UNUM.

You must be disabled and under the care of a physician to be eligible for STD benefits. Benefits begin after 8 calendar days of disability and the plan will pay for up to 26 weeks. Benefits are based on your years of service.

PAYMENT TIMEFRAME	YEARS OF SERVICE	STD BENEFIT*
Weeks 1 through 13	3 months through 3 years of service	66 2/3%
	4 through 9 years of service	75%
	10+ years of service	95%
Weeks 14 through 26	All years of service	60%

*STD benefits are a percentage of earning. Earnings do not include bonuses, overtime pay or any other extra compensation.

LONG TERM DISABILITY INSURANCE

St. Charles provides benefit eligible caregivers long term disability insurance at no cost to you, and you are automatically enrolled on the first of the month following 90 days of benefit eligible employment. Long term disability provides you with income if you are unable to work due to illness or injury. Our LTD plan is insured by UNUM.

Benefits begin once you have been disabled for 180 days and you meet the definition of disability. Once you have been approved for benefits, you will receive 60% of your base pay*, up to a monthly maximum of $5,000. Benefits may continue until age 65 or your Social Security normal retirement age.

*Earnings do not include bonuses, overtime pay or any other extra compensation. Your benefit will be reduced by other sources of income.

VOLUNTARY INDEMNITY PLANS

Included in our benefits package are three plans that will pay you a cash benefit if you contract any of the covered conditions or are hospitalized. These plans, insured by UNUM, provide cash that you can use to pay bills, medical copayments, car payments, rent or mortgage, etc. Carefully consider your needs if you were seriously ill, injured or hospitalized and were not receiving your full pay, or had some high cost medical bills. These plans are designed to provide you with an extra source of income to help in these situations. You are eligible for these plans on the first of the month following benefit eligible employment.

Accident Insurance

This plan will pay a benefit for treatment you need as the result of an accident. The benefit is a set amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur off-the-job, and it includes a range of incidents, from common injures to more serious events. You will receive a lump-sum cash benefit even if you receive benefits from other insurance. Use the benefit however you need – whether for out-of-pocket medical expenses or a vacation to celebrate your recovery – you decide.

You can purchase coverage on yourself, your spouse and/or children. You must enroll in order to cover your spouse and/or children. Benefit payments vary by the covered accident and treatment type. Please refer to the policy and your certificate for all details about the plan and the cost. No benefit will be paid for a date of diagnosis that is prior to your coverage effective date.

EXAMPLES OF COVERED INJURIES AND TREATMENT TYPES THAT WILL RESULT IN A PAYMENT:

- Accidental death
- Ambulance (air & ground)
- Burns
- Coma
- Concussion
- Dislocation
- Fracture
- Treatment in the Emergency Room

Critical Illness Insurance

This plan will pay a benefit if you are diagnosed with a covered illness. You will receive a lump-sum cash benefit even if you receive benefits from other insurance. Use the benefit however you need – the funds are yours to spend as you see fit.

You have a choice of coverage amounts and you can also purchase coverage on your spouse and/or children. You must enroll in order to cover your spouse and/or children. Benefit payments will depend on the covered condition.

Who can get coverage?

You:	Choose $10,000, $20,000 or $30,000 of coverage with no medical questions if you apply when first eligible
Your Spouse:	Spouses can get 50% of your coverage amount
Your Children:	Children from live birth to age 26 are automatically covered **at no extra cost**. Their coverage is 50% of your elected coverage. They are covered for all the same illnesses as the adults, plus these specific childhood illnesses: cerebral palsy, cleft lip or palate, cystic fibrosis, down syndrome and spina bifida. The diagnosis must occur after the child's coverage effective date.

Here are some examples of the covered conditions and the coverage, which is a percentage of the benefit you elect:

Critical Illness:
- Heart Attack (100%)
- Stroke (100%)
- Major organ failure requiring transplant (100%)
- End-stage renal (kidney) failure (100%)
- Coronary artery disease:
- Major (50%): coronary artery bypass graft or valve replacement
- Minor (10%): balloon angioplasty or stent placement

Cancer Conditions:
- Invasive Cancer (including all breast cancer) (100%)
- Non-invasive cancer (25%)
- Skin cancer - $500

Progressive Diseases:
- Amyotrophic Lateral Sclerosis (ALS) (100%)
- Dementia, including Alzheimer's disease (100%)
- Multiple Sclerosis (MS) (100%)
- Parkinson's disease (100%)
- Functional loss (100%)

Supplemental Conditions:
- Loss of sight, hearing or speech (100%)
- Benign brain tumor (100%)
- Coma (100%)
- Permanent Paralysis (100%)
- Occupational HIV, Hepatitis B, C, or D (100%)
- Infectious disease (25%)

Please refer to the policy and your certificate for all details about the plan and the cost. No benefit will be paid for a date of diagnosis that is prior to your coverage effective date, or is as a result of a pre-existing condition if a covered loss occurs during the first 12 months after your effective date. A pre-existing condition is one that, within the 12 months just prior to your coverage effective date, you have an injury or sickness, whether diagnosed nor not for which:

- Medical treatment, consultation, care or service, or diagnostic measurement were received or recommended to be received during that period;
- Drugs or medications were taken, or prescribed to be taken during that period; or
- Symptoms existed

The pre-existing provision does not apply to children who are acquired after your coverage effective date.

Hospital Indemnity Insurance

Hospital insurance helps you and your family cope with the financial impacts of a hospitalization. You receive benefits when you are admitted to the hospital for a covered illness, accident or childbirth. The money is paid directly to you and can you help you pay out-of-pocket expenses your medical plan does not cover, like deductibles, copays or coinsurance.

You can purchase coverage on your spouse, and/or children until their 26th birthday. You must enroll in order to cover your spouse and/or children. Benefit payments will depend on the hospital care received. What's included?

$1,500 for each covered hospital admission – once per year

$100 for each day of your covered hospital stay, up to 15 days – per insured, per calendar year

$200 for each day you spend in intensive care, up to 15 days – per insured, per calendar year

Please refer to the policy and your certificate for all details about the plan and the cost. No benefit will be paid for a date of diagnosis that is prior to your coverage effective date, or is as a result of a pre-existing condition if a covered loss occurs during the first 12 months after your effective date. A pre-existing condition is one that, within the 12 months just prior to your coverage effective date, you have an injury or sickness, whether diagnosed nor not for which:

- Medical treatment, consultation, care or service, or diagnostic measurement were received or recommended to be received during that period;
- Drugs or medications were taken, or prescribed to be taken during that period; or
- Symptoms existed.

The pre-existing provision does not apply to children who are acquired after your coverage effective date.

AIRLINK MEMBERSHIP – AIR AMBULANCE

If you are enrolled in our medical plan, you and your family can elect an AirLink membership which will begin the first of the month following the start of your benefit eligible employment. SCHS pays for memberships for full-time caregivers. Part-time caregivers can purchase an AirLink membership for $1.54 per pay period, which will be payroll deducted pre-tax. You can sign up for an AirLink membership through Workday. Make sure you complete the second step by clicking the AirLink weblink. If you are currently enrolled for AirLink and would like to make changes or updates, go directly to AirLink at: **https://www.airmedcarenetwork.com/businessplanregistration** Coupon Code: 5332-OR-BUS. Note, only dependents enrolled on a SCHS medical plan are eligible for the Airlink membership.

CAREGIVER ASSISTANCE PROGRAM

Our Caregiver Assistance Program provides professional help in dealing with personal concerns that impact you and your family at home or at work. You have access to confidential counseling for issues such as marital conflict, anxiety, depression, drug or alcohol abuse, grief, children's problems, and any other stressors. The confidential counseling services are available to caregivers and their family members by calling 541-706-2768. Services are available between the hours of 8 a.m. and 4:30 p.m. Monday through Friday (excluding holidays).

The Critical Incident Stress Management (CISM) team at St. Charles serves as a support network to provide you and your family crisis intervention with 24/7 access. Examples of appropriate CISM interventions include: suicide, death of a co-worker, serious injuries on the job, significant events involving children, sentinel events, personally threatening situations, or any significant event causing emotional distress. To access the CISM team, call 541-706-2715 and select option 3.

UNUM EMPLOYEE ASSISTANCE PROGRAM (EAP)

UNUM Work-Life Balance EAP can help you find solutions for the everyday challenges of work and home, as well as more serious issues involving your emotional and physical well being. Services are available to caregivers and their families who are covered on our UNUM LTD plan. Call **800-854-1446** for 24/7 access to counseling and other services or go online to **www.unum.com/lifebalance**. They can help you with:

- Child or elder care referrals
- Personal relationships
- Health information and online tools
- Legal consultations with licensed attorney and discounted legal work
- Financial planning
- Stress management
- Career development

ACCESS TO TRAVEL ASSISTANCE IS WORLDWIDE AND IS AVAILABLE 24/7

Within the US: 800-872-1414

Outside the US: (US access code) +609-986-1234

Via email: **medservices@assistamerica.com**

WORLDWIDE EMERGENCY TRAVEL ASSISTANCE

When you travel more than 100 miles from home, you have support from the UNUM worldwide emergency travel assistance program provided by Assist America. This program is available to caregivers who are covered on our long term disability plan and includes coverage for family members. Travel assistance speaks your language, helping you locate hospitals, embassies and other "unexpected" travel destinations when you need help when on the road. Use your travel assistance phone number to locate health care, replace a lost prescription, arrange transportation for a family member to join a hospitalized patient and much more.

LIFE PLANNING FINANCIAL AND LEGAL RESOURCES – FOR THE TERMINALLY ILL

Life planning services are available to beneficiaries and covered caregivers and their spouses who are terminally ill. These services include financial and legal support and grief counseling. Services are available to caregivers and their families who are covered on our UNUM LTD plan. For more information, or to speak with a counselor, call **800-422-5142** (multilingual) or visit the website at **members.healthadvocate.com** and enter UNUM-LifePlanning.

Retirement Plans

WHERE DO I GO FOR HELP?

For more information, or to make changes to your account, log on to **Fidelity NetBenefits** or call **800-343-0860**

If you would like guidance in choosing your investments, call a Fidelity workplace planning and guidance consultant at **800-642-7131**

RETIREMENT SAVINGS PLAN – 403(B)

Our retirement savings plan, under IRS code section 403(b), allows caregivers to save for retirement pre-tax through payroll deduction. Contributions and investment earnings are tax-deferred until the funds are withdrawn. To be enrolled in the plan caregivers must be at least age 18. Our 403(b) plan is administered by Fidelity, who also provides investment options for your funds.

All caregivers are eligible to participate on their dates of hire. After 90 days of employment, all new caregivers are automatically enrolled in the 403(b) program at a contribution rate of 6% of pay. Every April, your contribution will increase 1% of pay until you reach a 10% contribution rate to a maximum of 100% of your eligible pay. You can opt out of these automatic contributions, or change the percentage, by contacting Fidelity directly.

Once you have completed 12 months of service and are employed full or part-time, you will become eligible for employer contributions. The first 6% of pay (per pay period) that you contribute to your 403(b) account will be matched 100% by St. Charles. We have a true-up process in place if you choose to deposit the maximum amount into your 403(b) account at the beginning of the year. This allows you to continue to get the SCHS match throughout the year up to the 6% maximum. The calendar year IRS maximum you can contribute into your 403(b) is $22,500 or 100% of your pay. If you are age 50 and over, you can contribute an additional $7,500 per year in catch up contributions.

We encourage you to take an active role in your account and choose investment options that best suit your goals, time horizon and risk tolerance. You can make an investment election online in Fidelity NetBenefits or by phone at 1-800-343-0860. If you'd like guidance in choosing your investments, call a Fidelity workplace planning and guidance consultant at 1-800-642-7131. If you don't make an investment election, your contributions will be invested in the JP Morgan SmartRetirement Fund with the target retirement date closest to the year you might retire, based on your current age and assuming a retirement age of 65.

Vesting Schedule

Vesting refers to the percentage of your account you are entitled to receive when you are ready to take a distribution of the funds. It is the amount of the funds that you own, or are vested in. Any funds that you contribute, either through payroll deductions or roll overs from previous employers, are always 100% vested, meaning you have access to the entire amount. The value of what SCHS contributes, and any earnings they generate, varies by the years of participation in the plan as follows:

YEARS OF SERVICE	AMOUNT VESTED
1	0%
2	25%
3	50%
4	75%
5	100%

Note: Caregivers must complete 1,000 hours each calendar year in order to receive a year of vesting service.

Withdrawals

Withdrawals from the plan are generally permitted when you terminate employment, retire, reach age 59 1/2, or if you have severe financial hardship. Keep in mind that withdrawals are subject to income taxes and possibly early withdrawal penalties.

Rollovers

If you have funds in another tax favored retirement plan, you may be able to roll them over into our plan, thereby consolidating your retirement plan savings into one account. Only Plan Administrator approved balances from eligible 457(b), 401(k), 403(b), or 401(a) plans or an individual retirement account (IRA) may be rolled over into our 403(b) Retirement Savings Plan. Any distributions you receive prior to age 55 may be subject to the 10% federal penalty for early withdrawal, and you may be required to pay income tax on the funds.

Continuation of Coverage

If coverage for benefits ends due to termination, reduction in hours or job status, divorce or legal separation, or loss of dependent status, you and/or your covered family members may be able to continue your benefits by paying the premiums yourself. This could be through COBRA continuation, or other self pay options. For more information and/or the necessary paperwork, please contact our COBRA administrator, Accrue Cobra Management Services at 866-517-7580 x1 or email **cobrasupport@accruecms.com**. Here are the programs that you can continue after termination:

	WHEN COVERAGE ENDS	HOW TO CONTINUE YOUR COVERAGE
Medical Insurance	Last day of the month in which employment ends, or your family member loses coverage due to divorce, legal separation or loss of dependent status	By electing and paying for COBRA continuation
Dental Insurance	Last day of the month in which employment ends, or your family member loses coverage due to divorce, legal separation or loss of dependent status	By electing and paying for COBRA continuation
Vision Insurance	Last day of the month in which employment ends, or your family member loses coverage due to divorce, legal separation or loss of dependent status	By electing and paying for COBRA continuation
AirLink	Last day of the month in which employment ends, or your family member loses coverage due to divorce, legal separation or loss of dependent status	By contacting AirMedCare Network directly for individual enrollment options
Flexible Spending Accounts	Last day of the month in which employment ends	By electing and paying for COBRA continuation for your health care account only
Basic Life and AD&D	Date of Termination	Contact Human Resources for the necessary forms to port or convert your coverage. You must do so within 31 days of your termination.
Voluntary Life and AD&D	Date of Termination	Contact Human Resources for the necessary forms to port or convert your coverage. You must do so within 31 days of your termination.

Contact Information

Questions About:	CONTACT	PHONE OR CONTACT	WEBSITE
Medical, pharmacy, vision or dental benefits or claims	St. Charles Health Plan Administration	**benefits@stcharleshealth care.org**	**HR Caregiver Portal**
Enrollment or other general benefit questions	St. Charles Human Resources	**benefits@stcharleshealth care.org**	**HR Caregiver Portal**
Medical claims, eligibility and coverage	Regence of Oregon	866-240-9580	**www.regence.com**
Medical Pre-Authorization Services	Regence of Oregon	866-240-9580	**www.regence.com**
Medical PPO Network	Regence of Oregon Blue Card - Blue Cross Blue Shield	866-240-9580	**www.regence.com**
Virtual physician office visit or behavioral health counseling	Doctor on Demand	800-997-6196	**www.doctorondemand.com**
Virtual Physical Therapy	Hinge Health	855-902-2777	**hingehealth.com/stcharles2023**
Prescription claims and eligibility, pre-authorization	CVS Caremark	800-552-8159	**www.caremark.com**
Onsite purchase of prescriptions (up to 90 day supply)	The Community Pharmacy at St. Charles, Bend	541-706-7731	
VSP Vision Plan	Vision Service Plan	800-877-7195	**www.vsp.com**
Dental	Delta Dental of Oregon	888-217-2365	**www.deltadentalor.com**
COBRA	Accrue Cobra Management Services	866-517-7580 x1	**cobrasupport@accruecms.com**
Wellness Program	Engage for Health	541-706-5960	**www.engageforhealth.org**
Flexible Spending Accounts	Fidelity Investments	833-299-5089	**https://nb.fidelity.com/public/nb/schs/home**
Health Reimbursement Account (Select Plan Only)	Fidelity Investments	833-299-5089	**https://nb.fidelity.com/public/nb/schs/home**
Health Savings Account (CDHP only)	Fidelity Investments	800-343-0860	**https://nb.fidelity.com/public/nb/schs/home**

Questions About:	CONTACT	PHONE OR CONTACT	WEBSITE
Life, AD&D, Voluntary Term Life and AD&D	UNUM	866-220-8460	**www.unum.com**
Critical Illness, Whole Life, Accident & Hospital Indemnity Insurance Claims and Customer Service	UNUM	800-635-5597	**www.unum.com**
FMLA/OFLA Leaves, Short and Long Term Disability	UNUM	866-269-0759	**www.unum.com**
Caregiver or family Work-Life Issues	Caregiver Assistance Program	541-706-2768	
Work-Life Balance EAP	UNUM	800-854-1446	**www.unum.com/lifebalance**
Travel Assistance 24/7 Emergency Companion Services	UNUM/Assist America	In U.S. 800-872-1414 Outside U.S. (US access code) +609-986-1234	**www.assistamerica.com** Reference Number: 01-AA-UN-762490
403(b) Retirement Plan	Fidelity Investments	800-343-0860	**https://nb.fidelity.com/public/nb/schs/home**
Life Planning Financial & Legal Services (for terminally ill caregivers)	UNUM	800-422-5142	**members.healthadvocate.com** Enter: UNUM-LifePlanning
Air Ambulance Benefit	AirLink	541-241-4772	

IMPORTANT DOCUMENTS AND NOTICES

Your current Health Plan Documents are available on the Health Plan Administration page of CaregiverNet. These documents include the following:

- Health Plan Summary Plan Description (SPD) – this document provides detailed information on what our health plans provide, what's covered and what's not, and how it operates.
- Summary of Benefits – this document provides a high level summary of our benefits and how the plan will pay for certain services.
- Summary of Benefits and Coverage (SBC) – Under Health Care Reform, the Plan is required to summarize our health plans in this standard format so you can easily compare our plans to others.
- Dental Plan Summary Plan Description – this document provides detailed information on what our dental plan provides, what's covered and what's not, and how it operates.

For our Retirement Plan Summary Plan Description, go to the **HR Caregiver Portal** page of CaregiverNet. If you wish to obtain a paper copy please contact Human Resources at 541-706-7770.

Current Health Plan Notices are available on the Health Plan Administration page of CaregiverNet. The documents include the following items:

- St. Charles Health Plan Summary Annual Report
- Medicare Part D Creditable Coverage Notice
- HIPAA Notice of Privacy Practices
- Notice of Special Enrollment Rights
- Women's Health and Cancer Rights
- Premium Assistance under Medicare and Children's Health Insurance Program (CHIP)

These documents are also available upon request. If you would like a paper copy, please contact Health Plan Administration at 541-706-5980.

IMPORTANT NOTICE FROM ST. CHARLES HEALTH SYSTEM 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 St. Charles Health System 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. St. Charles Health System has determined that the prescription drug coverage offered by the St. Charles Health System Employee Health Care Plan ("Plan") 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 15 to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current St. Charles Health System coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current St. Charles Health System coverage, be aware that you and your dependents will be able to get this coverage back. To regain coverage you would have to re- enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

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 St. Charles Health System and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

Contact the person listed below for further information or call (541) 706-5981.

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 St. Charles Health System changes. You also may request a copy of this notice at any time.

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:	09/30/2022
Name of Entity/Sender:	St. Charles Health System
Contact--Position/Office:	Health Plan Administration
Address:	2500 N.E. Neff Road, Bend, OR 97701
Phone Number:	(541) 706-5980

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

Caregiver
Benefits